STATE OF MICHIGAN
IN THE SUPREME COURT

SARAH MARIE MARKIEWICZ,

Plaintiff-Appellant,

v

DAVID RANDAL MARKIEWICZ,

Defendant-Appellee,

Supreme Court No. 166782

Court of Appeals No. 363720

Macomb County CC: 2019-003236-DM

AMICI CURIAE BRIEF OF AMERICAN CIVIL LIBERTIES UNION OF MICHIGAN, CENTER FOR REPRODUCTIVE RIGHTS, MICHIGAN FERTILITY ALLIANCE, PLANNED PARENTHOOD OF MICHIGAN, AND THE NATIONAL CENTER FOR LESBIAN RIGHTS

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INTEREST AND IDENTITY OF AMICI CURIAE[1]

The **American Civil Liberties Union of Michigan** ("ACLU of Michigan") is the Michigan affiliate of a nationwide, nonpartisan organization with over one million members dedicated to protecting the rights guaranteed by the United States Constitution and our state constitutions. The ACLU of Michigan or its attorneys have supported or litigated hundreds of cases in Michigan's state and federal courts as a plaintiff, on behalf of plaintiffs, and as amicus curiae. Among those issues litigated are the constitutional right to reproductive freedom, the rights to procreate or not procreate, and procreation through assisted reproductive technology. See, e.g., *YWCA Kalamazoo v State of Michigan*, Court of Claims Docket No. 24-000093; *Planned Parenthood of Michigan v Attorney General*, Court of Claims Docket No. 22-000044; *Bohn v Ann Arbor Reproductive Medicine Associates, PC*, Case No. 213550, 213551, 1999 WL 33327194 (Mich App, 1999). The ACLU of Michigan was also one of three nonprofit organizations that led the citizen-initiated ballot measure, Proposal 22-3, to amend the Michigan Constitution in 2022.

The **Center for Reproductive Rights** ("the Center") is a global non-profit human rights organization working to ensure that reproductive rights are protected in law as fundamental human rights. This includes advocating for laws and policies that support all people's ability to make decisions about their reproductive lives. The Center's work on assisted reproduction—including in vitro fertilization, surrogacy, and gamete regulation—seeks to destigmatize infertility and promote equitable access to fertility care. Since its founding in 1992, the Center has litigated and appeared as amicus curiae in dozens of cases addressing critical reproductive health and constitutional issues before the United States Supreme Court and multiple state supreme courts.

[1] Pursuant to MCR 7.312(H)(5), amici curiae state that no counsel for a party authored this brief in whole or in part, nor did anyone, other than amici and their counsel, make a monetary contribution intended to fund the preparation or submission of the brief.

Michigan Fertility Alliance ("MFA") is a grassroots, citizen-led organization dedicated to advocating for families who rely on assisted reproduction and surrogacy to start or grow their families. MFA champions pro-family building policies that protect access to assisted reproduction, address infertility, support surrogacy, and protect parentage rights for children born through assisted reproduction.

Planned Parenthood of Michigan (PPMI"), which itself or through its predecessors has been in operation for at least the last one hundred years, is a not-for-profit corporation operating 14 health centers in Michigan, with headquarters in Ann Arbor. PPMI's mission is to promote healthy communities and the right of all individuals to manage their sexual health by providing reproductive health care and education, and serving as a strong advocate for reproductive justice. PPMI's health centers provide a wide range of reproductive and sexual health services to patients, including testing and treatment for sexually transmitted infections; contraception counseling and provision; HIV prevention services; pregnancy testing and options counseling; preconception counseling; gynecologic services, including menopause care; well-person exams; cervical and breast cancer screening; treatment of abnormal cervical cells; colposcopy; miscarriage management; and abortion. PPMI supported the adoption of Proposal 22-3, the Reproductive Freedom For All constitutional amendment, and has litigated to protect the right to reproductive freedom. See, e.g., *Planned Parenthood of Mich v Attorney General*, unpublished opinion of the Court of Claims, issued September 7, 2022 (Docket No. 22-000044-MM).

The **National Center for Lesbian Rights** ("NCLR") is a national nonprofit legal organization dedicated to protecting the safety and equality of lesbian, gay, bisexual, and transgender people and their families through litigation, public policy, and public education. Since its founding in 1977, NCLR has played a leading role in securing fair and equal treatment for

LGBT people and their families in cases across the country, including many about families created through assisted reproduction.

SUMMARY OF THE ARGUMENT

Amici curiae welcome this opportunity to address the Court concerning the disposition of cryopreserved (frozen) pre-embryos created through in vitro fertilization ("IVF") when the relationship between the two parties to the IVF process ends or the relationship between married parties to the IVF process terminates through divorce. The lower courts appropriately resolved this case by balancing the parties' interests, and judicial review and interpretation of the newly adopted reproductive freedom constitutional amendment, Article 1, § 28 of Michigan's 1963 Constitution, is not necessary in this case, nor would it change the outcome. Amici recognize and appreciate the emotional significance faced by both parties in this case—these are never easy cases—but the lower court did not err in its determination. This case presents a factually narrow set of circumstances limited to two people and their family-building process via IVF. Interpreting Article 1, § 28 to provide a one-size-fits-all rule to determine the zero-sum dispute in this case would be at odds with the amendment's text and purpose. There are better-suited vehicles in cases before the lower courts currently that present factual and legal questions with broader applicability and will give the Court an opportunity to guide future conduct in a wider set of circumstances. Amici respectfully request that the Court deny leave to appeal.

ARGUMENT

THE COURT SHOULD DENY LEAVE TO APPEAL

I. Applying Article 1, § 28, Would Not Change the Outcome of This Case.

A. Absent a valid, enforceable, and unambiguous contract, the Court of Appeals appropriately balanced the parties' competing interests in pre-embryo disposition.

In determining the disposition of frozen pre-embryos when the relationship between the two parties to the IVF process ends or the relationship between married parties to the IVF process terminates through divorce, state courts generally use one of three approaches: (1) contemporaneous mutual consent, (2) contract, or (3) balancing.

Applying the contemporaneous mutual consent approach leads to a frozen pre-embryo remaining frozen until the disputing parties agree on its disposition. See *Bilbao v Goodwin*, 217 A3d 977, 985 (Conn, 2019); *In re Marriage of Witten*, 672 NW2d 768, 777-778 (Iowa, 2003). Applying the contractual approach requires looking to the agreement the parties entered before receiving fertility care wherein they stipulated to the disposition of any pre-embryo(s) created and which is "presumed valid and enforceable." See, e.g., *Bilbao*, 217 A3d at 984, 992 (determining that the parties had an enforceable agreement); *Kass v Kass*, 91 NY2d 554; 696 NE2d 174 (1998) (holding that the parties' agreement controlled). Applying a balancing approach requires a court to consider and weigh the interests of both parties as they relate to the frozen pre-embryos. *Davis v Davis*, 842 SW2d 588, 603 (Tenn, 1992).

The mutual consent approach is generally disfavored by courts in other states.[2] See, e.g., *Jocelyn P v Joshua P*, 250 Md App 435, 488; 250 A3d 373 (2021); *In re Marriage of Rooks*, 429 P3d 579, 592; 2018 CO 85 (Colo, 2018); *Reber v Reiss*, 42 A3d 1131, 1136; 2012 Pa Super 86 (2012). As the Colorado Supreme Court persuasively explained, "[i]t is . . . unrealistic to think that parties who cannot reach agreement on a topic so emotionally charged will somehow reach resolution after a divorce is finalized." *Rooks*, 429 P3d at 592.

More standard is the application of the contractual approach, which first looks to the agreement the parties entered as valid and controlling unless it violates public policy. See *Jocelyn P*, 250 Md App at 469; *Bilbao*, 217 A3d at 986, 992; *Kass*, 91 NY2d at 565 (court encouraged advance directives before parties undergo fertility care "to think through possible contingencies" and to "minimize misunderstandings and maximize procreative liberty by reserving to the

[2] The lower court in this case opted not to apply the contemporaneous mutual consent approach, remarking that it is "inherently impractical." *Markiewicz v Markiewicz*, unpublished opinion of the Court of Appeals, issued December 7, 2023 (Docket No. 363720) at 9.

progenitors the authority to make what is in the first instance a quintessentially personal, private decision."); *Davis*, 842 SW2d at 598. But see *Witten*, 672 NW2d 768, 781 (rejecting this approach); *AZ v BZ*, 431 Mass 150, 159-160; 725 NE2d 1051 (2000) (noting that it would not uphold an agreement between the parties if it "would compel one donor to become a parent against his or her will"). This is consistent with best practices for informed consent to assisted reproductive technology. See American Society for Reproductive Medicine, *Informed Consent in Assisted Reproduction: An Ethics Committee Opinion* (2023) <https://www.asrm.org/practice-guidance/ethics-opinions/informed-consent-in-assisted-reproduction-an-ethics-committee-opinion-2023/> (accessed December 19, 2024).

In the absence of a controlling agreement, courts most often turn to the balancing approach—as the lower court did in this case—endeavoring to recognize and weigh the unique interests of the disputing parties, see, e.g., *Jocelyn P*, 250 Md App at 446; *Rooks*, 429 P3d at 593-594; *Davis*, 842 SW2d at 603-604. *Markiewicz*, unpub op at 8-9, quoting *Jessee v Jessee*, 74 Va App 40, 53; 866 SE2d 46 (2021). Balancing the disputing parties' interests is a common and equitable approach to determining the disposition of pre-embryos in this scenario. Under the balancing approach, courts use procreational autonomy as the overarching principle by which to assess the parties' interests. This approach contemplates the parties' interests in achieving or avoiding legal, genetic, and gestational parenthood. Balancing the interests of both parties demands that a court consider each party's constitutional rights, which include the right to procreate and the right *not* to procreate. See *Eisenstadt v Baird*, 405 US 438; 92 S Ct 1029; 31 L Ed 2d 349 (1972).

When balancing competing rights, a court should weigh the burdens that the various possible resolutions of the dispute would place on each party. As the Tennessee Supreme Court

pointed out in *Davis v Davis*—the leading case on establishing the balancing framework (and discussed in greater detail below)—this evaluation must begin by focusing on the possible outcomes that would infringe on each of the party's rights to procreational autonomy. *Davis*, 842 SW2d at 603. As set forth below, because allowing the pre-embryo to be transferred to a party's uterus will always infringe upon the objecting party's right to not become a parent if a pregnancy results and a child is born, while disallowing a transfer will not, in most circumstances, nullify the other party's ability to become a parent by other means, the balance should generally weigh in favor of the party wishing to avoid procreation. Here, appellee consented to the pre-embryo's use for the purpose of trying to become pregnant within the marriage, and after dissolution of the marriage, appellee asked this court and the lower courts for the pre-embryo to be discarded or donated to science because the marriage is dissolved. To find otherwise would impose affirmative, irrevocable, and lifelong emotional attachments and moral responsibilities as well as substantial obligations on appellee to become a parent to another child.

No matter which approach a court has applied in the cases discussed herein, no state high court has allowed one party's procreative use over the objection of the other. See e.g., *Davis*, 842 SW2d at 598; *Bilbao*, 217 A3d at 985; *Rooks*, 429 P3d at 592. These decisions clearly demonstrate an averseness to allow one party's interest in becoming a genetic parent to override the other party's right to procreational autonomy, including avoiding becoming a parent.

Appellant argues that granting the remaining frozen pre-embryo to the appellee would discriminatorily create a de facto rule in favor of men wishing to avoid parenthood. Appellant's Br at 40. Finding that the balance tips in favor of the person who does not want to procreate is not sex discrimination, as people of different genders assert the right to not procreate. See, e.g., *JB v MB*, 170 NJ 9; 783 A2d 707 (2001) (former wife seeking to avoid genetic parenthood). Indeed,

people of any gender may have a constitutional interest in not having their genetic material used against their wishes and will in another person's attempted pregnancy.

B. The Court of Appeals finding in favor of the party wishing to avoid genetic parenthood was fair and equitable.

Courts across jurisdictions have examined conflicting procreational autonomy claims, balanced competing parties' interests and factual assertions, and consistently held that the right not to procreate outweighs the right to procreate except in exceptional circumstances. In *Davis v Davis*, the Tennessee Supreme Court found that one individual's constitutional right to avoid genetic parenthood outweighed another individual's right to use or donate the pre-embryos for procreation. *Davis*, 842 SW2d at 604. The *Davis* court faced the exact clash of rights involved here: how to resolve a dispute between two individuals about the disposition of frozen pre-embryos in the absence of a prior directive explicitly settling the question. The Tennessee Supreme Court remarked that while it recognized the hardships the ex-wife had experienced undergoing IVF care, "she would have a reasonable opportunity, through IVF, to try once again to achieve parenthood in all its aspects—genetic, gestational, bearing, and rearing." *Id*. It noted further that, were the ex-wife unable or unwilling to seek IVF care again, "she could still achieve the child-rearing aspects of parenthood through adoption." *Id*. But in general, the court concluded, "the party wishing to avoid procreation should prevail." *Id*. In so finding, the court held that "any disposition which results in the gestation of the pre[-]embryos would impose unwanted parenthood . . . with all of its possible financial and psychological consequences." *Id*. at 603. The court recognized the presumption not as a brightline rule, but one that could involve a possible exception given that multiple competing rights were at stake.

In *AZ v BZ*, two parties had entered multiple agreements over the course of multiple IVF cycles, each of which included a clause giving one individual dispositional authority over any

remaining frozen pre-embryos. 431 Mass 150. But the agreements included additional vague language surrounding the dispositional authority question, and the Massachusetts Supreme Judicial Court expressed skepticism about how the multiple agreements affected the dispute. The court ultimately held that circumstances had changed substantially since the parties entered their initial agreement and that the individual who wished to avoid genetic and legal parenthood should prevail. *Id*. at 160. Notably, the court held that "even had the husband and the wife entered into an unambiguous agreement between themselves" regarding the frozen pre-embryos, the court "would not enforce an agreement that would compel" one of the parties to "become a parent against his or her will." *Id*. The court further held that, "as a matter of public policy, we conclude that forced procreation is not an area amenable to judicial enforcement." *Id*. This public policy "enhances the freedom of personal choice in matters of marriage and family life." *Id*. at 162 (internal quotations omitted). See also *Kotkowski-Paul v Paul*, 2022-Ohio-4567; 204 NE3d 66 (Ohio App, 2022).

In *JB v MB*, a divorced couple disagreed about the disposition of seven frozen pre-embryos they had created through IVF. 170 NJ 9. One party wished for the frozen pre-embryos to be "implanted or donated to other infertile couples." *Id*. at 14. The other party alleged that she had only ever intended for the pre-embryos to be used within the couple's marriage and sought destruction of the pre-embryos. *Id*. Focusing its analysis on New Jersey public policy, recognizing that individuals should not be bound by agreements requiring them to enter into or terminate familial relationships, the New Jersey Supreme Court sided with the party seeking to avoid parenthood, remarking that her "right not to procreate may be lost through attempted use or through donation of the pre-embryos" and, if any of the pre-embryos led to a pregnancy, it could "result in the birth of her biological child and could have life-long emotional and psychological

repercussions." *Id*. at 25. The court thereby firmly rejected the outcome that could result in a party's legal and genetic parenthood "against her will." *Id*. at 26.

Consistent through all of these cases is the recognition that an individual's right to avoid parenthood, regardless of gender or initial intentions upon entering an IVF agreement, should prevail when balancing the parties' interests, absent extenuating circumstances.

C. The Court of Appeals correctly held that Article 1, § 28 does not provide a dispositive rule for adjudicating the competing procreative rights claims at issue in this dispute.

Procreative freedom has a lengthy constitutional pedigree and is firmly grounded in the text of Michigan's 1963 Constitution. Michigan's 1963 Constitution provides this Court with guidance for cases implicating the right to reproductive freedom.

The right to personal autonomy and reproductive freedom is reflected in several sections of Michigan's 1963 Constitution. The Declaration of Rights includes section 1, resting all political power in the people; section 2, granting the people equal protection of the laws and freedom from discrimination; section 3, protecting the right to assembly; section 4, guaranteeing freedom of worship; section 5, guaranteeing freedom of speech and press; section 11, prohibiting unreasonable searches and seizures; section 16 protecting against cruel or unusual punishment; and most salient, section 28, guaranteeing the right to reproductive freedom. The right to bodily autonomy has also been recognized by Michigan courts through the years. See *Mays v Governor*, 506 Mich 157, 192; 954 NW2d 139 (2020) (recognizing the constitutional right to bodily autonomy); *Planned Parenthood of Michigan v Attorney General*, unpublished opinion of the Court of Claims, issued September 7, 2022 (Docket No. 22-000044-MM), pp 27, 33 (finding that Michigan's abortion ban violates abortion patients' fundamental right to bodily integrity and unjustifiably burdens different

classes of pregnant women in violation of the state constitution's Equal Protection Clause) (attached as Ex 1).

