IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

WOMEN'S HEALTH CENTER OF WEST VIRGINIA, Plaintiff, v. PATRICK MORRISEY, *et al*., Defendants.	Civil Action No. Hon.

EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Plaintiff Women's Center of West Virginia, on behalf of itself, its staff, its physicians, and its patients, hereby respectfully moves this Court for a temporary restraining order ("TRO") pursuant to Rule 65(b) of the Federal Rules of Civil Procedure, to block enforcement of the Governor of West Virginia's Executive Order 16-20 (the "Order") as applied to prohibit Plaintiff from providing abortion care when, in the physician's good-faith medical judgment and based on the panoply of relevant factors, delaying the abortion would prevent the patient from obtaining an abortion in West Virginia or would otherwise compromise the patient's long-term health. In support of this Motion, Plaintiff concurrently submits a memorandum and declarations, which are hereby incorporated within this Motion by reference.

Plaintiff also seeks a preliminary injunction pursuant to Rule 65(a) of the Federal Rules of Civil Procedure, blocking enforcement of the Order as applied in the way described above, in order to protect current and future patients from imminent and irreparable harm to their health, safety, and constitutional right to decide whether and when to bear a child.

As detailed more fully in the accompanying Memorandum of Law, Plaintiff satisfies the requirements for a TRO and subsequent preliminary injunctive relief. Because enforcement of the Order as applied in the way described above contravenes binding Supreme Court precedent, and also fails to serve—and indeed frustrates—the stated purposes of the Order, Plaintiff has established a substantial likelihood of success on the merits of its claim that this enforcement of the Order violates Plaintiff's patients' right to privacy under the Fourteenth Amendment to the U.S. Constitution. Further, Plaintiff has established that this enforcement of the Order will inflict irreparable constitutional, medical, emotional, psychological, and other harms on Plaintiff's patients for which there is no adequate remedy at law, as well as irreparably interfere with Plaintiff's and its physicians' ability to provide appropriate medical care. The balance of equities likewise weighs firmly in Plaintiff's favor and the relief Plaintiff requests will further the public interest. Finally, Plaintiff respectfully requests this Court exercise its discretion to waive the Federal Rule of Civil Procedure 65(c) security requirement. *See Pashby v. Delia*, 709 F.3d 307, 332 (4th Cir. 2013).

Accordingly, and for the reasons set forth in the accompanying Memorandum of Law, Plaintiff respectfully requests this Court:

1) Issue a TRO enjoining Defendants, their employees, agents, and successors in office, and all those acting in concert with them from enforcing the Order as applied to prohibit Plaintiff from providing abortion care when, in the physician's good-faith medical judgment and based on the panoply of relevant factors, delaying the abortion would prevent the patient from obtaining an abortion in West Virginia or would otherwise compromise the patient's long-term health;

2) Issue a preliminary injunction prior to the expiration of the TRO enjoining Defendants, their employees, agents, and successors in office, and all those acting in concert with them from enforcing the Order as applied to prohibit Plaintiff from providing abortion care when, in the physician's good-faith medical judgment and based on the panoply of relevant factors, delaying the abortion would prevent the patient from obtaining an abortion in West Virginia or would otherwise compromise the patient's long-term health.

If the Court wishes to schedule a hearing prior to issuing a TRO, Plaintiff respectfully requests that the Court schedule the hearing as soon as possible. Plaintiff is currently turning patients away who would otherwise receive abortion care Monday, April 27, Wednesday, April 29, and Thursday, April 30. Plaintiff's counsel will make themselves available for a telephonic or video conference hearing at the Court's earliest convenience.

Respectfully submitted this 24th day of April, 2020.

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CERTIFICATE OF SERVICE

I, Loree Stark, do hereby certify that on this 24th day of April, 2020, I electronically filed a true and exact copy of ***Emergency Motion for a Temporary Restraining Order and Preliminary Injunction*** with the Clerk of Court and all parties using the CM/ECF System.

/s/ Loree Stark________________________
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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

WOMEN'S HEALTH CENTER OF WEST VIRGINIA, Plaintiff, v. PATRICK MORRISEY, *et al*., Defendants.	Civil Action No. Hon.

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

The question before the Court is whether the state may exploit the pandemic to force people to remain pregnant, and even to give birth, against their will. Plaintiff is committed to minimizing the transmission of the virus and to preserving medical resources, but far from serving those purposes, the challenged action does the exact opposite. Halting abortion care does not halt patients' medical needs. Rather, because patients remain subject to the myriad and greater risks of being pregnant, their critical medical needs are ongoing—*not postponed*—and many of them will require urgent and emergent care, increasing demands on the health care system. Plaintiff seeks not a special exemption for abortion, but treatment consistent with other time-sensitive medical care that cannot be banned or delayed without causing irreparable harm. At the very least, applying the Order to medication abortions, which involve taking pills and no medical "procedure," is a clear case of overreach.

Plaintiff Women's Health Center of West Virginia ("WHC"), on behalf of itself, its staff, physicians, and patients, seeks a temporary restraining order ("TRO") and preliminary injunction

enjoining enforcement of Executive Order 16-20 (Mar. 31, 2020) ("the Order")[1] to the extent that it prohibits Plaintiff from providing abortion care when, in the physician's good-faith medical judgment, delaying the abortion would compromise the patient's long-term health or would prevent the patient from obtaining an abortion in West Virginia. As the American College of Obstetricians and Gynecologists ("ACOG") recently underscored, abortion care is an "essential" and "time-sensitive" service for which a delay of weeks, or even days, puts patients' health at risk.[2] Plaintiff seeks urgent relief because the challenged application of the Order violates its patients' constitutional rights, causes irreparable harm, and *undermines* the very safety interests the Order states as its goals.

The Order prohibits "elective medical procedures" in the name of "disrupt[ing] the spread of the virus" and "conserving limited medical personnel, personal protective equipment, and other … supplies." It indefinitely bars all procedures that "are not immediately medically necessary to preserve the patient's life or long-term health," with three exceptions. Those exceptions allow procedures that cannot be postponed without compromising long-term health or without becoming illegal, or that are religiously mandated. The Attorney General indicated that he views most if not all abortions as impermissible under the Order but has provided no additional guidance.

Accordingly, Plaintiff—the only outpatient abortion clinic in West Virginia—cancelled and is now denying all abortion appointments except for those patients who are on the cusp of

[1] Gov. Jim Justice, Executive Order No. 16-20 (Mar. 31, 2020), available at https://governor.wv.gov/Documents/EO%2016-20electiveprocedures.pdf, attached as Ex. A to Pl.'s Compl. for Declaratory & Injunctive Relief, filed herewith.

[2] ACOG *et al.*, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak, attached as Ex. 2 to Decl. of Coy Flowers, MD, FACOG, which is itself attached as Ex. B hereto.

being unable to get the essential, time-sensitive care they seek. The effect, as explained below, is that although WHC has the capacity to see patients as early in pregnancy as they can come to the clinic, patients cannot get care in West Virginia for up to 6 weeks after they seek it (or for patients with certain medical conditions, up to 11 weeks). That is a ban on abortion during those pre-viability windows of pregnancy. Delay on that scale is also clearly an unconstitutional, undue burden on pre-viability abortion. Moreover, it is imposing immediate, irreparable harm: abortion is many times safer than continued pregnancy and childbirth, and although extremely safe, abortion carries greater risks as pregnancy advances.

Plaintiff took substantial steps before the Order to respond to the pandemic, following public health guidance. It has now had to significantly curtail care to comply with the Attorney General's application of the Order, with disastrous effects on patients, and to the *disservice* of public health given that forcing people to remain pregnant imposes more strain on health care resources. Absent urgent relief, for as long as the Order remains in effect, Plaintiff's patients will continue to face immediate, irreparable harms: *increased* need for medical care including hospital resources during the pandemic, increased risk of exposure, serious threat to their health, emotional and financial harm during the pandemic and economic recession, and constitutional injury. Accordingly, Plaintiff respectfully asks the Court to grant its motion.

STATEMENT OF FACTS

A. Abortion Care in West Virginia

By the age of 45, one in four women in this country has an abortion. Decl. of Coy Flowers, MD, FACOG, in Supp. of Pls.' Emergency Mot. for TRO and Prelim. Inj., attached hereto as Ex. B ("Flowers Decl.") ¶ 7. It is one of the safest medical procedures available, substantially safer than the alternative: The risk of death associated with childbirth is

approximately fourteen times higher than that associated with abortion, and complications related to continued pregnancy and childbirth are far more common than complications from abortions. *Id.* ¶¶ 7–8. In West Virginia, high rates of chronic conditions such as diabetes, hypertension, and obesity increase the risk of morbidity and mortality during pregnancy. *Id.* ¶ 8. Abortion-related emergency room visits constitute just 0.01% of all U.S. emergency room visits among women of reproductive age in the United States. *Id.* ¶ 7. Although abortion is very safe, the mortality risk associated with it increases as pregnancy advances, and by eight weeks, the risk increases 38% with each week of delay. *Id.* ¶ 24.

The two main methods of abortion—medication and procedural—are safe and effective. A medication abortion patient first takes one pill, and then another 24–48 hours later, typically at home, essentially causing an early miscarriage. *Id.* ¶ 9. This method, which is neither a "surgery" nor a "procedure," is available up to 11 weeks and 0 days since the last menstrual period ("11.0 weeks LMP"). Some patients have contraindications or relative contraindications for it, counseling in favor of procedural abortion.[3] *Id.* ¶¶ 9–10; Decl. of Katie Quinonez in Supp. of Pls.' Emergency Mot. for TRO and Prelim. Inj., attached hereto as Ex. C ("Quinonez Decl.") ¶ 7.

