STATE OF MICHIGAN

COURT OF CLAIMS

NORTHLAND FAMILY PLANNING CENTER, on behalf of itself, its staff, its clinicians, and its patients; NORTHLAND FAMILY PLANNING CENTER INC. EAST, on behalf of itself, its staff, its clinicians, and its patients; NORTHLAND FAMILY PLANNING CENTER INC. WEST, on behalf of itself, its staff, its clinicians, and its patients; and MEDICAL STUDENTS FOR CHOICE, on behalf of itself, its members, and its members' patients,

Plaintiffs,

v

Case No. 24-000011-MM

Hon. Sima G. Patel

DANA NESSEL, Attorney General of the State of Michigan; MARLON I. BROWN, Acting Director of Michigan Licensing and Regulatory Affairs; and ELIZABETH HERTEL, Director of the Michigan Department of Health and Human Services, each in their official capacities, as well as their employees, agents, and successors,

Defendants,

and

THE PEOPLE OF THE STATE OF MICHIGAN,

Intervening Defendant.

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OPINION AND ORDER

On November 8, 2022, the people of Michigan approved Proposal 3 and explicitly enshrined a right to reproductive freedom in the Michigan Constitution. The Reproductive

Freedom for All amendment (RFFA) is now found in Const 1963, art 1, § 28. Under this constitutional amendment, Michiganders have the fundamental right to reproductive freedom, including the right to abortion care, and the state cannot deny, burden, or infringe upon this freedom barring a compelling state interest to protect the health of the individual seeking care. Additionally, any statute or regulation that denies, burdens, or infringes upon reproductive freedom must only do so in order to protect the patient's health, achieve this goal by the least restrictive means, be consistent with accepted clinical standards of practice and evidence-based medicine, and not infringe upon an individual's autonomous decision-making.

Plaintiffs Northland Family Planning Center, Northland Family Planning Center Inc., East, Northland Family Planning Center Inc., West (collectively "Northland"), and Medical Students for Choice (MSFC) filed this suit for declaratory and injunctive relief. Plaintiffs seek a declaration that four Michigan abortion regulations under MCL 333.17015 and MCL 333.17015a—a 24-hour mandatory waiting period, mandatory uniform informed consent for patients seeking an abortion, mandatory screening for coercion to abort, and a ban on advanced practice clinicians (APCs) performing an abortion (collectively the "challenged laws")—are unconstitutional under the RFFA. Plaintiffs further seek a permanent injunction barring the enforcement of these provisions.[1]

The Court hereby concludes that MCL 333.17015(1), (2)(d)-(g) and (i)-(j), (3)-(10), (11)(a)-(h), (13)-(14), and (18)-(20)—which encompass the mandatory 24-hour waiting period,

[1] On June 25, 2024, the Court preliminarily enjoined defendants from enforcing or implementing all parts of MCL 333.17015 (except MCL 333.17015(11)(i), as implicated by MCL 333.17015a), which includes the mandatory 24-hour waiting period, the mandatory uniform informed consent, and the ban on APCs providing abortion care. The Court denied plaintiffs' request to preliminarily enjoin enforcement and implementation of MCL 333.17015a and MCL 333.17015(11)(i) pertaining to coercion screening.

the mandatory uniform informed consent, the ban on APCs providing abortion care, and other statutory subsections inextricably intertwined with these provisions—are unconstitutional. Therefore, the Court GRANTS in part plaintiffs' request for a declaratory judgment. The remaining provisions of MCL 333.17015 and MCL 333.17015a do not violate the RFFA and are preserved due to the severability provision of MCL 333.17015(17). The Court GRANTS in part plaintiffs' request for a permanent injunction, enjoining the enforcement of the unconstitutional provisions of MCL 333.17015.

Given the length of this opinion and order, the Court includes a Table of Contents to guide the parties:

I. CONST 1963 ARTICLE 1, § 28— MICHIGAN'S FUNDAMENTAL RIGHT TO REPRODUCTIVE FREEDOM

In 2022, Michigan voters passed a landmark constitutional amendment enshrining the fundamental right to reproductive freedom into the Michigan Constitution. The RFFA provides, "Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care." Const 1963, art 1, § 28(1). Furthermore, "[a]n individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means." *Id*. The amendment instructs that "[a] state interest is 'compelling' only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." Const 1963, art 1, § 28(4). The state is precluded from discriminating "in the protection or enforcement of this fundamental right" to reproductive freedom. Const 1963, art 1, § 28(2). The amendment plainly states that it is self-executing and "[a]ny provision . . . held invalid shall be severable from the remaining portions" of the amendment. Const 1963, art 1, § 28(5).

However, the RFFA authorizes the state to "regulate the provision of abortion care after fetal viability, provided that in no circumstance shall the state prohibit an abortion that, in the professional judgment of an attending health care professional, is medically indicated to protect the life or physical or mental health of the pregnant individual."[2] Const 1963, art 1, § 28(1).

[2] "Fetal viability" is defined for purposes of the RFFA as "the point in pregnancy when, in the professional judgment of an attending health care professional and based on the particular facts of

II. PLAINTIFFS' CLAIMS AND DEFENDANTS' RESPONSES

Plaintiffs challenge the constitutionality of MCL 333.17015 and MCL 333.17015a under the RFFA. Plaintiffs filed suit against Attorney General Dana Nessel, in her official capacity, Director Marlon Brown, in his official capacity as Director of Michigan Licensing and Regulatory Affairs (LARA), and Director Elizabeth Hertel, in her official capacity as Director of Michigan Department of Health and Human Services (DHHS). Because AG Nessel, Director Brown, and Director Hertel acknowledged that the challenged laws are unconstitutional, the Court permitted the People of the State of Michigan (the People) to intervene as a defendant.[3]

AG Nessel concurs with plaintiffs that the challenged laws do not pass constitutional strict-scrutiny muster. AG Nessel contends that a judgment invalidating the entirety of the challenged statutes would be overbroad. MCL 333.17015(17) is a severability provision that preserves those statutory provisions that are not deemed unconstitutional.

Director Hertel likewise concurs that the challenged laws are unconstitutional under the strict-scrutiny standard of review. Additionally, Director Hertel challenges the credibility of the defense's expert witnesses. Director Hertel notes that Dr. Farr A. Curlin's "testimony was inherently biased, as he admitted to an ethical viewpoint at odds with" the RFFA, and that Dr. Curlin has no relevant experience in informed consent for abortion procedures. Similarly, Director Hertel contends Dr. Monique Chireau Wubbenhurst's testimony was biased and her opinions are at odds with the rights guaranteed in the RFFA.

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the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures." Const 1963, art 1, § 28(4).

[3] The People are represented by attorneys in the Attorney General's office, but are subject to a conflict wall permitting their work to provide an adversarial defense to the litigation.

Director Brown takes no position on the constitutionality of the challenged laws.

Intervening defendant argues that plaintiffs lack standing to challenge the constitutionality of the subject statutes. Intervening defendant also contends that the challenged laws are constitutional under the RFFA, because they protect the fundamental right of patients to secure an abortion in a knowing, informed, and voluntary way. Intervening defendant further argues the statutes do not discriminate against patients seeking an abortion as compared to patients seeking other medical care.

III. STANDING

Intervening defendant contends plaintiffs lack standing to bring the current action. The Court rejected this standing challenge in the January 21, 2025 opinion and order denying plaintiffs' motion for summary disposition. Nothing has changed and the Court again finds plaintiffs have standing to file suit. "The purpose of the standing doctrine is to assess whether a litigant's interest in the issue is sufficient to ensure sincere and vigorous advocacy." *Lansing Sch Ed Ass'n v Lansing Bd of Ed*, 487 Mich 349, 355; 792 NW2d 686 (2010) (cleaned up).

> [A] litigant has standing whenever there is a legal cause of action. Further, whenever a litigant meets the requirements of MCR 2.605, it is sufficient to establish standing to seek a declaratory judgment. Where a cause of action is not provided at law, then a court should, in its discretion, determine whether a litigant has standing. A litigant may have standing in this context if the litigant has a special injury or right, or substantial interest, that will be detrimentally affected in a manner different from the citizenry at large or if the statutory scheme implies that the Legislature intended to confer standing on the litigant. [*Id*. at 372.]

MCR 2.605(A)(1) provides that a court may enter a declaratory judgment "[i]n a case of actual controversy." An actual controversy exists, even absent actual injury or loss, "when a declaratory judgment is necessary to guide the plaintiff's future conduct in order to preserve the plaintiff's

legal rights." *Van Buren Charter Twp v Visteon Corp*, 319 Mich App 538, 545-546; 904 NW2d 192 (2017).

The Northland plaintiffs are "reproductive healthcare clinics" that provide medication and procedural abortion services and "regularly train[]" medical residents, fellows, and students "to provide abortion care." They must comply with the challenged laws in these endeavors. Plaintiff MSFC is a nonprofit organization that trains medical students and residents in abortion care services. It is also required to comply with the challenged laws, and contends it "must make up the difference in training" because these laws "are inconsistent with the best evidence-based medicine." Further, the named plaintiffs filed suit not only for themselves, but also on behalf of their staff, clinicians, members, patients, and members' patients.

Plaintiffs seek a declaratory judgment that the challenged laws violate the RFFA, as well as a permanent injunction against the enforcement of those statutes. There is an actual controversy in this case and plaintiffs demonstrated a special injury or right that is detrimentally affected in a manner different from the citizenry at large. Even if the Northland plaintiffs are "managers" who staff their clinics through independent contractors, as intervening defendant claims, their business is specially affected by the limitations on their operation. At their clinics, the Northland plaintiffs and their contractors must universally provide information that they claim is inaccurate and not applicable to every patient. They must comply with 24-hour waiting periods following the presentation of a signed paper copy of the informed consent form. And they are limited in the types of medical providers they can hire. MSFC is required to provide instruction consistent with the mandates in the challenged statutes that it alleges are not evidence based and are inconsistent with the real standard of care. These are special injuries different from the general public, giving plaintiffs standing to file this suit.

IV. THE CHALLENGED LAWS

Plaintiffs argue that the abortion regulations of MCL 333.17015 and MCL 333.17015a are unconstitutional under the RFFA because they deny, burden, and infringe upon a patient's fundamental right to reproductive freedom in accessing abortion care, and the laws do not achieve the compelling interest of protecting the patient's health by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine.

A. MCL 333.17015(1) and (3)—MANDATORY 24-HOUR WAITING PERIOD

Under MCL 333.17015(1) and (3), a "physician shall not perform an abortion . . . without the patient's informed written consent," and that consent must be obtained "not less than 24 hours before that physician performs an abortion . . . ."[4]

B. MCL 333.17015(3)-(8) and (11)— MANDATORY UNIFORM "INFORMED CONSENT" FOR ABORTION

MCL 333.17015(3) sets forth information that an abortion provider must give to a patient at least 24 hours before an abortion procedure.

[4] However,

> [i]f the attending physician, utilizing the physician's experience, judgment, and professional competence, determines that a medical emergency exists and necessitates performance of an abortion before the requirements of subsections (1), (3), and (6) can be met, the physician is exempt from the requirements of subsections (1), (3), and (6), may perform the abortion, and shall maintain a written record identifying with specificity the medical factors upon which the determination of the medical emergency is based. [MCL 333.17015(10).]

First, a physician or a qualified person assisting the physician[5] must "[c]onfirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus." MCL 333.17015(3)(a).

Second, a physician or a qualified person assisting the physician must "[o]rally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability" three things: (1) "the probable gestational age of the fetus the patient is carrying," (2) "information about what to do and whom to contact should medical complications arise from the abortion," and (3) "[i]nformation about how to obtain pregnancy prevention information through the [DHHS]." MCL 333.17015(3)(b).

Third, a physician or a qualified person assisting the physician must "[p]rovide the patient with a physical copy of the written standardized summary described in [MCL 333.17015(11)(b)][6]

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[5] MCL 333.17015(2)(h) defines a "qualified person assisting the physician" as

> another physician or a physician's assistant licensed under this part or [MCL 333.17501 *et seq*.], a fully licensed or limited licensed psychologist licensed under [MCL 333.18201 *et seq*.], a professional counselor licensed under [MCL 333.18101 *et seq*.], a registered professional nurse or a licensed practical nurse licensed under [MCL 333.17201 *et seq*.], or a social worker licensed under [MCL 333.18501 *et seq*.].

[6] MCL 333.10715(11)(b) directs the DHHS to

> develop, draft, and print, in nontechnical English, Arabic, and Spanish, written standardized summaries, based upon the various medical procedures used to abort pregnancies, that do each of the following:
>
> (*i*) Describe, individually and on separate documents, those medical procedures used to perform abortions in this state that are recognized by the [DHHS].
>
> (*ii*) Identify the physical complications that have been associated with each procedure described in subparagraph (*i*) and with live birth, as determined by the [DHHS]. In identifying these complications, the [DHHS] shall consider studies concerning complications that have been published in a peer review medical journal, with particular attention paid to the design of the study, and shall consult

that corresponds to the procedure the patient will undergo and is provided by the [DHHS]." MCL 333.17015(3)(c). If the procedure is "allowed under Michigan law," but has not been summarized by the DHHS, "the physician shall develop and provide a written summary that describes the procedure, any known risks or complications of the procedure, and risks associated with live birth . . . ." *Id*.

Fourth, a physician or a qualified person assisting the physician must "[p]rovide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the [DHHS] pursuant to [MCL 333.17015(11)(a)][7] at the gestational age nearest the probable gestational age of the patient's fetus." MCL 333.17015(3)(d).

> with the Centers for Disease Control and Prevention, the American Congress of Obstetricians and Gynecologists [ACOG], the Michigan State Medical Society, or any other source that the [DHHS] determines appropriate for the purpose.
>
> (*iii*) State that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if these symptoms occur and are intense or persistent, professional help is recommended.
>
> (*iv*) State that not all of the complications listed in subparagraph (*ii*) may pertain to that particular patient and refer the patient to the patient's physician for more personalized information.
>
> (*v*) Identify services available through public agencies to assist the patient during the patient's pregnancy and after the birth of the child, should the patient choose to give birth and maintain custody of the child.
>
> (*vi*) Identify services available through public agencies to assist the patient in placing the child in an adoptive or foster home, should the patient choose to give birth but not maintain custody of the child.
>
> (*vii*) Identify services available through public agencies to assist the patient and provide counseling should the patient experience subsequent adverse psychological effects from the abortion.

[7] MCL 333.10715(11)(a) directs the DHHS to:

Fifth, a physician or a qualified person assisting the physician must "[p]rovide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the [DHHS] under [MCL 333.9161]." MCL 333.17015(3)(e).

Sixth, a physician or a qualified person assisting the physician must "[p]rovide the patient with a physical copy of the prescreening summary on prevention of coercion to abort described in [MCL 333.17015(11)(i)]." MCL 333.17015(3)(f).