Article 1, § 28 of Michigan's 1963 Constitution provides that "[e]very individual has a fundamental right to reproductive freedom." Const 1963, art 1, § 28. That right "entails the right to make and effectuate decisions about *all* matters relating to pregnancy. . . ." *Id*. (emphasis added). Article 1, § 28 guarantees that every person can make and exercise their right to reproductive freedom without government intrusion or discrimination, and only permits such an intrusion if it is for the narrow purpose of protecting patient health, consistent with the standard of practice, and only when it does not infringe on the person's autonomy. *Id*. at § 28(1), (4). The Michigan Constitution thus protects a person's right to make and bring about the decision to procreate, for example, through childbirth or IVF. And the Michigan Constitution equally protects a person's right to effectuate a decision to prevent procreation, for example, through contraception or abortion. The right to procreate, and the right <u>not</u> to procreate, are thus both fundamental constitutional guarantees consisting of several related interests.[3]

This right to reproductive freedom can be understood only as giving both appellant and appellee a fundamental right to make decisions regarding the process of IVF and the resulting pre-embryos. Ultimately, it is a question about whether the parties will become parents. *Davis*, 842 SW2d at 598. Because both parties' rights are equally grounded in the Michigan Constitution, resolving the conflict between the parties in this context requires balancing the burdens imposed on each party by exercise of the other's right.

[3] Whether or not Article 1, § 28 is retroactive is not dispositive because both parties enjoyed the right to reproductive freedom when making IVF decisions under the Michigan Constitution, both as it existed prior to the effective date of Article 1, § 28, and currently.

Based on the law summarized above, the court below appropriately resorted to a balancing test, as have other jurisdictions resolving such disputes—including jurisdictions with broad state constitutional reproductive rights provisions. See *EB v RN*, 2024-Ohio-1455, ¶ 18; 242 NE3d 791 (Ohio App, 2024), *appeal not allowed*, 175 Ohio St 3d 1489; 2024-Ohio-4942; 243 NE3d 1290 (2024). In *EB v RN*, the Ohio Supreme Court denied leave to appeal in a pre-embryo dispute case, leaving in place a court of appeals decision employing a balancing test upon its determination that Ohio's reproductive freedom amendment[4] does not compel a particular outcome in a dispute where two parties contributed genetic material to a pre-embryo.[5] 175 Ohio St 3d 1489 (declining to hear appeal); 2024-Ohio-1455 at ¶¶ 16-20 (employing balancing test after concluding the state's reproductive freedom amendment did not control outcome in the case). The Court of Appeals also correctly concluded that even assuming state action, applying the reproductive freedom amendment to the facts of this case would not necessarily change the outcome.

II. This Case Is Not the Appropriate Vehicle to Interpret and Apply Article 1, § 28 of Michigan's 1963 Constitution for the First Time.

As with most courts of last resort, this Court should refrain from addressing the interpretation and applicability of Article 1, § 28 for the first time because no manifest injustice

[4] Ohio's reproductive rights amendment contains similar language to Michigan's reproductive rights amendment. Compare Ohio Const, art 1, § 22(1) ("Every individual has a right to make and carry out one's own reproductive decisions, including but not limited to decisions on contraception, fertility treatment, continuing one's own pregnancy, miscarriage care, and abortion.") with Mich Const 1963, art 1, § 28(1) ("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.").

[5] Amici do not take a position as to whether the ultimate conclusion reached by the Ohio Court of Appeals in *EB v RN* is correct. Amici point to the limited conclusion that the reproductive rights amendment did not control the outcome of the dispute, and the Ohio Supreme Court's decision to let that conclusion stand, as an example of a course of action this Court might take.

would result if the court declined review, and because there are cases percolating in the lower courts that involve factual and legal questions that have broader applicability.

In 2022, the United States Supreme Court revoked the federal right to abortion in *Dobbs v Jackson Women's Health Organization*, 597 US 215; 142 S Ct 2228; 213 L Ed 2d 545 (2022), overruling almost fifty years of precedent recognizing and protecting that right since *Roe v Wade*, 410 US 113, 93 S Ct 705, 35 L Ed 2d 147 (1973). In doing so, the Court purported to "return" the authority to regulate abortion to "the people and their elected representatives" in each of the 50 states. *Dobbs*, 597 US at 259. As a result of *Dobbs*, Michiganders faced the prospect that, for the first time in generations, they may have only state law and the Michigan Constitution to protect their reproductive freedom. But state law was restrictive at the time, and an amendment to the state constitution was the only vehicle to protect reproductive freedom long-term. The voters of Michigan responded resoundingly in the streets and at the polls, gathering a record number of signatures to place a proposed constitutional amendment on the ballot in November 2022 that would make clear that, in Michigan, the constitution protects everyone's right to bodily autonomy and to make the reproductive choices that are best for them and their families without government intrusion. Michigan voters overwhelmingly voted to pass the constitutional amendment.[6] Article 1, § 28, effective December 24, 2022, protects the right to make decisions related to the full spectrum of reproductive health care, not just abortion: "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,

[6] Wells, *Proposal 3 Passes, Enshrines Abortion Rights in Michigan Constitution*, Michigan Radio (November 9, 2022) <https://www.michiganpublic.org/politics-government/2022-11-09/proposal-3-passes-enshrines-abortions-rights-in-michigan-constitution> (accessed December 19, 2024).

contraception, sterilization, abortion care, miscarriage management, and infertility care." Const 1963, art 1, § 28(1).

Because of its recent adoption, only two cases have been brought under Article 1, § 28 seeking to enforce the right to reproductive freedom. See *The Young Women's Christian Ass'n of Kalamazoo v State of Michigan et al*, Court of Claims Docket No. 24-000093-MM (challenging the state Medicaid program's exceptional denial of coverage for most abortion patients); *Northland Family Planning Center v Nessel*, unpublished opinion of the Court of Claims, issued June 25, 2024 (Docket No. 24-000011-MM) (challenging the state's targeted restrictions of abortion providers, including mandatory waiting period and biased counseling requirements) (attached as Ex 2).

Litigation of these cases will likely—at a minimum—involve considerable party presentation and judicial analysis of the amendment's context, purpose, and scope, which may assist this Court in determining future questions of law related to pre-embryo disputes. This Court should not now, for the first time, decide a novel issue such as the application of Article 1, § 28 because, as explained in Section I above, the lower court appropriately considered each party's constitutional rights to procreate and not procreate, and no manifest injustice would abound if the lower court's decision were left intact. This Court grants review sparingly, and an application for leave to appeal may only be granted if it presents a circumstance listed in MCR 7.305(B). While the interpretation and applicability of Article 1, § 28 for the first time is an issue that involves "a legal principle of major significance to the state's jurisprudence," this case is not the right vehicle to make those determinations. The cases still percolating in the lower courts will give the Court a better opportunity to interpret the amendment's meaning and apply it to a wider range of cases, including future disputes over embryo disposition.

CONCLUSION

Amici recognize and appreciate the stakes of this dispute for both parties to this case: every determination in a pre-embryo dispute implicates possible emotional difficulty based on permanent events. The lower court did not err in its course of action, however, and appropriately balanced the parties' interests in this case. Absent a valid, enforceable, and unambiguous contract, the Court of Appeals appropriately balanced the parties' competing interests in determining the disposition of the pre-embryo and acted within its authority to hold that the appellee's right not to procreate should outweigh the appellant's right to procreate. Further judicial review and interpretation of the newly adopted reproductive freedom amendment, Article 1, § 28 of Michigan's 1963 Constitution, should not alter the outcome. The Court should await better-suited cases to address for the first time the scope and meaning of Article 1, § 28. For these reasons, amici respectfully request the Court deny leave to appeal.

Respectfully submitted,

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December 20, 2024

WORD COUNT STATEMENT

Pursuant to MCR 7.212(B)(3), I hereby certify that this document contains 3,756 countable words, based upon the word count of the word processing system used to prepare the brief.

Respectfully submitted,

/s/ Bonsitu Kitaba-Gaviglio
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Dated: December 20, 2024

STATE OF MICHIGAN

IN THE SUPREME COURT

SARAH MARIE MARKIEWICZ,

Plaintiff-Appellant,

Supreme Court No. 166782

Court of Appeals No. 363720

v

Macomb County CC: 2019-003236-DM

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Defendant-Appellee,

EXHIBITS TO
AMICI CURIAE BRIEF OF AMERICAN CIVIL LIBERTIES UNION OF MICHIGAN, CENTER FOR REPRODUCTIVE RIGHTS, MICHIGAN FERTILITY ALLIANCE, PLANNED PARENTHOOD OF MICHIGAN, AND THE NATIONAL CENTER FOR LESBIAN RIGHTS

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INDEX OF EXHIBITS

EXHIBIT 1

Planned Parenthood of Michigan v Attorney General,
unpublished opinion of the Court of Claims,
issued September 7, 2022
(Docket No. 22-000044-MM)

STATE OF MICHIGAN

COURT OF CLAIMS

PLANNED PARENTHOOD OF MICHIGAN, on behalf of itself, its physicians and staff, and its patients, and SARAH WALLET, M.D., M.P.H., FACOG, on her own behalf and on behalf of her patients,

Plaintiffs,

v

ATTORNEY GENERAL OF THE STATE OF MICHIGAN, in her official capacity,

Defendant,

and

MICHIGAN HOUSE OF REPRESENTATIVES and MICHIGAN SENATE,

Intervening Defendants.
_____/

OPINION AND ORDER

Case No. 22-000044-MM

Hon. Elizabeth L. Gleicher

OPINION AND ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR SUMMARY DISPOSITION, GRANTING IN PART AND DENYING IN PART INTERVENING DEFENDANTS' MOTION FOR SUMMARY DISPOSITION, AND PERMANENTLY ENJOINING THE ENFORCEMENT OF MCL 750.14

In this declaratory judgment action, plaintiffs, Planned Parenthood of Michigan and Sarah Wallett, M.D., M.P.H., FACOG, challenge the constitutionality of MCL 750.14, which prohibits all abortions except those performed "to preserve the life of [a] woman." Pending before the Court are cross-motions for summary disposition filed by plaintiffs and intervening defendants Michigan House of Representatives and Michigan Senate. The Court GRANTS plaintiffs' motion in part, GRANTS defendant intervenors' motion in part, and permanently enjoins defendant Attorney

General of the State of Michigan from enforcing MCL 750.14. The Court also orders that pursuant to MCL 14.30, the Attorney General must personally serve on the prosecuting attorneys she is statutorily charged with supervising a copy of this opinion and the accompanying order, and must advise the prosecuting attorneys that MCL 750.14 has been declared unconstitutional.

I. PROCEDURAL BACKGROUND

Plaintiffs, Planned Parenthood of Michigan and Dr. Wallett filed this lawsuit on April 7, 2022, naming as defendant the Attorney General of the State of Michigan. Plaintiffs' complaint asserts that MCL 750.14 violates the Due Process, Equal Protection, and Retained Rights provisions of the Michigan Constitution, and the Elliott-Larsen Civil Rights Act, (the ELCRA), MCL 37.2101 *et seq*. The complaint seeks declaratory and injunctive relief.

The Court granted plaintiffs' motion for a preliminary injunction on May 17, 2022. Less than one month later, the Court granted a motion filed by members of the Michigan House of Representatives and Michigan Senate to intervene as party-defendants. The intervenors also sought reconsideration of the Court's May 17 opinion, contending that the Court had incorrectly determined that this case presents an actual controversy and erroneously weighed the preliminary-injunction factors. The Court denied the motion for reconsideration on June 15, 2022.

Pending before the Court are three motions for summary disposition. Plaintiffs moved for summary disposition on June 29, 2022, seeking judgment based on the constitutional and statutory challenges to MCL 750.14 outlined in their complaint. The intervenors' first motion for summary disposition, filed on July 12, 2022, asserts that the Court lacks jurisdiction because the matter is non-adversarial, not ripe, and plaintiffs lack standing. The intervenors filed a second motion for summary disposition on July 26, 2022, arguing that plaintiffs' constitutional and statutory claims

have no merit, and that judgment should be entered in their favor. The intervenors also filed a motion to stay further proceedings, which the Court has addressed in a separate opinion and order.

II. SUMMARY DISPOSITION PRINCIPLES COMMON TO THE MOTIONS

Defendant-intervenors' first motion for summary disposition is brought under MCR 2.116(C)(4) and (C)(8), and the second under (C)(8). Summary disposition is appropriate under MCR 2.116(C)(4) when a court lacks subject-matter jurisdiction. A motion brought under MCR 2.116(C)(8) tests the factual sufficiency of the complaint. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152, 159-160; 934 NW2d 665 (2019). When considering a (C)(8) motion, a court accepts the complaint's allegations as true and decides the motion on the pleadings alone. *Id.* at 160. A motion under MCR 2.116(C)(8) may be granted only when a claim is so clearly unenforceable that no factual development might justify recovery. *Id.*

Plaintiffs' motion for summary disposition is brought under MCR 2.116(C)(10). In support of the motion, plaintiffs filed an affidavit signed by Dr. Wallett. The intervenors' response to plaintiffs' (C)(10) motion incudes an "expert declaration" signed by Farr A. Curlin, M.D., a specialist in internal medicine and Co-Director of the Theology, Medicine, and Culture Initiative at Duke Divinity School. Summary disposition is appropriate under MCR 2.116(C)(10) when "there is no genuine issue with respect to any material fact and the moving party is entitled to judgment as a matter of law." *Emagine Entertainment, Inc v Dep't of Treasury*, 334 Mich App 658, 663; 965 NW2d 720 (2020) (citation and quotation marks omitted). The Court examines the documentary evidence submitted by the parties to determine whether, after drawing all reasonable inferences in favor of the nonmovant, a genuine issue of material fact exists. *Id.*

III. INTERVENORS' FIRST SUMMARY DISPOSITION MOTION

The intervenors' first motion for summary disposition presents three arguments: no actual controversy exists under MCR 2.605, the matter is not ripe for adjudication, and plaintiffs lack standing. These contentions ignore that the purpose of a declaratory-judgment action is to seek the adjudication of rights *before* injury occurs, "to settle a matter before it ripens into a violation of the law or a breach of contract, or to avoid multiplicity of actions by affording a remedy for declaring in expedient action the rights and obligations of all litigants." *Rose v State Farm Mut Auto Ins Co*, 274 Mich App 291, 294; 732 NW2d 160 (2006). From the start, this lawsuit has fulfilled those purposes.

A. ACTUAL CONTROVERSY

Intervenors' "actual controversy" briefing reprises the same arguments made in their motion for reconsideration. In denying reconsideration, the Court rejected those arguments without elaboration, relying on the analysis contained in its May 17 opinion and order. The Court incorporates that analysis here.

But whether an actual controversy existed when the Court entered its preliminary-injunction order is no longer a relevant legal issue. With the addition of the intervenors as defendants, the parties are indisputably adverse. A controversy presently exists regarding the constitutionality of MCL 750.14, and a declaratory judgment is necessary to guide plaintiffs' future conduct.

Plaintiffs seek a declaration that MCL 750.14 is unconstitutional. Intervenors vigorously assert that the law passes constitutional muster in all regards. Indeed, intervenors highlighted in

their motion for intervention that their adversarial legal position supplied the basis for intervention, in part because it established the adversity requisite to justiciability: "There is no question that the Legislature has strong interests in ensuring that constitutional challenges to Michigan statutes present an actual controversy suitable for judicial resolution and, when necessary, in defending judicial challenges. No existing party will adequately represent those interests here . . . ." The intervenors' adverse participation satisfies the "actual controversy" requirement for a declaratory judgment under MCR 2.605(A)(1). See *City of Springfield v Washington Pub Power Supply Sys*, 752 F2d 1423, 1427 (CA 9, 1985) ("any doubt" regarding the existence of a justiciable controversy at the beginning of the litigation was resolved by the intervention of a party taking an adversarial position), and 13 Fed Prac & Proc Juris § 3530 (3d ed) ("[A] case conceived in cooperation may be saved by intervention of a genuine adversary who represents the rights that otherwise might be adversely affected.").

B. RIPENESS

The intervenors next contend that because "no state authority has sought to enforce the statute at issue," plaintiffs' claims are not ripe for adjudication. This argument elides that the ripeness analysis in a declaratory action differs from that undertaken in an ordinary lawsuit. Under MCR 2.605, "a court is not precluded from reaching issues before actual injuries or losses have occurred." *Shavers v Kelley*, 402 Mich 554, 589; 267 NW2d 72 (1978). The basic purpose of a declaratory judgment act is to provide declaratory judgments without awaiting a breach of existing rights. See *id.* Intervenors have failed to engage with this reasoning, and instead merely re-hash the arguments made in their motion for reconsideration. Moreover, the events that followed this Court's preliminary-injunctive order establish that plaintiffs' claims are ripe for decision.

After the Court entered the preliminary injunction order, the United States Supreme Court overruled *Roe v Wade*, 410 US 113; 132; 93 S Ct 705; 35 L Ed 2d 147 (1973), in *Dobbs v Jackson Women's Health Org*, __ US__ ; 142 S Ct 2228 ; 213 L Ed 2d 545 (2022). The parties agree that MCL 750.14 became enforceable after *Dobbs*, and that absent an injunction, the Attorney General may prosecute abortion providers. And although the current Attorney General has publicly disavowed any intent to do so, her term of office expires at the end of 2022. Whether she will be re-elected is unknown. The Court notes that "[m]id-litigation assurances are all too easy to make and all too hard to enforce[.]" *W Alabama Women's Ctr v Williamson*, 900 F3d 1310, 1328 (CA 11, 2018), abrogated on other grounds by *Dobbs*, 142 S Ct 2228. And this Attorney General's promise will not bind her successor, whether a new Attorney General assumes office in 2023 or later.