Procedural (sometimes called surgical) abortion is not what is commonly understood to be "surgery"—it involves no incision and WHC uses no general anesthesia. Flowers Decl. ¶ 11; Quinonez Decl. ¶ 7. In the first and early second trimester, these are suction curettage ("aspiration") procedures, using a suction curette to gently empty the uterus, typically in five to

[3] Contraindications for medication abortion include confirmed or suspected ectopic pregnancy, intrauterine device in place, current long-term systemic corticosteroid therapy, chronic adrenal failure, known coagulopathy or anticoagulant therapy, and intolerance or allergy to mifepristone. Most clinical trials also have excluded women with severe liver, renal or respiratory disease, or uncontrolled hypertension or cardiovascular disease (angina, valvular disease, arrhythmia, or cardiac failure). Patients are also not good candidates for medical abortion if they are unable to understand or adhere to care instructions, require quick completion of the abortion process, or are not available for follow-up contact or evaluation. Flowers Decl. ¶ 10.

ten minutes. Flowers Decl. ¶ 11; Quinonez Decl. ¶ 7. At WHC, all abortions use either medication or aspiration methods. *Id.* Quinonez Decl. ¶ 7. WHC provides aspiration abortions up to 16.0 weeks LMP. *Id.* In 2019, WHC performed 1,144 abortions: 466 medication abortion and 678 aspiration procedures. *Id.* ¶ 8. On Mondays, WHC provides only medication abortions; on Wednesdays and Thursdays, it provides medication and procedural abortions. *Id.* ¶ 7.

Nationally, later abortions generally use the dilation and evacuation ("D&E") method, in which clinicians dilate the cervix further and use instruments as well as suction to empty the uterus; it is often a two-day procedure. Flowers Decl. ¶ 11. West Virginia bans D&E and bans abortion at and after 22.0 weeks LMP. *See* W. Va. Code §§ 16-2O-1 & 16-2M-4.

Patients end a pregnancy for multiple reasons. Many speak of their careful consideration, and the extreme stress and burdens that inform their decision. Many lack financial and personal support to help raise a child, or an additional child, at that time in their lives, and are unable to add to the people they already support, including existing children (a majority already have at least one child), parents, and/or other family. Others have medical conditions that make pregnancy and childbirth particularly risky. Flowers Decl. ¶ 13; Quinonez Decl. ¶ 13.

Having made their decision, patients access abortion as quickly as they can, but many face great obstacles. Some discover they are pregnant only later in pregnancy. Many suffer delays because they lack money, transportation, and childcare. Flowers Decl. ¶ 14; Quinonez Decl. ¶ 14. Especially with a vehicle in poor condition, or no vehicle, having to travel many miles on the state's difficult road system greatly delays access to, or even prevents, abortion care. Flowers Decl. ¶ 14.b. Adolescents may delay because they fear discovery and familial retribution, sometimes violent. *Id*. Patients, especially if low-income, may have difficulty getting an (often unpaid) day off work. *Id*. As patients are delayed, the cost of the procedure goes up,

requiring patients to take time to raise funds to pay for later, more expensive, treatment. *Id.* ¶ 39; Quinonez Decl. ¶ 42. A large portion of WHC patients are struggling financially, 40% have Medicaid as their health insurance. Quinonez Decl. ¶ 14. These obstacles are even greater during the pandemic, which has cost patients their jobs; closed schools and thus eliminated school-hours childcare; and made it more difficult or risky to access the state's already limited public transportation. *Id.* ¶ 15; Flowers Decl. ¶ 15.

WHC is committed to doing its part to minimize the spread of COVID-19 and conserve medical resources. Before the Order, it took steps to achieve goals consistent with guidelines from the Centers for Disease Control and Prevention ("CDC") and the National Abortion Federation. It is offering only time-sensitive, medically necessary care, having cancelled all routine appointments, including annual gynecological exams. Quinonez Decl. ¶¶ 16–18. WHC has also reduced the number of abortion patients it sees per day from 20 to 14; excluded support people from accompanying patients into the clinic except for parents accompanying minors; suspended its program through which volunteer escorts support patients and protect their privacy as they enter the clinic, which is often, even during this crisis, surrounded by anti-abortion protestors; screened patients for COVID-19 symptoms by phone before making any appointment, and physically, including a temperature-check, at check-in; rearranged waiting room furniture to enforce social distancing; implemented CDC guidelines on when staff may return after experiencing any COVID-19 symptoms; increased the frequency of sanitation of high-touch areas; and posted signage on minimizing transmission. *Id.* ¶¶ 19–21.

B. The Challenged Order

The Governor issued the challenged Order on March 31, and it remains in effect

indefinitely, until he lifts it. There is no indication that he will do so soon,[4] and social distancing measures persist, including school closures until the fall, which the Governor announced only days ago.[5]

The Order "prohibit[s] elective medical procedures" for the stated purpose of protecting "public health … by further limiting the movement of persons and occupancy of premises … and by conserving limited medical personnel, personal protective equipment, and other … supplies in light of … treatment needs for COVID-19 patients." It bans

> all elective medical procedures … provided that patients will still have access to urgent, medically necessary procedures like those needed to preserve the patient's life or long-term health; and provided that this prohibition applies equally to all types of elective medical procedures performed in hospitals, offices, and clinics throughout the state.

Order at 2. It defines "'elective' … procedures" as those "that are not immediately medically necessary to preserve the patient's life or long-term health," but it excludes from that definition "procedures that cannot be postponed without compromising the patient's long-term health, procedures that cannot be performed consistent with other law at a later date, or procedures that

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[4] On April 20, the Governor issued Executive Order 28-20, amending the Order by allowing hospitals and ambulatory surgical centers ("ASCs") regulated by the West Virginia Office of Health Facility Licensure and Certification to submit a detailed plan, and ask that office for permission, to resume "more urgent elective medical procedures." Gov. Jim Justice, Executive Order No. 28-20 (Apr. 20, 2020), available at https://governor.wv.gov/Documents/2020%20Executive%20Orders/Executive-Order-April-20-2020-Elective-Surgeries.pdf. There is no explanation of what "more urgent elective medical procedures" means. In any event, WHC is not an ASC, and so is not eligible to submit a plan.

[5] Office of the Gov., *COVID-19 UPDATE: Gov. Justice announces West Virginia schools to remain closed for rest of academic year* (April 21, 2020), available at https://governor.wv.gov/News/press-releases/2020/Pages/COVID-19-UPDATE-Gov.-Justice-announces-West-Virginia-schools-to-remain-closed-for-rest-of-academic-year.aspx; *see also, e.g.*, Gov. Jim Justice, Executive Order No. 18-20 (April 1, 2020), https://governor.wv.gov/Documents/2020%20Proclamations/EO%2018-20.pdf (primary election postponed from May 12 to June 9); Hoppy Kercheval, *How long will our patience last?*, West Virginia Metro News, Apr. 14, 2020, http://wvmetronews.com/2020/04/14/how-long-will-our-patience-last/ (Governor Justice asserting, despite some encouraging signs, "We're not where we need to be yet"); *id.* (West Virginia's "COVID-19 Czar," Dr. Clay Marsh, insisting that to ease restrictions, "We would like to see the number of positive cases go down for 14 days consistently").

are religiously mandated." *Id.* The Order does not further explain the three exceptions.

While the Order was the first executive order issued during the pandemic prohibiting some medical procedures, it was not the first time the state has spoken to this issue. While previous Department of Health and Human Resources ("DHHR") guidance explicitly stated that DHHR "relies upon licensed health care professionals … to exercise their best clinical judgment in the implementation" of restrictions, *see* DHHR, Emergency Recommendations for Health Care Providers (Mar. 26, 2020), the Order contains no such assurances. DHHR's Guidance does not bind the Attorney General or the Governor, who both have enforcement authority over the Order and have expressed hostility to abortion. Indeed, Attorney General Morrissey has signed on to several amicus briefs supporting state efforts to use the COVID-19 crisis to ban or restrict access to abortion.[6] And when asked at a press conference about the Order's impact on abortion, the Governor referred the question to the Attorney General.[7]

Based on the reasonable fear that state actors could use the Order to ban or severely restrict abortion, WHC, through counsel, sought assurance from Defendants Crouch, Challa, and Morrissey that the Order did not apply to prescribing and dispensing medications (and thus

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[6] *See e.g.,* Br. of 18 States as *Amici Curiae* in Supp. of Defs.' Emergency Mot. for Stay & Appeal, *Marshall v. Robinson*, No. 20-11401 (11th Cir. Apr. 20, 2020); Br. of 18 States as *Amici Curiae* in Supp. of Pet'rs' Pet. for Mandamus, *In re Rutledge*, No. 20-1791 (Entry ID No. 4903719) (8th Cir. Apr. 16, 2020); Br. of the States of Ala., Alaska, Ark., Idaho, Ind., Ky., La., Miss., Mo., Mont., Neb., Okla., S.C., S.D., Tenn., Tex., Utah, & W. Va. as *Amici Curiae* in Supp. of Appellants, *Preterm-Cleveland v. Yost*, No. 20-3365 (Doc. No. 20-1) (6th Cir. Apr. 3, 2020); Br. of the States of Ala., Ark., Idaho, Ind., Ky., La., Miss., Mo., Neb., Ohio, Okla., S.C., S.D., Tenn., Utah, & W. Va. as *Amici Curiae* in Supp. of Pet'rs' Emergency Mot. to Stay, *In re Abbott*, No. 20-50264 (Doc. No. 00515365774) (5th Cir. Mar. 31, 2020).