The statute further requires the "physician personally" and "in the presence of the patient" orally provide information about two things: the "specific risk" of the procedure the patient will undergo, and the "specific risk" if "the patient chooses to continue the pregnancy." MCL 333.17015(6)(b)(*i*), (*ii*).

The requirements of MCL 333.17015(3)(c) through (f) may be fulfilled by a patient accessing the DHHS website at least 24 hours before an abortion procedure, reviewing the required information, and printing a confirmation from the site verifying that the patient reviewed the information required in MCL 333.17015(3)(c) through (f) at least 24 hours before the abortion procedure.[8] MCL 333.17015(5). The patient must provide "the valid confirmation form" to the

> Produce medically accurate depictions, illustrations, or photographs of the development of a human fetus that indicate by scale the actual size of the fetus at 2-week intervals from the fourth week through the twenty-eighth week of gestation. Each depiction, illustration, or photograph must be accompanied by a printed description, in nontechnical English, Arabic, and Spanish, of the probable anatomical and physiological characteristics of the fetus at that particular state of gestational development.

[8] MCL 333.17015(11)(g) requires the DHHS to "[d]evelop, operate, and maintain an internet website that allows a patient considering an abortion to review the information required in [MCL 333.17015](3)(c) through (f)." The DHHS must also "ensure that a confirmation form can be printed by the patient from the internet website that will verify the time and date the information

abortion provider. *Id*. If the form is not downloaded and brought to the appointment, a provider may not provide care until the form has been completed and 24 hours have elapsed from the time of completion. MCL 333.17015(2)(j), (3). The requirements of MCL 333.17015(3) "cannot be fulfilled by the patient accessing an internet website other than" the DHHS site. MCL 333.17015(4). The requirements of MCL 333.17015(3) may also be fulfilled by the abortion provider "at a location other than the health facility where the abortion is to be performed." *Id*.

Alternatively, an abortion provider may provide copies of the required documents to the patient at least 24 hours before the abortion procedure by delivering the documents to the patient in one or more of the following manners: (1) in person; (2) by registered mail, return receipt requested; (3) by parcel delivery service that requires the recipient to provide a signature in order to receive delivery of a parcel; or (4) by facsimile transmission. MCL 333.17015(2)(j).

After the expiration of the 24-hour waiting period but before performing the abortion procedure, MCL 333.17015(8) requires an abortion provider to obtain the patient's signature on the DHHS's standardized acknowledgment and consent form confirming that the patient received the information mandated in MCL 333.17015(3).

C. MCL 333.17015(1)—PROVIDER BAN

MCL 333.17015(1) provides that "a *physician* shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort." (Emphasis added.) Thus, in Michigan, only a licensed physician may provide abortion

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was reviewed." *Id*. However, the printed confirmation form "becomes invalid 14 days after the date and time printed on the confirmation form." *Id*.

care, precluding APCs from doing so. APCs include nurse practitioners, certified nurse midwives, and physician assistants.

D. MCL 333.17015(11)(i) and MCL 333.17015a—Coercion Screening

MCL 333.17015a requires abortion providers to orally counsel and screen women for "coercion to abort" with the screening tools developed by the DHHS under MCL 333.17015(11). Such screening can be performed before or after the 24-hour waiting period. This statutory provision also requires abortion facilities[9] to post notices regarding coercion and domestic abuse as described in MCL 333.17015(11)(i).[10]

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[9] This includes "[a] private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed . . . ." MCL 333.17015a(5).

[10] MCL 333.17015(11)(i) provides, in pertinent part:

> After considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic and Sexual Violence Prevention and Treatment Board, the Michigan Coalition to End Domestic and Sexual Violence or successor organization, and the American Medical Association, do all of the following:
>
> (*i*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a notice that is required to be posted in facilities and clinics under [MCL 333.17015a]. The notice must be at least 8-½ inches by 14 inches, be printed in at least 44-point type, and contain at a minimum all of the following:
>
> (A) A statement that it is illegal under Michigan law to coerce an individual to have an abortion.
>
> (B) A statement that help is available if an individual is being threatened or intimidated; is being physically, emotionally, or sexually harmed; or feels afraid for any reason.
>
> (C) The telephone number of at least 1 domestic violence hotline and 1 sexual assault hotline.
>
> (*ii*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a prescreening summary on prevention of coercion to abort that, at a minimum, contains the information required under

V. PRINCIPLES OF REVIEW

"[T]he primary and fundamental rule of constitutional or statutory construction . . . is to ascertain the purpose and intent as expressed in the constitutional or legislative provision in question." *Adair v Michigan*, 486 Mich 468, 477; 785 NW2d 119 (2010) (cleaned up). The "Court typically discerns the common understanding of constitutional text by applying each term's plain meaning at the time of ratification." *Wayne Co v Hathcock*, 471 Mich 445, 468-469; 684 NW2d 765 (2004). We must "give effect to the common understanding of the text," *Lansing v Michigan*, 275 Mich App 423, 430; 737 NW2d 818 (2007), and avoid an interpretation that creates "a constitutional invalidity." *Mich United Conservation Clubs v Secretary of State (After Remand)*, 464 Mich 359, 411; 630 NW2d 297 (2001) (CAVANAGH, J., dissenting).

Plaintiffs have presented a facial challenge to the constitutionality of MCL 333.17015 and MCL 333.17015a. A statute may have been constitutional when enacted by the Legislature, but rendered invalid by a later amendment to the Constitution. See *Gaylord v Gaylord City Clerk*, 378 Mich 273, 321; 144 NW2d 460 (1966). See also Const 1963, art 1, § 7 ("The common law and the statute laws now in force, *not repugnant to this constitution*, shall remain in force until they expire by their own limitations, or are changed, amended or repealed.) (Emphasis added). The party challenging the facial constitutionality of an act must establish that no set of circumstances exists under which the act would be valid. The fact that the act might operate unconstitutionally under some conceivable set of circumstances is insufficient." *League of Women Voters of Mich v Secretary of State*, 508 Mich 520, 534-535; 975 NW2d 840 (2022) (cleaned up). "Our task, then,

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> subparagraph (*i*) and notifies the patient that an oral screening for coercion to abort will be conducted before giving written consent to obtain an abortion. . . .

is to determine whether [the statute] is unconstitutional in the abstract, rather than to analyze the statute 'as applied' to the particular case." *Id.*

The state may not deny, burden, or infringe upon an individual's fundamental right to reproductive freedom unless it has a compelling state interest in "protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." Const 1963, art 1, § 28(4). "It is settled law that the legislature may not act to impose additional obligations on a self-executing constitutional provision." *League of Women Voters*, 508 Mich at 536 (cleaned up).

Plaintiffs argue that the challenged laws are unconstitutional because they deny, burden, and infringe upon a patient's fundamental right to reproductive freedom in accessing abortion care, and do not achieve the compelling interest of protecting the patient's health by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine. Intervening defendant contends that the challenged laws protect the fundamental right to reproductive freedom by ensuring that right is exercised in a knowing, informed, and voluntary way, without denying, burdening, or infringing upon the right to access abortion care.

As an initial matter, it is necessary to identify the appropriate legal standard applicable to the challenged laws. The Court agrees with plaintiffs that a strict-scrutiny standard applies, as stated in the text of the RFFA. That is, the challenged laws can only pass constitutional muster if they: (1) do not deny, burden, or infringe upon an individual's fundamental right to make and effectuate decisions about abortion care, and (2) if the laws do deny, burden, or infringe upon that right, they do so, in the least restrictive means possible, (a) only to achieve the purpose of

protecting the health of an individual seeking care, (b) consistent with accepted clinical standards of practice and evidence-based medicine, and (c) the laws do not infringe on that individual's autonomous decision-making.

Intervening defendant previously contended, and continues to argue, that the RFFA "is largely a codification of the prior federal law on abortion," i.e. a return to the state of the law under *Roe v Wade*, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147 (1973); *Planned Parenthood of Southeastern PA v Casey*, 505 US 833; 112 S Ct 2791; 120 L Ed 2d 674 (1992); and *Mahaffey v Attorney General*, 222 Mich App 325; 564 NW2d 104 (1997). As the Court previously ruled, the undue burden standard articulated by the majority opinion in *Casey* is *not* the governing standard in Michigan.

In *Roe v Wade*, the United States Supreme Court held that a woman's fundamental due process right to privacy encompasses a right to abortion. *Roe*, 410 US at 153-155. Restrictions on abortion, the Court explained, were subject to strict scrutiny and could be justified only by a demonstration of a compelling state interest. *Id*. at 155. During the first trimester of pregnancy, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Id*. at 164. Before viability, a state could regulate abortion "in ways that are reasonably related to maternal health." *Id*. After viability, a state may "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id*.

In *Casey v Planned Parenthood*, the Supreme Court softened the strict-scrutiny standard adopted in *Roe*. As in the current case, *Casey* involved constitutional challenges to statutes requiring a woman seeking an abortion to give her informed consent prior to the procedure, and

that she be provided with certain information at least 24 hours before the abortion is performed. Each of these provisions were facially challenged, with plaintiffs seeking preliminary and permanent injunctions. *Casey* distilled from *Roe* three essential holdings:

> First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without *undue interference* from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health. And third is the principle that the State has legitimate interests *from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child*. [*Casey*, 505 US at 846 (emphasis added).]

The *Casey* majority explained that the "[c]onstitutional protection of the woman's decision to terminate her pregnancy derives from the Due Process Clause of the Fourteenth Amendment." *Id*.

While recognizing that an individual has a due process privacy right to access abortion, *Casey* also recognized a competing legitimate state interest in protecting the life of a fetus from the outset of the pregnancy. The Court noted that though an individual has a constitutional liberty interest to have some freedom to terminate a pregnancy, "[t]he woman's liberty is not so unlimited, however, that *from the outset* the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted." *Id*. at 869 (emphasis added). To that end, the Court reasoned:

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted

> children as well as a certain degree of state assistance if the mother chooses to raise the child herself. [*Id.* at 872.]

"It follows that States are free to enact laws to provide a reasonable framework for a woman to make a decision that has such profound and lasting meaning." *Id*.

From this line of reasoning, *Casey* created the "undue burden" test, explaining:

> Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause. [*Id.* at 874.]

Thus, the *Casey* Court concluded that state regulation that burdened access to abortion was permissible, so long as it did not pose an "undue burden," because of the State's competing interest in the potential for life:

> The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. Not all burdens on the right to decide whether to terminate a pregnancy will be undue. In our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty. [*Id*. at 876.]

The undue burden test in *Casey* was inextricably connected to the Court's determination that states have a compelling interest in potential for life. Thus, the Court concluded that state regulation of abortion care was permissible so long as it did not place an *undue burden* on an individual's access to abortion. "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a *substantial obstacle* in the path of a woman seeking an abortion before the fetus attains viability." *Id*. at 878.

The Michigan Court of Appeals adopted the *Casey* standard, holding that MCL 333.17015 was constitutional under the Due Process Clause of the Michigan Constitution because the statute bears a reasonable relationship to a permissible legislative purpose. *Mahaffey v Attorney General*, 222 Mich App at 344. The Court noted that "[t]he stated purposes behind the informed-consent law are to ensure that a woman's decision to obtain an abortion is informed, voluntary, and reflective, and to protect, within the limits of federal constitutional law, the life of the fetus." *Id.* at 344. Citing *Casey*, the Court concluded that "[t]hese are legitimate legislative objectives," and the statute was constitutional under the Michigan Constitution, as it existed in 1997. *Id*.

Michigan voters dramatically changed the Michigan Constitution by adopting the RFFA. The RFFA does not recognize the potential for life in a nonviable fetus as a compelling state interest. As a result, the compromise, undue-burden test developed in *Casey* and adopted in *Mahaffey* has no place in jurisprudence interpreting the RFFA. The language of the RFFA is explicit: "A state interest is 'compelling' only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." Const 1963, art 1, § 28(4). Furthermore, the fundamental right to reproductive freedom, which includes abortion care, "shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means." Const 1963, art 1, § 28(1). Thus, the relevant inquiry to determine whether the challenged laws are constitutional under the RFFA starts with determining whether the laws deny, burden, or infringe upon an individual's freedom to make and effectuate decisions about abortion care. "Undue" is not a part of the constitutional text.

VI. WITH LIMITED EXCEPTION, THE CHALLENGED LAWS DENY, BURDEN, AND INFRINGE UPON PATIENTS' REPRODUCTIVE FREEDOM IN VIOLATION OF THE RFFA

The Court finds that, with limited exceptions, the challenged laws violate the RFFA. Most of the statutory requirements burden or infringe upon individuals' reproductive freedom, are not based on a compelling state interest to protect the health of individuals seeking abortion care, are not consistent with the accepted standard of care and evidence-based medicine, and infringe on autonomous decision-making. The statutory provisions of MCL 333.17015(11)(i) and MCL 333.17015a, governing coercion screening, pass constitutional muster.

The Court will address each category of restrictions challenged in the statutes separately by summarizing the statutory requirements, detailing the evidence presented at trial, and then analyzing whether the statute denies, burdens, or infringes upon the individual's reproductive freedom. In Section VII of this opinion, the Court will address whether there is a compelling state interest to protect the health of the individual seeking abortion care; if so, whether the statute provides that protection in the least restrictive means necessary; whether the statutory requirement is consistent with the accepted standard of care and evidence-based medicine; and whether the statute infringes on the individual's autonomous decision-making.

A. 24-Hour Mandatory Waiting Period

The 24-hour mandatory waiting period forces patients to delay constitutionally protected abortion care by at least 24 hours after receiving information mandated by the state. MCL 333.17015(1) and (3).

Plaintiffs contend the waiting period does not serve patient health. Plaintiffs also contend that the Legislature singled out abortion care for these more stringent requirements. Plaintiffs

assert that mandatory waiting periods do not improve decision-making or protect against regret, reproductive coercion, or mental health harms. Instead, plaintiffs argue the 24-hour mandatory waiting period harms patients by increasing incremental risk from the abortion procedure and imposing significant logistical barriers that force patients to obtain care later in pregnancy, when the risks from abortion procedures are higher.

Intervening defendant contends that plaintiffs interpret the terms "burden," "infringe," and "deny" in the RFFA too broadly. Intervening defendant instead asserts that the Constitution prohibits improper or significant intrusions into or oppression against a patient's right to reproductive care. Intervening defendant urges that the 24-hour waiting period ensures that an individual can exercise their right in an informed, voluntary, and reflective manner, and the impact on the right to access abortion care is only incidental.

1. Renee Chelian

Renee Chelian has worked in the abortion care field for almost 50 years and is the founder and executive director of Northland. Northland provides between 7,000 and 8,000 abortions per year, including medication abortions up to 12 weeks gestation,[11] first-trimester abortions (aspiration), and second-trimester abortions (dilation and evacuation—D&E).