More pertinent is that several county prosecutors have publicly expressed an intent to pursue prosecutions of abortion providers unless enjoined from doing so. After this Court entered a preliminary injunction, two county prosecutors filed an action for superintending control in the Court of Appeals seeking to nullify this Court's injunctive order. The Court of Appeals issued an order denying superintending control but suggesting that county prosecutors were not bound by this Court's preliminary injunction. *In re Jarzynka*, unpublished order of the Court of Appeals, entered August 1, 2022 (Docket No. 361470). The petitioning prosecutors promptly announced their intent to begin prosecuting abortion providers. A temporary restraining order entered in a different case by a different judge prevented immediate prosecutions.

The intervenors center their ripeness challenge on the concept that "[a] claim is not ripe if it rests upon contingent future events that may not occur as anticipated, or may not occur at all." *Citizens Protecting Michigan's Constitution v Sec'y of State*, 280 Mich App 273, 282; 761 NW2d

210 (2008), aff'd in part and lv den in part 482 Mich 960 (2008). Given the direct and public threats of immediate prosecution, abortion providers face a credible risk of arrest unless MCL 750.14 is deemed unconstitutional, and its enforcement enjoined.

Finally, the United States Supreme Court has held that "it is not necessary that petitioner first expose himself to actual arrest or prosecution to be entitled to challenge a statute that he claims deters the exercise of his constitutional rights." *Steffel v Thompson*, 415 US 452, 459; 94 S Ct 1209; 39 L Ed 2d 505 (1974). See also *Doe v Bolton*, 410 US 179, 188; 93 S Ct 739; 35 L Ed 2d 201 (1973) ("The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief."), abrogated on other grounds by *Dobbs*, 142 S Ct 2228. The very real threat of prosecutions of abortion providers eliminates any ripeness concerns.

C. STANDING

The intervenors next challenge plaintiffs' standing to bring an action intended to vindicate the constitutional rights of their patients. "The general rule is that one person may not raise the denial of another person's constitutional rights." *Citizens for Pretrial Justice v Goldfarb*, 415 Mich 255, 271; 327 NW2d 910 (1982). But "when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights," third party standing is recognized. *Warth v Seldin*, 422 US 490, 510; 95 S Ct 2197; 45 L Ed 2d 343 (1975). See also *US Dep't of Labor v Triplett*, 494 US 715, 721; 110 S Ct 1428; 108 L Ed 2d 701 (1990), in which the Supreme Court recognized the third-party standing of an attorney to sue raising the

due-process rights of his clients. In the abortion context, the Supreme Court has "long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations." *June Med Servs LLC v Russo*, ___ US ___; 140 S Ct 2103, 2118; 207 L Ed 2d 566 (2020), abrogated on other grounds by *Dobbs*, 142 S Ct 2228. The Court adopts the reasoning of *June Medical Services* and a plethora of predecessor cases, and finds that plaintiffs have standing to pursue the constitutional claims of their patients here.

D. JUSTICIABILITY SUMMARY

Defendant intervenors' first motion for summary disposition, based on an alleged lack of subject-matter jurisdiction and standing, is DENIED in its entirety for the reasons stated above.

IV. THE DUE-PROCESS ISSUES

Plaintiffs and the intervenors have filed cross-motions for summary disposition regarding the substantive grounds for relief set forth in plaintiffs' complaint. Whether filed under MCR 2.116(C)(8) or (C)(10), a motion for summary disposition posits that a trial is unnecessary because there are no genuine disputes as to any material facts and the movant is entitled to judgment as a matter of law. Although plaintiffs and the intervening defendants have filed affidavits in support of their motions for summary disposition, no material facts are in dispute.

Counts II and VI of plaintiffs' complaint raise due-process challenges to MCL 750.14. Count II asserts that MCL 750.14 violates abortion patients' fundamental right to bodily integrity as guaranteed by the Due Process Clause of the Michigan Constitution, Const 1963, art 1, § 17. Count VI contends that the statute violates a fundamental right to privacy flowing from the same constitutional provision.

The intervenors' July 26, 2022 motion challenges plaintiffs' due-process claims from several angles, contending that: *Mahaffey v Attorney General*, 222 Mich App 325; 564 NW2d 104 (1997), forecloses the Court's recognition of a due-process right protective of abortion access distinct from the federal constitution; the right to bodily integrity the Court previously recognized is "properly understood as a part of the right to privacy" and therefore incapable of supporting a right to abortion access under *Mahaffey*; even absent *Mahaffey*, Michigan's Due Process Clause is coextensive with its federal counterpart; and that MCL 750.14 does not violate the right to bodily integrity recognized by our Supreme Court in *Mays v Governor of Mich*, 506 Mich 157, 195; 954 NW2d 139 (2020).

Plaintiffs' motion for summary disposition presents almost mirror image due-process arguments: that the rights of privacy and bodily integrity found in Michigan's Constitution protect the right to abortion, and that *Mahaffey* "insufficiently considered the Michigan Constitution's support for an independent state-law right to abortion grounded in the privacy interests protected by its Due Process Clause[.]"

The Court agrees with the intervenors' interpretation of *Mahaffey* to an extent. In its opinion granting a preliminary injunction, this Court specifically acknowledged that although the Court of Appeals held in *Mahaffey* that Michigan's Constitution provides "a generalized right of privacy," the Court also held that the right does not include a right to abortion. Accordingly, the Court grants summary disposition to intervenors on Count VI of plaintiffs' complaint.[1]

[1] "Michigan has long recognized the common-law tort of invasion of privacy." *Lewis v LeGrow*, 258 Mich App 175, 193, 670 NW2d 675 (2003). Indeed, *De May v Roberts*, 46 Mich 160, 9 NW 146 (1881), is among the first reported decisions in the United States allowing a tort recovery

The Court disagrees with the intervenors, however, regarding the breadth of *Mahaffey*'s holding and its precedential effect on plaintiffs' bodily-integrity claim. Plaintiffs' argument that MCL 750.14 unconstitutionally infringes on the right to bodily integrity was not considered in *Mahaffey*. Indeed, the right of bodily integrity was not of constitutional dimension until 2018, when the Court of Appeals decided *Mays v Snyder*, 323 Mich App 1; 916 NW2d 227 (2018), aff'd by equal division 506 Mich 157 (2020). *Mahaffey* did not address the constitutionality of MCL 750.14 through a bodily-integrity lens, nor was it asked to. Contrary to the intervenors' argument, *Mahaffey* does not impede a determination that MCL 750.14 conflicts with the right to bodily integrity.

The Court has also rejected the intervenors' argument that the right to bodily integrity described in *Mays* does not encompass a woman's right to terminate her pregnancy. But with the benefit of additional briefing, including particularly helpful briefs filed by amici curiae, the Court now expands on both its previous bodily-integrity analysis and its conclusion that the meaning of due process under the Michigan Constitution is broad enough to include a woman's right to abortion.

A. FACTUAL BACKGROUND

Before proceeding to the facts, it helps to restate the statute at issue. MCL 750.14 reads:

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premised on an invasion of privacy theory. *Dalley v Dykema Gossett, PLLC*, 287 Mich App 296, 306; 788 NW2d 679 (2010). *De May* arose from the presence of a non-physician third party during the plaintiff's labor and delivery. Speaking of the birth at the center of the case, the Supreme Court observed: "To the plaintiff the occasion was a most sacred one and no one had a right to intrude unless invited or because of some real and pressing necessity which it is not pretended existed in this case." *De May*, 46 Mich at 165. If confronted with a privacy theory in the reproductive decision-making context, our Supreme Court may find *De May* instructive.

> Any person who shall wilfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, shall be guilty of a felony, and in case the death of such pregnant woman be thereby produced, the offense shall be deemed manslaughter.
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> In any prosecution under this section, it shall not be necessary for the prosecution to prove that no such necessity existed.

The parties agree that this statute requires a woman to carry her pregnancy to delivery under nearly all circumstances. Pregnancies resulting from rape or incest are not excepted from the law. If the woman's physician concludes that continuing the pregnancy will permanently damage that woman's health, the law offers no recourse. If the woman has no social support or means to support the child, or if having the child means forgoing an education or employment, the law requires the woman to make the sacrifices. If the fetus suffers from a disability or deformity incompatible with life, the law requires carrying the pregnancy to term regardless of the physical or emotional consequences. This is the legal landscape against which the Court must evaluate the undisputed evidence in this case.

Plaintiffs' motion for summary disposition includes an affidavit signed by plaintiff Sarah Wallett, M.D., a board-certified obstetrician-gynecologist who performs abortions in Michigan. Along with her medical credentials, Dr. Wallett has a Master of Public Health degree from the University of Michigan. Dr. Wallett's affidavit describes the services offered at Planned Parenthood of Michigan, and presents general information related to pregnancy, abortion, and

childbirth. The affidavit signed by Dr. Curlin on behalf of the intervenors does not challenge the health-related information supplied by Dr. Wallett.[2]

Dr. Wallett avers that "pregnancy and childbirth carry significant medical risk." The risk of death associated with childbirth, she reports, is estimated to be 8.8 deaths per 100,000 live births. The estimated overall risk of maternal mortality is 23.8 deaths per 100,000 live births. In contrast, "less than one woman dies for every 100,000 abortion procedures." The affidavit continues that during pregnancy, women "are more prone to blood clots, nausea and vomiting, dyspnea (breathing discomfort), hypertensive disorders, urinary tract infections, and anemia, among other complications." Pregnancy also "may aggravate preexisting health conditions such as hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary disease."

Dr. Wallett explains that health conditions may arise during pregnancy that threaten life or long-term health, including and hematologic (blood) disorders. Some pregnancy complications, such as ectopic pregnancy, are fatal if not treated rapidly. Childbirth, too, is a "significant medical event," carrying risks of death and the need for an open abdominal surgery (cesarean section), which in turn exposes a person to a variety of potentially life-threatening complications.

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[2] Dr. Curlin's affidavit addresses whether enforcement of MCL 750.14 "would violate the right to bodily integrity that is respected in the ethical doctrine of informed consent," and specifically whether "the right to refuse medical interventions entails a corollary right to obtain those interventions." In Dr. Curlin's view, the "right to bodily integrity" corresponds to a right "to refuse" medical intervention rather than a right to obtain an intervention, particularly when the intervention at issue – abortion – involves a "living human fetus." Dr. Carlin asserts: "If the living human fetus is recognized as deserving of any moral regard, then it follows that there can be no general positive right to abortion." Dr. Curlin does not express any opinions or offer any data regarding the public health aspects of criminalizing abortion, or the comparative medical risks of pregnancy, childbirth, and abortion.

Restricting or curtailing the ability to obtain abortion services substantially worsens health outcomes and living conditions during all pregnancies, the affidavit explains, and especially for people of color and the economically vulnerable.

According to Dr. Wallett – and undisputed here – "Abortion is one of the safest and most common medical services performed in the United States today." The risk of death associated with childbirth is more than 12 times higher than that associated with abortion. Pregnancy-related complications are far more common in those who elect to give birth than those who choose to terminate their pregnancies. Dr. Wallett reports that of the 29,669 induced abortions performed in Michigan in 2020, the Michigan Department of Health and Human Services reported just seven immediate complications. And according to Dr. Wallett, approximately one in four Americans will have an abortion by age 45.

The data provided in Dr. Wallett's affidavit establish that abortion is safe and routinely performed. For some, abortion is lifesaving. For others, abortion preserves health and permits a subsequent healthy and desired pregnancy. The uncontested evidence supports that when performed by a physician, the medical risks of abortion are far lower than those of childbirth. The evidence also establishes that abortion is an essential component of obstetrical care because it saves lives and preserves health.

If criminalized, Dr. Wallett attests, abortion will continue to occur. Self-performed abortions, or abortions performed by non-physicians, will endanger lives, health, and reproductive futures. Other likely consequences of criminalizing abortions include an increase in deaths due to complications of pregnancy and childbirth.

The statute's sweeping application, combined with this factual background, informs the Court's consideration of the parties' competing bodily integrity arguments. Manifestly, criminalizing abortion will eliminate access to a mainstay healthcare service. For 50 years, Michiganders have freely exercised the right to safely control their health and their reproductive destinies by deciding when and whether to carry a pregnancy to term. Eliminating abortion access will force pregnant women to forgo control of the integrity of their own bodies, regardless of the effect on their health and lives. The evidence further establishes that the enforcement of a 1931 law withdrawing that right will have dire public-health consequences.

The legal issue presented is whether our state's Constitution empowers the Legislature to override personal health decisions by compelling a person to use her body in a manner not of her own choosing. As discussed below, the Court finds that such compulsion destroys the sphere of bodily integrity and personal autonomy underlying the liberty component of the Due Process Clause, Const 1963, art 1, § 17.

B. BODILY INTEGRITY AND THE MICHIGAN CONSTITUTION

The intervenors insist that the Due Process Clauses of the Michigan and United States Constitutions are coextensive. Similarly, the intervenors propose that the right to privacy and the right to bodily integrity are one and the same, the latter subsumed within and indistinguishable from the former, which *Mahaffey* held inapplicable to abortion access. Michigan's Constitution does not mention abortion, the intervenors continue, and there is no "principled" basis to interpret it differently than the United States Supreme Court interpreted the federal Constitution in *Dobbs*.

The intervenors are surely correct the right to privacy and the right to bodily integrity are both rooted the idea that there are attributes of "personhood" on which the government may not tread. But common philosophical roots do not produce identically aligned rights.

The right to privacy is a generalized "right to be let alone by other people." *Katz v United States*, 389 US 347, 350–351; 88 S Ct 507; 19 L Ed 2d 576 (1967). As conceptualized by Justice Thomas Cooley, "The right to one's person may be said to be a right of complete immunity: to be let alone." Cooley, Torts, 2d ed (1888), p 29. Justice Louis Brandeis understood the right as pertaining to the public disclosure of private facts. See *Beaumont v Brown*, 401 Mich 80, 109; 257 NW2d 522 (1977), overruled on other grounds by *Bradley v Saranac Community Sch Bd of Ed*, 455 Mich 285, 302; 565 NW2d 650 (1997). The right to bodily integrity is narrower and more exacting than either of those formulations.

Unlike the common-law right to privacy, the right to bodily integrity emphasizes one's exclusive use and control of one's own *body*. "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pac R Co v Botsford*, 141 US 250, 251; 11 S Ct 1000; 35 L Ed 734 (1891). The right is "indispensable," declared the Sixth Circuit in *Guertin v Michigan*, 912 F3d 907, 918 (CA 6, 2019), the "first among equals." These recognitions of the primacy of the right correspond with a universal understanding that bodily autonomy is inherent to human dignity.

Contrary to the intervenors' argument, the right to bodily integrity protects more finite interests than those generally falling within the catch-all "privacy" rubric. By analogy, the rights

subsumed under the designation "*Miranda* rights"[3] include the right to counsel during custodial interrogation, and the right to refuse to self-incriminate. The contours of those two rights are readily distinguishable despite their shared label. Similarly, the "right to privacy"—to be let alone—includes a bundle of rights that have nothing to do with bodily integrity. See *Dalley v Dykema Gossett, PLLC*, 287 Mich App 296; 788 NW2d 679 (2010) (the right to privacy includes the right to be free from intrusion upon seclusion); *Pallas v Crowley-Milner & Co*, 334 Mich 282, 285; 54 NW2d 595 (1952) (the right to privacy is violated by the unconsented publication of a photograph); and *Doe v Mills*, 212 Mich App 73, 80; 536 NW2d 824 (1995) (the right to privacy protects against the public disclosure of embarrassing private facts).

The case law describing the right to bodily integrity usually flows from controversies involving medical treatment, characterizing the right as synonymous with the freedom to protect one's self-determination by making autonomous medical choices. Typical cases involve the nonconsensual entry into a person's body for medical purposes, such as *Rochin v California*, 342 US 165, 169; 72 S Ct 205; 96 L Ed 183 (1952), or forced treatment in the face of a competent patient's objection, such as *Cruzan v Director, Mo Dep't of Health*, 497 US 261; 110 S Ct 2841; 111 L Ed 2d 224 (1990). Concurring Justice Sandra Day O'Connor acknowledged in *Cruzan* that "Requiring a competent adult to endure . . . procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment." *Id.* at 289 (O'CONNOR, J., concurring). The right to bodily integrity encompasses the freedom to decide how one will use her own body, a right independent of that of privacy generally. The intervenors'

[3] *Miranda v Arizona*, 384 US 436; 86 S Ct 1602 (1966).

argument that the right to bodily integrity and the right to privacy are necessarily co-extensive has no legal or logical validity.

The Court easily dispenses with the intervenors' next argument: that a ban on abortion has nothing to do with bodily integrity because pregnancy "does not involve any 'nonconsensual entry into the body.' " As any woman who has experienced pregnancy and delivery knows, the process is utterly transformative of every bodily function. From early pregnancy through birth, hormonal changes, biochemical adaptations, and the presence of a growing, moving and ultimately exiting fetus take control of a woman's body, not to mention her mind. When pregnancy is desired, the word "intrusion" is likely low on the list of a mother's descriptors of the process. But when pregnancy is unwelcome, dangerous, or likely to result in negative health consequences, it is indeed a "bodily intrusion."