[7] Governor Jim Justice, *Gov. Justice holds press briefing on COVID-19 response - April 2, 2020*, YouTube (Apr. 2, 2020) at 44:01–44:17, https://www.youtube.com/watch?v=tLrYGT-efrs (Reporter: "Governor, can you speak to concerns that a ban on elective medical procedures was a backdoor way to limit access to abortions?" Governor Justice: "Well, I think our Attorney General needs to speak on that more than I."). Governor Justice has also identified himself with anti-abortion causes and supported increased regulation of abortion providers. *See e.g.*, Anthony Izaguirre, *Gov. Jim Justice signs 'born alive' abortion bill*, WHSV3, Mar. 2, 2020, https://www.whsv.com/content/news/Gov-Jim-Justice-to-sign-born-alive-abortion-bill-despite-questions-568402141.html.

performing no "procedure"), and did not ban abortion care which is both urgent and time-sensitive.[8] Decl. of Loree Stark in Supp. of Pls.' Emergency Mot. for TRO and Prelim. Inj., attached hereto as Ex. A ("Stark Decl.") ¶ 3, 7; Quinonez Decl. ¶¶ 23–24. The Attorney General replied that medication abortions are "procedures" under the Order, and that "no procedure is subject to a blanket exemption. Rather, one or more of the exceptions in the Order must be demonstrated on a case-by-case basis." Ltr. from Att'y Gen. Patrick Morrisey to Loree Stark (2, 2020), attached as Ex. 6 to Stark Decl, which is itself attached hereto as Ex. A.

WHC did not seek a "blanket exemption," but rather assurance that, when determining what patients could not be delayed, WHC clinicians could exercise their judgment to provide care under the Order on the same basis as clinicians providing other medical care. But given the hostile climate and the Attorney General's indications that, in his view, most if not all patients should be unable to obtain abortion care as long as the Order remains in effect, WHC had no choice but to adopt a very restrictive policy. Quinonez Decl. ¶¶ 26–27.

To ensure that it will not be subject to an enforcement action or other penalties, WHC is providing care only to patients who are at or near the legal limit for medication abortion in West Virginia and to patients whose long-term health would be compromised by losing their ability to obtain abortion in the state. *Id.* ¶ 28. In practice, this means WHC has provided abortion care only to (A) patients at or near 11.0 weeks LMP, after which medication abortions could no longer "be performed consistent with other law"[9] under the Order, and (B) to patients at or near

[8] Guidance from the DHHR defines "urgent" health care as "any health care service that, were it not provided, is at high risk of resulting in serious or irreparable harm, or both, to a patient if not provided within 24 hours to 30 days." DHHR, Emergency Recommendations for Health Care Providers (March 26, 2020), available at https://dhhr.wv.gov/COVID-19/Documents/Emergency-Recommendations_Health-Care-Providers.pdf. Abortion certainly fits into this category. *See* Flowers Decl. ¶ 24 (risks of abortion care increase every week the procedure is delayed).

[9] *See* W. Va. Code Ann. § 30-3-14(c)(13) (barring prescription of and "prescription drug … other than in … accordance with accepted medical standards").

16.0 weeks LMP, who would otherwise lose the ability to have any abortion in West Virginia, and thus clearly need "procedures that cannot be postponed without compromising the patient's long-term health" under the Order. Quinonez Decl. ¶¶ 29–31. Of the 49 patients WHC had scheduled for abortion in April before the Order, it had to cancel or reschedule 45, more than 90%. Quinonez Decl. ¶ 36. Of the 27 patients scheduled for abortion care the week of April 6, the clinic was able to provide care for only three patients, and the next week it was able to provide care for only six patients. *Id.* Based on the average number of abortion patients in April of 2017, 2018, and 2019, WHC would expect to provide abortion care to 105 patients this month; thus far it has seen nine. *Id.* ¶ 40. All patients seeking new appointments must either delay their care for up to 6 weeks, or, for patients with contraindications for medication abortion, up to 11 weeks, to fit in these restricted windows or be turned away entirely. *Id.* ¶ 32. If it does otherwise, WHC risks losing its license, its staff could face civil penalties, and its physicians could lose their licenses and face civil penalties. *See* W. Va. Code §§ 5-3-2, 7-4-1,16-5B-6, 30-3-14.

While WHC continues to provide abortions to the extent it can, it faces ongoing, targeted scrutiny. Last week, at the Governor's request, DHHR representatives phoned WHC to inquire how it was complying with the Order.[10] Quinonez Decl. ¶ 33. It is clear that the medical judgments of WHC's physicians will be subject to increased scrutiny. WHC is thus constrained to conform to an extremely narrow interpretation of the Order, under which it must turn away the vast majority of patients seeking time-sensitive abortion care. *Id.* ¶ 35.

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[10] Attorney General Morrissey had singled out abortion providers for increased scrutiny before. In 2013, when there were still two abortion providers in the state, General Morrisey began an unprompted review of abortion regulations in which he demanded the clinics respond in writing to a list of questions about abortion regulations and medical procedures. *See* Sharona Coutts, *West Virginia AG Continues Quest for Abortion Restrictions, Despite Lack of Evidence*, Rewire News (Oct. 30, 2013), available at https://rewire.news/article/2013/10/30/west-virginia-ag-continues-quest-for-abortion-restrictions-despite-lack-of-evidence/.

C. The Impact of Halting Abortion

Abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible." Flowers Decl. ¶ 16 (quoting ACOG *et al.*, *supra* n.2). That is why medical authorities advise, "To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure." *Id.* Other preeminent medical organizations agree. The World Health Organization ("WHO") emphasized that "services related to reproductive health," including "[a]bortion," are "essential services during the COVID-19 outbreak." *Id.* ¶ 17. The American Medical Association ("AMA")—the country's largest medical organization and one of its foremost medical and public health authorities—concurs. Its March 30, 2020, statement disapproves of state efforts "to ban or dramatically limit women's reproductive health care" during the COVID-19 outbreak by "labeling procedures as 'nonurgent.'" *Id.* ¶ 18.

The Order is halting care for weeks or in some cases months. *Id.* ¶ 5; Quinonez Decl.¶ 32. Delay on this scale greatly increases risks to patients, and bars others from receiving abortion care at all. The notion that this in any way minimizes COVID-19 transmission or preserves medical resources lacks any medical foundation. Flowers Decl. ¶ 28.

1. The Impact on Patients

From the onset of pregnancy, every patient is at risk of complications. Even an uncomplicated pregnancy challenges the patient's entire physiology and stresses most major organs. A pregnant patient's lungs must work harder to breathe, while the pregnancy puts pressure on the lungs, leaving many, if not most, patients feeling chronically out of breath.

Flowers Decl. ¶¶ 19–20. The heart pumps 30–50% more blood during pregnancy, which results in the kidneys becoming enlarged, and the liver produces more clotting factors, which in turn increases the risk of blood clots or thrombosis. *Id.* ¶ 22. Pregnant patients are very likely to experience gastrointestinal symptoms including nausea and vomiting, which in the most severe cases can result in dehydration that must be treated with IV fluids and medications. *Id.* ¶ 21. Patients who suffer from chronic conditions including asthma, diabetes, hypertension, gallbladder disease, immunological conditions, thyroid disease, lung disease, and diagnosed or undiagnosed cardiac conditions are more likely to experience complications. While some patients might be aware of their preexisting conditions, others (particularly those who have never been pregnant before) might not be aware of their preexisting conditions and may delay in seeking medical evaluation until the need for care is urgent or emergent. *Id.* ¶ 23. Pregnant patients also remain at risk for miscarriage throughout their pregnancy. *Id.* ¶ 35Seventeen percent of all pregnancies end in miscarriage and management usually requires medical evaluation and, frequently, hospital care. *Id.* All of these conditions can reach a level of severity that lead the patient to seek medical evaluation or urgent or emergency care. *Id.* ¶¶ 21–23 & 35.

While abortion is very safe, the associated risks increase as pregnancy advances. Accessing abortion as early in pregnancy as possible is the single most important factor for ensuring the safety of abortion. The risk of death associated with abortion, while extremely small, increase as pregnancy advances; by eight weeks, it increases 38% with each week of delay. *Id.* ¶ 24. The mortality risk at 14–17 weeks is more than eight times the risk at eight weeks or less. *Id.* Delaying an abortion by a week in the second trimester significantly increases the mortality risk. *Id.* The same is true for abortion complications: they are rare, but the risk of complication increases as pregnancy advances. *Id.* ¶ 25. Major complications—those requiring

hospital admissions, surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortions; they occur twice as frequently in the second trimester as in the first. *Id.*

In addition to the medical risks associated with remaining pregnant and delaying abortions, delay also increases a patient's emotional, financial, and psychological stressors during an extremely stressful public health crisis. *Id.* ¶¶ 39–43; Quinonez Decl. ¶¶ 42. WHC patients have expressed extreme distress upon learning that they cannot access care for weeks, or in some cases, months, and this may be particularly dire for patients who lack social support or have underlying psychosocial conditions. Quinonez Decl. ¶ 36–37; Flowers Decl. ¶ 41. For those whose pregnancy results from sexual violence, being forced to carry an unwanted pregnancy for weeks is an unconscionable burden. Flowers ¶ 42. These patients' increasing pregnancy symptoms may also compromise their privacy. *Id.* ¶ 43. Because the cost of procedural abortion increases as pregnancy advances, those patients will face greater financial burdens to access care. *Id.* ¶ 39; Quinonez Decl. ¶ 42. Finally, because so many patients, especially those with low incomes, already have extreme difficultly accessing care, the operation of the Order is an added hurdle that patients will be unable to overcome. Flowers Decl. ¶ 44; Quinonez Decl. ¶ 44.

Even if the COVID-19 emergency ends sooner than expected, patients will have suffered greatly increased health risks and much added psychological distress from the additional weeks of pregnancy they were forced to endure. Flowers Decl. ¶ 45; Quinonez Decl. ¶ 41. Further, because WHC is the only abortion clinic in the state, patients will be delayed in obtaining care even after the Order is lifted because one clinic will simply not have the capacity to immediately meet the pent-up demand that accrued while the Order was in place. Quinonez Decl. ¶ 41; Flowers Decl. ¶ 45. Even if the Order were lifted in May, it would be impossible for WHC to provide care for all the patients who were delayed in April *and* all the patients needing new

appointments in May. Quinonez Decl. ¶ 41. With WHC's schedule reduced to allow for social distancing, it will be able to provide care to a maximum of 133 abortion patients in May 2020. *Id.* If April's abortion patients were forced to wait until May, WHC would expect a demand of approximately 200 patients needing care. *Id.* Many of them will be further along in pregnancy and thus face higher medical costs, and therefore greater burdens. *Id.*; Flowers Decl. ¶ 45. Additionally, a number of patients who would otherwise have received care in April will have to be referred out of state because they will, by then, be too far along to receive care at WHC. Quinonez Decl. ¶ 41.