Ms. Chelian testified that the 24-hour waiting period has hindered some patients from obtaining an abortion. She provided an example of a patient that came in at 23.6 weeks (the legal cut-off in Michigan) but who had not printed the time-stamped form from the DHHS website. Northland referred the patient to the National Abortion Federation (NAF) and out-of-state

[11] Medication abortions require Mifeprex and misoprostol. The patients take the Mifeprex (mifespristone) in the office and the misoprostol at home. However, both drugs are mailed to the patient if they are telehealth patients.

providers because Northland could not legally provide the service the next day. Ms. Chelian also testified that other patients were denied a medication abortion and forced to undergo a more invasive procedure with higher risk because of the 24-hour delay. Ms. Chelian estimated that approximately 10 patients were turned away each month for failure to provide confirmation from the DHHS website that they had reviewed the mandatory material at least 24 hours earlier.

Ms. Chelian noted that since the preliminary injunction was entered, patients have been able to get a procedure scheduled within 24 hours, sometimes even the same day. One patient was able to secure an abortion on the final available day (23.6 weeks) when a hospital made a same-day referral following the diagnosis of a fatal fetal anomaly. Before the injunction, the mandatory paperwork to be completed 24 hours in advance was a major hurdle. Many patients do not have Internet or printer access. Those patients had to arrange transportation, time off work, and/or childcare to travel to the clinic to collect the paperwork and then again for their appointment.

Ms. Chelian did not testify that no patient needed a waiting period before securing an abortion, only that this should be assessed on a case-by-case basis. At Northland facilities, if the provider determined that a patient was "highly conflicted," the provider would refer the patient for counseling to assist in the decision-making process. Ms. Chelian conceded that approximately five to six patients change their mind every week between the three Northland clinics. That number had not changed since the preliminary injunction was entered.

2. Dr. Charise Loder

Dr. Charise Loder is a board-certified obstetrician-gynecologist (OB/GYN) licensed to practice medicine in the state of Michigan. For the last 10 years, she has provided full-spectrum OB/GYN care, from labor and delivery to contraception and abortion. Dr. Loder has authored and

co-authored over a dozen peer-reviewed articles on a variety of topics related to reproductive health issues, including contraception, abortion, and access to healthcare. She currently serves as a clinical assistant professor in OB/GYN at the University of Michigan. She teaches a course in reproductive justice and autonomy. In 2018, she was appointed as the director of Clinical Family Planning Services at the University of Michigan and manages the Complex Family Planning Clinic, which focuses on pregnancy termination for patients with pregnancy complications or fetal abnormalities. In that role, Dr. Loder authored clinical guidelines on medication abortion, early pregnancy loss, and labor induction for fetal loss or pregnancy termination. She provides approximately 100 medication abortions, 150 aspiration abortions, and 100 D&E abortions annually.[12] Dr. Loder is a member of the American College of Obstetricians and Gynecologists (ACOG) and the Society of Family Planning.

Dr. Loder opined that the mandatory 24-hour waiting period is contrary to evidence-based standard-of-care and informed-consent practices. Dr. Loder explained that in her years as a practitioner, she has not encountered a single patient that has benefited from Michigan's 24-hour delay law. And in her opinion, there is no reason why a patient's consent cannot be deemed "informed" and "given freely" unless they have first been provided certain uniform information at least 24 hours in advance of their abortion. Dr. Loder explained that under accepted standards of care, true informed consent is an individualized process that is designed to serve patient autonomy over anything else. Dr. Loder noted that Michigan law does not require physicians to deviate from

[12] As part of her fellowship in family planning, she performed abortions at the Northland Southfield clinic from 2016 to 2017.

their informed-consent standards, which are based on their ethical obligations as physicians and evidence-based medicine, for any other procedure the way the 24-hour waiting period does.

Dr. Loder further opined that under the accepted standard of care, patients should receive abortion care as soon as possible once they have made their decision and delaying a patient's care by even one day is a tremendous barrier. For patients whose pregnancies are close to 11 weeks, the barriers imposed by the 24-hour waiting period can mean patients lose the option of a medication abortion or, given that some clinics in Michigan only offer medication abortion, any abortion at all. Abortion care also becomes more expensive and complex as gestational age increases and, in some cases, patients are unable to overcome the logistical and financial barriers caused by the delay in care and are not able to receive their abortion. Dr. Loder reiterated Ms. Chelian's concerns that many patients do not know to or cannot print the DHHS confirmation form, resulting in patients having to travel to a facility twice and requiring them to take another day off from work, arrange for additional childcare, and either travel back home and return to the hospital or clinic, or find accommodations nearby for the night. Dr. Loder explained that some patients who qualified for an emergency abortion without a waiting period are unaware of the exception and may needlessly delay necessary abortion care in serious circumstances.

Dr. Loder testified that she had to turn away at least one patient a day for not having the form printed 24 hours ahead of the scheduled abortion procedure. Dr. Loder had considered including the link to the DHHS website through the patient portal to fix this problem, but testing revealed it was not physically possible to transfer the timestamped page at the end of the website to the patient portal to eliminate the need for printing.

Dr. Loder testified that mandating a patient wait 24 hours after receiving material from the DHHS does not change outcomes. By the time a patient has decided to have an abortion, they have already considered their circumstances and talked to their support people. "[A]lmost universally patients have reflected on the risks of pregnancy and not being pregnant and know that abortion care is the right thing for them." The delay is not used to screen the patient for other medical issues.

3. Professor Kayte Spector-Bagdady

Professor Kayte Spector-Bagdady is a lawyer and a health law and bioethics scholar who specializes in informed consent and medical decision-making. Her academic work primarily focuses on the law's role in shaping the informed-consent process and doing research with diverse patient communities regarding how informed-consent regulations impact the patient and research participant experience. She is currently interim co-director at the Center for Bioethics and Social Sciences in Medicine, at which she oversees the clinical ethics consult service, and is an assistant professor at the University of Michigan Medical School. She is also the chair of the Research Ethics Committee, an ethicist on the Michigan Medicine Human Data and Biospecimen Release Committee, and a clinical ethicist.

Professor Spector-Bagdady opined that the 24-hour waiting period forces needless delay on patients after they consent to a procedure. While recognizing that the ostensible reason for the delay is to ensure that patients are given sufficient time for consideration of their choice, Professor Spector-Bagdady related that she is unaware of any scientific literature demonstrating that waiting 24 hours improves the patient's ability to make a medical decision for themselves. In addition, she noted that the mandatory waiting period fails to account for time a patient may have waited and deliberated on their choice before contacting a medical facility. Professor Spector-Bagdady

concluded that the 24-hour waiting period does not improve a patient's capacity to make a good decision for themselves regarding a legally allowable procedure or serve an interest in informed consent. Instead, she opined that its intent is to erect a barrier between the patient and a legal medical procedure and restrict free choice in medical decision-making by adding logistical burdens. She reasoned that the 24-hour waiting period only serves to constrain choice by making abortion logistically complex to access, such that some patients will be delayed in obtaining the procedure or denied access to the care they require. Instead, Professor Spector-Bagdady opined that providers should offer care as soon as is medically appropriate, and when patients who are competent give their consent, when they choose.

4. Dr. Natasha Bagdasarian

Dr. Natasha Bagdasarian is the Chief Medical Officer of the State of Michigan. She serves on the Governor's Cabinet and chairs Michigan's Public Health Advisory Council. Dr. Bagdasarian was appointed to her post by Director Hertel under MCL 333.2202(2), which makes her responsible to the Director for the medical content of the DHHS's policies and programs. Dr. Bagdasarian also practices internal medicine with a specialty in infectious diseases. She has published nearly 40 peer-reviewed articles on public health issues.

Dr. Bagdasarian opined that the 24-hour waiting period imposes a medically inappropriate barrier to receiving reproductive care. She testified that the 24-hour waiting period serves no valid medical purpose. In fact, she opined that the waiting period discriminates against patients seeking abortions. For example, a male patient seeking a vasectomy is not required to reflect on his reproductive healthcare decision for an arbitrary amount of time before undergoing the permanent sterilization procedure. Dr. Bagdasarian further noted that the 24-hour waiting period is potentially affirmatively harmful, insofar as it delays the patient's exercise of their decision-making authority

until later in their pregnancy. Obtaining an abortion later in pregnancy is positively correlated with the procedure's invasiveness and adverse health outcomes. It is potentially harmful for patients who need to take time off of work and arrange transportation and childcare. Although the patient could access the DHHS materials and form at home and avoid two trips to the clinic, most women do not know about the requirement, and the material on the Internet does not satisfy all elements of the 24-hour notice provisions in any event. Dr. Bagdasarian testified from her experience as a young doctor working at a public health clinic in Ypsilanti that her impoverished patients with transportation and childcare issues often missed follow-up appointments, and the same would be true for patients seeking abortion care.

5. Dr. M. Antonia Biggs

Dr. M. Antonia Biggs is a social psychologist, researcher, associate professor, and director of Advancing New Standards in Reproductive Health (ANSIRH) in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco. ANSIRH conducts multi-disciplinary social science research on issues relating to reproductive health. Dr. Biggs focuses her work on abortion and mental health. She has over 100 peer-reviewed publications, in additional to authoring chapters in books and editorials. She is a member of the Society of Family Planning and former member of the American Psychological Association (APA).

Dr. Biggs was a key researcher in the preeminent study on the long-term mental health impacts of abortion, the Turnaway Study. The study followed 956 patients across 20 states who sought abortions just before and just after the 23.6-week cutoff date, and compared the mental health impacts between the group granted an abortion and the group denied an abortion over a

five-year period. The results of the study were that women who were denied an abortion because they sought the procedure too late in the pregnancy suffered slightly higher levels of long-term mental health issues.

Dr. Biggs testified that the provisions of the challenged statutes requiring mental health warnings and imposing a mandatory 24-hour waiting period do not benefit patients and, in fact, increase symptoms such as anger and anxiety. Further, research showed that by the time a patient reports to an abortion provider, they are "very certain" about their decision, as compared to other medical procedures. There is no empirical evidence that a 24-hour waiting period increases certainty. Rather, being forced to wait after making the decision increases stress. It also increases the chance of compromising the privacy of the patient.

6. Dr. Monique Chireau Wubbenhurst

Dr. Monique Chireau Wubbenhurst is a practicing OB/GYN with over 30 years' experience, much of that experience with minority, poor, inner city and rural populations. She has worked at over 25 hospitals and clinics, and 10 different professional and academic institutions, but does not have a tenured position. She has not engaged in any peer-reviewed studies regarding abortion care and bases her opinions on her years of clinical experience. Dr. Wubbenhurst has never performed an elective abortion, but has conducted abortion procedures for deceased fetuses and in medical emergencies. She defines abortion as intentional feticide, meaning the goal of the procedure is the death of the fetus or embryo. Dr. Wubbenhurst contrasts this to termination of pregnancy, which is done when the fetus has died or when an induction is done early for a live fetus in order to save the life of mother or fetus. Dr. Wubbenhurst believes abortion is not healthcare, is harmful to women, should not be permitted even in cases of rape and incest, and offends God. Dr. Wubbenhurst has described abortion in the case of a fetal anomaly as based on

a "eugenic mindset" similar to the Nazi party. She is a member of the American Association of Pro-Life OB/GYNs and served on the board of Americans United for Life.

Dr. Wubbenhurst opined that the 24-hour waiting period is necessary as no doctor would perform any procedure immediately. She believed the waiting period should be even longer, because informed consent is a process "over a period of days." The waiting period is needed to help identify any "potential medical or psychological problems," "provide patient education," and give the patient time for reflection. Time to reflect is necessary in Dr. Wubbenhurst's estimation because "there's at least some research to suggest that most women would like to parent their children, but they don't see how they're going to do it."[13] Additionally, research establishes that patients experience stress, measured by increased blood pressure, in clinical settings, limiting their ability to make a reflective choice. In her experience, even in rural and underserved areas, Dr. Wubbenhurst did not believe the 24-hour waiting period was a burden. She had observed that patients in these scenarios "would always come back for the second visit. They would find a way to come back." Dr Wubbenhurst promoted a longer waiting period despite her belief that the risk of mortality or morbidity from an abortion increases 38% for each gestational week.

Dr. Biggs asserted that Dr. Wubbenhurst's literature review was inadequate. Dr. Wubbenhurst focused on flawed studies and omitted the most important studies. The breadth of Dr. Wubbenhurst's alleged experience was also challenged at trial. Although she claimed in the current case to have provided care for innumerable patients suffering abortion complications, she

[13] Dr. Wubbenhurst did not cite the studies she relied on for the proposition that most women want to carry to term and that viewing an ultrasound or fetal development chart is pivotal. This testimony was challenged with a study showing that 98.4% of women who view the ultrasound prior to an abortion procedure choose to have the abortion.

testified in 2017, in a deposition during a Texas suit, that she had provided care for only four patients suffering complications from an induction abortion. And Dr. Wubbenhurst admittedly relied on no studies to support her belief that a 24-hour or longer waiting period reduces abortion regret.

7. Dr. Farr A. Curlin

Dr. Farr A. Curlin is a general internist focusing on hospice and palliative care, and a professor of clinical medical ethics at Duke University Medical Center's Trent Center for Bioethics, Humanities & History of Medicine. He is also co-director of the Theology, Medicine, and Culture Initiative at the Duke Divinity School, where he teaches a course on healthcare in a theological context, and Senior Fellow in Duke University's Kenan Institute for Ethics. Dr. Curlin has published approximately 150 peer-reviewed papers. Dr. Curlin provides his opinions in this case based on his expert experience in medical ethics and as a physician. He is not an expert in obstetrics or clinical abortion care. Dr. Curlin does teach about the ethics surrounding abortion care. Dr. Curlin testified that an *elective* abortion can never be ethical and claimed it is "a scientific fact" that an embryo is a human being.

Dr. Curlin testified that the 24-hour waiting period is "consistent with well-established norms of medical ethics." The timeframe is a "reasonable number," but not a "magic number." Dr. Curlin asserted that a waiting period is important even though some witnesses testified about the high decisional certainty rates among patients seeking abortions. "Certainty has nothing to do with informed consent." Time is required to ensure that the patient has read and comprehended the information about their procedure and are voluntarily agreeing to it. The wait may be a burden, "but it's the kind of burden that's really intrinsic to the informed consent process." Dr. Curlin found it incredible that Northland representatives asserted that no patient ever found the waiting

period and informed consent material helpful, contending this established the witnesses' inherent bias. But Dr. Curlin agreed that the waiting period could impose a hardship on patients trying to return for the procedure.

8. Analysis

Based on the testimony presented at trial, and after weighing the relative credibility of the witnesses and examining the evidence presented, the Court finds that the mandatory 24-hour waiting period burdens and infringes upon patients' rights to reproductive freedom. The mandatory delay exacerbates the burdens that patients experience seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a patient will have to disclose their decision to others, and potentially forcing the patient to forgo a medication abortion for a more invasive procedure.

B. Mandatory Uniform Informed Consent

The mandatory uniform informed consent provisions are found in MCL 333.17015. Subsection (2) contains definitions relevant to the remainder of the act.