The intervenors' central contention is that the right to bodily integrity now enshrined in Michigan's Constitution does not include a right to abortion. *Mays*' holding that our Constitution's Due Process Clause encompasses "an individual's right to bodily integrity free from unjustifiable governmental interference" constitutes binding precedent. *Mays v Snyder*, 323 Mich App at 58–59 (citation and quotation marks omitted). See also *Mays*, 506 Mich at 195 (affirming the Court of Appeals by equal division).[4] The intervenors tacitly acknowledge that *Mays* recognized a new

[4] Citing *Mays*, the intervenors also contend that "to survive dismissal, the alleged violation of the right to bodily integrity must be so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience." 323 Mich App at 60 (citation and quotation marks omitted). The intervenors fundamentally misunderstand the context of the Court's statement. *Mays* considered whether Michigan courts should recognize a constitutional *tort* claim arising from a violation of the right to bodily integrity. To justify a *tort* claim against the state, a constitutional violation must involve conduct that is not merely negligent, but egregious or outrageous: "To sustain a substantive due process claim against municipal actors, the governmental conduct must be so arbitrary and

right protected by *Michigan's* Constitution. Even so, the intervenors urge, the right does not apply to abortion. The *Dobbs* majority opinion, on which the intervenors rely, expressed that view of the federal constitution:

> The Constitution makes no reference to abortion, and no such right is implicitly protected by any constitutional provision, including the one on which the defenders of *Roe* and *Casey* now chiefly rely—the Due Process Clause of the Fourteenth Amendment. That provision has been held to guarantee some rights that are not mentioned in the Constitution, but any such right must be "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty." [*Washington v Glucksberg*, 521 US 702, 721; 117 S Ct 2258; 138 L Ed2d 772 (1997)] (internal quotation marks omitted).
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> The right to abortion does not fall within this category. [*Dobbs*, ___ US at ___; 142 S Ct at 2242].

Decisions of the United States Supreme Court interpreting identically worded provisions do not preclude Michigan Court from adopting a more capacious construction. "In interpreting our Constitution, we are not bound by the United States Supreme Court's interpretation of the United States Constitution, even where the language is identical." *People v Goldston*, 470 Mich 523, 534; 682 NW2d 479 (2004). "[O]ur courts are not obligated to accept what we deem to be a major contraction of citizen protections under our constitution simply because the United States Supreme Court has chosen to do so. We are obligated to interpret our own organic instrument of government." *Sitz v Dep't of State Police*, 443 Mich 744, 763; 506 NW2d 209 (1993). The Michigan Supreme Court has acknowledged the independent authority of our Due Process Clause, explaining that although its language is identical to that of Fourteenth Amendment, "Const 1963, art 1, § 17 may, in particular circumstances, afford protections *greater than or distinct from* those

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capricious as to shock the conscience." *Mettler Walloon, LLC v Melrose Twp*, 281 Mich App 184, 198; 761 NW2d 293 (2008). The "egregious" and "outrageous" standard has no bearing in a case challenging a statute's facial unconstitutionality.

offered by US Const Am XIV, § 1." *AFT Mich v Michigan*, 497 Mich 197, 245; 866 NW2d 782 (2015) (footnotes omitted, emphasis added).

"[T]he ultimate task facing" a court confronting the "interpretation of particular Michigan constitutional provisions is to respectfully consider federal interpretations of identical or similar federal constitutional provisions, but then to undertake by traditional interpretive methods to independently ascertain the meaning of the Michigan Constitution." *People v Tanner*, 496 Mich 199, 223 n 17; 853 NW2d 653 (2014). Here, that process yields the conclusion the liberty component of our Due Process Clause must be interpreted more broadly than in *Dobbs*.

Our Supreme Court's paradigm for evaluating whether a right falls within the "liberty" aspect of the Due Process Clause differs from that of the Supreme Court of the United States in an important way. Rather than requiring a right to be "deeply rooted in this Nation's history or tradition," and "implicit in the concept of ordered liberty," when interpreting Michigan's Constitution "the most pressing rule" is "that the provisions for the protection of life, liberty and property are to be largely and liberally construed in favor of the citizen." *Lockwood v Nims*, 357 Mich 517, 557; 98 NW2d 753 (1959) (quotation marks omitted). See also *Shavers*, 402 Mich at 598 ("the concepts of 'liberty' and 'property' protected by due process 'are not to be defined in a narrow or technical sense but are to be given broad application.' ") (Citations omitted.) These commands flow from differing constitutional histories and the two instruments' profound dissimilarities.

The differences in the constitutions' language, structure and history are at the heart of the "compelling reason" framework, which guides a court's consideration of whether a Michigan constitutional provision should be interpreted differently than its federal counterpart. *Goldston*,

470 Mich at 534. In evaluating whether Michigan's Constitution includes a right not recognized by the United States Supreme Court we consider:

> 1) [T]he textual language of the state constitution, 2) significant textual differences between parallel provisions of the two constitutions, 3) state constitutional and common-law history, 4) state law preexisting adoption of the relevant constitutional provision, 5) structural differences between the state and federal constitutions, and 6) matters of peculiar state or local interest. [*Id.*, quoting *People v Collins*, 438 Mich 8, 31 n 39; 475 NW2d 684 (1991) (alteration in original).]

Four *Goldston* factors weigh in favor if interpreting Michigan's Due Process Clause more expansively than its federal counterpart: our state's constitutional history charts a unique course for the interpretation of personal rights; the structural differences between the two constitutions warrant interpreting our Due Process Clause more expansively than the United States Supreme Court interprets the federal provision; our Constitution contains text relevant to due process that has no counterpart in the United States Constitution, and a matter of "peculiar" state interest – the promotion of the public health – points toward interpreting our Constitution in a manner that preserves and protects the health of our citizens.[5]

Although the starting point dictated by *Goldston* and its predecessors is the language of the federal Constitution, "this emphatically does not mean that" that the drafters of state constitutions

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[5] The *Goldston* factors originated in a footnote to Justice Boyle's majority opinion in *People v Catania*, 427 Mich 447, 466 n 12; 398 NW2d 343 (1986). Justice Boyle borrowed the factors from an opinion of the Supreme Court of Washington, *State v Gunwall*, 106 Wash 2d 54, 58-63; 720 P2d 808 (Wash, 1986) (en banc). See *id.* In *Catania* and *Gunwall*, the fourth factor is stated as: "[*m*]*atters of particular* state interest or local concern." Gunwall, 106 Wash at 67 (emphasis omitted); see also *Catania*, 427 Mich at 466 n 12 (emphasis added). In *Collins*, 438 Mich at 31 n 39, and later cases including *Goldston*, the word "particular" became "peculiar." One of the definitions of "peculiar" includes "particular," and the Court assumes that is what the Supreme Court meant in the cases that followed *Catania*. See *Merriam-Webster's Collegiate Dictionary* (11th ed).

"intended to hitch interpretation of the state constitution to evolving Supreme Court jurisprudence." Clint Bolick, *Principles of State Constitutional Interpretation*, 53 Ariz St LJ 771, 787 (2021). Rather, the *Goldston* factors implicitly instruct that our state's unique history must drive the inquiry into whether our 1963 Constitution's Due Process Clause should be interpreted more expansively than the parallel provision of the federal constitution.

In finding no federal due-process right to abortion, *Dobbs* relied on a version of history that began in the 13th Century and ended in 1868, when the federal Due Process Clause was ratified. Almost a century, two world wars, a constitutional amendment granting women the right to vote, the emergence of the civil rights movement, and a sea change in the laws regarding women's status in society separate the adoption of the Fourteenth Amendment from the ratification of our 1963 Constitution. The intervenors' insistence that a Michigan court's interpretation of our 1963 Constitution's Due Process Clause should echo *Dobbs*' interpretation of the federal Clause ignores that history, as well as the history-driven underpinnings of the "compelling reason" framework. A court charged with an examination of the ideas giving rise to a 1963 Constitution is not assisted by an historical analysis of a clause drafted in a far different social and legal environment. What was "deeply rooted" in history and tradition in 1868, a focal point in *Dobbs*, bears little resemblance to the understanding of personal freedom, particularly for women and people of color, motivating those who drafted and ratified our 1963 Constitution. The Court therefore rejects the intervenors' claim that this Court must reflexively adhere to *Dobbs*'s conclusions about the reach of the federal Due Process Clause.

Historical changes also play a role in the analysis of the more direct question at the heart of this case: whether a "compelling reason" exists to conclude that the enforcement of MCL 750.14 would violate our Due Process Clause. Thirty consequential years stand between the enactment of

MCL 750.14 and the ratification of our Constitution. In *People v Nixon*, 42 Mich App 332, 339; 201 NW2d 635 (1972), remanded on other grounds, 389 Mich 809 (1973), the Court of Appeals described that during that time,

> medical science has made tremendous strides . . . No longer is an induced abortion, when performed by a licensed physician in an antiseptic environment, a matter of so great a danger that it justifies a blanket denial of the right to secure such medical services. Not only has modern medical science made a therapeutic abortion reasonably safe, but it would now appear that it is safer for a woman to have a hospital therapeutic abortion during the first trimester than to bear a child.

The Court's previous opinion sketched the history of Michigan's abortion legislation, highlighting that the statutory evolution of the criminal proscriptions demonstrated that their primary purpose was the protection of maternal health. A health purpose can no longer justify criminalizing abortion given the safety of the procedure and our Constitution's specific protection of public health.

Our state's constitutional history confirms that the drafters of our Constitution intended and expected that the document would house new rights. Article 1, § 23, provides that "[t]he enumeration in this constitution of certain rights shall not be construed to deny or disparage others retained by the people." The Official Record reflects that when adding this new provision to our state's Constitution, the drafters foresaw that it would encourage an expansive interpretation of civil and personal rights. They declared that the retained rights provision "recognizes that no bill of rights can ever enumerate or guarantee all the rights of the people and that liberty under law is an ever growing and ever changing conception of a living society developing in a system of ordered liberty." 1 Official Record, Constitutional Convention 1961, p 470. Buttressing that the retained rights provision means that a right need not be specifically name to be included within concept of due process is the Address to the People, 2 Official Record, Constitutional Convention 1961, p

3365, accompanying Const 1963, art 1, § 23, explaining: "This is a new section taken from the 9th amendment to U. S. Constitution. It recognizes that no Declaration of Rights can enumerate or guarantee all the rights of the people – that it is presently difficult to specify all such rights which may encompass the future in a changing society."[6]

In 1963, the People ratified a constitution for the twentieth century and beyond, expecting that their document would safeguard present and newly emerging liberties as our country continued its rapid transformation after the Second World War. In contrast, the *Dobbs* majority looked *backwards*, clinging to a version of history that started "in the earliest days of the common law." *Dobbs*, 142 S Ct at 2254. When it comes to the recognition of civil and political rights, our state's Constitution charges us to look forward, and to inform our conclusions about the liberties enjoyed by our people in the lights of an "ever changing conception of a living society." 1 Official Record, p 470. The intent of the framers, manifested by their explanations of the new Constitution, are pertinent to the third *Goldston* factor ("state constitutional and common-law history") and supplies a compelling reason to interpret Michigan's Due Process Clause independently of the United States Supreme Court—with an eye toward "guaranteeing" rights that become established over time rather than eradicating them.[7]

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[6] Count V of plaintiffs' complaint sets forth a claim under the Article I, § 23 of the Michigan Constitution. The Court respectfully disagrees with plaintiffs that this provision *creates* rights. In the Court's view, this section is an interpretive *rule*. It reminds courts that not every right will be found in the constitutional text, and that when it comes to rights, reflexively searching for a word in the text is an incorrect approach.

[7] Pre-*Dobbs*, the United States Supreme Court employed a similar analysis. See *Obergefell v Hodges*, 576 US 644, 664; 135 S Ct 2584; 192 L Ed 2d 609 (2015) ("The generations that wrote and ratified the Bill of Rights and the Fourteenth Amendment did not presume to know the extent of freedom in all of its dimensions, and so they entrusted to future generations a charter protecting

Relevant to the first, second and fifth *Goldston* factors, the text and structure of Michigan's Constitution also differ from the federal Constitution in several relevant respects, adding more compelling reasons to interpret the charters differently. These dissimilarities are particularly salient because they reinforce that due process includes protecting and fostering the health and the bodily integrity of Michigan women.

It was not an accident that the framers of the 1963 Constitution placed a Declaration of Rights at its very beginning, presenting "constitutionally guaranteed individual rights . . . drawn to restrict governmental conduct and to provide protection from governmental infringement and excesses." *Woodland v Mich Citizens Lobby*, 423 Mich 188, 204; 378 NW2d 337 (1985). While the first three articles of the federal Constitution enumerate and describe the powers of the *government*, Article I of Michigan's Constitution bestows on our *citizens* 24 different and specific personal rights, including several that do not appear in the federal document. The Kansas Constitution shares a similar structure. The Kansas Supreme Court has observed: "By this ordering, demonstrating the supremacy placed on the rights of individuals, preservation of these natural rights is given precedence over the establishment of government." *Hodes & Nauser, MDS, PA v Schmidt*, 309 Kan 610, 660-661; 440 P3d 461 (Kan, 2019).

Our Constitution also contains a provision that does not appear in the federal Constitution. Article 4, § 51 states: "The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the

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the right of all persons to enjoy liberty as we learn its meaning. When new insight reveals discord between the Constitution's central protections and a received legal stricture, a claim to liberty must be addressed.").

protection and promotion of the public health." Not long after the 1963 Constitution was ratified, the Supreme Court commented regarding this provision: "This new section, together with the traditional public policy of this State, must be held to limit the powers of the legislature and of government generally to such legislative acts and such governmental powers as exhibit a public purpose." *City of Gaylord v Beckett*, 378 Mich 273, 295; 144 NW2d 460 (1966).

The protection of public health interlaces with plaintiffs' bodily integrity claim. Article 4, § 51 restricts the Legislature's ability to enact statutes that disserve the public health. By depriving women of the right to make autonomous health choices, MCL 750.14 irreconcilably conflicts with the Constitution's public-health mandate. Our Declaration of Rights makes preeminent the personal liberty of our people, protecting against "the arbitrary exercise of governmental power," *AFT Michigan v Michigan*, 497 Mich at 245. Our Constitution's public-health commandment and the primacy of its focus on individual rights support that a statute endangering health by denying a right to abortion deprives Michiganders of due process of law.

The Court previously stated that

> [f]orced pregnancy, and the concomitant compulsion to endure medical and psychological risks accompanying it, contravene the right to make autonomous medical decisions. If a woman's right to bodily integrity is to have any real meaning, it must incorporate her right to make decision about the health events most likely to change the course of her life: pregnancy and childbirth.

A law denying safe, routine medical care not only denies women of their ability to control their bodies and their lives – it denies them of their dignity. Michigan's Constitution forbids this violation of due process.

Because the right to bodily integrity is fundamental, the state may enact laws that burden the right only when the laws serve a compelling governmental interest. *Phillips v Mirac, Inc*, 470

Mich 415, 432–433; 685 NW2d 174 (2004). To justify a law conflicting with a fundamental right, the government must demonstrate that the law is "narrowly tailored to serve a compelling state interest." *Sheardown v Guastella*, 324 Mich App 251, 258; 920 NW2d 172 (2018).

As recognized in *Roe* and all post-*Roe* abortion related cases until *Dobbs*, the state has an interest in protecting both maternal health and potential life. No evidence supports that enforcement of MCL 750.14 would protect maternal health. To the contrary, criminalizing abortion will endanger the lives and health of Michigan women.

In *Roe*, the United States Supreme Court applied the strict scrutiny rubric, concluding that not until fetal viability was "the State's important and legitimate interest in potential life . . . 'compelling.' " *Roe*, 410 US at 163. In *Planned Parenthood of SE Penn v Casey*, 505 US 833, 874; 112 S Ct 2791, 2819; 120 L Ed 2d 674 (1992) (plurality opinion), overruled by *Dobbs*, 142 S Ct 2228, the Supreme Court jettisoned the trimester framework, and adopted an "undue burden" standard: "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."

Casey, however, involved a statute regulating abortion, not criminalizing it. The *Casey* plurality explained: "Not all governmental intrusion is of necessity unwarranted; and that brings us to the other basic flaw in the trimester framework: even in *Roe*'s terms, in practice it undervalues the State's interest in the potential life within the woman." *Id.* at 875. The question presented here is whether the state's interest in protecting potential life justifies a law criminalizing abortion in all circumstances except "to preserve the life of [a] woman." MCL 750.14.

The intervenors advocate that the state's interest in the protection of prenatal life so vastly outweighs a woman's interest in bodily integrity that the latter right should be disregarded.[8] In *Roe*, the Court rejected the intervenors' argument, explaining:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer. [*Roe*, 410 US at 160.]

The Court adopts that reasoning. Fifty years of conflict regarding *Roe* have proven that consensus regarding when life begins is impossible. Inherent in the right of bodily integrity is the right to bodily autonomy, to make decisions about how one's body will be used, "a right of self-determination in matters that touch individual opinion and personal attitude." *W Va State Bd of Ed v Barnette*, 319 US 624, 630–631; 63 S Ct 1178; 87 L Ed 1628 (1943). The state has no compelling interest in forcing a woman to surrender her rights to her "individual opinion[s] and personal attitude[s]" about when life begins, or to relinquish her bodily autonomy and integrity, before fetal viability. MCL 750.14 is not narrowly tailored to further the state's interest in viable fetal life, and therefore cannot survive strict scrutiny analysis.[9]

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[8] The Court's previous opinion discounted the intervenors' claim that the Legislature enacted MCL 750.14 to preserve fetal life. Amici curiae have provided an extensive and highly informative discussion of the history of abortion laws that calls into serious question the "fetal life" theory. That history supports that Michigan's abortion statute was enacted during an historical period in which lawmakers were more focused on maintaining women's roles as mothers and caretakers than in fetal well-being. For the purposes of this litigation, however, the Court will assume that MCL 750.14 was intended to preserve fetal life.