Under the Order, the vast majority of patients seeking timely abortion care will be forced to travel out of state, if they have the resources to do so. Quinonez Decl. ¶¶ 42–43; Flowers Decl. ¶ 46. Travel is always a great burden, especially to patients with low incomes, and those burdens are heightened because of COVID-19. Flowers Decl. ¶ 46; Quinonez Decl. ¶ 43. Today, travel is harder, more expensive, takes longer, and entails the risk of exposure to the virus. Flowers Decl. ¶ 46; Quinonez Decl. ¶ 43. Travel will also delay care, pushing some patients past the point at which they can have an aspiration abortion. Flowers Decl. ¶ 46. If they can access care at all, they will have to have the more complicated D&E procedure. *Id.*

Those patients who are unable to travel out of state and unable to obtain care in the narrow windows that the Order allows will remain pregnant against their will and give birth, with all the risks that entails, or may seek to end their pregnancies outside the regulated medical setting, which presents further risks to the patient's health and can result in complications requiring urgent or emergent hospital care. Flowers Decl. ¶ 47; Quinonez Decl. ¶¶ 43–44.

2. The Impact on the Health Care System

Delaying or banning abortion will neither minimize COVID-19 transmission nor preserve

personal protective equipment ("PPE") and hospital resources. Medication and procedural abortions in West Virginia require minimal PPE and no hospital resources. Quinonez Decl. ¶¶ 10–12; Flowers Decl. ¶¶ 29–32. Further, patients delayed in obtaining abortion remain pregnant and subject to all the attendant risks described above. Medical evaluation and urgent and emergent care for pregnant women requires more PPE, more interaction between patients and health care providers, and more hospital resources than abortion. Moreover, the extreme delay the Order imposes will force some patients to carry to term simply because, given the logistical difficulties they face, especially during the pandemic, they cannot travel to the clinic during the precise, tiny windows the Order allows. Those who carry to term will use far greater PPE and hospital resources. Flowers Decl. ¶¶ 28–37.

The vast majority of abortions take place in the outpatient setting, and do not require a sterile field and or extensive PPE. *Id.* ¶ 29. An abortion at WHC requires a single in-person visit, and, consistent with current CDC guidelines, uses minimal PPE. Flowers Decl. ¶¶ 29–32; Quinonez Decl. ¶ 11. For procedural abortion, only a small number of staff are involved. Quinonez Decl. ¶ 11. WHC clinicians use surgical masks, gowns, reusable protective eyewear, gloves, and shoe coverings. *Id.* Only physicians use sterile gloves. *Id.* Gloves are changed between patients; all other PPE is reused unless soiled. *Id.* WHC does not use or have any N-95 masks, the PPE believed to be in shortest supply. *Id.* ¶ 10; Flowers Decl. ¶ 31. Medication abortion requires even less PPE. Quinonez Decl. ¶ 12; Flowers Decl. ¶¶ 29–32. Only two clinicians are involved in the administration of medication abortion and each uses only nonsterile gloves and masks. Quinonez Decl. ¶ 12. The gloves are changed between patients; the masks are reused unless soiled. *Id.*

Comparatively, patients with continuing pregnancies require significantly more

interaction with the health care system—well before they approach term. Flowers Decl. ¶¶ 19–23 & 32–33. Pregnant patients routinely go to the hospital for evaluation multiple times. Each time they do, they interact with hospital staff and increase the use of PPE. A substantial proportion of pregnant women seek emergency care at least once during their pregnancy. *Id.* ¶¶ 32–33. In one recent study, 49% visited the emergency department at least once, and 23% visited twice or more. *Id.* ¶ 33. Patients with comorbidities such as diabetes, hypertension and obesity—which West Virginians experience at increased rates—are more likely to present to the emergency department for urgent or non-urgent care. *Id.* Pregnant patients with severe symptoms consistent with COVID-19—including shortness of breath, which is an extremely common symptom of pregnancy—are advised to seek immediate care in the emergency department or an equivalent unit that treats pregnancy. *Id.* at ¶ 34. When these patients go to an emergency department, health care providers will use the appropriate amount of PPE *for a suspected COVID-19 patient*. *Id.* ¶ 34. Patients who miscarry require medical evaluation and often hospital care, and miscarriage becomes more complicated as pregnancy progresses. *Id.* at ¶ 35.

Of course, patients who carry to term and deliver will use extensive hospital resources and PPE. Pregnancy lasts 40 weeks LMP, and even an uncomplicated pregnancy generally requires at least one prenatal appointment per month, but patients whose pregnancies are complicated by preexisting conditions or are otherwise high-risk may require twice as many visits. Although the use of telemedicine visits is encouraged when possible during the COVID-19 pandemic, each in-person visit will likely require at least gloves and masks. During an actual birth, almost all of which occur in hospitals in West Virginia, multiple medical providers attend to the patient, each requiring multiple gowns, masks, and gloves. A patient who delivers remains in the hospital 24–48 hours for a vaginal birth and 72–96 hours for a caesarean section. Patients

with complicated or high-risk pregnancies may remain in the hospital longer—requiring even more PPE and hospital resources. *Id.* at ¶ 36.

ARGUMENT

STANDARD OF REVIEW

Plaintiff seeks a TRO and preliminary injunction to prevent ongoing, irreparable injury: halting pre-viability abortion except in the narrow windows near the point at which medication abortion and procedural abortion become unavailable, and preventing physicians from using their medical judgment to determine whether delaying the abortion would cause harm to a patient's long-term health. All four relevant factors weigh heavily in Plaintiff's favor: (1) likelihood of success on the merits; (2) likelihood of irreparable harm absent relief; (3) the balance of equities; and (4) the public interest. *See Winter v. Nat. Res. Dep't Cent.*, 555 U.S. 7, 20 (2008); *see also Mountain Valley Pipeline, LLC v. W. Pocahontas Props. Ltd. P'ship*, 918 F.3d 353, 366 (4th Cir. 2019). Plaintiff is likely to succeed on the merits because the Order as applied to halt pre-viability abortions directly contravenes decades of binding precedent, and *undermines* the health and safety interests it purports to serve. Moreover, injunctive relief will prevent severe and irreparable harm to Plaintiff's patients, is consistent with the balance of equities, and serves the public interest. Accordingly, this Court should grant Plaintiff's motion.

I. PLAINTIFF WILL SUCCEED ON THE MERITS OF ITS SUBSTANTIVE DUE PROCESS CLAIM

Under *Roe v. Wade*, 410 U.S. 113 (1973), the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution protects a woman's right to choose abortion, *id.* at 153–54, and prior to viability, a state may not ban abortion, *id.* at 163–65; *see also, e.g.*, *Bryant v. Woodall*, 363 F. Supp. 3d 611, 628 (M.D.N.C. 2019) ("[A] state is never allowed to prohibit any swath of pre-viability abortions outright[.]"), *appeal docketed*, No. 19-1685 (4th Cir. June 26,

2019). Rather, a state may proscribe abortion only after viability, and even then, it must allow abortion where necessary to preserve the life or health of the patient. *Roe*, 410 U.S. at 163–64. Moreover, to evaluate abortion restrictions, as opposed to abortion bans, the Supreme Court developed the undue burden test first outlined in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). As the Supreme Court held, "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877; *see also Bryant*, 363 F. Supp. 3d at 630; *Daniel v. Underwood*, 102 F. Supp. 2d 680, 685 (S.D. W. Va. 2000); *Richmond Med. Ctr. for Women v. Gilmore*, 55 F. Supp. 2d 441, 460 (E.D. Va. 1999), *aff'd*, 224 F.3d 337 (4th Cir. 2000). A restriction that, "while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (quoting *Casey*, 505 U.S. at 877). In other words, "*Casey* requires courts to consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2298. As discussed below, the burdens of pushing patients further into their pregnancy—to the detriment of their health and possibly forcing them to carry to term—outweigh the purported benefits of the Order, and thus the Order imposes a substantial obstacle in the path of people seeking abortion.

Defendants may claim, relying on *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), that the constitutionality of the Order should be evaluated under a deferential standard of review. But the Supreme Court in *Jacobson* repeatedly cautioned that while the state has authority to "safeguard the public health and the public safety," that authority is extended "only to the condition that no rule prescribed by a state, nor any regulation adopted by a local

governmental agency acting under the sanction of state legislation, shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument." *Id.* at 25. In other words, *Jacobson* does not insulate a government's unconstitutional actions from court review during times of emergency. *See Robinson v. Att'y Gen.*, No. 20-11401, 2020 WL 1952370, at *5 (11th Cir. Apr. 23, 2020) ("But just as constitutional rights have limits, so too does a state's power to issue executive orders limiting such rights in times of emergency."). Indeed, the *Casey* Court cited *Jacobson* for the proposition that state interests cannot "justify[] any plenary override of individual liberty claims." 505 U.S. at 857.

Moreover, *Jacobson* did not articulate an independent, deferential standard for evaluating all constitutional violations in times of a pandemic. Instead, it stands for the basic premise that the state can exercise police power in an emergency, subject to constitutional limitations.[11] *See Robinson*, 2020 WL 1952370, at *55 (*Jacobson* "was not an absolute blank check for the exercise of governmental power."); *Preterm-Cleveland v. Att'y Gen. of Ohio*, 2020 WL 1957173, at *11 (S.D. Ohio Apr. 23, 2020) ("The State's emergency powers analysis found in *Jacobson* and the substantive-due-process analysis found in *Roe* and *Casey* should be applied together in light of the COVID-19 pandemic, the subject-matter of this case, and the holdings of those cases."). *Jacobson* was decided decades before the Court developed heightened standards of scrutiny for laws violating constitutional rights, *see United States v. Carolene Prod. Co.*, 304 U.S. 144, 152 n.4 (1938), as well as today's substantive due process law. To say that *Jacobson* was intended to bypass higher standards of scrutiny for violations of constitutional rights is

[11] *Jacobson* was decided in 1905, the same year as *Lochner v. New York*, 198 U.S. 45 (1905), at a time when courts were called on to address whether particular enactments were "within the police power of the state." *Id.* at 57. In today' jurisprudence, *Jacobson*'s holding is unremarkable, in that a state is assumed to have the power to enact laws for the public health that are reasonable and as limited by the Constitution.

anachronistic at best. Indeed, rather than affirming that *Jacobson* allowed the state to suspend the constitutional right to bodily integrity during a pandemic, the Supreme Court has since characterized *Jacobson* as "*balancing* an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan by Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (emphasis added).