- Subsection 3 requires that the provider, at least 24 hours before a procedure:
    - confirm that the patient is pregnant, MCL 333.17015(3)(a);
    - orally describe the probable gestational age of the fetus, give information about what to do and whom to contact in case of complications arising from the abortion, and provide pregnancy prevention information developed by the DHHS, MCL 333.17015(3)(b);
    - provide the patient with a standardized summary developed by the DHHS regarding the procedure involved, or, if a DHHS summary is not available, develop a summary that includes the known risks of the procedure and live birth meeting other statutory requirements, MCL 333.17015(3)(c);
    - provide the patient with a depiction, illustration, or photograph and description of the fetus supplied by the DHHS, MCL 333.17015(3)(d);

- provide a physical copy of a prenatal and parenting information pamphlet, MCL 333.17015(3)(e);

- provide a copy of the prescreening summary on coercion prevention, MCL 333.17015(3)(b).

- Subsection 4 instructs where the requirements of Subsection 3 can be fulfilled (a qualified provider's office, local health department, through the DHHS website). MCL 333.17015(4).

- Subsection 5 then provides instructions on how a patient may fulfill the requirements of subsection (3)(c) through (f) on the DHHS website, including confirmation and printing requirements at least 24 hours before the procedure. MCL 333.17015(5).

- Subsection 6 mirrors Subsection 3, but provides instructions to the provider regarding obtaining the patient's consent 24 hours before the procedure. MCL 333.17015(6).

- Subsection 7 instructs that a patient's personal health information is not to be disclosed around others. MCL 333.17015(7).

- Subsection 8 concerns ultrasounds, and a provider's requirements to obtain, provide, and retain patient consent forms. If the patient is given an ultrasound before a procedure (which is required by the standard of medical care), the provider is required to offer to show the patient an image of the ultrasound, and offer to provide the patient with a physical copy of the image. MCL 333.17015(8).

- Subsection 9 governs how and when providers may obtain payment for services, proscribing payment before the 24-hour, mandatory waiting period expires unless a series of requirements are met. MCL 333.17015(9).

- Subsection 10 provides a "medical emergency" exception to the 24-hour waiting period following standardized informed-consent requirements in Subsections (1), (3), and (6). MCL 333.17015(8).

- Subsection 11 details what the DHHS must do in order to implement and facilitate the standardized informed-consent process and mandatory 24-hour waiting period. The DHHS must:

    - produce standardized illustrations and depictions of the fetus at gestational ages, in nontechnical English, Arabic, and Spanish, with probable anatomical and physiological characteristics, MCL 333.17015(11)(a);

    - develop, draft, and print standardized summaries of various abortion medical procedures that describe the procedures and identify complications associated with the procedures and live birth, MCL 333.17015(11)(b)(*i*) and (*ii*);

    - state that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that

if these symptoms occur and are intense or persistent, professional help is recommended**,** MCL 333.17015(11)(b)(*iii*);

- provide a disclaimer that all the complications identified in the provided literature may not apply in all cases, MCL 333.17015(11)(b)(*iv*);

- identify services available to assist the patient—who is seeking abortion care—in finding pregnancy assistance and assistance after childbirth, if the patient chooses to forgo the abortion, MCL 333.17015(11)(b)(*v*);

- identify services available to assist the patient—who is seeking abortion care—in finding adoption and foster care options after childbirth, MCL 333.17015(11)(b)(*vi*);

- identify services available if the patient needs counseling should they experience adverse psychological effects from the abortion, MCL 333.17015(11)(b)(*vii*);

- develop and implement the standardized consent form, MCL 333.17015(11)(c);

- make the forms and information developed by the DHHS available to providers, MCL 333.17015(11)(d);

- develop standardized summaries regarding abortion procedures, MCL 333.17015(11)(e);

- develop forms for local health departments to use to verify confirmation of pregnancy, MCL 333.17015(11)(f);

- develop, operate, and maintain a website where patients can access information required in subsection (3)(c) through (f), along with the consent forms and verification process, MCL 333.17015(11)(g);

- include on the website a list of health care providers, facilities, and clinics that offer to perform ultrasounds free of charge, MCL 333.17015(11)(h);

- Consider the standards and recommendation of various listed organizations and do the following:

    - Develop notices to be posted at facilities that contain statements that it is illegal under Michigan law to coerce an individual to have an abortion, that help is available if an individual is being threatened or intimidated, and telephone number of at least one domestic violence hotline and one sexual assault hotline.

    - Develop, draft, and make available a prescreening summary on prevention of coercion to abort, and notice that oral screening on coercion will occur before written consent to obtain an abortion is given.

    - Develop, draft, and implement coercion screening training tools for providers.

    - Develop, draft, and implement protocols and training tools advising providers on what to do if a patient discloses coercion. MCL 333.17015(11)(i).

- Subsection 12 contains a disclaimer that a physician is not required to disclose information beyond what a reasonably qualified physician would. MCL 333.17015(12).

- Subsection 13 states that a consent form using the format set forth in the statute is presumed valid, but can be rebutted by a preponderance of the evidence that consent was obtained illegally. MCL 333.17015(13).

- Subsection 14 states that a certification signed by a local health department representative is presumed valid, but that presumption can be rebutted by a preponderance of the evidence. MCL 333.17015(14).

- Subsection 15 states that the statute does not create a right to abortion. MCL 333.17015(15).

- Subsection 16 states, notwithstanding other provisions, a person shall not perform an illegal abortion. MCL 333.17015(16).

- Subsection 17 is a severability provision, which states that if some portions of the statute are deemed invalid, other parts remain operable. MCL 333.17015(17).

- Subsection 18 states that, if requested by the patient, a local health department must provide a pregnancy test to determine gestational age and, if pregnancy is confirmed, complete a certification under (11)(f). The health department does not need to follow these mandates if requirements of Subsection (3)(a) have already been met. MCL 333.17015(18).

- Subsection 19 states that a patient's identity is to remain confidential and can only be disclosed if informed consent is litigated. MCL 333.17015(19).

- Subsection 20 instructs the local health department regarding confidentiality and duty to destroy identifying patient information within 30 days after assisting a patient. MCL 333.17015(20).

MCL 333.17015a instructs that a provider must orally screen a patient for coercion to abort using the screening tools in subsection (11), and that the screening may occur after the informed-consent requirements in subsection (3) have been met. The statute further provides that, if a patient

discloses domestic violence, even without coercion to abort, the provider shall follow protocols developed by the DHHS and set forth in subsection (11).

Plaintiffs argue that the mandatory informed-consent requirements in MCL 333.17015 and MCL 333.17015a burden and infringe upon the right to receive abortion care. Plaintiffs assert that the mandatory counseling is at odds with the standard of care, which requires medical providers to give individualized, patient-centered advice. Plaintiffs also argue that the laws require abortion providers to give inapplicable information (like pregnancy and parenting information) and inaccurate information (such as showing pictures of the gestational age of the fetus with comparisons to pieces of fruit, which plaintiffs argue are not always accurately depicted). Plaintiffs further assert that there is no medically necessary reason to show patients seeking an abortion a depiction of a fetus or provide parenting advice, and doing so places an emphasis on choosing against an abortion, is stigmatizing, paternalistic, and unnecessary. Plaintiffs maintain that no other medical procedure in Michigan requires a similar uniform informed consent. In all other instances, informed consent is left to the discretion of medical professionals and the dictates of their ethical and professional obligations.

Intervening defendant argues that the informed-consent statute does not place an *undue* burden on obtaining abortion care, and is in keeping with the state's compelling interest to protect the health of the patient.

1. Renee Chelian

Ms. Chelian testified that many patients found the informed consent requirements confusing and the DHHS website difficult to navigate. The process of reviewing the information on the website takes a significant amount of time and if the user needs to stop, their progress could

not be saved. Many users did not have access to a printer and were hesitant to print their confirmations at public places. Patients often had to reschedule their procedure because they could not successfully complete the online review and print the confirmation page.

Ms. Chelian testified that patients were often frustrated when the provider reviewed all the mandatory information with them again, after the patient was already required to review the information on line. It created a hostile situation and sowed seeds of distrust between the patient and doctor. Forcing patients to review state-mandated materials even once is inconsistent with NAF guidelines. Since the preliminary injunction was entered, Northland staff has spent less time "on the phone talking about the state website" and more time with patients. This reduced wait times to secure an appointment and created opportunities for patients to come in on the spur of the moment when childcare or transportation became available.

Ms. Chelian testified that in some cases, it was cruel to provide irrelevant information to patients seeking an abortion. Pictures of fetuses with normal development and information about parenting and adoption, for example, could not assist a patient seeking an abortion because of a severe or fatal fetal anomaly. And most patients do not ask to see a fetal development chart and only some ask to see the ultrasound performed to determine the fetus's gestational age. Even if an abortion is sought for an otherwise healthy fetus, it is not the standard of care to provide prenatal and parenting information to a patient who has chosen abortion. Such information should only be provided if requested. Northland provides information about alternatives to abortion if a patient is uncertain about what she wants to do and asks.

Ms. Chelian agreed that patients should be advised of the potential medical risks of an abortion procedure. However, she opined that a patient need not be warned about every risk

connected to each type of procedure; only the procedure the patient will actually have. Ms. Chelian testified that the Legislature only requires doctors to advise patients of all procedure alternatives in relation to abortion and no other category of healthcare. Finally, Ms. Chelian testified that warning patients they may feel anger, grief, guilt, or shame after an abortion is misleading. These are common feelings even after a miscarriage or putting a child up for an adoption. These feelings may also occur in pregnancy and after giving birth.

2. Dr. Charise Loder

Dr. Loder described the risks associated with different abortion procedures. She explained that 99 out of 100 women experience no complication with medication and aspiration abortion, and 98 out of 100 patients experience no complication with a D&E abortion. She testified that the mandatory information "overly emphasized" the risks of these procedures while "downplay[ing]" the risks of childbirth, which kills 14 patients in 100,000 births.

The mandatory information must be provided in person, by registered or certified mail, or by fax. Dr. Loder testified that her patients do not have fax machines. Service by certified mail was not viable because most patients are not home during the day to sign for service. Forcing patients to make two trips—one to collect the materials and the other for the abortion procedure—imposes obstacles for patients at the University of Michigan because of parking issues. Additionally, at any clinic, the patient faces obstacles of trying to find transportation or childcare and taking time off of work for two trips.

Dr. Loder testified that it is against the standard of care to provide a patient information irrelevant to or inaccurate in their situation. Rather, a doctor should consider the individual patient's medical history and information about their pregnancy to identify the risks and

complications that may occur. Similarly, Dr. Loder opined it is improper to give every patient seeking an abortion information about the option of childbirth. She cited the example of a patient whose fetus has a fatal skeletal anomaly and would not survive childbirth. Consistent with the standard of care, Dr. Loder's clinics provided informed-consent forms for each type of abortion procedure, detailing the information relevant to that procedure. Dr. Loder has also selected or developed preprinted material to further educate patients about the "average description[]" of many procedures, but only provides this information in connection with a doctor-patient conversation. The difference is that the statute requires this information be provided before speaking to a doctor, while the standard of care is to provide this information in an educated way while or after meeting with the doctor. Further, it is not the standard of care to provide information about a more invasive procedure simply because there is a 1% risk that a patient attempting a medication abortion may have to have a more invasive procedure as a follow up. If that complication arises, the physician can address it with the patient and secure consent at that time.

The DHHS-developed fetal development pictures are not to scale and are "overly detailed how large they are in their life." This leads patients to believe their pregnancies are farther along than in reality. Further, some of the fruits and vegetables used as comparison items are not within the common understanding and can themselves vary in size. It is not an accepted clinical standard to give fetal development charts to patients seeking an abortion. A patient does not need to know the size of the tissue they will pass in an abortion, only the amount of bleeding they might experience.

Dr. Loder testified that much of the mandated information is inaccurate. Dr. Loder conceded that she would advise abortion patients that they may experience sadness, grief, or guilt after an abortion, but she provides the same advice after a miscarriage. She testified that studies

had refuted the statement in the mandated information that an abortion increases the risk of later preterm births. The mandated information about second trimester labor induction abortion was out-of-date. A patient now needs to stay at the hospital only one day, not three. Pitocin is no longer used, only mifepristone and misoprostol. The information about D&E, on the other hand, downplayed the pain a patient might experience.

3. Professor Kayte Spector-Bagdady

Based on her years of experience, research, and expertise in the field of bioethics, Professor Spector-Bagdady opined that the challenged laws do not improve—and in fact, undermine—informed consent to a medical procedure. She articulated that informed consent should be focused on a neutral and timely presentation of the most important risks, benefits, and alternatives such that the patient can decide in line with their own values without the coercive influence of the state, clinician, or others on that decision. Professor Spector-Bagdady further explained that the purpose of informed consent is to protect patients' bodily integrity and right to medical self-determination. The common-law standard that has developed over time establishes that physicians have a duty to disclose medical risks and benefits related to a proposed procedure, and the relevant standards allow for flexibility and tailoring to a patient's circumstances. It includes specific information about the diagnosis and prognosis. Informed consent also involves the patient's capacity to understand the information, which must be judged individually. In jurisdictions like Michigan, the scope of the disclosure is tied to the professional standard of care.

Professor Spector-Bagdady testified that providing a fetal development chart is not consistent with informed consent. The doctor noted that "very few, if any, I think none," of the patients would be seeking an *elective* abortion at 28 weeks, the cutoff date for the chart. Further,

it is irrelevant to informed consent for any procedure to show the patient images of the material to be removed from their body.

The provision of state published standard summaries of abortion procedures is also not consistent with informed consent. The benefits, risks, and alternatives must be relevant to the individual patient. A patient with a nonviable pregnancy does not need to understand the risks or benefits of live childbirth as an alternative to abortion. The warning about negative emotions is not consistent with the standard of care and is not supported by research. In fact, the medical literature following the Turnaway Study disproves that patients are likely to suffer depression, sadness, and guilt following an abortion. The mandated disclosures are not saved by the statutory provision advising patients to review the materials and then discuss with their doctor. It serves as a bait and switch and undermines the patient's confidence in their provider.

Professor Spector-Bagdady noted that the Legislature also governs the informed consent for genetic testing. The statute requires the state to produce an informed consent form addressing the material risks, benefits, and alternatives to a genetic test. But the Legislature does not mandate the use of the form. Rather, use of the form creates a presumption of informed consent.

4. Dr. Natasha Bagdasarian

Dr. Bagdasarian testified that informed consent is necessary to respect a patient's bodily autonomy. To that end, a provider should give the patient the best information tailored to their condition and goals. If a patient expresses the goal to terminate a pregnancy, the informed consent process should be geared toward that goal. Accordingly, it would be inappropriate to give the patient irrelevant information about parenting following childbirth. Providing information about

breastfeeding and safe sleep practices to a patient seeking an abortion is coercive and designed to invoke feelings of guilt.