[9] Because MCL 750.14 is facially unconstitutional and has not been enforced, the Court need not address its deficiencies as applied to post-viability situations when the health of the mother is at stake, or any other aspects of the statute's potential enforcement.

Summarizing, the Court finds that any enforcement of MCL 750.14 would violate a woman's constitutional right to bodily integrity. Accordingly, the Court DENIES the intervenors' motion for summary disposition regarding Count II of plaintiffs' complaint, and GRANTS plaintiffs' motion for summary disposition on this Count.

V. EQUAL PROTECTION

Count III of plaintiffs' complaint alleges that MCL 750.14 violates Michigan's Equal Protection Clause, Const 1963, art 1, § 2: "No person shall be denied the equal protection of the laws . . . ." The complaint asserts that MCL 750.14 treats pregnant women seeking abortion differently than those seeking to continue their pregnancies, depriving those choosing abortion of their right to bodily integrity. The law also creates an illegal sex-based classification, plaintiffs claim, by withholding from pregnant women (and pregnant women alone) the power to make autonomous decisions related to reproduction, thereby entrenching "stereotypical, antiquated, and overbroad generalizations about the roles and relative abilities of men and women."

The intervening defendants' motion for summary disposition argues that plaintiffs' equal protection arguments are foreclosed by *Mahaffey*'s holding that there is no right to abortion under the Michigan Constitution, and by *Dobbs*' determination that "a State's regulation of abortion is not a sex-based classification and is thus not subject to the 'heightened scrutiny' that applies to such classifications." *Dobbs*, 142 S Ct at 2245.

The Court is unpersuaded by the intervenors' arguments and DENIES the intervenors' motion for summary disposition of Count III. *Mahaffey* did not address the equal-protection claims articulated here, and this Court's consideration of Michigan's Equal Protection Clause is not cabined by *Dobbs*. Although our Supreme Court has declared that "Michigan's equal protection

provision is coextensive with the Equal Protection Clause of the United States Constitution," *Shepherd Montessori Ctr Milan v Ann Arbor Charter Twp*, 486 Mich 311, 318; 783 NW2d 695 (2010), the Court promptly tempered that statement with this footnote:

> By this, we do not mean that we are bound in our understanding of the Michigan Constitution by any particular interpretation of the United States Constitution. We mean only that we have been persuaded in the past that interpretations of the Equal Protection Clause of the Fourteenth Amendment have accurately conveyed the meaning of Const 1963, art 1, § 2 as well. [*Id.* at 318 n 7, quoting *Harvey v Michigan*, *Harvey v Michigan*, 469 Mich 1, 6, n 3; 664 NW2d 767 (2003), 6, n 3; 664 NW2d 767 (2003) (quotation marks omitted)].

As discussed above, the courts of this state may interpret provisions of Michigan's Constitution independently of the Supreme Court of the United States, both to protect Michiganders' individual rights, and when "compelling reasons" support doing so. Compelling reasons exist here.

Our Constitution's structure differs in fundamental ways from that of the United States Constitution. The framers placed our Declaration of Rights at the forefront of the document, conveying the prominence of the liberties it promises. The very first lines of our Constitution's Declaration of Rights create a frame of reference for considering the right to equal protection of the laws that has no counterpart in the United States Constitution: "All political power is inherent in the people. Government is instituted for their equal *benefit*, security and *protection*." Const 1963, art 1, § 1 (emphasis added). The concepts of equal "benefits" and equal "protection" are at the heart of the equal protection clause.

The equal-protection clauses of both constitutions require that the law treat similarly situated similarly, absent a reason to distinguish between them. *Shepherd Montessori Ctr*, 486 Mich at 318. The first question a court confronts when analyzing an equal-protection claim is whether the plaintiff was treated differently than a similarly situated comparator. *Id.* If the answer

is yes, the court considers the level of judicial scrutiny to apply to the reasons offered for the distinction. If the law treats similarly situated people differently based on the exercise of a fundamental constitutional right, as here, the law may be upheld only "if it passes the rigorous strict scrutiny standard of review: that is, the government bears the burden of establishing that the classification drawn is narrowly tailored to serve a compelling governmental interest." *Id.* at 319. This means that the Legislature may not disadvantage a group exercising a fundamental unless a compelling reason supports their unequal treatment, and the law is carefully crafted to further an important governmental objective. *Id.*

Plaintiffs' motion for summary disposition contends that MCL 750.14 draws two types of unconstitutional distinctions triggering strict scrutiny. Pregnant women who seek to protect their health and well-being by exercising their fundamental right to abortion are denied a safe medical procedure, while similarly situated women who elect to carry to term receive a full panoply of health services, thereby enjoying their right to bodily integrity. Plaintiffs secondly assert that because MCL 750.14 applies only to women, "in operation it enforces the archaic, sex-based stereotype that the biological capacity for pregnancy should determine the course of a person's life."

Intervenors' response recapitulates the reasoning of *Mahaffey* and *Dobbs*, insisting that they govern plaintiffs' equal-protection claim. Because the law "applies equally to both male and female abortion providers," the intervenors continue, it "does not create a sex-based classification." The intervenors add: "Insofar as the challenged law distinguishes between women who seek abortion and women who seek to carry their children to term, it is still subject to rational basis review; women who seek abortion are not a suspect class."

The Court finds plaintiffs' arguments more persuasive. Michigan's Constitution protects the right of all pregnant people to make autonomous health decisions. MCL 750.14 denies the fundamental rights of bodily integrity and autonomy to one constitutionally protected decision; under the law, women who seek abortion must sacrifice that fundamental right. Because the law's enforcement conflicts with a fundamental right it must be strictly scrutinized to determine whether it serves a compelling state interest.

The intervenors proffered justification for the law is the protection of potential fetal life. The history surrounding the law's 1931 enactment does not support this 2022 view of its purpose.[10] Even if the intervenors' version of the legislative history were accurate, the intervenors have not attempted to explain why that interest must always overcome the constitutionally protected interest of a pregnant woman in the control of her body. By depriving women who choose abortion the ability to exercise a fundamental right while protecting the same right for pregnant women who choose to continue their pregnancies, MCL 750.14 violates Michigan's Equal Protection Clause.

Plaintiffs' second ground for seeking injunctive relief under the Equal Protection Clause flows from *Casey*'s recognition that "The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."

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[10] An amicus curiae brief submitted by four distinguished professors of history and law makes a far stronger case that passage of the 1931 law was fueled by "a pervasive world view in which women's status in law, and their bodily integrity, were consistently compromised." The professors present abundant evidence supporting their thesis that "sex-stereotyped views of women, nativist sentiments, religious bigotry, eugenic aims, and fears about maternal mortality and morbidity from pregnancy termination have animated Michigan's laws restricting abortion." The intervenors admit to none of these Legislative purposes and have advanced no evidence regarding the legislative history of MCL 750.14. But because this is a motion under MCR 2.116(C)(10), the Court will construe the historical evidence developed by amici in favor of the intervenors' "protection of fetal life" claim, despite that the intervenors have presented nothing to support it.

Casey, 505 US at 856 (opinion of the court). Plaintiffs contend that criminalizing abortion denies the *benefits* of equal citizenship to women, precisely what 1963 Const art 1, §§1 and 2 forbid.

The "benefits" of equal citizenship are myriad and incapable of summary. For some women, the ability to pursue educational or career plans are a central benefit of equal citizenship, and the fundamental rights of bodily integrity and autonomy protect their right to continue along those pathways. For others, pregnancy is much desired, but due to health issues or fetal anomalies, a woman may determine that terminating the pregnancy is the safest option. And many women seeking abortion already have children. For them, concerns about their financial and emotional abilities to take good care of their existing children drive the abortion decision. See Priscilla J. Smith, *Responsibility for Life: How Abortion Serves Women's Interests In Motherhood*, 17 JL & Pol'y 97, 105 (2008) ("Over 60% of women obtaining abortions already have children. One study found that 61% of the women had children; with 34% having two or more children."). Exercising the right to bodily integrity means exercising the right to determine *when* in her life a woman will be best prepared physically, emotionally, and financially to be a mother. "[A]bortion serves the goal of gaining the freedom to raise children and to mother them in conditions of equality." *Id.* at 138.

Consistent with the Supreme Court's observation in *Casey* that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives," 505 US at 856, fifty years of reproductive freedom have seen a vast expansion in the number of Michigan women in the professions, politics, and the workplace. By criminalizing abortion, MCL 750.14 prevents a woman who seeks to exercise a constitutional right from controlling her ability to work or to go to school, and thereby determining for herself the shape of her present and future life.

The law also controls her ability to be the mother she wants to be. The statute not only compels motherhood and its attendant responsibilities; it wipes away the mother's ability to make the plans she considers most beneficial for the futures of her existing or desired children. Despite that men play necessary role in the procreative process, the law deprives only *women* of their ability to thrive as contributing participants in world outside the home and as parents of wanted children. MCL 750.14 forces a pregnant woman to forgo her reproductive choices and to instead serve as "an involuntary vessel entitled to no more respect than other forms of collectively owned property." Lawrence H. Tribe, *Deconstructing Dobbs*, The New York Review of Books, September 22, 2022, available at <https://www.nybooks.com/articles/2022/09/22/deconstructing-dobbs-laurence-tribe/> (accessed September 6, 2022). In doing so, the statute not only reinforces gender stereotypes, but "perpetuate[s] the legal, social, and economic inferiority of women." *United States v Virginia*, 518 US 515, 534; 116 S Ct 2264; 135 L Ed 2d 735 (1996).

Article I, § 2 of our Constitution does not permit the Legislature to impose unjustifiable burdens on different classes of pregnant women. It also forbids treating pregnant women as unequal to men in terms of their ability to make personal decisions about when and whether to be a parent. Accordingly, the Court GRANTS summary disposition plaintiffs regarding Count III of their complaint.

VI. REMAINING SUMMARY DISPOSITION ARGUMENTS

Because the Court's resolution of two of plaintiffs' claims suffices to grant full relief, the Court will not address the remaining arguments of the parties, including the arguments regarding the Retained Rights Clause and ELCRA.

VII. DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

For the reasons discussed in this opinion, the Court declares MCL 750.14 unconstitutional on its face and GRANTS plaintiffs' motion for a declaratory judgment to that effect.

MCR 3.310(C) governs the form and scope of injunctive orders. It provides that an order granting an injunction:

> (1) must set forth the reasons for its issuance;
>
> (2) must be specific in terms;
>
> (3) must describe in reasonable detail, and not by reference to the complaint or other document, the acts restrained; and
>
> (4) is binding only on the parties to the action, their officers, agents, servants, employees, and attorneys, and on those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise.

The order granting a permanent injunction and accompanying this opinion provides as follows:

Plaintiffs filed this action challenging the constitutionality of MCL 750.14 on multiple grounds. Plaintiffs and the intervening defendants filed cross-motions for summary disposition under MCR 2.116(C)(4), (C)(8), and (C)(10). Extensive briefs were filed by all three parties. The Court also had the benefit of many insightful amici curiae briefs.

In the opinion accompanying this order and incorporated by reference, the Court has detailed the legal and factual bases for its findings that MCL 750.14 violates the Due Process and Equal Protection Clauses of the Michigan Constitution. As explained in the opinion, MCL 750.14 is facially unconstitutional because its enforcement would deprive pregnant women of their right to bodily integrity and autonomy, and the equal protection of the law. Based on the reasoning set

forth in the Court's opinion, plaintiffs have proven actual success on the merits of these two aspects of their pleaded claims, and that they have no alternative or adequate remedy other than permanent injunctive relief to preserve their constitutional rights.

Enforcement of MCL 750.14 will endanger the health and lives of women seeking to exercise their constitutional right to abortion. Enforcement also threatens pregnant women with irreparable injury because without the availability of abortion services, women will be denied appropriate, safe, and constitutionally protected medical care.

MCL 750.14 also threatens plaintiffs Planned Parenthood and Sarah Wallett, M.D., because they are subject to felony prosecution and imprisonment for performing a medically necessary procedure that their patients are constitutionally entitled to have. Thus, the Court finds that plaintiffs and their patients have proved irreparable injury.

The Court further finds that issuing a permanent injunction will cause no damage to the defendant Attorney General or the intervenors. The harm to women, on the other hand, is a wholesale denial of their fundamental right to an abortion, necessitating permanent injunctive relief.

This Court finds that issuing a permanent injunction does not adversely affect the public interest because the public interest is served by an order protecting the constitutional rights of the public: in this case, the constitutionally protected right of women to abortion access.

Accordingly, the Court orders that defendant Attorney General is permanently enjoined from enforcing MCL 750.14.

The Court further orders that the Attorney General shall personally serve a copy of this order and the accompanying opinion on every county prosecuting attorney in the State of Michigan and must advise the county prosecuting attorneys that this Court has declared MCL 750.14 unconstitutional.

Under MCR 3.310(C)(4), the permanent injunction issued today "is binding only on the parties to the action, their officers, agents, servants, employees, and attorneys, and on those persons in active concert or participation with them who receive actual notice of the order by personal service or otherwise." In an unpublished order, the Court of Appeals has stated that "[b]ecause county prosecutors are local officials, jurisdiction of the Court of Claims does not extend to them." *In re Jarzynka*, unpublished order of the Court of Appeals, entered August 1, 2022 (Docket No 361470), p 3. The Court of Appeals also declared in *Jarzynka* that county prosecutors are not "agents" of the Attorney General, and therefore were not bound by the Court's preliminary injunction. See *id.* at 5.

This Court's permanent-injunctive order does not conflict with the Court of Appeals' order. The "jurisdiction" of the Court of Claims is not at issue today, as the Court's order binds the Attorney General – indisputably, a state officer – and the intervening defendants. In any event, the unambiguous language of MCR 3.310(C)(4) *compels* this Court to order that the injunction also binds the "agents" of the Attorney General as well as those "persons in active concert or participation with [her] who receive actual notice of the order by personal service or otherwise." Although the Court of Appeals stated in *Jarzynka* that county prosecutors are not "agents" of the Attorney General, this Court is not bound by the nonprecedential order issued in *Jarzynka*, a separate case. See MCR 7.215(C). Moreover, published case law and statutory authority call into question the accuracy of the dicta within the Court of Appeals' order. In light of the legal

uncertainty triggered by the *Jarzynka* order, the Court has elected to clarify the legal reasons underlying its order that the Attorney General must notify county prosecutors of the permanent injunction and must serve them with the opinion and order.

MCL 14.30 states: "The attorney general shall *supervise* the work of, consult *and advise* the prosecuting attorneys, in all matters pertaining to the duties of their offices." (Emphasis added.) Informing county prosecutors of the injunction and its basis are consistent with "advising" them regarding a matter "pertaining to the duties of their offices." MCL 14.30 also compels the Attorney General to "supervise" county prosecuting attorneys when they act under the authority of the People of the State of Michigan rather than in their independent capacities or as agents of their respective counties. See *Shirvell v Dep't of Attorney Gen*, 308 Mich App 702, 751; 866 NW2d 478 (2015) ("[T]he Attorney General has supervisory powers over the prosecuting attorneys in this state.").

The Court of Appeals has defined "supervise" as meaning "hav[ing] the charge and direction of." *People v Cline*, 276 Mich App 634, 645; 741 NW2d 563 (2007) (alteration in original). The meaning of the term comprehends having the authority to direct or control. See, e.g., *Smith v City of Bayard*, 625 NW2d 736, 737 (Iowa, 2001) (" 'Supervise' means the act of 'oversee[ing] with the powers of direction and decision the implementation of one's own or another's intentions . . . .' ") (alteration in original; citation omitted), and *Coghlin Electrical Contractors, Inc v Gilbane Bldg Co*, 472 Mass 549; 36 NE3d 505, 517 (Mass 2015) (citation omitted) (" 'to supervise' means 'to oversee, to have oversight of, to superintend the execution of or performance of [a thing], or the movements or work of [a person]; to inspect with authority; to inspect and direct the work of others.' ") (citation omitted; alterations in original). Applying the

common sense meaning of the term "supervise" as it is used in MCL 14.30, the Attorney General has the authority to control and direct the actions of county prosecutors.