Plaintiffs do not disagree that a state's unique interests during a time of emergency can be considered by the Court, but it must be done in the context of the existing framework for analyzing the constitutional right to abortion under existing abortion jurisprudence. As discussed below, that unique interest, preserving health care resources, should be considered and weighed within the *Roe* and *Casey* framework. And for the same reasons that the Order violates the *Casey* and *Whole Woman's Health* balancing test, it also violates the balancing dictated by *Jacobson*.[12] *See Robinson*, 2020 WL 1952370, at *6 (denying motion to stay preliminary injunction where district court "read[] these two lines of cases[, *i.e.*, *Casey* and *Jacobson*,] together"); *see also id.* at *8. Accordingly, Plaintiff is likely to succeed on the merits of its claim under any test.

A. As Applied, the Order Bans Pre-viability Abortion

The Supreme Court has repeatedly reaffirmed: at no point before viability may a state ban abortion. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2309; *Casey*, 505 U.S. at 846, 871; *Roe*, 410 U.S. at 153–54, 163–65. Following that rule, appellate courts have uniformly rejected attempts to ban pre-viability abortion.[13] Likewise, district courts uniformly blocked a wave of

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[12] Even if this Court looked to *Jacobson* as frozen in time, and without the benefit of over 100 years of constitutional jurisprudence, the Order still falls because it "has no real or substantial relation to the protection of the public health and the public safety." *Jacobson*, 197 U.S. at 31. As discussed below, the Order, as interpreted to halt abortion, does not further the state's unique interest during this pandemic of preserving health care resources and goes "beyond what was reasonably required for the safety of the public," therefore "compel[ling] the courts to interfere." *Id.* at 28.

[13] *E.g.*, *Jackson Women's Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020) (per curiam) ("*Jackson III*") (ban

bans enacted in 2019.[14]

As applied, the Order violates this precedent. Although abortion is urgent and medically necessary care that cannot be delayed, Attorney General Morrissey's letter made clear that most if not all abortions are "prohibit[ed]" under the Order. *See* Ltr. from Patrick Morrisey to Loree Stark (2, 2020), attached as Ex. 6 to Stark Decl., which is itself attached hereto as Ex. A. Under the Order, a patient cannot access care unless at or near either the legal limit for medication abortion (11.0 weeks LMP) or the limit for obtaining any abortion (16.0 weeks LMP). The windows during which the Order is halting care are pre-viability periods in pregnancy: from four to ten weeks and from eleven to fifteen weeks. *See* Quinonez ¶ 32. The Order is thus unconstitutionally prohibiting the vast majority of abortion care.

B. As Applied, the Order Creates an Undue Burden

Even if this Court applies the undue burden test used to evaluate abortion restrictions (as opposed to bans on abortion), the undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. The Order fails that test. As applied, the Order is unconstitutionally

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on abortions starting at six weeks); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265, 268–69 (5th Cir. 2019) ("*Jackson II*") (ban at fifteen weeks); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015) (ban at six weeks), *cert. denied*, 136 S. Ct. 981 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117–19 (8th Cir. 2015) (ban at twelve weeks), *cert. denied*, 136 S. Ct. 895 (2016); *Isaacson v. Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013) (ban at twenty weeks), *cert. denied*, 571 U.S. 1127 (2014); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996) (same), *cert. denied*, 520 U.S. 1274 (1997); *Sojourner T v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992) (ban on all abortions), *cert. denied*, 507 U.S. 972 (1993); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69, 1371–72 (9th Cir. 1992) (same), *cert. denied*, 506 U.S. 1011 (1992).

[14] *See, e.g.*, *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (ban on nearly all abortions); *SisterSong v.Women of Color Reprod. Justice Collective v. Kemp*, 410 F. Supp. 3d 1327 (N.D. Ga. 2019) (ban at six weeks); *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Parson*, 389 F. Supp. 3d 631 (W.D. Mo. 2019), *modified*, 408 F. Supp. 3d 1049 (W.D. Mo. 2019) (ban on abortions at various weeks before viability); *Little Rock Family Planning Servs. v. Rutledge*, 397 F. Supp. 3d 1213 (E.D. Ark. 2019) (ban at eighteen weeks); *Jackson Women's Health Org. v. Dobbs*, 379 F. Supp. 3d 549 (S.D. Miss. 2019), *aff'd*, 951 F.3d 246 (5th Cir. 2020) (ban at six weeks); Order Granting Stipulated Prelim. Inj. as to State Defs., *Planned Parenthood Ass'n of Utah v. Miner*, No. 2:19-cv-00238 (D. Utah Apr. 18, 2019), ECF No. 34 (ban at eighteen weeks)
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imposing inexcusable, dangerous delay on some patients, and simply blocking abortion altogether for others. *See Roe*, 410 U.S. at 153–54, 163–65. The Order's stated purpose, which WHC shares, is to limit virus transmission and conserve medical resources, but halting abortion as the Order is doing has the opposite effect. Thus, the burdens of the Order clearly outweigh its benefits.

Courts throughout the country have enjoined executive orders similar to the one challenged here, finding that the plaintiffs are likely to succeed on the merits of their claim that the orders unduly burden access to abortion. *See, e.g.*, *Adams & Boyle, P.C. v. Slatery*, No. 3:15-cv-00705, slip op. (M.D. Tenn. Apr. 17, 2020), Dkt. No. 244 (granting preliminary injunction against Tennessee executive order that halted all procedural abortions), *administrative stay denied*, No. 20-5408 (6th Cir. Apr. 20, 2020); *S. Wind Women's Ctr. LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1932900 (W.D. Okla. Apr. 20, 2020) (preliminarily enjoining executive order as to most abortions effective immediately, and as to all abortions as of April 24), *appeal docketed*, No. 20-6055 (10th Cir. Apr. 21, 2020); *Little Rock Family Planning Servs. v. Rutledge*, No. 4:19-cv-00449-KGB, 2020 WL 1862830 (E.D. Ark. Apr. 14, 2020) (temporarily restraining application of executive order to all procedural abortions), *mandamus granted in part sub. nom. In re Rutledge*, __ F.3d __, 2020 WL 1933122 (8th Cir. Apr. 22, 2020); *Robinson v. Marshall*, No. 2:19cv365-MHT, 2020 WL 1847128, at *8–9 (M.D. Ala. Apr. 12, 2020) (granting preliminary injunction to allow health care providers to make individualized determinations regarding provision of abortion care), *stay denied sub nom.*, *Robinson v. Att'y Gen.*, No. 20-11401, 2020 WL 1952370 (11th Cir. Apr. 23, 2020); *Preterm-Cleveland v.* Att*'y* Gen. *of Ohio*, No. 1:19-cv-360, 2020 WL 1932851 (S.D. Ohio Mar. 30, 2020) (granting TRO allowing providers to make case-by-case basis determinations regarding provision of abortion care), *stay*

denied and appeal dismissed, No. 20-3365, 2020 WL 1673310 (6th Cir. Apr. 6, 2020); *Preterm-Cleveland* 2020 WL 1957173, at *17(preliminarily enjoining enforcement of executive order in such a way as to prohibit abortion providers from making case-by-case determinations regarding patients' need for abortion services).[15]

Because the delay imposed by the Order imposes burdens without any countervailing benefits it should be enjoined.[16]

1. The Order Places a Severe Burden on Patients

By delaying abortion for weeks or months, the Order is undeniably increasing the medical risks to patients and imposing severe harm. The Supreme Court recently held that 3-week wait times for an appointment would impose a burden.[17] *See Whole Woman's Health*, 136 S. Ct. at 2318. Delay on this scale is unquestionably a substantial obstacle to pre-viability

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[15] In *In re Abbott*, over a vigorous dissent, the Fifth Circuit issued an opinion granting a writ of mandamus concerning a now-expired Texas executive order. While recognizing that courts have a duty to weigh the benefits and burdens of abortion restrictions, the Fifth Circuit determined that the district court had, *inter alia*, failed to adequately consider the evidentiary record before it. *See In re Abbott*, __ F.3d __, 2020 WL 1911216, at *14 (5th Cir. Apr. 20, 2020). And the Eighth Circuit's divided decision two days ago, *In re Rutledge*, is an outlier in that it allowed *no* procedural abortions despite the challenged order's indeterminate end date, absent further district court findings. *See In re Rutledge*, 2020 WL 1933122, at *8. Moreover, other courts have rejected the Fifth and the Eighth Circuit's approach; indeed, after those circuits issued their decisions, the Eleventh Circuit denied a motion to stay the preliminary injunction issued in Alabama, *Marshall v. Robinson*, No. 20-11401 (11th Cir. Apr. 23, 2020), and the Ohio district court issued a preliminary injunction, *Pre-Term Cleveland*, 2020 WL 1957173.

[16] *See supra* 21 & n.13, 14*; see also*, *e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013) (affirming injunction of abortion restriction that would subject patients "to weeks of delay" and noting that "delay in obtaining an abortion can result in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal"); *Adams & Boyle P.C.*, No. 3:15-cv-00705, slip op. at 9 (in light of postponement and cancellation of abortion procedures, "the Court finds that, for purposes of seeking a preliminary injunction, plaintiffs have shown that [a COVID-19 health order] 'plac[es] a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus'" (citing *Casey*, 505 U.S. at 877)).