Dr. Bagdasarian testified that the unrequested provision of a fetal development chart would also have a coercive effect. Dr. Bagdasarian noted that intervening defense counsel asked at her deposition whether it was important to know the approximate size of the fetus so the patient could "pick out the fetal parts" when released from the body during a medication abortion. The fetal tissue at that point is the size of a poppy seed and could not be found without a microscope. In this way, even the attorney was confused by the overly large sized images of the fetus in the mandated fetal development chart. And many abortions are sought because of congenital abnormalities. The images in the fetal development chart do not correspond with the involved fetus and may confuse the patient or give the patient false hope.

Dr. Bagdasarian testified a patient having a medication abortion should not be required to review information about more invasive methods of abortion. Further, it is premature to force a patient to read descriptions of each type of abortion before the patient has even spoken to the provider about the type of abortion that is best for them under the circumstances. Not only is the information irrelevant, but every patient is different and the risk of particular harms vary by individual. The risk warnings should be individualized to ensure that patients with high risk factors are given correct information.

In relation to the warnings about negative emotions following an abortion, Dr. Bagdasarian testified that every individual is different and the same negative emotions could follow many other procedures, such as hysterectomy or mastectomy. The better course is for a medical provider consulting with the patient to explain the potential emotions in a more nuanced and relevant way.

Overall, Dr. Bagdasarian opined, "It just doesn't make a lot of sense for legislators with no medical background to insert themselves in this conversation between a healthcare provider and a patient."

In relation to the list of available ultrasound technicians that must be included in the state materials, Dr. Bagdasarian testified that the DHHS is required to include a provider of free ultrasounds on the list even if the provider does not employ licensed medical professionals. This could be dangerous because a person unqualified to read the ultrasound image might miss an ectopic pregnancy or major congenital issues, or could even improperly age the fetus. The DHHS is required to add any requesting provider, even if the provider is an anti-abortion group with the goal of encouraging patients not to pursue abortion. The nature of the ultrasound provider is not evident from the list and a patient would have to research each. However, as the list is published by a government source, patients likely assume that research has already been done.

5. Dr. M. Antonia Biggs

Dr. Biggs focused on the mandatory mental health warnings under the challenged statutes. She testified that the statement that people having an abortion are likely to experience sadness, regret, and other negative mental health outcomes was not evidence based. The Turnaway Study showed that those who received an abortion and those who were denied experienced similar levels of various mental health outcomes, but that those denied an abortion experienced a higher level of anxiety, stress, and low self-esteem in the six months after the abortion decision. Further study revealed that abortion was not the cause of many of the negative mental health outcomes observed. Rather, those with a history of mental health conditions, trauma, or abuse were more likely to suffer adverse mental health outcomes after seeking an abortion.

Dr. Biggs also cited studies by the APA and the National Academy for Sciences, Engineering, and Medicine. These studies similarly found that having an abortion does not increase a patient's risk of adverse mental health outcomes. The most commonly reported emotion following an abortion was relief. Although many participants felt negative emotions, such as sadness, at the same time, emotions do not translate to a negative mental health outcome. Patients reported "situational regret," meaning they regretted the situations that led them to choose abortion, but not the abortion itself. The Turnaway Study also asked participants about the helpfulness of mandated abortion counseling materials. Those exposed to such materials reported that they were not helpful. Ultimately, Dr. Biggs asserted the mandated mental health warnings are not evidence-based, they are misleading, and they increase the stigma connected to abortion.

6. Dr. Monique Chireau Wubbenhurst

Dr. Wubbenhurst testified that standardized informed consent materials with good graphics and easy-to-understand text are beneficial, especially when patients have limited literacy. She finds it paternalistic for a doctor to pick and choose what information an individual patient will find relevant. For the "most optimal consent," a provider should make available as much information as possible.

Dr. Wubbenhurst testified that an abortion patient needs information about all procedure types. She asserted that one in 20 women receiving a medication abortion will require a surgical procedure to complete the abortion. Moreover, the gestational date may be inaccurate, requiring the provider to change procedure methods. Dr. Wubbenhurst opined the procedure summaries required to be given to all abortion patients in Michigan were accurate. She also testified that it was accurate to describe carrying a child to term and either parenting or placing the child for adoption as alternatives to abortion. Dr. Wubbenhurst asserted that this was not a burden, because

"research shows that a majority of women would prefer to parent their child," but feel they cannot for various reasons. Dr. Wubbenhurst also testified that the rate of fatal fetal anomalies is rather low, especially as research into fetal surgery has increased lifesaving opportunities, meaning that it is not cruel to provide information about carrying to term to all patients.

Dr. Wubbenhurst testified that she has provided care "for thousands of women" during the course of her career, "many of whom have had an abortion." She testified that these women reported feelings "of sadness, guilt, anger, trouble sleeping, or doing daily activities after an abortion." Dr. Wubbenhurst disagreed that the mandatory warning about these emotions implied negative mental health outcomes and opined that the warning included accurate information. However, Dr. Biggs reviewed Dr. Wubbenhurst's deposition testimony and opined that Dr. Wubbenhurst conflated negative emotions with a diagnosed mental health condition.

Dr. Wubbenhurst criticized the Turnaway Study on which many of plaintiffs' experts relied. She noted that only 19% of the original 956 patients participated for the entire five-year period. She surmised that the patients with the most negative experiences would be most likely to drop out of the study, leaving skewed data. She referred to this phenomenon as attrition bias. A broader literature review, Dr. Wubbenhurst testified, revealed that studies have reached vastly different results when measuring the emotional impact of abortion. Dr. Wubbenhurst also complained that the raw data had not been uploaded to a data depository for further analysis by outside researchers.

Dr. Wubbenhurst further found no problem with providing all patients seeking an abortion a fetal development chart. She opined that knowing the size of the fetus "has a bearing on the amount of pain" the patient will feel in passing the tissue, both in a miscarriage and a medication

abortion. In her experience, "gestational age associates with the amount of pain." "[U]nderstanding the spectrum of fetal development is helpful" to a patient in deciding whether to continue a pregnancy. Although the fetal development chart might not be completely accurate for all pregnancies, Dr. Wubbenhurst asserted that the generalization is necessary given the volume of information on deviations and anomalies. However, Dr. Wubbenhurst admitted she had reviewed no studies finding that the provision of a fetal development chart improved decision-making.

Dr. Wubbenhurst testified that in her experience, clinics labeled by plaintiffs' experts as "crisis pregnancy centers" do have providers on staff who can read and interpret ultrasounds. In 1998 and 1999, Dr. Wubbenhurst's OB/GYN practice shared a building with a crisis pregnancy center, and she personally provided the ultrasound services for that clinic. More recently, Dr. Wubbenhurst asserted she was acquainted with the director of a crisis pregnancy center in Michigan (although she could not remember their name) and that clinic had sonographers to perform the ultrasounds and physicians to review them. Dr. Wubbenhurst had conducted two webinars for crisis pregnancy centers and learned about their practices and services at that time. Moreover, the websites of many listed ultrasound providers indicate that the clinic has a sonographer on staff.

Dr. Wubbenhurst also testified that "there is research to suggest that the death rate is higher for women who undergo abortion than for women who carry to term," heightening the standard for patient education. The 2002 article relied upon by Dr. Wubbenhurst, however, tracked women who had induced abortion in 1989 for eight years, and counted all deaths regardless of the cause.

7. Dr. Farr A. Curlin

Dr. Curlin defined informed consent "as a matter of respect for the patient's bodily integrity" requiring that the patient not have a "medical intervention without their duly informed consent." Dr. Curlin testified "that it is [a] very ordinary practice, widely across medicine to . . . give people standardized information" about a procedure as a tool to secure informed consent. This "frequently" includes information that may not be relevant to the particular patient. The provider does not always know what is relevant to the particular patient and the standardized information opens the door for conversations between the doctor and patient. The patient can "click through the online form" without giving serious consideration to material they find irrelevant. Once with the provider, the provider can tailor the information to the patient. The statutes provide a minimum threshold or floor for information.

Dr. Curlin reviewed the materials prepared by the DHHS in response to MCL 333.17015(11) and found them to be "a model of even-handed scientifically accurate provision of information that a reasonable person might want to know." Dr. Curlin opined that nothing in the materials was skewed to convince a woman not to abort.

Dr. Curlin testified that the required information about post-abortion negative emotions was accurate. In fact, Dr. Biggs cited a study showing that 24% of women "had primarily negative emotions" in the week following an abortion. Dr. Curlin opined informed consent requires a patient to receive information about the various available treatment options, giving the patient an option to refuse treatment.

Dr. Curlin found the fetal development chart "reasonably accurate," although admitting this was outside the scope of his medical expertise. Studies have shown that some women decide

against an abortion after reviewing such information, proving this type of information was helpful to those patients' informed consent. In relation to the breadth of information mandated on the DHHS site, Dr. Curlin asserted a patient could simply skim over the information that is not relevant to them.

Dr. Curlin opined, in part, that states should require specific information be given to abortion patients because abortion providers have inherent biases and a vested interest in their practices that would color the information otherwise given. Dr. Curlin further testified that ACOG actively seeks to skew abortion information, promoting the presentation of inaccurate information to patients.

8. Analysis

The Court finds that many provisions in MCL 333.17015 burden and infringe upon a patient's right to make and effectuate decisions about abortion care. The entirety of Subsection (3) fails strict-scrutiny review. As already noted, the mandatory 24-hour waiting period of MCL 333.17015(3) burdens and infringes upon access to abortion care.

Subsection (3)(a) requires a provider to confirm that a patient seeking an abortion is pregnant and to determine the likely gestational age of the fetus. This is obviously a standard-of-care issue. No doctor would perform any abortion on a patient who is not pregnant and no doctor would recommend or perform an abortion procedure without confirming gestational age. Failure to do either of these steps would surely lead to a medical malpractice case.

Subsection (3)(b) requires the provider to orally describe certain information in a manner designed to ensure that the particular patient understands. That information is (*i*) gestational age, (*ii*) where to seek help for abortion complications, and (*iii*) how to obtain contraception

information from the DHHS. Again, provision of the information in Subsections (3)(b)(*i*) and (*ii*) is part of the standard of care, making the statutory provisions unnecessary. Subsection (3)(b)(*iii*) is, however, problematic. Patients visit abortion providers for one purpose, to secure an abortion, not for general gynecological care. Further, many women want to be pregnant but seek an abortion to preserve their health or because the pregnancy is not viable. It would burden or infringe upon reproductive rights to ask if such a patient would like information about contraception. Forcibly giving DHHS-produced materials on the subject without a request is paternalistic and stigmatizing, making the patient feel belittled for becoming pregnant.

Subsection (3)(c) requires a physician to provide the DHHS standard summary of the particular procedure to be performed. Plaintiff's experts explained that these descriptions inflate the risks of the abortion procedures while downplaying the risks of childbirth. Only defense witness Dr. Curlin claimed that abortion is riskier than childbirth. Although this subsection requires the provider to share only the summary of the planned procedure, this cannot "unring the bell" of the information gleaned from materials required to be provided at least 24 hours before the procedure. The conversation between patient and provider under Subsection (3) is the second step in the mandatory informed-consent process. At least 24 hours earlier, the patient must review the entire packet of DHHS-created materials, including descriptions of each type of abortion procedure. MCL 333.17015(5). The patient's access to abortion care has already been burdened and infringed upon by being forced to review irrelevant and inaccurate materials.

Subsection (3)(d) also infringes upon and burdens a patient's right to access reproductive care. Plaintiff's experts universally agreed that fetal development charts are irrelevant for a patient seeking abortion care. A patient seeking to terminate a pregnancy does not require information about the growth of a fetus. The information is coercive and stigmatizing as the only reason for

requiring it is to dissuade an abortion patient. Providing the chart to a patient seeking an abortion for a nonviable pregnancy or severe fetal anomalies is cruel. For the same reasons, subsection (3)(e)'s requirement that all patients receive information about prenatal care and parenting burdens and infringes upon patient rights.

MCL 333.17015(4), (5), and (6) govern the provision of information under the subsections of MCL 333.17015(3). Subsection (7) is inextricably linked to the presentation of information required in Subsections (3) and (6). Similarly, Subsections (8)-(10) are integrated with the informed-consent process. If Subsections (3) and (6) burden and infringe upon a patient's rights, Subsections (4), (5), (8), and (10) do as well.

Subsection (11) explains the duty of the DHHS to produce the material to be provided to abortion patients under Subsections (3) and (6). Subsection (11)(a) requires provision of the DHHS-created fetal development chart. As noted, the provision of a fetal development chart without a request from the patient is inconsistent with the standard of care, and the material is irrelevant to the provision of abortion care.

Subsection (11)(b) governs the production of the procedure summaries that will be provided to patients. This subsection requires the DHHS to develop separate descriptions for each procedure type and to include information about potential complications with each type.[14] Subsection (11)(b)(*iii*) requires each summary to state that as a result of having an abortion, a patient "may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or

[14] Subsection (11)(e) limits the DHHS to including only information about Federal Drug Administration-approved drugs in the procedure summaries. Although this provision is not objectionable standing alone, it has no purpose without Subsection (11)(b).

sex, or anger." Plaintiff's experts testified that there is no causation between abortion and negative emotions or adverse mental health outcomes. The Turnaway Study found no substantial difference between the negative emotions felt by patients who secured an abortion and those who were denied an abortion shortly after the legal cut-off date. The witnesses testified that the same negative emotions accompany pregnancy, miscarriages, and various surgical procedures. Moreover, studies show that negative emotions connected to abortion are more often caused by the situation that led to the abortion, rather than the abortion itself. The provision of this information is not evidence-based, and instead results in stigmatizing patients seeking abortions. Subsection (11)(b)(*iv*) requires the DHHS to indicate that not all patients will experience all complications described in the procedure summaries. This statement is insufficient to ease the burden of receiving inaccurate and coercive information about mental health outcomes.

Subsections (11)(b)(*v*) and (*vi*) require the DHHS to identify services to assist patients during their pregnancy and with parenting, as well as information about foster care and adoption should the patient choose to carry to term. The Court discerns no issue with providing this type of information if requested by an undecided patient. However, such information is irrelevant to a patient who has chosen abortion. The provision of this material is intended to increase the guilt of a patient choosing abortion, thereby unduly burdening and infringing upon the patient's access to abortion care.

Subsection (11)(c) makes clear that abortion providers must share all the information from the DHHS materials with each patient, regardless of its accuracy or relevance to the particular patient. The DHHS must develop a standardized acknowledgment and consent form, attesting, in part, that the patient received information about the development of a fetus, the selected procedure,

the potential complications of the procedure, and prenatal and parenting information. This subsection thereby also unduly burdens the patient's care.

Subsection (11)(f) requires the DHHS to develop a form that local health departments may use to certify the fact of a pregnancy for a requesting patient. This form is rendered unnecessary by the invalidation of other statutory provisions. The same is true of Subsection (18), as it is tied solely to the requirements of Subsection (11)(f).