Two cases from the Sixth Circuit arising in Michigan have held that when bringing felony charges under state law, county prosecutors act as agents of the state. See *Cady v Arenac Co*, 574 F3d 334, 345 (CA 6, 2009) ("[W]hen County Prosecutor Broughton made the decisions related to the issuance of state criminal charges against Cady, the entry of the DPA, and the prosecution of Cady, he was acting as an agent of the state rather than of Arenac County. His actions therefore cannot be attributed to Arenac County, and Arenac County cannot be held liable for Broughton's actions even if those actions violated Cady's rights."), and *Platinum Sports Ltd v Snyder*, 715 F3d 615, 619 (CA 6, 2013), citing MCL 14.30 ("As for local prosecutors, they answer to the Attorney General, who is obligated to 'supervise the work of . . . prosecuting attorneys.' "). The Sixth Circuit noted in *Platinum Sports* that "[a]ny effort by a prosecutor at this point to enforce" a statute declared unconstitutional "would be *ultra vires*." *Id.* These rulings are in accord with long-standing legal doctrine that a court's declaration that a penal statute is unconstitutional prohibits its enforcement. See, analogously, *Ex parte Young*, 209 US 123, 159; 28 S Ct 441; 52 L Ed 714 (1908):

> The act to be enforced is alleged to be unconstitutional; and if it be so, the use of the name of the state to enforce an unconstitutional act to the injury of complainants is a proceeding without the authority of, and one which does not affect, the state in its sovereign or governmental capacity. It is simply an illegal act upon the part of a state official in attempting, by the use of the name of the state, to enforce a legislative enactment which is void because unconstitutional.

The Court recognizes that federal case law it has cited are considered persuasive rather than precedentially binding. However, no published Michigan case law binding on this Court supports a contrary position. Because county prosecutors are at least arguably agents of the

Attorney General for the purpose of the enforcement and prosecution of felonies, the Court construes MCL 14.30 to require their personal notification of the injunction.

The Court also notes that under MCL 14.101,

> [t]he attorney general of the state is hereby authorized and empowered to intervene in any action heretofore or hereafter commenced in any court of the state whenever such intervention is necessary in order to protect any right or interest of the state, or of the people of the state. Such right of intervention shall exist at any stage of the proceeding, and the attorney general shall have the same right to prosecute an appeal, or to apply for a re-hearing or to take any other action or step whatsoever that is had or possessed by any of the parties to such litigation.

This statute provides the Attorney General with the power to intervene in any action commenced by a prosecutor that the Attorney General believes to be ultra vires.

This is a final order that resolves the last pending claim and closes the case.

Date: September 7, 2022

Elizabeth L. Gleicher
Judge, Court of Claims

EXHIBIT 2

Northland Family Planning Center v Nessel,
unpublished opinion of the Court of Claims,
issued June 25, 2024
(Docket No. 24-000011-MM)

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.
_____/

OPINION AND ORDER

On November 8, 2022, the people of Michigan voted to approve Proposal 3 and explicitly enshrine a right to reproductive freedom in the Michigan Constitution. 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 does deny, burden, or infringe 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 seeking a declaration that three Michigan abortion regulations under MCL 333.17015 and 333.17015a—a 24-hour mandatory waiting period, mandatory uniform informed consent for women seeking an abortion, and a ban on advanced practice clinicians performing an abortion (collectively the "challenged laws")—are unconstitutional under Const 1963, art 1, § 28. Plaintiffs seek declaratory relief holding that the challenged laws are unconstitutional, and preliminary and permanent injunctions barring their enforcement.

The Court hereby concludes that the balancing of the pertinent factors weighs in favor of granting partial preliminary injunctive relief. For the reasons set forth in this opinion, plaintiffs' motion for preliminary injunction is GRANTED in part and DENIED in part. The Court holds that, based on the record before it, defendants are preliminarily enjoined 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 DENIES the request

to preliminarily enjoin enforcement and implementation of MCL 333.17015a and MCL 333.17015(11)(i).

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. Const 1963, art 1, § 28(1) 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." Furthermore, an "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." *Id*.

II. PLAINTIFFS' COMPLAINT AND MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs filed a complaint for declaratory and injunctive relief challenging the constitutionality of MCL 333.17015 and 333.17015a under Const 1963, art 1, § 28. 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). Plaintiffs also concurrently moved for a preliminary injunction.

Defendants AG Nessel, Director Brown, and Director Hertel responded to the motion for preliminary injunction. AG Nessel concurs with plaintiffs that the challenged laws do not pass constitutional strict-scrutiny muster, and that plaintiffs are likely to prevail on the merits. AG Nessel therefore concurs that a preliminary injunction would be appropriate. However, AG Nessel argues that the scope of the requested preliminary injunction is overbroad because it invalidates statutory provisions that are not unconstitutional, and the statute contains a severability provision that preserves valid segments. Director Brown does not oppose plaintiffs requested injunctive relief.

Director Hertel likewise concurs that the challenged laws are likely unconstitutional; however, Director Hertel argues that the injunctive relief requested by plaintiffs would not solve the harm alleged because the named defendants cannot insulate abortion providers from criminal consequences should they stop adhering to the challenged laws. Director Hertel, instead, requests that the injunction issue against the intervening defendant, the People of the State of Michigan.

Because AG Nessel, Director Brown, and Director Hertel acknowledge that the challenged laws are unconstitutional, the Court permitted the People of the State of Michigan (the People) to intervene as a defendant.[1] The intervening defendant opposes plaintiffs' requested relief and argues that the challenged laws are constitutional under § 28.

III. THE CHALLENGED LAWS

Plaintiffs challenge the constitutionality of abortion regulations under MCL 333.17015 and 333.17015a. In support, plaintiffs have attached the affidavits of a number of expert witnesses,

[1] 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.

which will be discussed in further detail in subsection IV. The People have not attached or relied on any expert testimony in support of their arguments.

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 . . . ." Plaintiffs challenge this mandatory 24-hour waiting period, asserting that it does not serve patient health. Plaintiffs assert that mandatory waiting periods do not improve decision making or protect against regret, reproductive coercion, or mental health harms. Instead, plaintiffs argue that the 24-hour, mandatory waiting period harms patients by increasing incremental risk and imposing significant logistical barriers that force patients to obtain care later in pregnancy.

The People, on the other hand, argue that the 24-hour waiting period does not "deny, burden, or infringe upon" a patient's reproductive freedom because it does not unduly burden access. Instead, the People argue that the 24-hour waiting period is designed to ensure 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. The People further argue that the challenged laws are afforded a presumption of constitutionality, and plaintiffs have not overcome this burden.

B. MCL 333.17015 and MCL 333.17015a— MANDATORY UNIFORM "INFORMED CONSENT" FOR ABORTION

MCL 333.17015, described by the intervening defendant as an informed-consent statute and by plaintiffs as mandatory biased counseling, sets forth information that an abortion provider must give to a patient before providing any medical services 24 hours before the procedure. Specifically, under subsection (3) the statute provides that "a physician or a qualified person

assisting the physician shall do all of the following [six things] not less than 24 hours before that physician performs an abortion upon a patient who is pregnant," MCL 333.17015(3):

First, "[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." *Id.*

Second, "[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, "the probable gestational age of the fetus the patient is carrying," "information about what to do and whom to contact should medical complications arise from the abortion," and "[i]nformation about how to obtain pregnancy prevention information through the department of health and human services." *Id.*

Third, "[p]rovide the patient with a physical copy of the written standardized summary . . . that corresponds to the procedure the patient will undergo and is provided by the department of health and human services," and 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, "[p]rovide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the department of health and human services . . . at the gestational age nearest the probable gestational age of the patient's fetus." *Id.*

Fifth, "[p]rovide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the department of health and human services[.]" *Id.*

Sixth, "[p]rovide the patient with a physical copy of the prescreening summary on prevention of coercion to abort . . . ." *Id.*

Moreover, under subsection (6), 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).

MCL 333.17015a requires abortion providers to orally counsel and screen women for "coercion to abort," along with requirements to post information regarding coercion and domestic abuse.

As directed by § 17015(11)(c), the DHHS has developed a uniform written consent form in keeping with the above requirements.[2] Patients are required to download and complete an "Informed Consent Confirmation Form" available on the DHHS site at least 24 hours before an abortion procedure. MCL 333.17015(5). 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(3). Significantly, no other medical procedure in Michigan requires a similar set of prescribed 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.

Plaintiffs argue that the mandatory informed-consent requirements in MCL 333.17015 and MCL 333.17015a are unconstitutional under Const 1963, art 1, § 28 because they burden and

[2] MCL 333.17015(11)(b), requires the DHHS to generate a written consent form and "written standardized summaries" for a patient's review. See <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent/informed-consent-for-abortion-for-patients> (accessed June 24, 2024).

infringe on the right to receive abortion care without serving a legitimate compelling state interest. They assert that the uniform informed-consent counseling is at odds with the standard of care, which requires medical providers to give individualized, patient-centered advice in keeping with the applicable professional and ethical standards. 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. In support, plaintiffs have attached the affidavits of a number of expert witnesses, which will be discussed in further detail below.

Intervening defendant argues that the informed-consent statute is not unconstitutional because it 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.

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 can provide abortion care, precluding Advanced Practice Clinicians (APCs) from doing so. APCs include nurse practitioners, certified nurse midwives, and physician assistants.

Plaintiffs argue that the ban is arbitrary and needlessly limits APCs from providing medical care that is otherwise within their scope of practice and licensure, thus placing logistical burdens

on obtaining abortion care by arbitrarily restricting the number of available providers. 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.[3] In Michigan, APCs are able to prescribe and oversee the use of controlled substances, and nurse midwives are permitted to attend deliveries, all of which is 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.

IV. PLAINTIFFS" EXPERTS' AFFIDAVITS IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

The state cannot 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). Plaintiffs have attached affidavits from a number of expert witnesses to support

[3]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 June 24, 2024).

their arguments that the challenged laws are unconstitutional under § 28. The experts have provided opinions regarding accepted clinical standards in their respective fields and have cited to peer-reviewed scientific literature in support of their opinions. The experts' opinions, therefore, speak directly to whether the challenged laws achieve the goal of protecting patient health, in keeping with accepted standards of clinical practice and evidence-based medicine.

DR. M. ANTONIA BIGGS

Dr. M. Antonia Biggs is a social psychologist researcher and associate professor at Advancing New Standards in Reproductive Health (ANSIRH) in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (UCSF). ANSIRH conducts rigorous, innovative, and multi-disciplinary social science research on issues relating to reproductive health. Based on her years of experience, research, and participation in the field of social psychology in the context of reproductive health, Dr. Biggs opines that Michigan's 24-hour delay does not enhance decision making or prevent adverse psychological outcomes due to abortion; the vast majority of abortion patients are certain about their decision before seeking care, and mandatory waiting periods do not improve certainty. The waiting period does, however, harm patients by imposing barriers to care. Citing a number of scientific studies in support, Dr. Biggs explains that while mandatory delay laws do not change most patients' certainty in their decisions, the mandatory delay laws exacerbate the burdens that patients experience seeking abortion care by increasing costs, prolonging wait times, increasing the risk that a patient will have to disclose the decision to others, and potentially preventing a patient from having the type of abortion the patient prefers.

Dr. Biggs also opines that, while mandatory waiting periods like Michigan's have been justified as a way to prevent mental health harms to patients, decades of empirical research looking

at the effects of abortion on a patient's mental health have found that there is no evidence that safe, legal abortion care contributes to mental health harms, whether due to regret or anything else. Dr. Biggs further explains that based on her research and analysis, there is no evidence that mandatory waiting periods protect the decision making of people experiencing reproductive coercion and, contrarily, impose barriers that are likely to harm such patients.

Dr. Biggs sums up her opinions as follows:

> [R]ecent studies confirm that most women seeking abortions are certain about the abortion decision when they present for care. While some women may want more time to make the best decision for them, the evidence does not support that a mandated waiting period improves their decision-making. Under current practice and the guidance of professional organizations like the American College of Obstetricians and Gynecologists, women are counseled and encouraged to take all the time they want before accessing care. Abortion providers follow this guidance and their ethical duties when counseling patients and obtaining informed consent, including by screening for reproductive coercion. There is no evidence to suggest that women benefit psychologically or emotionally from being required to wait before accessing care. Instead, state-mandated delays may have negative effects on women's emotional well-being and increase the costs of accessing care. For these reasons, it is my opinion that Michigan's 24-Hour Delay harms patients, while providing no benefit to them.

Professor Kayte Spector-Bagdady

Professor Kayte Spector-Bagdady is 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 and an assistant professor of obstetrics and gynecology at the University of Michigan Medical School. She is also the chair of the Research Ethics Committee, the ethicist on the Michigan Medicine Human Data and Biospecimen Release Committee, and a clinical ethicist.

Professor Bagdady reviewed the 24-hour mandatory waiting period and mandatory informed-consent counseling provisions in MCL 333.17015 and MCL 333.17015a, and, based on her years of experience, research, and expertise in the field of bioethics, she opines that the challenged laws do not improve—and in fact, undermine—informed consent to a medical procedure. She articulates 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 Bagdady further explains 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. In jurisdictions like Michigan, the scope of the disclosure is tied to the professional standard of care.

Professor Bagdady opines 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 Bagdady relates 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 notes 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 Bagdady concludes 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 opines 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 reasons 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 Bagdady opines that providers should offer care as soon as is medically appropriate, and when patients who are competent give their consent when they choose.

Professor Bagdady also offers expert opinions regarding the mandatory counseling requirements. She states that the law requires that clinicians deliver uniform informational and counseling materials, which she opines are unnecessary, irrelevant, inaccurate, misleading, and/or stigmatizing. Professor Bagdady observes that the materials appear designed to persuade people to forgo abortion regardless of their personal circumstances or desires. She concludes that attempting to dissuade or persuade a patient of a particular treatment option is never appropriate under the doctrine of informed consent, much less to interfere with personal decision making based on the ideological view that a medical service is wrong. She further opines that the mandatory informed-consent laws only serve to constrain choice by requiring the doctor provide irrelevant, misleading, false, and/or stigmatizing information to coerce the patient into not choosing an abortion.

For example, she notes that MCL 333.17015 requires the DHHS to create materials that inform patients of risks of "depression" and "feelings of guilt" and " [i]dentify services available through public agencies" should a patient "experience subsequent adverse psychological effects from" an abortion. MCL 333.17015 (11)(b)(iii), (vii). However, Bagdady states that scientific studies have shown that women are more likely to experience lower self-esteem, lower life satisfaction, and more anxiety symptoms if they cannot access a wanted abortion than similarly

situated women who are able to access a wanted abortion.[4] Professor Bagdady explains that informing patients that these things may occur as the result of an abortion when in fact the opposite is true—patients are less likely to experience these symptoms if they can have an abortion—is false and misleading. Far from adding to the necessary information a patient needs to make an informed choice about whether to have an abortion, it misleads patients and gives them false information. Similarly, Professor Bagdady opines that the provisions requiring disclosure of parenting resources is a weighted disclosure against abortion care, and is exactly the type of irrelevant information that should not be a part of a physician's informed-consent dialogue with their patient.

Instead of relying on the formulaic information mandated by the challenged laws, Professor Bagdady opines that informed consent should be driven by the relevant standard of care for pregnant patients, as informed by the American College of Obstetricians and Gynecologists (ACOG). According to ACOG, "[t]he highest ethical standard for adequacy of clinical information requires that the amount and complexity of information be tailored to the desires of the individual patient and to the patient's ability to understand this information."[5] Professor Bagdady points out that ACOG opposes laws that "interfere with the ability of physicians to have open, honest, and confidential communications with their patients."[6] Citing ACOG's Committee opinion on

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[4] Citing Biggs et al, *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Study*, 74 JAMA Psych 169-78 (2017), available at <https ://jamanetwork.com/journals/jamapsychiatry/fullarticle/2592320> (accessed June 24, 2024.)

[5] The American College of Obstetricians and Gynecologists, *Committee Opinion No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (February 2021), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology> (accessed June 24, 2024).

[6] *Id*.

Informed Consent, Professor Bagdady notes that laws that "interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's professional medical judgment" are contrary to informed consent.[7] "Examples of legislative interference in the informed-consent process include state-mandated consent forms" and "laws that require physicians to give, or withhold, specific information when counseling patients before undergoing an abortion."[8] Professor Bagdady also notes that ACOG opposes mandatory waiting periods because they increase risk and are unnecessary.[9]

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 gynecological and obstetric care, from labor and delivery to contraception and abortion. Dr. Loder has authored and co-authored over a dozen peer-reviewed journal articles on a variety of topics related to reproductive health issues, including contraception, abortion, and access to healthcare. She is currently serving as a clinical assistant professor in obstetrics and gynecology at the University of Michigan. In 2018, she was appointed the director of Clinical Family Planning Services at the University of Michigan.

Dr. Loder, consistent with the expert opinions provided by Professor Bagdady, also opines that the mandatory 24-hour waiting period and mandated informed-consent laws are contrary to evidence-based standard of care and informed-consent practices. Dr. Loder explains that, in her

[7] *Id.*

[8] *Id.*

[9] ACOG, *Abortion Access Fact Sheet*, available at <https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet> (accessed June 24, 2024).

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 explains 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 notes that Michigan law does not require physicians to deviate from 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 also opines that under the accepted standard of care, patients should receive abortion care as soon as possible once a patient has 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, which is typically the point at which medication abortion is no longer available in Michigan, 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, an 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. Further, Dr. Loder notes confusion caused by the waiting period sometimes results in patients having to travel to a facility twice, thereby 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 explains that the mandatory waiting period sometimes causes confusion when a medical emergency may require emergent abortion care. Because of the wording of the

statute, patients may not be aware of the medical emergency exception to the waiting period, and may needlessly delay access to abortion care in serious circumstances where any delay potentiates adverse results to the patient's health.