[17] In *Casey*, the Supreme Court considered even a *24-hour* delay as a "close[] question," noting its "troubling" effects. 505 U.S. at 885–86. The Court upheld this waiting period because, and only because, it held that "we cannot say that the waiting period imposes a real health risk." *Id.* at 886. Here, the health risks are significant and indisputable.

abortion.[18]

While patients are denied abortion, they remain pregnant, with all the inherent risk that entails. As described above, *see* supra 12–13 even an uncomplicated pregnancy can lead to serious, sometimes dire, complications, and the risk is greatly increased for patients with preexisting conditions. Thus, well before birth—in the period immediately after they would otherwise have obtained abortion care—the Order forces people to remain pregnant and they will require medical care, some of it urgent and emergent, some of it hospital-based, and entailing the risk of COVID-19 exposure. Flowers Decl. ¶ 6. As described above, *see supra* 13–14, forcing patients to carry unwanted pregnancies also burdens them emotionally and psychologically, especially those who lack social support, have preexisting psychosocial conditions, need to keep their care private, and/or are pregnant as a result of sexual violence. Flowers Decl. ¶¶ 41–43.

Further, as described above, *supra* 13, while abortion is extremely safe, the risks increase markedly as pregnancy advances. Flowers Decl. ¶ 24. As leading medical associations have explained, abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[19] The cost of abortion likewise increases as pregnancy advances, adding financial burden to the medical harm inherent in delay. Quinonez ¶ 41; *see also Preterm-Cleveland*, 2020 WL 1957173,

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[18] *See e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2314—18 (longer wait times burden patients); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015); *McCormack v. Hiedeman*, 694 F.3d 1004, 1016-–17 (9th Cir. 2012); *Adams & Boyle P.C.*, *et al. v. Herbert Slaterly, et al.*, No. 3:15-cv-00705 (M.D. Tenn. April 17, 2020), ECF. No. 244, slip op. at 10), ECF244 at 10 "Delaying a woman's access to abortion even by a matter of days can result in her having to undergo a lengthier and more complex procedure that involves progressively greater health risks."); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1356-–60 (M.D. Ala. 2014); *Robinson v. Marshall*, No. 2:19CV365-MHT, 2020 WL 1847128 (M.D. Ala. Apr. 12, 2020), at *8 ("[A] postponement of an abortion may cause serious harm, or a substantial risk of serious harm, to that woman's health … for at least some women, even a short delay can make an abortion (or the ongoing pregnancy) substantially riskier[.]").

[19] ACOG *et al*., *supra* n.2.

at *12(holding that "[a] delay in surgical abortion could cause a substantial risk of serious harm or serious harm to a patient's health because delaying surgical abortion increases risks associated with abortion").

Some patients who have the means seek to avoid the medical risks of continued pregnancy and delayed abortion by attempting to travel out of state, notwithstanding the risks of travel right now. Flowers Decl. ¶ 46; Quinonez Decl. ¶ 42. Among other burdens (including financial and emotional), this increased travel will jeopardize their health, both by increasing their risk of COVID-19 exposure and by delaying their abortion care even further while raising funds and organizing logistics. Flowers Decl. ¶ 46; Quinonez ¶ 42. Moreover, patients seeking out-of-state care may well be delayed to the point at which abortion is generally a *two*-day procedure, thus doubling the exposure risks and PPE needed. Flowers Decl. ¶ 46. Such travel also increases the likelihood that a patient who contracts COVID-19 elsewhere will bring it back into their home and into the state.

However, particularly during the pandemic—with incomes slashed, transportation limited, and childcare impossible to come by—many patients would be unable to travel to access care out of state. Quinonez Decl. ¶ 15; Flowers Decl. ¶ 15. Some will remain pregnant for weeks or months, until they can access care as close as possible to either 11.0 weeks or 16.0 weeks LMP in West Virginia, but, particularly in light of the pandemic, it will be extremely difficult if not impossible for some patients to make it to the clinic in the narrow time frames the Order allows abortion to occur. This is particularly true for many WHC patients who, as described above, *supra* 13–15, already face multiple barriers in accessing care. The additional barrier imposed by the Order will be insurmountable for some. *See, e.g.*, *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 833 (7th Cir. 2018) (18-hour

delay "places a large barrier to access" on women seeking abortions); *Robinson*, 2020 WL 1847128, at *7 ("It is abundantly clear, and the court now finds, that a delay [from April 12] until April 30 will pose a tremendous, and sometimes insurmountable, burden for many women"); *id.* at *10 ("medical restrictions [which] would amplify existing challenges, pose severe health risks, and render abortions functionally unavailable for at least some women" constitute "extensive burdens").

For those patients whom the Order will block altogether from obtaining an abortion,[20] the medical repercussions alone are profound. The risk of death associated with childbirth is approximately *fourteen times* greater than that associated with abortion, Flowers Decl. ¶ 8, and every pregnancy-related complication is more common among people giving birth than among those having abortions. *Id.* To avoid these results, patients may attempt to terminate their pregnancies outside the regulated medical setting, which—if the patient resorts to unsafe methods—will increase the likelihood of complications necessitating hospitalization. *Id.* ¶ 47. *Whole Woman's Health*, 136 S. Ct. at 2321 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, faute de mieux, at great risk to their health and safety."). They will also suffer significant emotional, psychological and economic repercussions. *See* Flowers Decl. ¶ 41.

While many factors affect how each individual patient is burdened by the law, under the Order, Plaintiff's physicians are allowed to take only a very limited number of factors into account when assessing patients. *See supra* 10. Like all clinicians, WHC clinicians ought to be

[20] Additionally, the demand for services after the Order is lifted is likely to strain WHC's capacity, further delaying or blocking patient's access to care. Quinonez Decl. ¶ 41.

able to consider the panoply of relevant medical and life circumstances that inform the case-by-case determination of the patient's course of treatment. Those factors properly include those reported by the patient, such as her medical history, underlying health problems, whether she is facing domestic violence, and economic and logistical circumstances that would preclude her from travelling back to the clinic if delayed. But WHC clinicians fear that if they take into account the full panoply of factors in making their good-faith medical determination, they will be second-guessed by Defendants and face penalties.

Prohibiting physicians from using their medical judgment to assess patients' eligibility for the exceptions is not only in contrast to the DHHR's previous guidance, *see supra* 8, but it is also contrary to Supreme Court precedent. Indeed, the Supreme Court has repeatedly held that health care providers must have the discretion to use their medical judgment when interpreting laws that restrict access to abortion. For example, in *Doe v. Bolton*, 410 U.S. 179 (1973), the Court underscored the importance of affording physicians adequate discretion in exercising medical judgment in a vagueness challenge to a Georgia statute requiring that a physician's decision to perform an abortion must rest upon "his best clinical judgment." *Id.* at 191–92. The Court found it critical that that judgment "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." *Id*. at 192; *see also Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64 (1976) (holding that, in the context of a statute that restricted abortion after viability, determining viability must be a matter for the judgment of the responsible attending physician, not politicians); *Colautti v. Franklin*, 439 U.S. 379, 396–97 (1979) (same). Courts that have preliminarily enjoined executive orders similar to the one challenged here have similarly held that the orders prohibited abortion providers from using their medical judgment to determine

whether delaying the abortion would harm patients' health. *See Preterm-Cleveland*, 2020 WL 1957173, at *16–*17 (holding that abortion providers must be afforded the same ability to use their medical judgment as any other health care provider); *Robinson*, 2020 WL 1847128, at *14 ("[T]o proceed with lawful abortions [under an order restricting abortions during the COVID-19 pandemic], providers must be *confident* that their exercise of reasonable medical judgment will not be met with unconstitutional or bad-faith prosecution") (emphasis in original).

2. The Order Undermines, Rather than Advances, the State's Interests

Whole Woman's Health dictates that the Court also assess the benefits the Order confers. *See* 136 S. Ct. at 2309. Halting abortion during the pandemic and economic crisis does not serve the Order's stated goals; it undermines them.

As explained above, patients who remain pregnant are at risk of serious complications that will require non-urgent, urgent, and emergent care. Flowers Decl. ¶¶ 20, 23 & 33. Treatment for pregnancy complications, which are frequent, will involve multiple trips to health care facilities, especially for high-risk patients. *Id.* ¶ 33. Indeed, pregnant patients frequently seek care in the emergency room, with 49% going at least once and 23%, twice or more. *Id.* Additionally, those the Order forces to remain pregnant run the risk of being among the 17% of pregnant patients who miscarry, which also requires medical care. *Id.* ¶ 35. Patients miscarrying frequently seek emergency room care—often multiple times—using PPE and hospital resources, and risking virus exposure. *Id.* Of course, patients forced to carry to term or to seek care outside the medical setting (possibly resorting to unsafe means) will have *increased* need for medical and hospital resources. *Id*. ¶ 47.

By contrast, allowing pregnant patients to obtain timely abortions on an outpatient basis will spare hospital resources, preserve PPE, minimize travel, and protect patient health, including

by reducing their risk of COVID-19 exposure. Legal abortion is very safe and complications associated with abortion—especially those requiring hospital care—are exceedingly rare. *Id.* ¶ 25; *see also Whole Woman's Health*, 136 S. Ct. at 2311–12, 2315. Abortion necessitates minimal PPE. Flowers Decl. ¶ 29; Quinonez Decl. ¶ 11. WHC does not use any N-95 masks, the PPE which is believed to be in shortest supply. Quinonez Decl. ¶ 10; Flowers Decl. ¶ 31. Additionally, WHC has already taken significant measures to protect its patients and staff in accordance with national guidelines. Quinonez Decl. ¶¶ 19–21.