Subsection (11)(d) requires the DHHS to make available to abortion providers all materials developed under Subsections (11)(a), (b), (c), (f), and (i). As all but Subsection (11)(i) burden and infringe upon patient rights, Subsection (11)(d) must be radically revised to survive constitutional scrutiny.

Subsection (11)(g) requires the DHHS to create a website from which a patient could access the materials required to be provided 24 hours in advance of an abortion procedure. The DHHS was required to develop a final page from which a patient could print a time and date-stamped confirmation form, attesting that the patient reviewed the information. However, the information mandated under Subsection (3) and (6) burdens and infringes upon a patient's access to abortion care. Patients can no longer be required to access the DHHS website and print out a confirmation to bring to the abortion provider. This provision, too, burdens and infringes upon patient rights.

Subsection (11)(h) requires the DHHS to include a list of free ultrasound providers on its informed-consent website. That website will no longer be required following this judgment and

so no longer will this requirement.[15] Subsection (13) is also no longer required; it provides that the form printed from the DHHS website creates a presumption that the patient's consent is valid. Similarly, Subsection (14)'s creation of a presumption that a health department's certification under Subsection (11)(f) is valid is no longer required.

Subsections (19) and (20) maintain the confidentiality of patients required to review information and seek certifications and confirmations in invalidated portions of MCL 333.17015. While the anonymity and privacy of all patients is of utmost important, there will no longer be a link between the DHHS or local health departments and patients seeking abortion. These provisions will no longer have a subject to protect.

Overall, the Court finds that the discussed statutory provisions burden and infringe upon a patient's right to make and effectuate decisions about abortion care. Those provisions include those requiring the DHHS to develop and providers to present information to abortion patients about the risks associated with live birth (when the medical procedure at-issue is abortion care); illustrations and depictions of the fetus; prenatal care, parenting and adoption; and offering the patient to see images of any ultrasound performed are designed to guide a patient away from the choice of having an abortion by juxtaposing content that is clearly more relevant and suitable to those seeking to complete a pregnancy. Such information certainly impacts the patient's choice to seek abortion care and encroaches on the patient's decision-making process. The provisions therefore burden and infringe upon a patient's right to make and effectuate decisions about abortion care.

[15] The Court will address Subsection (11)(i) in relation to coercion screening in Section VI.B.4.

Similarly, by directing the DHHS what it must do in order to implement the mandatory informed-consent requirements, the Legislature further burdens and infringes upon a patient's right to make and effectuate decisions about abortion care. In this way, Subsection (11) squarely inserts the DHHS into the patient-provider relationship. The mandatory nature of the information that the DHHS is required to develop and disseminate, and the very fact that the DHHS is placed in between the patient and provider, has an impact on how a patient makes and effectuates decisions regarding abortion care. This impact is not merely incidental or tangential. The informed-consent provisions, read as whole, are designed to force a patient to consider the alternative of *not* having an abortion. The manner in which the information is presented is not neutral; it is designed to eschew abortion in favor of completing a pregnancy and further stigmatize a patient seeking abortion care. This forced deliberation, through the mandatory informed-consent process, burdens and infringes upon a patient's right to make and effectuate decisions about abortion care. The State is metaphorically putting its finger on the scale, thereby infringing upon a patient's deliberative process.

C. APC Provider Ban

Plaintiffs argue that the statutory limitation on abortion providers arbitrarily and needlessly limits APCs from providing medical care otherwise within their scope of practice and licensure, thus placing logistical burdens on obtaining abortion care. Plaintiffs contend that APCs routinely manage miscarriages in Michigan by administering the same medical protocols involved with abortion care. In keeping with their scope of practice and professional standards, APCs provide

safe abortion care in other states.[16] In Michigan, APCs are able to prescribe and oversee the use of controlled substances, and certified nurse midwives are permitted to attend deliveries, all of which are riskier and more complex than early abortion care. Plaintiffs argue that the APC ban does not serve a legitimate medical purpose and instead artificially limits the number of abortion care providers in the state. As a result, it creates barriers to abortion access, increases patient wait times, and increases travel distances. This impact exacerbates provider shortages and is acutely felt in rural and underserved communities.

Intervening defendant argues that limiting abortion providers to licensed physicians does not burden, restrict, or infringe upon accessing abortion care, and is in keeping with the state's compelling interest that patients receive high quality medical care from competent medical providers.

1. Renee Chelian

Ms. Chelian testified that in those states where APCs are permitted to provide abortion care, they did so just as safely as physicians. Allowing APCs to perform abortions was consistent with NAF guidelines. And Ms. Chelian had no qualm with hiring APCs for the Northland practices, but at the time of trial, the clinics were fully staffed.

2. Dr. Charise Loder

Dr. Loder testified that she has provided training for APCs, giving her an informed opinion. Certified nurse midwives are permitted to employ the same medications used in medication abortion to induce labor and to treat early pregnancy loss. Based on her observation in the field,

[16]See Yannow, *It's Time to Integrate Abortion Into Primary Care*, 103 Am J Public Health, 14-16 (January 2013) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3518342/> (accessed May 12, 2025).

Dr. Loder opined that APCs could safely provide medication abortion care to patients. Similarly, APCs already insert IUDs, which requires the same skills as dilation and suction aspiration procedures. Dr. Loder had observed APCs insert dilators, the first step in a D&E, but not complete a D&E. Dr. Loder testified that APCs could recognize abortion complications as easily as a physician. Certified nurse midwives, for example, already recognize and manage pregnancy and labor complications. The physician-only rule is contrary to evidence-based medicine supporting that APCs can safely perform these procedures.

The physician-only rule has contributed to the shortage of abortion providers in the state. Most abortion clinics and providers are in southern Michigan, and there is a need in northern Michigan and the Upper Peninsula. Upper Peninsula health departments already rely on APCs to provide contraceptive care. Further, Dr. Loder had circulated surveys before the preliminary injunction entered and learned that a large number of APCs were interested in providing medication abortion care. Since the injunction entered, APCs had provided such care at Planned Parenthood of Michigan and the University of Michigan.

3. Dr. Natasha Bagdasarian

Dr. Bagdasarian testified that the medications and procedures used for medication abortion are the same as used in early miscarriage care. APCs already provide miscarriage care and so could safely provide medication abortions. Other APCs manage labor and delivery. The risk of complication or death from childbirth is much higher than with an abortion. Accordingly, Dr. Bagdasarian testified that with the proper training and certification, an APC could provide abortion care just as safely as a physician. Permitting APCs to provide abortion care would help ease the physician shortage in rural parts of the state, especially the Upper Peninsula.

4. Dr. Amy Levi

Dr. Amy Levi is a certified nurse midwife and women's health nurse practitioner. In other words, she is an APC with a PhD in nursing. From 1987 through 2012, Dr. Levi provided a full scope of OB/GYN care for patients. She consults with the New Mexico Department of Health on its reproductive health access project. Dr. Levi also coordinates regular meetings of abortion providers in New Mexico. Dr. Levi was the vice president of academic affairs and director for the Office of Interprofessional Education for the New Mexico Health Sciences Center and is an endowed professor of midwifery at New Mexico's College of Nursing. Dr. Levi has published in peer-reviewed journals on various topics, including articles about midwives providing abortion care.

Dr. Levi testified that APCs include nurse practitioners, nurse midwifes, and physician assistants. Dr. Levi testified that APCs have become much more prevalent in the United States and often provide care in underserved communities, such as rural and poor urban areas. Prohibiting APCs from performing abortion care reduces the number of qualified providers and limits the ability of those in underserved communities to find care. Studies in Colorado and New England established that there are APCs who would like to be trained in abortion care.

Dr. Levi testified about the education, licensing, and certification of APCs in Michigan. APC formal education has become longer over the years to reflect the roles they fill. They must complete on-the-job training, just like physicians. A certified nurse midwife, for example, must complete not only nursing school, but also graduate from an accredited midwifery program. This could be a masters or doctoral program. The student must then pass a certification examination. The same is true of nurse practitioners. These APCs' practices are limited to the scope of their

certifications. Certified nurse midwifes and nurse practitioners operate independently in Michigan. A physician's assistant, on the other hand, works under the supervision of a physician.

Dr. Levi has trained APCs to provide abortion care—both in class and skill-based, simulated training. Dr. Levi personally conducted research into the safety of APC-provided abortion care based on the practices of 43 California-based APCs who were trained to perform aspiration abortion. The study revealed no difference in the outcomes between APC and physician-provided abortions. The study was published in two peer-reviewed journals. Similar research conducted by the World Health Organization, the American Public Health Association, and ACOG reached the same result.

Dr. Levi opined that APCs can be trained to safely provide abortion care. Many already provide miscarriage management, which is very similar to medication or aspiration abortion in the first trimester. In Michigan, APCs already use the same medications used in abortion to manage miscarriages. Twenty-two states permit APCs to provide medication abortion care and 20 allow APCs to perform aspiration abortions. In the past decade, it became more common for APCs to be permitted to provide abortion care. Similar to physicians, an APC may expand the scope of care they provide by engaging in workshops, continuing education, and finding relevant on-the-job training opportunities. Many APCs provide services much more difficult and riskier than abortion care. For example, certified nurse midwifes independently respond to emergency situations during labor and APCs manually remove placentas, a procedure much more invasive than an aspiration abortion. And complications arising from childbirth occur much more frequently than abortion complications.

Ultimately, Dr. Levi testified that prohibiting APCs from providing abortion care does not protect patient health.

5. Dr. Monique Chireau Wubbenhurst

Dr. Wubbenhurst testified that in her experience, APCs have far less educational and clinical requirements than physicians, and therefore could not safely perform abortion procedures. Dr. Wubbenhurst testified that some APCs enter their professional programs with only an Associate's Degree. Because APCs practice over a wide range of clinical areas, their education is more general, rather than being focused on OB/GYN or reproductive healthcare. Physicians, on the other hand, have Bachelor's Degrees and four years of residency with thousands of hours of training.

Dr. Wubbenhurst asserted that there existed an international study (but she could not remember the name) regarding APCs providing second trimester abortions. Dr. Wubbenhurst did not provide information about the results of the research, only that she believed APCs should not perform second trimester abortions. Dr. Wubbenhurst did not believe it would be safe for APCs to provide abortion care in underserved rural areas. Complications can be best managed at a hospital and abortions should be performed nearby.

6. Dr. Farr A. Curlin

Dr. Curlin testified that it would not be unethical for a state to permit APCs to perform abortion care. However, it is also consistent with the standard of care and protection of the bodily integrity of patients to limit the provision of abortion care to providers "who are most able and most trained to deal with its complications." Dr. Curlin noted that serious complications arise "in an unfortunate small minority of" abortion cases and OB/GYNs and physicians would be better

trained and more experienced to deal with those issues. This protects a patient's bodily autonomy to decide to have children in the future. However, Dr. Curlin admitted he was not familiar with the scope of practice of APCs in Michigan, or about the regulations and statutes governing their licensure.

7. Analysis

The Court finds that the APC provider ban arbitrarily limits abortion providers to physicians only, and burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care. Having access to a provider is necessarily linked to being able to make and effectuate decisions about whether to seek abortion care. The artificial limitation on the available pool of abortion providers imposes logistical barriers to abortion access, increasing patient wait time and travel distances. This exacerbates existing provider shortages, leading to large swathes of Michigan without access to nearby abortion care. By allowing APCs to perform some abortion services, the number of healthcare professionals available to individuals seeking care would increase dramatically. The increased number of healthcare professionals would, in turn, increase access to abortion care for individual patients.

D. COERCION SCREENING

MCL 333.17015a requires providers to orally screen patients to determine if someone is coercing them to have an abortion. MCL 333.17015(11)(i) requires the DHHS to develop screening tools to assist providers. These provisions further require providers to post notices in their facilities to advise patients that coercion to abort is a crime and outline available resources.

1. Renee Chelian

Ms. Chelian testified that in her experience coercion to abort is "rare." It is more common for a woman to be forced into or to continue a pregnancy. Independent of the anti-coercion law, Northland has a duty to report domestic and child abuse and does so. Ms. Chelian testified that the state-mandated poster regarding coercion was on display in all Northland facilities. However, she thought it "unfair" and "not accurate" that these materials did not also address coercion to become or remain pregnant. Ms. Chelian found the language on the poster concerning because it references the illegality of the coercion to abort. Many patients are fearful of the police and do not want to see their loved one jailed over the coercion.

In relation to the sample questions outlined in the screening tool developed pursuant to the statute, Ms. Chelian opined the questions were too direct to secure true answers. Coercion screening must be more nuanced and the provider must build a rapport with the patient to ensure the accuracy of the responses. The provider must rely not just on the patient's answers but also their body language and reactions to questions. Northland includes some coercion screening questions in the medical history form sent to a patient ahead of the appointment because it is less threatening. Ms. Chelian testified that Northland would continue screening for coercion regardless of the law.

2. Dr. Charise Loder

Dr. Loder testified that she screens all her patients for domestic violence and other social stressors. It is important to do these screenings in person to establish trust, observe the patient's body language, and observe their interaction with their partner. There is no one effective way to screen for coercion; it must be judged case-by-case. The coercion law, however, requires providers

to explicitly ask the patient whether someone is forcing them to have an abortion. This is not effective, and negatively impacts the trust between patient and doctor. And the law is unnecessary because coercion screening is already part of the standard of care.

Dr. Loder testified that the mandatory direct questions about coercion are most concerning in cases where a pregnant woman makes the difficult decision to abort in consultation with her healthcare providers and family after learning of a fatal fetal anomaly or that the pregnancy would harm the life of the mother.

However, the abortion coercion law is inadequate because it fails to recognize that many patients are coerced to become or remain pregnant.

3. Dr. M. Antonia Biggs

Dr. Biggs testified that legislatively mandated coercion screening tools for abortion are redundant. She further opined it made little sense to legislate against coercion to abort because it is a much more common scenario for a woman to be coerced to maintain a pregnancy in an abusive relationship. The Turnaway Study found that 5% of women seeking an abortion were in violent relationships. Dr. Biggs noted that the mandatory 24-hour waiting period does not decrease the chance of coercion and actually increases the danger for a woman in an abusive relationship.

4. Dr. Natasha Bagdasarian

Dr. Bagdasarian testified that coercion screening should be individualized. The provider must create a rapport with the patient to elicit truthful responses. The statutory requirement is unnecessary because screening a patient for coercion is already part of the standard of care.

Dr. Bagdasarian agreed that the statute's mandate that the provider create a safe environment in which to ask the coercion screening questions is not a burden. It is not a burden to normalize the screening process. It is only a burden to ask the outlined questions if those questions have already been addressed in a prior conversation. Dr. Bagdasarian also agreed that the statute allows the DHHS to modify the screening tool to fix problems that may arise. Although the statutory requirements do not impose a burden, Dr. Bagdasarian opined it was unnecessary for a statute to exist mandating this screening.