Dr. Loder also opines that the mandatory uniform informed-consent provisions are contrary to the individualized approach required for informed consent under the standard of care for an OB/GYN, and thus contrary to evidence-based medicine. Additionally, Dr. Loder states that the information misleadingly presents safety statistics, and legally obligates physicians to inform patients about risks that are not supported, and in some cases invalidated, by scientific research, violating the accepted standards of informed consent.

Dr. Loder also provides an expert opinion regarding the ban on APCs, such as nurse midwives, physician assistants, and licensed nurse practitioners, from providing any abortion care under MCL 333.17015(1). Dr. Loder explains that many APCs are qualified through their education, training, and experience to provide various types of early abortion care and there is no medical basis for a law that prevents them from doing so. Based on her practice and the training she provides to residents, fellows, and medical students in the state of Michigan, Dr. Loder opines that APCs are well qualified to safely contribute to early abortion care through the provision of medication abortion and could be trained to provide first trimester procedural abortion as safely as physicians. She noted that APCs in Michigan are already permitted to prescribe and oversee the use of medications, including misoprostol and/or mifepristone that are routinely used for medication abortion, for miscarriage management, and IUD insertion.

Dr. Loder further states that the pool of abortion providers in the United States is already limited and many people in Michigan are unable to receive the abortion care they seek because they live hours away from the nearest provider. Eliminating the provider ban would greatly

increase abortion access throughout the state. In Dr. Loder's opinion, there is no medically legitimate reason not to do so. Dr. Loder notes that, in keeping with her opinion, ACOG, the American Public Health Association, and the World Health Association have all concluded that laws prohibiting qualified APCs from providing abortion care are without medical foundation and that these types of restrictions represent a significant barrier to safe abortion care.[10]

Dr. Loder explains:

> APCs provide care in rural areas and underserved settings far more frequently than gynecologists and obstetricians. Permitting APCs to provide abortion care increases accessibility and reduces the costs and burdens of obtaining the procedure by decreasing appointment wait times, shortening travel distances, and minimizing the costs associated with, among other things, lost wages, childcare, and travel expenses. Alleviating these types of costs and burdens creates particular benefits for women in rural and underserved urban areas who have to travel great distances to get care in Michigan.

Dr. Loder concludes that utilizing APCs will increase how frequently clinics can perform abortions, expand the number of providers and learning opportunities for students, and integrate abortion services into family practice and community health clinics.

Renee Chelian

Renee Chelian is the founder and executive director of Northland. She has worked in the abortion care field for almost 50 years. The Northland clinics provide approximately 8,000 abortions per year to patients. Ms. Chelian attests, in her capacity as executive director of the facilities, that Northland providers offer counseling to patients that is completely individualized to each patient's needs, and do not provide abortions to patients who are uncertain about the decision,

[10] Loder Affidavit, citing The American College of Obstetricians and Gynecologists, *Issue Brief Advanced Practice Clinicians and Abortion Care Provision*, available at <https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-advanced-practice-clinicians-and-abortion-care-provision> (accessed June 24, 2024).

rendering the mandatory informed-consent laws superfluous and burdensome. Ms. Chelian further attests that she has never seen the 24-hour mandatory waiting period benefit anyone. Northland's counseling process ensures that patients are informed about their care and that providers address any other needs patients may have. For patients who are uncertain, they are given all the time needed to come to a decision. Northland does not provide abortions to people who are undecided and provides resources and referrals to a therapist if needed.

Conversely, Ms. Chelian attests that the 24-hour mandatory waiting period imposes barriers to accessing abortion. Delays can prevent some patients from accessing the method that is best for them. For example, a patient might become ineligible for medication abortion as a result of a delay. Or other patients may be prevented from obtaining an abortion altogether. Although the abortion care provided by Northland clinics remains very safe, the risks associated with abortion increase as pregnancy advances. Abortion procedures also become more expensive and complex as pregnancy advances, which may disparately impact historically oppressed communities.

Ms. Chelian further attests that the informed-consent laws do not serve the purpose of individualized informed-consent. To the degree that any of the law's components are necessary for a particular patient to give informed consent, Ms. Chelian states that Northland providers already give that information based on their ethical obligations and evidence-based practice.

Pamela Merritt

Pamela Merritt is the executive director for plaintiff MSFC, a nonprofit organization whose mission is to assist medical students and residents to maintain access to abortion and family planning education and training, including through curriculum reform, training in a clinic setting, and abortion training institutes. As executive director, Ms. Merritt is responsible for the

management and organization for MSFC. Consistent with the opinions given by Ms. Chelian, Ms. Merritt reiterates that the 24-hour waiting period, informed-consent laws, and APC provider bans in Michigan do not further patient care and arbitrarily limit access.

Amy Levi, PhD, CNM, WHNP

Dr. Amy Levi is a certified nurse midwife (CNM) and women's health nurse practitioner (WHNP) with over thirty years of experience in midwifery and midwifery education. She is currently employed as a consultant with the New Mexico Department of Health's Reproductive Health Access Project. In addition to this role, she teaches the abortion module at University of New Mexico (UNM) College of Nursing; an abortion course on ECHO, a telemedicine program used by doctors, midwives, and clinic nurses; and abortion-related webinars for healthcare professionals. Abortion care training for APCs has been the central focus of her career. In addition to a distinguished career at UNM, Dr. Levi has authored or supervised numerous studies and systematic reviews evaluating how restrictions on APCs' scope of practice—that is, rules defining which services licensed APCs can provide and under what circumstances they can provide them—undermine health care delivery and access to care. Dr. Levi opines, based on her decades of experience, teaching, research, and practice, that the provider ban does not advance patient health but instead unnaturally restricts the provision of abortion care, which harms patient wellbeing. APCs can and have for years provided abortion care in early pregnancy safely and effectively around the country. There is no health justification for excluding APCs from providing abortion in early pregnancy in Michigan consistent with their training, experience, and scope of practice.

Dr. Levi explains that NPs, CNMs, and PASs are highly trained clinicians who provide a wide spectrum of care. NPs provide a broad array of health services, including taking health histories and performing physical exams, diagnosing and treating acute and chronic illnesses,

providing immunizations, performing procedures, ordering and interpreting lab tests and x-rays, coordinating patient care across multiple providers, providing health education and counseling, and prescribing and managing medications and other therapies. CNMs provide primary and specialized care to women, including: primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, some care for newborns, and treatment of sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications including controlled substances and contraceptive methods; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order the use of medical devices. PAs are licensed health professionals who practice medicine in collaboration with physicians and other providers. Their responsibilities include diagnosing illness, creating treatment plans, and prescribing medications.

Dr. Levi also explains that APCs safely and effectively prescribe medication abortion in 22 states. The primary medication abortion protocol in the United States—a two drug regimen of mifepristone followed by misoprostol—is one of the safest medication regimens available today, with a risk profile that is on par with Advil's or Tylenol's. APCs also commonly manage miscarriages by using misoprostol and/or mifepristone. Mifepristone and misoprostol are safer than many drugs commonly prescribed by APCs, which include risky controlled substances. In 20 states, APCs provide abortion by procedure in early pregnancy in the same way they manage miscarriages: by using gentle suction, which is known as an aspiration procedure. An aspiration abortion is far safer than many procedures APCs already perform—CNMs provide obstetrical care, for example, and childbirth is far more dangerous than any method of abortion.

Dr. Levi further explains that APCs are subject to rigorous professional standards nationwide, including in Michigan. APCs are subject to two layers of regulation: licensure and scope of practice. NPs, CNMs, and PAs all have to pass rigorous training protocols and licensing and accreditation tests in order to practice in Michigan, in keeping with national standards. Furthermore, APCs are limited in their scope of practice in Michigan by state law and requirements set forth by their respective licensing boards.

Citing peer-reviewed literature and research, Dr. Levi opines that there is no medical reason to restrict APCs from providing abortion care in keeping with their licensure and scope of practice. APCs are capable of providing a high-standard of care, with good patient outcomes and satisfaction. On the other hand, restricting APCs from providing care disproportionately impacts rural and underserved communities, where APCs are key providers of healthcare.

Dr. Levi further notes that every mainstream professional organization to weigh in on APCs providing abortion care has affirmed that these clinicians should not be prohibited from providing abortion care. ACOG published an opinion in December 2020 calling for the repeal of requirements that only physicians or obstetrician-gynecologists provide abortion care.[11] As part of their justification for this position, they stated, "research from several countries indicates that outcomes are similar to those when the service is provided by physicians" and "several reports show no differences in outcomes in first-trimester . . . abortion by health care practitioner type and indicate that trained advanced practice clinicians can safely provide abortion services," providing multiple citations from the scholarly literature to support these statements. ACOG recommended in its Committee Opinion on Abortion Training and Education, published in 2014 and reaffirmed

[11] Citing The American College of Obstetricians and Gynecologists, *ACOG Committee Opinion No. 815* (November 2020), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion>(accessed June 24, 2024).

in 2019 and 2022, that the pool of non-obstetrician-gynecologist providers, including family physicians and APCs, be expanded by opposing restrictions that limit abortion provision to physicians only.[12] They observed that such restrictions limit the education and training received by APCs and access to care by patients. Similarly, Physicians for Reproductive Health urged policymakers to eliminate burdensome restrictions on the provision of abortion care by APCs in a press release dated April 1, 2020.[13] The American Public Health Association issued a Policy Statement in 2011 stating, "[t]here is evidence that with appropriate education and training, NPs, CNMs, and PAs can competently provide all components of medication abortion care (pregnancy testing counseling, estimating gestational age by exam and ultrasound, medical screening, administering medications, and post-abortion follow-up care)[.]"[14] They recommended that APCs be engaged in the provision of early abortions and that scope-of-practice regulations should align with this recommendation.

Dr. Levi reasons that, given Michigan's licensing requirements, which are consistent with the national landscape, Michigan's provider ban is inconsistent with how APCs are otherwise regulated. In fact, APCs in Michigan manage early miscarriage using the very same medications and procedures used in providing early abortion care. Given the literature cited in her affidavit, Dr. Levi states that there is no logical reason for this. APCs can generally prescribe medication

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[12] Citing The American College of Obstetricians and Gynecologists, *Committee Opinion No. 612* (November 2014), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2014/11/ abortion-training-and-education> (accessed June 24, 2024).

[13] Citing Physicians for Reproductive Health, Press Release: Reproductive Health Care Providers: Abortion Is Essential (April 1, 2020), available at <https://prh.org/press-releases/reproductive-health-care-providers-abortion-is-essential/> (accessed June 24, 2024).

[14] American Public Health Association, *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants: Policy Number 20112*, available at <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants> (accessed June 24, 2024) .

and provide services within their experience, training, and scope of practice. In sum, Dr. Levi opines that the provider ban has no medical justification. The requirement actually undermines patient wellbeing by artificially constricting the provision of essential healthcare. Abortion is an essential and time-sensitive component of comprehensive healthcare. Michigan's provider ban is inconsistent with the nationwide trajectory toward allowing APCs to perform all services within their education and training, especially in rural and medically underserved areas where the need is greatest.

Dr. Natasha Bagdasarian, Chief Medical Executive for the State of Michigan[15]

Dr. Natasha Bagdasarian is the Chief Medical Officer of the State of Michigan. She was appointed to the 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, in her official capacity, opined that the challenged laws impose duties that require health care providers to violate the standard of care.

Dr. Bagdasarian opined that the 24-hour waiting period imposed by MCL 333.17015(3) imposes a medically inappropriate barrier to receiving reproductive care. The waiting period serves no valid medical purpose and is in fact discriminatory; a male patient seeking a vasectomy is not forced to reflect on their reproductive health care decision for an arbitrary amount of time.

[15] Dr. Bagdasarian's affidavit was not attached to the motion for preliminary injunction, or any of the defendants' responses to the motion. It was, instead, attached to Director Hertel's answer to plaintiffs' complaint, which was filed a week before the hearing on the motion for preliminary injunction. The affidavit does, however, speak directly to whether the challenged laws are constitutional under § 28 and the Court will consider the affidavit in deciding the motion for preliminary injunction. In order to give intervening defendant time to process and respond to the affidavit, the court allowed expansive supplemental briefing to address the affidavit, as well as to expound on any legal issues raised during the hearing. All briefs have been submitted and the legal arguments will be addressed in this opinion.

Dr. Bagdasarian further notes that the 24-hour waiting period potentially is 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 the patient's pregnancy is positively correlated with the procedure's invasiveness and adverse health outcomes.

Regarding the mandatory informed-consent requirements, Dr. Bagdasarian opines that the communications are coercive and, at times, medically irrelevant to the patient. For example, the patient must be provided with "a physical copy of the prenatal care and parenting information pamphlet" before the 24-hour waiting period can begin to run. MCL 333.17015(3)(e). In parallel, the DHHS must identify services available "to assist the patient during the patient's pregnancy and after the birth of the child" and "to assist the patient in placing the child in an adoptive or foster home." MCL 333.17015(11)(b)(v)–(vi). None of this is relevant to a patient seeking to terminate their pregnancy and is coercive. Additionally, the same information must be provided to *all* patients, including to those whose pregnancies are nonviable.

Dr. Bagdasarian also takes issue with the challenged laws because they put the DHHS in between the patient/provider relationship because the laws require the department to mandate that the provider give the patient a host of required "standardized" information that should instead be given by the provider on an individualized basis tailored to each patient's unique needs. These requirements place the DHHS in the shoes of the patient's care provider, forcing the DHHS to (1) administer large portions of the informed-consent process and (2) co-opt the treating health care provider's judgment and decision-making authority.

Dr. Bagdarasian also attests that the challenged laws result in patients receiving information that fails to account for the fetus's probable gestational age. For example, if a patient has been carrying a fetus for 14 weeks, but the fetus became nonviable and stopped developing at

week 8, that patient might understandably refer to materials concerning procedures and risk that are not relevant to them, leading to inaccurate information about the risks relating to abortion care. Dr. Bagdasarian notes that the challenged laws acknowledge that the information the DHHS is forced to provide may not be relevant because the materials are required to "[s]tate that not all of the complications listed . . . may pertain to that particular patient and refer the patient to the patient's physician for more personalized information." MCL 333.17015(11)(b)(iv). Elsewhere, the challenged laws state that all of the information—relevant and irrelevant—is "required" to be reviewed by the patient. MCL 333.17015(11)(g).

Dr. Bagdasarian opines that the challenged laws have a coercive effect insofar as a patient might develop a fear of risks that are not relevant to them personally. The standardized information that is not tailored to individual needs can also needlessly lead to confusion, which can interfere with patient care.

Dr. Bagdasarian also notes that the challenged laws require the DHHS to provide information about emotional risks attendant to an abortion that is contradicted by the best available scientific evidence. Whereas the DHHS must publish "the physical complications that have been associated with each [abortion] procedure . . . and with live birth," it must also call special attention to the Legislature's conclusion 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 such feelings may be "intense or persistent." MCL 333.17015(11)(b)(ii), (iii). Dr. Bagdasarian notes that this statement is contradictory to data demonstrating that patients who received an abortion had levels of depression and anxiety similar to or lower than patients who were denied an abortion. This requirement again inserts the DHHS into an informed-consent process that should

be individualized. Moreover, it is coercive, as it presents a biased risk assessment that fails to account for the emotional harms likely to arise from carrying an unwanted pregnancy to term.

Dr. Bagdasarian also offers her expert opinions regarding MCL 333.17015a, the standardized "coercion to abort" screening tools. She opines that such a screening is redundant of the standard of care specific to reproductive health because providers licensed to perform abortions will administer a patient-specific coercion screening as a matter of course. The DHHS's statutory duty to set forth a one-size-fits-all coercion screening represents an improper informed-consent process it is not qualified to administer.

Dr. Bagdasarian also addresses the DHHS's obligation under the challenged laws to provide "a list of health care providers, facilities, and clinics that offer to perform ultrasounds free of charge." MCL 333.17015(11)(h). She notes that through its obligation to refer patients to entities other than licensed "health care providers," the DHHS could unfortunately be funneling patients to so-called "crisis pregnancy centers"—profoundly coercive environments, often staffed by non-medically trained staff, whose mission might include convincing a person seeking an abortion to instead carry a pregnancy to term in an affront to that person's right to make and effectuate their own decisions.[16] The DHHS has no regulatory authority over such entities, yet it is being required to advertise these entities and expose patients to their potentially coercive objectives, which are nonmedical in nature. In addition to being coercive, it is possible that these entities—which need not and do not have medical licensure—perform ultrasounds without anyone on staff with the training required to interpret the results. This has real consequences for a patient's informed consent. For example, the unlicensed person performing the ultrasound may fail to

[16] Citing The American College of Obstetricians and Gynecologists, *Issue Brief: Crisis Pregnancy Centers* (Oct 2022), p 1, available at <https://www.acog.org/advocacy/abortion-is-essential/trending-issues/issue-brief-crisis-pregnancy-centers> (accessed June 25, 2024).

identify and communicate a fetal abnormality or a nonviable pregnancy to the patient. A misinformed patient may make critical decisions about the future of their pregnancy, including choosing to carry a pregnancy to term, based on incomplete or outright misleading information. Dr. Bagdasarian concludes that, by being required under the challenged laws to direct patients to unlicensed entities with a bias against a patient's preferred reproductive health care choices, the DHHS is complicit in a deeply flawed informational process masquerading as informed consent. This is antithetical to a patient's right to autonomous decision making.