With respect to medication abortion specifically, any benefit is even more illusory because medication abortion requires even less PPE than procedural abortion and involves even less interaction between patient and clinician, *see* Quinonez Decl. ¶ 12; Flowers Decl. ¶ 30, as district courts examining attempts to restrict medication abortion through COVID-19 related executive orders have found. *See, e.g.*, *See Preterm-Cleveland*, 2020 WL 1957173, at *14 (holding that delaying abortion services until the legal limit will not conserve PPE); *Robinson*, 2020 WL 1847128, at *11 n.15("Indeed, the State Health Officer conceded that administering a medication abortion 'may not itself' require the use of PPE. He justified delaying medication abortions based on the risk of possible complications requiring a surgical abortion or emergency medical care. However, the rate of such complications is extremely low, a fact that [he] admitted he did not know when he made the decision that medication abortions should be postponed." (internal citations omitted)); *S. Wind Women's Ctr. LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094, at *2 (W.D. Okla. Apr. 6, 2020) ("Further, the Court concludes that the benefit to public health of the ban on medication abortions is minor and outweighed by the intrusion on Fourteenth Amendment rights caused by that ban."); *id.* at *3 (for "medication abortion," the "interpersonal contact and PPE" and "percentage of complications resulting in hospitalization"

are lower than for "surgical abortion"); *see also Whole Woman's Health*, 136 S. Ct. at 2311–12, 2315 (complications associated with medication abortion, including those requiring hospital care, are exceedingly rare).

The irrationality of subjecting medication abortion to executive orders intended to delay non-essential medical *procedures* is self-evident. In fact, a number of states—including those currently attempting to apply their emergency orders to procedural abortions—have decided *not* to enforce those orders as to medication abortion. *See, e.g.*, *Little Rock Family Planning Servs.*, 2020 WL 1862830, at *2 (medication abortions permitted under Arkansas COVID-19 executive order); *Adams & Boyle P.C.*, No. 3:15-cv-00705, slip op. at 1, ECF No. 244 at 1 (same with respect to Tennessee COVID-19 executive order); *Preterm-Cleveland*, 2020 WL 1957173, at *5–6.).

3. The Burdens of the Challenged Action Clearly Outweigh the Benefits

The final step in the undue burden analysis "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. Here, enforcing the Order as applied to halt care—up to six weeks for most patients, and up to eleven weeks for patients with contraindications for medication abortion—enormous burdens, confers no benefits, and is plainly unconstitutional. WHC will thus succeed on the merits of its substantive due process claim.

II. PLAINTIFF'S PATIENTS WILL SUFFER IRREPARABLE HARM ABSENT THE REQUESTED RELIEF

Plaintiff's patients will suffer serious and irreparable harm absent the requested relief. First, significantly delaying or banning pre-viability abortions violates their constitutional rights, inflicting *per se* irreparable harm. *See, e.g.*, *Johnson v. Bergland*, 586 F.2d 993, 995 (4th Cir. 1978) ("Violations of first amendment rights constitute per se irreparable injury.") (citing *Elrod*

v. Burns, 427 U.S. 347, 373 (1976)); *Am. Fed'n of Teachers-W. Va., AFL-CIO v. Kanawha Cty. Bd. of Educ.*, 592 F. Supp. 2d 883, 905 (S.D. W. Va. 2009) (violation of "fundamental constitutional right … demonstrate[s] irreparable harm"). Forcing patients to remain pregnant inflicts serious physical, emotional, and psychological consequences that alone constitute irreparable harm. *See e.g.*, *Elrod*, 427 U.S. at 373–74; *Planned Parenthood of Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013).

Likewise, although abortion is extremely safe, Flowers Decl. ¶ 24, "an extended delay in obtaining an abortion can cause irreparable harm by resulting in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Ind. & Ky.*, 896 F.3d at 832 (internal quotation omitted); *see also, e.g.*, *Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 960 (S.D. Ohio 2015) (irreparable harm where "patients could face a delay"). This "disruption or denial of … care cannot be undone after a trial on the merits." *Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) (internal quotation marks omitted), *cert. denied sub nom. Andersen v. Planned Parenthood of Kan. & Mid-Mo.*, 139 S. Ct. 638 (Mem.) (2018). Forcing patients to remain pregnant also prolongs the time during which they unwillingly face the risks of pregnancy itself, and—because pregnancy vastly increases their near-term need for medical care—increases their risk of COVID-19 exposure. Flowers Decl.¶ 37.

Accordingly, numerous courts have found that the deprivation of abortion care for a period of weeks or longer—including during this crisis—would result in irreparable injury. *See Adams & Boyle P.C.*, No. 3:15-cv-00705, slip op. at 10 ("Delaying a woman's access to abortion even by a matter of days can result in her having to undergo a lengthier and more complex

procedure that involves progressively greater health risks … or can result in her losing the right to obtain an abortion altogether. Therefore, plaintiffs have demonstrated that enforcement of [a COVID-19 health order] causes them irreparable harm."); *Robinson*, 2020 WL 1847128, at *15 (holding that any denial of women's "fundamental right to privacy" constitutes irreparable injury); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *6 ("Plaintiffs here have demonstrated imminent, irreparable harm absent entry of injunctive relief, as their patients will be substantially delayed in or prevented from exercising their right to abortion access."); *Preterm-Cleveland*, 2020 WL 1957173, at *15 ("enforcement would, per se, inflict irreparable harm"). This Court should reach the same conclusion here.

III. THE REMAINING FACTORS SUPPORT INJUNCTIVE RELIEF

That Defendants would inflict these irreparable harms on patients in the midst of a global pandemic—increasing their risk of COVID-19 exposure and/or their risks from continued pregnancy, with no attendant public health benefit—only underscores the need for injunctive relief. Forcing those who seek abortions to remain pregnant increases demands on the health care system, including PPE and in-person clinical interactions. Forcing West Virginians to travel elsewhere for care would also increase COVID-19 risk for them and others.

A preliminary injunction will equalize access to urgent medical care in West Virginia. It will preserve the status quo of the state's balancing of public health interests as it existed prior to the challenged action. *See Pashby v. Delia*, 709 F.3d 307, 319 (4th Cir. 2013) ("[P]reliminary injunction … protect[s] the status quo and … prevent[s] irreparable harm during the pendency of a lawsuit." (internal citation omitted)). Likewise, an injunction will align access to this necessary care with the recommendations of national medical authorities.

Here, despite Defendants' efforts to pit public health against patients' constitutional

rights, the two are consistent and "upholding constitutional rights surely serves the public interest." *Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 521 (4th Cir. 2002). Particularly where Plaintiff is already taking appropriate steps to protect the safety of its patients, staff, and community, injunctive relief is supported by the balance of harms and the public interest.

IV. A BOND IS NOT NECESSARY IN THIS CASE

This Court has discretion to and should waive FRCP 65(c)'s bond requirement. *See Pashby*, 709 F.3d at 331–32; *see also, e.g.*, *T. v. Bowling*, No. 2:15-cv-9655, 2016 WL 4870284, at *15 n.10 (S.D. W. Va. Sept. 13, 2016); *Hernandez v. Montes*, No. 5:18-cv-5-D, 2018 WL 405977, at *2 (E.D.N.C. Jan. 12, 2018). The preliminary injunction will result in no monetary loss for Defendants. Moreover, Plaintiff is a non-profit health care provider dedicated to serving low-income and underserved communities, and a bond would strain its already-limited resources.

CONCLUSION

For these reasons, this Court should grant Plaintiff's motion and prohibit enforcement of the Order as applied to prohibit Plaintiff from providing abortion care when, in the physician's good-faith medical judgment and based on the panoply of relevant factors, delaying the abortion would prevent the patient from obtaining an abortion in West Virginia or otherwise compromise the patient's long-term health.

Respectfully submitted this 24th day of April, 2020.

By Counsel,

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**Statement of Visiting Attorney Forthcoming*

/s/ Loree Stark____________________
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Attorneys for Plaintiff

WOMEN'S HEALTH CENTER OF WEST VIRGINIA, Plaintiff, v. PATRICK MORRISEY, *et al*., Defendants.	Civil Action No. Hon.

CERTIFICATE OF SERVICE

I, Loree Stark, do hereby certify that on this 24th day of April, 2020, I electronically filed a true and exact copy of ***Memorandum of Law in Support of Plaintiff's Emergency Motion for Temporary Restraining Order and Preliminary Injunction*** with the Clerk of Court and all parties using the CM/ECF System.

/s/ Loree Stark______________________
West Virginia Bar No. 12936

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

WOMEN'S HEALTH CENTER OF WEST VIRGINIA,

Plaintiff,

v.

PATRICK MORRISEY *et al*.,

Defendants.

Civil Action No.

Hon.

DECLARATION OF LOREE STARK IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Loree Stark declares and states the following:

1. I am the Legal Director of the American Civil Liberties Union of West Virginia and the counsel of record for Plaintiff Women's Health Center of West Virginia in this case.

2. On Tuesday, March 31, 2020, Plaintiff became aware of the Governor of West Virginia's Executive Order 16-20 (the "Order"). Citing the outbreak of the COVID-19 virus and West Virginia's State of Emergency declaration, the Order prohibits "elective medical procedures." According to the Order, those include all procedures that "are not immediately medically necessary to preserve the patient's life or long-term health," with three exceptions: 1) "procedures that cannot be postponed without compromising the patient's long-term health," 2) "procedures that cannot be performed consistent with other law at a later date," and 3) "procedures that are religiously mandated." The Order took effect on April 1, 2020. A copy of the Order is attached as Exhibit 1.

3. On April 1, 2020, I emailed a letter to Bill J. Crouch at the West Virginia Department of Health and Human Resources and Kishore K. Challa at the West Virginia Board

of Medicine to confirm our reading of the Order to allow WHC to continue providing abortions for its patients. A copy of the letter is attached as Exhibit 2.

4. My letter stated that WHC shares the Governor's commitment to reducing the spread of COVID-19 and protecting the health and safety of both patients and health care workers while continuing to ensure access to essential health services. My letter further stated our reading that the abortions WHC provides, including medication abortions, which are not "procedures" at all, may continue under the Order because they are urgent, medically necessary care. I requested that the Department of Health & Human Resources and the Board of Medicine confirm that both medication abortions and procedural abortions may continue under the Order and that the respective agencies do not intend to enforce the Order against WHC based on its provision of abortion services.