The mandatory coercion posters are also in-line with the DHHS's role of advising the public about public health issues. There are similar posters in women's restrooms about sex trafficking and domestic violence. The posters about abortion coercion are not a burden because no one mandates the patients to read them or to sign a document stating they have read them.

5. Professor Kayte Spector-Bagdady

Professor Spector-Bagdady teaches her students to be alert for signs of coercion. One sign is a patient who keeps looking to a partner or family member for answers to questions in the exam room. Other signs are shaking or sweating.

6. Dr. Monique Chireau Wubbenhurst

Dr. Wubbenhurst testified that in her experience in rural impoverished areas and internationally, "abortion is common, and it's not uncommon to be destructive." "[T]here is evidence that many women are coerced into abortion," such as in situations of domestic abuse and human trafficking. A patient cannot give informed consent if they are coerced into a procedure. Dr. Wubbenhurst cited a study finding that 40% of abortion patients are victims of domestic

violence. She also testified that "research suggests that in most abortions women experience coercion of some sort."[17]

Unlike plaintiffs' witnesses, Dr. Wubbenhurst opined that asking direct questions, but in a gentle and compassionate way, during a coercion screening is a good practice. If the screener is hesitant, the patient may become suspicious and trust is lost. Dr. Wubbenhurst found the suggested questions in the statute "helpful" and common for standardized screening tools. The tools are especially useful in Michigan, which Dr. Wubbenhurst described as being in the top 10 states for human trafficking.

7. Dr. Farr A. Curlin

Dr. Curlin found it reasonable to require coercion screening before an abortion and for the state to provide a model of how that screening should look. Voluntariness is required for true informed consent. Dr. Curlin conceded that coercion is also employed to force women to become or remain pregnant.

8. Analysis

Plaintiffs have not met their burden of establishing that the coercion screening requirements burden or infringe upon a patient's access to abortion care. The witnesses agree that coercion screening is a necessary step in abortion care. Informational posters warning patients about the illegality of abortion coercion and providing resources to patients facing such coercion protect patient rights to reproductive care of all kinds. Contrary to the position of some witnesses,

[17] Dr. Wubbenhurst's testimony in this regard was contradicted by the study she relied on, as it showed a possible 10% rate of coercion.

nothing in the statutes requires providers to ask specific or direct questions during a coercion screening. The statutes permit providers to tailor their questions and interact with patients in an organic way.

VII. WITH LIMITED EXCEPTION, THE CHALLENGED LAWS DO NOT ACHIEVE THE GOAL OF PROTECTING PATIENT HEALTH BY THE LEAST RESTRICTIVE MEANS, CONSISTENT WITH ACCEPTED CLINICAL STANDARDS OF PRACTICE AND EVIDENCE-BASED MEDICINE

Having determined that the vast majority of the challenged laws' provisions burden and infringe upon a patient's right to make and effectuate decisions about abortion care, the next step in the constitutional analysis under the RFFA is to determine whether the state has put forth a compelling interest, and then whether the challenged laws achieve that interest by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine, without infringing upon an individual's autonomous decision-making.

Under the plain language of the RFFA, the only compelling state interest can be the health of the patient seeking care. The Court agrees with intervening defendant that the ostensible goal of the challenged laws is to protect patient health. The inquiry, however, does not stop there. In order to survive the constitutional challenge, the challenged laws must *achieve* the purpose of protecting patient health, by the least restrictive means, and be consistent with accepted clinical standards of practice and evidence-based medicine. This is where intervening defendant's argument unravels.

Against the mountain of expert opinions and citation of accepted clinical standards and medical literature submitted by plaintiffs establishing that the challenged laws *do not* protect patient health and *are contrary* to accepted clinical standards of practice and evidence-based medicine (set forth in extensive detail in preceding sections), intervening defendant has produced

two witnesses deeply entrenched in the national anti-abortion movement who have frequently and widely testified in favor of complete abortion bans. These witnesses believe abortion is murder and an offense to God. Dr. Wubbenhurst's testimony was based on theologically skewed studies from journals known to support anti-abortion views. Dr. Wubbenhurst's testimony also made clear that she interpreted the findings of studies in ways the studies' authors cautioned against. Intervening defendant has not attacked the qualifications or credibility of plaintiffs' experts.

The plain language of the RFFA unambiguously requires that the challenged laws *achieve* the goal of protecting patient health and be consistent with established clinical standards and evidence-based medicine. The only way for the Court to inquire into this element is to rely on the expert evidence submitted by the parties. The defense experts' evidence is too impeached to assist their position.

Plaintiffs' experts have opined that the 24-hour waiting period does not protect the health of a patient seeking care and, in fact, hinders patient care by delaying care by an arbitrary 24-hours. Clinical research has shown that there is no correlation between having a patient wait 24 hours and the patient achieving better physical and psychological outcomes. Contrary to Dr. Wubbenhurst's testimony, there is no evidence that the delay is used by providers to review a patient's medical history to ensure the safety of the procedure for the patient. Rather, the delay is used solely to force the patient to further consider their choice, i.e., to dissuade the patient from securing an abortion. The Turnaway Study supports that the vast majority of patients seeking an abortion have high decisional certainty and low levels of regret following the procedure.

The mandatory 24-hour waiting period also is not consistent with the accepted standard of care and evidence-based medicine. Again, the Turnaway Study demonstrated that patients seeking

an abortion do not universally need additional time to reflect on their decision. No other reproductive care available to men or women is governed by the Legislature in this manner.

Moreover, the mandatory 24-hour waiting period infringes upon autonomous decision-making. The waiting period forces needless delay on patients after they are able to consent to a procedure, thus burdening and infringing upon a patient's access to abortion care.

The mandatory standard informed-consent provisions likewise fail strict-scrutiny review because plaintiffs' experts, as well as ACOG and other nationally recognized organizations, conclude that the uniform standard-of-care provisions are inconsistent with the highly individualized and patient-specific informed-consent process. There is no reason to deviate from individualized informed consent, and no basis to argue that qualified licensed medical providers will deviate from their ethical and professional obligations without state interference. The evidence submitted by plaintiffs establishes the overwhelming medical consensus is that mandatory informed-consent schemes, enacted to persuade people to continue pregnancies despite their personal circumstances and wishes, do not serve patient health and decision-making and are contrary to the standard of care. Intervening defendants' evidence to the contrary is incredible and not scientifically strong. It does not overcome the evidence produced by plaintiffs before and at trial.

The APC provider ban likewise does not withstand strict-scrutiny constitutional review. The APC ban excludes qualified clinicians from providing abortion care without any medical justification. APCs are fully capable of providing early abortion care. APCs in Michigan currently provide the very same care to patients experiencing miscarriage as they could for patients seeking early abortions. Numerous other states allow APCs to provide early abortions. And leading

medical authorities have concluded that laws prohibiting qualified APCs from providing these services are without medical foundation and erect barriers to care.

Intervening defendant argues that restricting abortion-care providers to physicians will ensure patients receive only the highest quality care, thus making the ban constitutional. This argument is not persuasive, especially in light of the strong evidence presented by plaintiffs that many APCs already provide care similar to medication abortion and dilation procedures safely and effectively. The Court agrees with plaintiffs' argument and concludes that the APC provider ban fails strict-scrutiny constitutional review.[18]

As noted, the coercion screening requirements of MCL 333.17105(11)(i) and MCL 333.17015a do not burden or infringe upon patients' reproductive freedom. Accordingly, the Court need not consider whether these provisions promote the compelling state interest of protecting patient health, whether the screening requirements achieve their goal by the least restrictive means, or whether they are consistent with the accepted standard of care and supported by evidence-based medicine.

VIII. SEVERABILITY

Finding that the 24-hour waiting period, mandatory uniform informed-consent procedures, and the APC ban burden and infringe upon patient rights, do not promote a compelling state interest, and are not consistent with acceptable standards of care or supported by evidence-based

[18] Plaintiffs also argue that the challenged laws are unconstitutional under the RFFA because the laws are discriminatory. The Court does not reach this argument, having concluded that the challenged laws are unconstitutional for the reasons discussed in this opinion.

medicine, the question remains what becomes of those statutory provisions that are not constitutionally infirm. MCL 333.17015(17) is a severability clause and states:

> If any portion of this act or the application of this act to any person or circumstances is found invalid by a court, that invalidity does not affect the remaining portions or applications of the act that can be given effect without the invalid portion or application, if those remaining portions are not determined by the court to be inoperable.

Under this subsection, any portions of MCL 333.17015 and MCL 333.17105a that remain valid should remain operable. This is consistent with the legislative principle set forth in MCL 8.5 "that if invalid or unconstitutional language can be deleted from an ordinance and still leave it complete and operative then such remainder of the ordinance be permitted to stand." *In re request for Advisory Opinion Regarding Constitutionality of 2011 PA 38*, 490 Mich 295, 345; 806 NW2d 683 (2011) (cleaned up).

Whatever relief the Court grants in relation to the unconstitutional provisions of the challenged statutes, that relief cannot extended to those provisions not deemed unconstitutional.

IX. RELIEF

The Court enters a declaratory judgment that MCL 333.17015(1), (2)(d)-(g), (2)(i)-(j), (3)-(10), (11)(a)-(h), (13)-(14), and (18)-(19) are unconstitutional. Although not every invalidated provision seems objectionable on its face, many are so inextricably linked to the unconstitutional informed-consent mandates that they cannot stand alone.[19] Many of definitions in Subsection (2)

[19] For example, Subsections (4)-(7) provide instructions to a provider regarding how to implement and follow Subsection (3); Subsection 11 provides instructions to the DHHS regarding how to implement the statute. Other subsections, while on their face may be neutral (like an obligation to keep patient information confidential) are nonetheless entwined with the 24-hour waiting period and mandatory informed-consent form. The very information that is being referenced is contained

are found only in the invalidated statutory provisions, rendering them invalid as well. The Court further declares that the references to MCL 333.17015(3) and broadly to MCL 333.17015(11) in MCL 333.17015a are unconstitutional. The definitions of abortion in Subsection (2)(a); "coercion to abort" in Subsection (2)(b); "domestic violence" in Subsection (2)(c); and "qualified person assisting the physician" in Subsection (2)(h) appear in statutory provisions that remain intact. These definitions therefore remain viable. The Court also found that MCL 333.17015(11)(i), (12), (15), (16), and (17), and MCL 333.17015a do not fail strict-scrutiny review. Because of the severability provision in the statute, these provisions remain in effect.

Plaintiffs have sought a permanent injunction against the enforcement of the unconstitutional statutory provisions. Just like a preliminary injunction, a permanent injunction is an extraordinary remedy to be entered "only when justice requires, there is no adequate remedy at law, and there is a real and imminent danger of irreparable injury." *Janet Travis, Inc v Preka Holdings, LLC*, 306 Mich App 266, 274; 856 NW2d 206 (2014). The Court of Appeals has outlined various factors relevant to a Court's decision to enter a permanent injunction, including:

> (a) the nature of the interest to be protected, (b) the relative adequacy to the plaintiff of injunction and of other remedies, (c) any unreasonable delay by the plaintiff in bringing suit, (d) any related misconduct on the part of the plaintiff, (e) the relative hardship likely to result to defendant if an injunction is granted and to plaintiff if it is denied, (f) the interests of third persons and of the public, and (g) the practicability of framing and enforcing the order or judgment. [*Id*. (cleaned up).]

The Court must "balance the benefit of an injunction to a requesting plaintiff against the damage and inconvenience to the defendant, and will grant an injunction if doing so is most consistent with justice and equity." *Id*. at 274-275.

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in the form, which is subject to the 24-hour waiting period. It is impossible to sever the seemingly neutral requirements because those requirements are still governed by the 24-hour waiting period.

The interest to be protected in this case is the fundamental right to reproductive freedom. The Court has deemed the majority of the provisions in the challenged laws to unconstitutionally burden and infringe upon that right. To protect the fundamental rights of the people of Michigan, the Court must permanently enjoin the enforcement of those provisions. No defendant will face undue hardship as a result of this injunction. Indeed, the burden on the state of regulating and overseeing abortion care will be reduced to the same level of regulation and oversight as any other medical procedure, easing any hardship placed on the state. Granting a permanent injunction is, therefore, in the best interest of all parties to this proceeding.

X. CONCLUSION

For the reasons set forth above, the Court concludes that MCL 333.17015(1), (2)(d)-(g), (2)(i)-(j), (3)-(10), (11)(a)-(h), (13)-(14), and (18)-(19), which include the mandatory 24-hour waiting period, the mandatory uniform informed consent, and the ban on APCs providing abortion care, are unconstitutional and thus GRANTS a declaratory judgment and a permanent injunction against the enforcement and implementation of these provisions. The Court further concludes that MCL 333.17015a and MCL 333.17015(11)(i) are not unconstitutional and thus DENIES the request to permanently enjoin enforcement and implementation of those statutory provisions, although references to MCL 333.17015(3) and broadly to (11) must be read out of MCL 333.17015a. This is a final order resolving all issues in this case.

Date: May 13, 2025

Sima G. Patel
Judge, Court of Claims

APPENDIX

To assist the parties, the following clarifies the statutory provisions declared unconstitutional and of which enforcement is permanently enjoined:

~~(1) Subject to subsection (10), a physician shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort.~~

(2) For purposes of this section and section 17015a:

(a) "Abortion" means the intentional use of an instrument, drug, or other substance or device to terminate a woman's pregnancy for a purpose other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a fetus that has died as a result of natural causes, accidental trauma, or a criminal assault on the pregnant woman. Abortion does not include the use or prescription of a drug or device intended as a contraceptive.

(b) "Coercion to abort" means an act committed with the intent to coerce an individual to have an abortion, which act is prohibited by . . . MCL 750.213a.

(c) "Domestic violence" means that term as defined in . . . MCL 400.1501.

~~(d) "Fetus" means an individual organism of the species Homo sapiens in utero.~~

~~(e) "Local health department representative" means an individual who meets 1 or more of the licensing requirements listed in subdivision (h) and who is employed by, or under contract to provide services on behalf of, a local health department.~~

~~(f) "Medical emergency" means a condition which, on the basis of the physician's good-faith clinical judgment, so complicates the medical condition of a pregnant individual as to necessitate the immediate abortion of the individual's pregnancy to avert the individual's death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.~~

~~(g) "Medical service" means the provision of a treatment, procedure, medication, examination, diagnostic test, assessment, or counseling, including, but not limited to, a pregnancy test, ultrasound, pelvic examination, or an abortion.~~

(h) "Qualified person assisting the physician" means another physician or a physician's assistant licensed under this part or part 175, a fully licensed or limited licensed psychologist licensed under part 182, a professional counselor licensed under part 181, a registered professional nurse or a licensed practical nurse licensed under part 172, or a social worker licensed under part 185.