Dr. Bagdasarian also takes issue with the requirement in MCL 333.17015(1) that only a "physician" may provide abortion care in Michigan. She notes that abortions can be safely administered by other types of health care providers, such as advanced practice registered nurses, nurse midwives, or physician assistants. Needlessly restricting the supply of eligible care providers denies, burdens, and infringes a person's fundamental right to make and effectuate a decision to obtain an abortion. Noting that nonphysicians such as midwives are permitted to deliver infants, MCL 333.17101 *et seq*., Dr. Bagdasarian concludes that the disparate treatment with respect to abortion care is inexplicable, since abortions induced within the standard of care are safer than childbirth.

In sum, Dr. Bagdasarian concludes that the challenged laws deny, burden, and interfere with a patient's right to make and effectuate decisions about abortion care.

V. ANALYSIS

A. PRELIMINARY INJUNCTION LEGAL STANDARD

Plaintiffs seek preliminary injunctions barring the enforcement of MCL 333.15015 and MCL 333.17015a. The parties have briefed the issue, the Court has allowed supplemental briefing, and has held a hearing under MCR 3.310(A)(l).

A party seeking a preliminary injunction bears the burden of demonstrating entitlement to relief based on the following factors:

> (1) the likelihood that the party seeking the injunction will prevail on the merits, (2) the danger that the party seeking the injunction will suffer irreparable harm if the injunction is not issued, (3) the risk that the party seeking the injunction would be harmed more by the absence of an injunction than the opposing party would be by the granting of the relief, and (4) the harm to the public interest if the injunction is issued. [*Davis v Detroit Fin Review Team*, 296 Mich App 568, 613; 821 NW2d 896 (2012) (cleaned up).]

This type of relief is "an extraordinary and drastic use of judicial power that should be employed sparingly and only with full conviction of its urgent necessity." *Id*. (cleaned up).

B. CONSTITUTIONALITY OF MCL 333.17015 AND MCL 333.17015a—SUBSTANTIAL LIKELIHOOD THE PLAINTIFFS WILL PREVAIL ON THE MERITS

First, for plaintiffs to be entitled to the equitable relief of preliminary injunction, they must establish a likelihood of success on the merits, namely, that MCL 333.17015 and MCL 333.17015a are unconstitutional under Const 1963, art 1, § 28. For the reasons discussed below, the Court concludes that plaintiffs meet this element.

"[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 comes clothed in a presumption of constitutionality" because we presume that "the Legislature does not intentionally pass an unconstitutional act." *Cruz v Chevrolet Grey Iron Div of Gen Motors Corp*, 398 Mich 117, 127; 247 NW2d 764 (1976). "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 Michigan v Secretary of State*, 508 Mich 520, 534–35; 975 NW2d 840 (2022) (cleaned up). "Our task, then, is to determine whether [the statute] is unconstitutional in the abstract, rather than to analyze the statute 'as applied' to the particular case." *Id.*

1. Const 1963, Art 1, § 28:
The Fundamental Right to Reproductive Freedom and Strict-Scrutiny Standard for any State Laws that Deny, Burden, or Infringe on that Right

The Right to Reproductive Freedom, Const 1963, article 1, § 28, which was adopted by the voters of Michigan, provides:

> (1) 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.
>
> An 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.
>
> Notwithstanding the above, the state may 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) The state shall not discriminate in the protection or enforcement of this fundamental right.

> (3) The state shall not penalize, prosecute, or otherwise take adverse action against an individual based on their actual, potential, perceived, or alleged pregnancy outcomes, including but not limited to miscarriage, stillbirth, or abortion. Nor shall the state penalize, prosecute, or otherwise take adverse action against someone for aiding or assisting a pregnant individual in exercising their right to reproductive freedom with their voluntary consent.
>
> (4) For the purposes of this section:
>
> 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.
>
> "Fetal viability" means: the point in pregnancy when, in the professional judgment of an attending health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.
>
> (5) This section shall be self-executing. Any provision of this section held invalid shall be severable from the remaining portions of this section.

"It is settled law that the legislature may not act to impose additional obligations on a self-executing constitutional provision." *League of Women Voters of Michigan v Secretary of State*, 508 Mich 520, 536; 975 NW2d 840 (2022) (cleaned up).

Plaintiffs argue that the challenged laws are unconstitutional under § 28 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. The intervening defendant, on the other hand, argues that the laws do not deny, burden, or infringe upon the right to access abortion care because they do not unduly burden a patient's access to abortion care and, even if they do, they pass the compelling-interest standard, which intervening defendant characterizes as strict-scrutiny review See *Planned Parenthood of Southeastern Pennsylvania v Casey*, 505 US 833, 878; 112 S Ct 2791; 120 L Ed 2d (1992).

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 § 28. 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 only to achieve the purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and the laws do not infringe on that individual's autonomous decision-making.

The Court disagrees with intervening defendant that, by adopting § 28, the voters of Michigan merely reverted the state of the law back to what it was before the United States Supreme Court reversed *Roe v Wade*, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147 (1973), and its progeny in *Dobbs v Jackson Women's Health Org*, 597 US 215; 142 S Ct 2228; 213 L Ed 2d 545 (2022). The Court rejects intervening defendant's argument that the undue burden standard articulated by the majority opinion in *Casey* is now 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 Supreme Court declared, "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, the Supreme Court continued, 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*. *Casey*, like the challenged laws here, also involved constitutional challenges to statutes requiring that a woman seeking an abortion give her informed consent prior to the abortion 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 "Constitutional 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 on 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 Gen*, 222 Mich App 325, 344; 564 NW2d 104 (1997). 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.*

But Michigan voters dramatically changed the Michigan Constitution by adopting § 28 of Article 1 of Michigan's 1963 Constitution. Section 28 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 § 28. Instead, the language of § 28 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 § 28 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.

2. The Challenged Laws Deny, Burden, or Infringe upon the Fundamental Reproductive Freedom to Make and Effectuate Decisions about Abortion Care

The first step in testing the constitutional validity of the challenged laws is to determine whether the laws deny, burden, or infringe upon the fundamental reproductive freedom to make and effectuate decisions about abortion care under § 28. As explained in the preceding section, the Court rejects the intervening-defendant's argument that the state may burden making or effectuating decisions about abortion care, so long as the regulations do not *unduly* burden such decisions. The plain language of § 28 does not support that argument. Turning to whether the challenged laws burden or infringe upon the freedom to make and effectuate decisions about abortion care,[17] the Court finds, on the record currently before it and for purposes of issuing preliminary injunctive relief, that they do.

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). The record currently before the Court is sufficient to convince the Court that plaintiffs have demonstrated a substantial likelihood of success on the merits as to the question of whether the 24-hour waiting period is unconstitutional. That is, at this time, the Court is convinced that the mandatory delay exacerbates the burdens that patients experience seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a

[17] The challenged laws do not, on their face, deny abortion care.

patient will have to disclose their decision to others, and potentially preventing a patient from having the type of abortion that they prefer. The 24-hour 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. This burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care.

Mandatory Uniform Informed Consent

The Court is also convinced that the current record compels the conclusion that plaintiffs are likely to prevail—with one exception noted below—on the question of whether the mandatory uniform informed-consent requirements impermissibly burden and infringe upon a patient's freedom to make and effectuate decisions about abortion care. An overview of MCL 333.17015 and MCL 333.17015a is necessary to begin the analysis because plaintiffs argue that the entirety of both statutes are unconstitutional and should be preliminarily enjoined from enforcement. MCL 333.17015 is long, winding, and at times repetitive, so, as a consequence, the Court's overview of the statute is lengthy. The provisions are summarized as follows.

The statute is titled "Performance of abortion; informed consent; duties of physician; requirements," and in keeping with this title, starts in subsection (1) by mandating 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." Subsection (2) sets out definitions that govern the statute, and the remainder sets forth the substance of the standardized informed consent and how it is to be administered:

- 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 with the abortion, and pregnancy prevention information through 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, only this time providing 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 can 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 24-hour waiting period 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 association 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—find pregnancy assistance and 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—find 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 1 domestic violence hotline and 1 sexual assault hotline.

  - Also 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, 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 do. 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 too 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 DHHS set forth in subsection (11).

The Court is satisfied that, at this time, some of provisions in § 17015 appear to very clearly burden and infringe upon a patient's right to make and effectuate decisions about abortion care. Those provisions are in bold above, and include:

- providing information about risks associated with live birth (when the medical procedure at-issue is abortion care);
- giving patients illustrations and depictions of the fetus;
- providing patients with information about prenatal care, parenting and adoption, and
- offering the patient to see images of any ultrasound performed.

This information guides 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.

Subsection 11 also appears, on the record available to the Court at this stage, to clearly burden and infringe upon a patient's right to make and effectuate decisions about abortion care. This subsection, directing the DHHS what it must do in order to implement the mandatory

informed-consent requirements on patients and providers, squarely inserts the DHHS in between the patient and 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, contrary to the argument made by the intervening defendant, 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. 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.

Nevertheless, the Court concludes that plaintiffs have not met their burden of establishing the requisite likelihood of success as to all of the informed-consent provisions. To that end, MCL 333.17015a and the provisions in § 17015(11)(i) that address oral counseling against coercion and providing resources to victims of domestic violence present a closer call as to whether they burden and infringe upon a patient's freedom to make and effectuate decisions about abortion care. The directives of § 17015a appear to the Court to have less of an effect on a patient's decision-making than those noted above since they are not tied to the mandatory 24-hour waiting period and patients can receive the counseling without any delay to care. The Court does not foreclose the possibility of reaching a different decision in the future; rather, the Court simply concludes that plaintiffs' likelihood of success on the merits as to this particular provision is not so apparent at this time as to warrant preliminary injunctive relief as to § 17015a.

APC Provider Ban

Likewise, the APC provider ban, which arbitrarily limits abortion providers to physicians only, appears to the Court at this time to burden and infringe 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 that currently lack physicians to provide 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. Thus, the Court is satisfied at this stage with plaintiffs' ability to show the requisite likelihood of success with respect to the question of whether the limitation of abortion providers to physicians burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care.

3. The Challenged Laws Do Not Appear to Pass Strict-Scrutiny Review: They 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 challenged laws appear highly likely to burden and infringe upon a patient's right to make and effectuate decisions about abortion care, the next step in the constitutional analysis under Const 1963, art 1, § 28, 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 § 28, 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 *nothing*. Intervening defendant has not attacked the qualifications or credibility of the experts presented by the plaintiffs. Nor has intervening defendant presented any countervailing experts providing a contrary point of view to rebut the opinions. On the record submitted to the Court on this motion for preliminary injunction, the only expert medical opinions presented have resoundingly agreed that the challenged laws do not achieve the goal of protecting patient health and are inconsistent with accepted clinical standard of practice.

Intervening defendant makes the confusing argument that the Court should not consider the affidavit evidence, and instead rely on its legal arguments to conclude that the challenged laws achieve the goal to protect patient health. The Court disagrees. The plain language of § 28 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. Indeed, courts routinely rely on the parties' evidentiary submissions when weighing requests for

preliminary injunctive relief. See, e.g., *Slis v State*, 332 Mich App 312, 363-364; 956 NW2d 569 (2020). And given that intervening defendant has not submitted any expert evidence to support its arguments, the Court finds them unpersuasive.

The 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. On the current record, the Court is convinced that plaintiffs have demonstrated a substantial likelihood of success on their argument that this provision does not survive strict-scrutiny constitutional review.

The mandatory standard informed-consent provisions likewise appear, at this stage, to fail strict-scrutiny review because all the 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 that 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. Given that intervening defendant has not provided any contrary medical evidence, the Court agrees with plaintiffs' argument and concludes that the mandatory informed-consent provisions—with the one exception noted above—do not appear at all likely to survive strict-scrutiny constitutional review.

The APC provider ban likewise does not appear to be capable of withstanding 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 makes the argument that restricting abortion-care providers to physicians will ensure that patients receive only the highest quality care, thus making the ban constitutional. This argument is not persuasive, especially in light of the evidence presented by plaintiffs. Given that intervening defendant has not provided any contrary medical evidence, the Court agrees with plaintiffs' argument and concludes that the APC provider ban appears highly likely to fail strict-scrutiny constitutional review.[18]

C. REMAINING PRELIMINARY INJUNCTION FACTORS

The Court finds a strong likelihood, on the record presented, that plaintiffs will prevail on the merits of their constitutional challenge, as discussed above. The Court likewise finds that the remaining factors favor granting plaintiffs' motion for preliminary injunction.

Plaintiffs and their patients face a serious danger of irreparable harm if their fundamental right to reproductive freedom to make and effectuate decisions regarding abortion care is burdened or infringed upon. "Courts have . . . held that a plaintiff can demonstrate that a denial of an

[18] Plaintiffs also argue that the challenged laws are unconstitutional under Const 1963, art 1, § 28 because the laws are discriminatory. The Court does not reach this argument, having concluded that there is a high likelihood, based on the record before the Court, that the challenged laws are unconstitutional for the reasons discussed in this opinion.

injunction will cause irreparable harm if the claim is based upon a violation of the plaintiff's constitutional rights." *Overstreet v Lexington-Fayette Urban Co. Gov't*, 305 F3d 566, 578 (CA 6, 2002). "[T]o establish irreparable harm based upon the denial of a constitutional right, the plaintiff must first show a substantial likelihood of success on the underlying constitutional claim." *Bokhari v Metro Gov't of Nashville & Davidson Cty*, unpublished opinion of the United States District Court for the Middle District of Tennessee, issued April 9, 2012 (Case No. 3:11-00088), citing *Overstreet*, 305 F3d at 578. As noted above, plaintiffs have made this required showing of success on their fundamental right to reproductive freedom claim. Moreover, abortion is a time-sensitive procedure. Delaying a patient's access to abortion even by a matter of days can result in the patient having to undergo a lengthier and more complex procedure that involves progressively greater health risks, or can result in the patient losing the right to obtain an abortion altogether. Therefore, plaintiffs have demonstrated that enforcement of MCL 333.17015 causes irreparable harm.

Next, the balancing of hardships weighs in plaintiffs' favor. As discussed above, based on the record before the Court, plaintiffs have a strong likelihood of prevailing on the merits of their constitutional claim. Plaintiffs have likewise shown that they will suffer irreparable harm—in the form of ongoing constitutional violations—if they are not provided preliminary injunctive relief. Intervening defendant, on the other hand, has not provided any analysis on what harm it will suffer if a preliminary injunction is issued, instead arguing that plaintiffs will not prevail on the merits. The Court concludes that the balance of harms on the present record weighs in favor of granting the preliminary injunction.

Last, the Court concludes that the public interest militates toward granting the preliminary injunction because "it is always in the public interest to prevent the violation of a party's

constitutional rights." *G & V Lounge, Inc v Michigan Liquor Control Comm*, 23 F3d 1071, 1079 (CA 6, 1994).

D. SEVERABILITY

Defendants AG Nessel and Director Hertel urge the Court to only issue a preliminary injunction as to those provisions of MCL 333.17015 and MCL 333.17015a that, under the record presented, the Court deems likely violate Const 1963, art 1, § 28. 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 that remain valid should remain operable. Mindful of this legislative directive, the Court nonetheless finds that all parts of MCL 333.17015 (except those that implement MCL 333.17015a) are subject to the preliminary injunction.

On pages 37-41 of this opinion, the Court set forth in bullet format the subsections of MCL 333.17015, giving a brief description of each subsection. After a thorough review of the entire statute, the Court finds that each subsection is inextricably intertwined with the provisions setting forth the 24-hour mandatory waiting period and the mandatory informed consent that the Court finds, on this record, are likely unconstitutional under § 28.[19] For this reason, the Court

[19] For example, subsections 4-7 provide instructions to a provider regarding how to implement and follow subsection 3; subsection 11 provides instructions to 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 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.

preliminarily enjoins defendants from enforcing or implementing all sections of MCL 333.17015 (except MCL 333.17015(11)(i), as explained below).

The Court finds, however, based on the record before it, that MCL 333.17015a should not be preliminarily enjoined from enforcement. That statute provides:

> (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). 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).
>
> (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).
>
> (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.

Under this statute, a provider must orally screen a patient for coercion to abort when the patient presents for care and provides guidance on a provider's additional responsibilities should a patient disclose coercion or domestic violence. As discussed in the preceding sections, the Court

concludes that this requirement does not, on the record presented, likely burden or infringe upon a patient's right to make and effectuate decisions regarding abortion care and, as a result, is likely not unconstitutional. This statute is therefore not preliminarily enjoined from enforcement.

MCL 333.17015a mentions MCL 333.17015(11) a number of times, referencing the DHHS's screening tools, protocols, and notices developed regarding coercion and domestic violence. See MCL 333.17015(11)(i). As a result, MCL 333.17015(11)(i) is not subject to the preliminary injunction. All other sections of MCL 333.17015 are preliminarily enjoined from enforcement and implementation.

VI. CONCLUSION

For the reasons set forth above, plaintiffs' motion for preliminary injunction is GRANTED in part and DENIED in part. The Court holds that, based on the record before it, defendants are preliminarily enjoined 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 DENIES the request to preliminarily enjoin enforcement and implementation of MCL 333.17015a and MCL 333.17015a.

This order does not resolve the last pending claim and the case remains open.

Date: June 25, 2024

Sima G. Patel
Judge, Court of Claims