~~(i) "Probable gestational age of the fetus" means the gestational age of the fetus at the time an abortion is planned to be performed.~~

~~(j) "Provide the patient with a physical copy" means confirming that the patient accessed the internet website described in subsection (5) and received a printed valid confirmation form from the website and including that form in the patient's medical record or giving a patient a copy of a required document by 1 or more of the following means:~~

~~(*i*) In person.~~

~~(*ii*) By registered mail, return receipt requested.~~

~~(*iii*) By parcel delivery service that requires the recipient to provide a signature in order to receive delivery of a parcel.~~

~~(*iv*) By facsimile transmission.~~

~~(3) Subject to subsection (10), a physician or a qualified person assisting the physician shall do all of the following not less than 24 hours before that physician performs an abortion upon a patient who is pregnant:~~

~~(a) Confirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus.~~

~~(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:~~

~~(*i*) The probable gestational age of the fetus the patient is carrying.~~

~~(*ii*) Information about what to do and whom to contact should medical complications arise from the abortion.~~

~~(*iii*) Information about how to obtain pregnancy prevention information through the department of health and human services.~~

~~(c) Provide the patient with a physical copy of the written standardized summary described in subsection (11)(b) that corresponds to the procedure the patient will undergo and is provided by the department of health and human services. If the procedure has not been recognized by the [DHHS], but is otherwise allowed under Michigan law, and the [DHHS] has not provided a written standardized summary for that procedure, the physician shall develop and provide a written summary that describes the procedure, any known risks or complications of the procedure, and risks associated with live birth and meets the requirements of subsection (11)(b)(*iii*) through (*vii*).~~

(d) Provide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the [DHHS] pursuant to subsection (11)(a) at the gestational age nearest the probable gestational age of the patient's fetus.

(e) Provide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the [DHHS] under section 9161.

(f) Provide the patient with a physical copy of the prescreening summary on prevention of coercion to abort described in subsection (11)(i).

(4) The requirements of subsection (3) may be fulfilled by the physician or a qualified person assisting the physician at a location other than the health facility where the abortion is to be performed. The requirement of subsection (3)(a) that a patient's pregnancy be confirmed may be fulfilled by a local health department under subsection (18). The requirements of subsection (3) cannot be fulfilled by the patient accessing an internet website other than the internet website that is maintained and operated by the [DHHS] under subsection (11)(g).

(5) The requirements of subsection (3)(c) through (f) may be fulfilled by a patient accessing the internet website that is maintained and operated by the [DHHS] under subsection (11)(g) and receiving a printed, valid confirmation form from the website that the patient has reviewed the information required in subsection (3)(c) through (f) at least 24 hours before an abortion being performed on the patient. The website must not require any information be supplied by the patient. The [DHHS] shall not track, compile, or otherwise keep a record of information that would identify a patient who accesses this website. The patient shall supply the valid confirmation form to the physician or qualified person assisting the physician to be included in the patient's medical record to comply with this subsection.

(6) Subject to subsection (10), before obtaining the patient's signature on the acknowledgment and consent form, a physician personally and in the presence of the patient shall do all of the following:

(a) Provide the patient with the physician's name, confirm with the patient that the coercion to abort screening required under section 17015a was performed, and inform the patient of the right to withhold or withdraw consent to the abortion at any time before performance of the abortion.

(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:

(*i*) The specific risk, if any, to the patient of the complications that have been associated with the procedure the patient will undergo, based on the patient's particular medical condition and history as determined by the physician.

(*ii*) The specific risk of complications, if any, to the patient if the patient chooses to continue the pregnancy based on the patient's particular medical condition and history as determined by a physician.

(7) To protect a patient's privacy, the information set forth in subsection (3) and subsection (6) must not be disclosed to the patient in the presence of another patient.

(8) If at any time before the performance of an abortion, a patient undergoes an ultrasound examination, or a physician determines that ultrasound imaging will be used during the course of a patient's abortion, the physician or qualified person assisting the physician shall provide the patient with the opportunity to view or decline to view an active ultrasound image of the fetus, and offer to provide the patient with a physical picture of the ultrasound image of the fetus before the performance of the abortion. After the expiration of the 24-hour period prescribed under subsection (3) but before performing an abortion on a patient who is pregnant, a physician or a qualified person assisting the physician shall do all of the following:

(a) Obtain the patient's signature on the acknowledgment and consent form described in subsection (11)(c) confirming that the patient has received the information required under subsection (3).

(b) Provide the patient with a physical copy of the signed acknowledgment and consent form described in subsection (11)(c).

(c) Retain a copy of the signed acknowledgment and consent form described in subsection (11)(c) and, if applicable, a copy of the pregnancy certification form completed under subsection (18)(b), in the patient's medical record.

(9) This subsection does not prohibit notifying the patient that payment for medical services will be required or that collection of payment in full for all medical services provided or planned may be demanded after the 24-hour period described in this subsection has expired. A physician or an agent of the physician shall not collect payment, in whole or in part, for a medical service provided to or planned for a patient before the expiration of 24 hours from the time the patient has done either or both of the following, except in the case of a physician or an agent of a physician receiving capitated payments or under a salary arrangement for providing those medical services:

(a) Inquired about obtaining an abortion after the patient's pregnancy is confirmed and the patient has received from that physician or a qualified person assisting the physician the information required under subsection (3)(c) and (d).

(b) Scheduled an abortion to be performed by that physician.

(10) If the attending physician, utilizing the physician's experience, judgment, and professional competence, determines that a medical emergency

~~exists and necessitates performance of an abortion before the requirements of subsections (1), (3), and (6) can be met, the physician is exempt from the requirements of subsections (1), (3), and (6), may perform the abortion, and shall maintain a written record identifying with specificity the medical factors upon which the determination of the medical emergency is based.~~

(11) The [DHHS] shall do each of the following:

~~(a) Produce medically accurate depictions, illustrations, or photographs of the development of a human fetus that indicate by scale the actual size of the fetus at 2-week intervals from the fourth week through the twenty-eighth week of gestation. Each depiction, illustration, or photograph must be accompanied by a printed description, in nontechnical English, Arabic, and Spanish, of the probable anatomical and physiological characteristics of the fetus at that particular state of gestational development.~~

~~(b) Subject to subdivision (e), develop, draft, and print, in nontechnical English, Arabic, and Spanish, written standardized summaries, based upon the various medical procedures used to abort pregnancies, that do each of the following:~~

~~(*i*) Describe, individually and on separate documents, those medical procedures used to perform abortions in this state that are recognized by the [DHHS].~~

~~(*ii*) Identify the physical complications that have been associated with each procedure described in subparagraph (*i*) and with live birth, as determined by the department. In identifying these complications, the department shall consider studies concerning complications that have been published in a peer review medical journal, with particular attention paid to the design of the study, and shall consult with the Centers for Disease Control and Prevention, [ACOG], the Michigan State Medical Society, or any other source that the [DHHS] determines appropriate for the purpose.~~

~~(*iii*) State that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if these symptoms occur and are intense or persistent, professional help is recommended.~~

~~(*iv*) State that not all of the complications listed in subparagraph (*ii*) may pertain to that particular patient and refer the patient to the patient's physician for more personalized information.~~

~~(*v*) Identify services available through public agencies to assist the patient during the patient's pregnancy and after the birth of the child, should the patient choose to give birth and maintain custody of the child.~~

(*vi*) Identify services available through public agencies to assist the patient in placing the child in an adoptive or foster home, should the patient choose to give birth but not maintain custody of the child.

(*vii*) Identify services available through public agencies to assist the patient and provide counseling should the patient experience subsequent adverse psychological effects from the abortion.

(c) Develop, draft, and print, in nontechnical English, Arabic, and Spanish, an acknowledgment and consent form that includes only the following language above a signature line for the patient:

"I, _____, voluntarily and willfully hereby authorize Dr. _____ ("the physician") and any assistant designated by the physician to perform upon me the following operation(s) or procedure(s):

_____

(Name of operation(s) or procedure(s))

_____

A. I understand that I am approximately _____ weeks pregnant. I consent to an abortion procedure to terminate my pregnancy. I understand that I have the right to withdraw my consent to the abortion procedure at any time before performance of that procedure.

B. I understand that it is illegal for anyone to coerce me into seeking an abortion.

C. I acknowledge that at least 24 hours before the scheduled abortion I have received a physical copy of each of the following:

1. A medically accurate depiction, illustration, or photograph of a fetus at the probable gestational age of the fetus I am carrying.

2. A written description of the medical procedure that will be used to perform the abortion.

3. A prenatal care and parenting information pamphlet.

D. If any of the documents listed in paragraph C were transmitted by facsimile, I certify that the documents were clear and legible.

E. I acknowledge that the physician who will perform the abortion has orally described all of the following to me:

1. The specific risk to me, if any, of the complications that have been associated with the procedure I am scheduled to undergo.

~~2. The specific risk to me, if any, of the complications if I choose to continue the pregnancy.~~

~~F. I acknowledge that I have received all of the following information:~~

~~1. Information about what to do and whom to contact in the event that complications arise from the abortion.~~

~~2. Information pertaining to available pregnancy related services.~~

~~G. I have been given an opportunity to ask questions about the operation(s) or procedure(s).~~

~~H. I certify that I have not been required to make any payments for an abortion or any medical service before the expiration of 24 hours after I received the written materials listed in paragraph C, or 24 hours after the time and date listed on the confirmation form if the information described in paragraph C was viewed from the state of Michigan internet website.".~~

~~(d) Make available to physicians through the board and the Michigan board of osteopathic medicine and surgery, and to any person upon request, the copies of medically accurate depictions, illustrations, or photographs described in subdivision (a), the written standardized summaries described in subdivision (b), the acknowledgment and consent form described in subdivision (c), the prenatal care and parenting information pamphlet described in section 9161, the pregnancy certification form described in subdivision (f), and the materials regarding coercion to abort described in subdivision (i).~~

~~(e) In developing the written standardized summaries for abortion procedures under subdivision (b), include in the summaries only medication that has been approved by the United States Food and Drug Administration for use in performing an abortion.~~

~~(f) Develop, draft, and print a certification form to be signed by a local health department representative at the time and place a patient has a pregnancy confirmed, as requested by the patient, verifying the date and time the pregnancy is confirmed.~~

~~(g) Develop, operate, and maintain an internet website that allows a patient considering an abortion to review the information required in subsection (3)(c) through (f). After the patient reviews the required information, the department of health and human services shall ensure that a confirmation form can be printed by the patient from the internet website that will verify the time and date the information was reviewed. A confirmation form printed under this subdivision becomes invalid 14 days after the date and time printed on the confirmation form.~~

~~(h) Include on the informed consent internet website operated under subdivision (g) a list of health care providers, facilities, and clinics that offer to perform~~

~~ultrasounds free of charge. The list must be organized geographically and include the name, address, and telephone number of each health care provider, facility, and clinic.~~

(i) After considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic and Sexual Violence Prevention and Treatment Board, the Michigan Coalition to End Domestic and Sexual Violence or successor organization, and the American Medical Association, do all of the following:

(*i*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a notice that is required to be posted in facilities and clinics under section 17015a. The notice must be at least 8-1/2 inches by 14 inches, be printed in at least 44-point type, and contain at a minimum all of the following:

(A) A statement that it is illegal under Michigan law to coerce an individual to have an abortion.

(B) A statement that help is available if an individual is being threatened or intimidated; is being physically, emotionally, or sexually harmed; or feels afraid for any reason.

(C) The telephone number of at least 1 domestic violence hotline and 1 sexual assault hotline.

(*ii*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a prescreening summary on prevention of coercion to abort that, at a minimum, contains the information required under subparagraph (*i*) and notifies the patient that an oral screening for coercion to abort will be conducted before giving written consent to obtain an abortion.

(*iii*) Develop, draft, and print screening and training tools and accompanying training materials to be utilized by a physician or qualified person assisting the physician while performing the coercion to abort screening required under section 17015a. The screening tools must instruct the physician or qualified person assisting the physician to orally communicate information to the patient regarding coercion to abort and to document the findings from the coercion to abort screening in the patient's medical record.

(*iv*) Develop, draft, and print protocols and accompanying training materials to be utilized by a physician or a qualified person assisting the physician if a patient discloses coercion to abort or that domestic violence is occurring, or both, during the coercion to abort screening. The protocols must instruct the physician or qualified person assisting the physician to do, at a minimum, all of the following:

(A) Follow the requirements of section 17015a as applicable.

(B) Assess the patient's current level of danger.

(C) Explore safety options with the patient.

(D) Provide referral information to the patient regarding law enforcement and domestic violence and sexual assault support organizations.

(E) Document any referrals in the patient's medical record.

(12) A physician's duty to inform the patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would possess.

~~(13) A written consent form meeting the requirements set forth in this section and signed by the patient is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that consent was obtained through fraud, negligence, deception, misrepresentation, coercion, or duress.~~

~~(14) A completed certification form described in subsection (11)(f) that is signed by a local health department representative is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that the physician who relied upon the certification had actual knowledge that the certificate contained a false or misleading statement or signature.~~

(15) This section does not create a right to abortion.

(16) Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

(17) If any portion of this act or the application of this act to any person or circumstances is found invalid by a court, that invalidity does not affect the remaining portions or applications of the act that can be given effect without the invalid portion or application, if those remaining portions are not determined by the court to be inoperable.

~~(18) Upon a patient's request, a local health department shall comply with the following:~~

~~(a) Provide a pregnancy test for that patient to confirm the pregnancy as required under subsection (3)(a) and determine the probable gestational stage of the fetus. The local health department need not comply with this subdivision if the requirements of subsection (3)(a) have already been met.~~

~~(b) If a pregnancy is confirmed, ensure that the patient is provided with a completed pregnancy certification form described in subsection (11)(f) at the time the information is provided.~~

~~(19) The identity and address of a patient who is provided information or who consents to an abortion pursuant to this section is confidential and is subject to disclosure only with the consent of the patient or by judicial process.~~

~~(20) A local health department with a file containing the identity and address of a patient described in subsection (19) who has been assisted by the local health department under this section shall do both of the following:~~

~~(a) Only release the identity and address of the patient to a physician or qualified person assisting the physician in order to verify the receipt of the information required under this section.~~

~~(b) Destroy the information containing the identity and address of the patient within 30 days after assisting the patient under this section.~~

MCL 333.17015a:

(1) At the time a patient first presents at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed for the purpose of obtaining an abortion~~, whether before or after the expiration of the 24-hour period described in section 17015(3),~~ the physician or qualified person assisting the physician shall orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11)(i). ~~The oral screening required under this subsection may occur before the requirements of section 17015(3) have been met with regard to that patient.~~

(2) If a patient discloses that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11)(i).

(3) If a patient discloses coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11)(i).

(4) If a patient who is under the age of 18 discloses domestic violence or coercion to abort by an individual responsible for the health or welfare of the minor patient, the physician or qualified person assisting the physician shall report that fact to a local child protective services office.

(5) A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i). A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall make available in an area of its facility that is accessible to patients, employees, and visitors publications that contain information about violence against women.

(6) This section does not create a right to abortion. Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

IT IS SO ORDERED. This order resolves the last pending claim and closes the case.