5. By letter dated April 1, 2020, Mark A. Spangler, Executive Director of the Board of Medicine, writing on behalf of the Medical Board, replied. Rather than respond substantively, he indicated merely that the Board had informed licensees of the existence of the Order and would post any further information it received about the Order on its COVID-19 website. A copy of the letter is attached as Exhibit 3.

6. The Governor and other state officials, including the Attorney General, held a press conference on April 1, 2020. During that press conference, the Attorney General stated that the Order applies to abortion facilities, which was never in doubt.

7. After the press conference, I emailed a letter to the Attorney General further seeking to confirm our understanding of the impact of the Order on WHC and its patients. I requested that he confirm that both medication abortions and procedural abortions may continue

under the Order and that he does not intend to enforce the Order against WHC based on its provision of abortion services. A copy of the letter is attached as Exhibit 4.

8. I subsequently received a letter on April 1, 2020, from Attorney General Morrisey stating that he would respond by April 2, 2020. A copy of the letter is attached as Exhibit 5.

9. On April 2, 2020, I received a letter from Attorney General Morrisey stating:

> After consultation with the Governor's office, as the office which issued Executive Order No. 16-20 ("Order"), the Order's reference to "procedures" does not exclude procedures that require prescribing and administering medication in a hospital or clinic setting. Further, we do not agree that all "medication abortions and procedural abortions may continue under the Order." The Order applies broadly to all procedures, and no procedure is subject to a blanket exemption. Rather, one or more of the exceptions in the Order must be demonstrated on a case-by-case basis.

A copy of the letter is attached as Exhibit 6.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 22, 2020.

/s/ *Loree Stark*
Loree Stark

EXHIBIT 1

STATE OF WEST VIRGINIA

EXECUTIVE DEPARTMENT

At Charleston

EXECUTIVE ORDER NO. 16-20

By the Governor

WHEREAS, a State of Emergency was declared on the Sixteenth Day of March, Two Thousand Twenty for all counties in West Virginia (the "State of Emergency Declaration"), to allow agencies to coordinate and create necessary measures to prepare for and respond to the outbreak of respiratory discasc caused by a novel coronavirus now known as COVID-19; and

WHEREAS, Chapter 15, Article 5, Section 6 of the Code of West Virginia authorizes the Governor to, among other things, control ingress and egress to and from a disaster arca or an area where large-scale threat exists, the movement of persons within the area, and the occupancy of premises therein, and to perform and exercise other functions, powers, and duties that are necessary to promote and secure the safety and protection of the civilian population; and

WHEREAS, Executive Order 9-20 ordered, among other things, all individuals within the State of West Virginia to stay at home or their place of residence unless performing an essential activity, which term "essential activity" included travel for certain medical care and treatment; and

WHEREAS, further measures are necessary to protect the health, safety, and welfare of the public, to disrupt the spread of the virus, and to mitigate the impact of COVID-19, including the prohibition of elective medical procedures throughout the state; and

WHEREAS, prohibiting elective medical procedures is necessary during this state of emergency to protect the public health, safety, and welfare by further limiting the movement of persons and occupancy of premises throughout the state, and by conserving limited medical personnel, personal protective equipment, and other necessary medical equipment and supplies in light of existing and anticipated treatment needs for COVID-19 paticnts.

NOW, THEREFORE, I, JIM JUSTICE, pursuant to the authority vested in me pursuant to the provisions of Chapter 15, Article 5, Section 6 and Chapter 15, Article 5, Section 1 of the Code of West Virginia, hereby **DECLARE** and **ORDER**, effective as of 12:00 AM, Eastern Standard Time, on the First day of April, Two Thousand Twenty, that all elective medical procedures are hereby prohibited; provided that patients will still have access to urgent, medically necessary procedures like those needed to preserve the patient's life or long-term health; and provided that this prohibition applies equally to all types of elective medical procedures performed in hospitals, offices, and clinics throughout the state. The term "elective" includes medical procedures that are not immediately medically necessary to preserve the patient's life or long-term health, except that procedures that cannot be postponed without compromising the patient's long-term health, procedures that cannot be performed consistent with other law at a later date, or procedures that are religiously mandated shall not be considered "elective" under this Order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of West Virginia to be affixed.

DONE at the Capitol in the City of Charleston, State of West Virginia, this Thirty-first day of March, in the year of our Lord, Two Thousand Twenty in the One Hundred Fifty-seventh year of the State.

GOVERNOR

By the Governor

SECRETARY OF STATE

EXHIBIT 2

P O Box 3952
Charleston WV 25339-3952

(304) 345-9246
www.acluwv.org

April 1, 2020

Bill J. Crouch, MPH
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100 East
Charleston, WV 25301
sent via email: dhhrsecretary@wv.gov

Kishore K. Challa, MD, FACC
West Virginia Board of Medicine
101 Dee Dr., Suite 103
Charleston, WV 25311
sent via email to be forwarded upon receipt: Mark.A.Spangler@wv.gov

Dear Mr. Crouch and Dr. Challa,

The ACLU of West Virginia represents Women's Health Center of West Virginia ("WHC"), a licensed outpatient clinic in Charleston providing a range of reproductive health services, including medication and procedural abortion care. We seek to confirm our understanding of the impact of Executive Order No. 16-20 (Mar. 31, 2020), on the clinic and its patients. As you know, this Order took effect a few hours ago, at midnight.

We note at the outset that WHC shares the Governor's commitment to reducing the spread of COVID-19 and protecting the health and safety of both patients and healthcare workers while continuing to ensure access to essential health services. To that end, WHC has already taken significant measures, consistent with public health guidelines, to mitigate this public health emergency—such as screening patients for COVID-19 upon arrival, imposing strict social distancing measures, and barring visitors.

The Executive Order bans "elective procedures," which it defines as "medical procedures that are not immediately medically necessary to preserve the patient's life or long term health." It specifies that "procedures that cannot be postponed without compromising the patient's long-term health, procedures that cannot be performed consistent with other law at a later date, or procedures that are religiously mandated shall not be considered 'elective.'"

We believe that the abortions WHC provides may continue under the Order. First, because medication abortions entail the prescription and dispensing of two medications and are thus not "procedures," they do not fall within the terms of the Order. Second, we believe that abortion procedures fall within the Order's exceptions. As you may know, the American College of Obstetricians and Gynecologists, along with numerous other well-respected medical associations, issued a statement on March 18, 2020, on Abortion Access During the COVID-19 Outbreak. The medical groups stated:

> To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic,

> abortion should not be categorized as such a procedure. It is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.[1]

We further note that because West Virginia law severely restricts second-trimester abortion, *see* W. Va. Code §§ 16-2O-1, 16-2M-4, abortion is *always* a service that "cannot be performed consistent with other law at a later date," once a patient has been forced past a certain number of weeks of pregnancy.

Please confirm by 4:00 ET today that you agree that both medication abortions and procedural abortions may continue under the Order, and that you do not intend to enforce the Order against WHC based on its provision of abortion services.

Sincerely,

Loree Stark
Legal Director
ACLU of West Virginia
lstark@acluwv.org
cell: 914-393-4614

[1] Am. Coll. of Obstetricians & Gynecologists, Am. Board of Obstetrics & Gynecology, Am. Ass'n of Gynecologic Laparoscopists, Am. Gynecological & Obstetrical Soc'y, Am. Soc'y for Reprod. Med., Soc'y for Acad. Specialists in Gen. Obstetrics & Gynecology, Soc'y of Fam. Plan., and Soc'y for Maternal-Fetal Med., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

EXHIBIT 3

State of West Virginia
Board of Medicine

101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
Fax (304) 558-2084
www.wvbom.wv.gov

KISHORE K. CHALLA, MD, FACC
PRESIDENT

CATHERINE C. SLEMP, MD, MPH
SECRETARY

ASHISH P. SHETH, MD
VICE PRESIDENT

MARK A. SPANGLER, MA
EXECUTIVE DIRECTOR

April 1, 2020

VIA EMAIL
Loree Stark, Legal Director
ACLU of West Virginia
PO Box 3952
Charleston, WV 25339-3952
lstark@acluwv.org

Re: Executive Order 16-20

Dear Ms. Stark:

On behalf of the West Virginia Board of Medicine, I write in response to your correspondence of earlier today regarding the above-referenced gubernatorial Executive Order. The West Virginia Board of Medicine is the state agency charged with protecting the health and safety of the public through licensure, regulation and oversight of medical doctors (MDs), podiatric physicians (DPMs), and collaborating physician assistants (PAs).

On March 16, 2020, Governor Justice, declared a State of Emergency to address the COVID-19 pandemic. During the declared state of emergency, the Board has been focusing its efforts on facilitating protection of the public by encouraging provider surge, sharing information regarding temporary regulation suspensions and COVID-19 with licensees, and reducing regulatory strain on providers and patients during these difficult times.

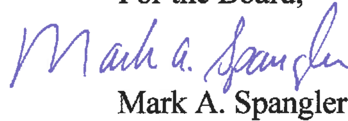
Throughout the course of the State of Emergency to date, there has been significant fluidity in terms of the roll-out of regulation suspension and COVID-19 response information. The Board strives to provide current information as soon as regulatory guidance becomes available from the appropriate parties. Earlier today, the Board provided the following information to its licensees regarding Executive Order 16-20:

> On March 31, 2020, Governor Justice executed two new Executive Orders that affect West Virginia providers. Executive Order 16-20 bans elective medical procedures in all practice settings, effective today. The Executive Order defines elective procedures as "medical procedures that are not immediately medically necessary to preserve the patient's life or long-term health, except that procedures

> that cannot be postponed without compromising the patient's long-term health, procedures that cannot be performed consistent with other law at a later date, or procedures that are religiously mandated shall not be considered 'elective'[.]" The Executive Order also provides that "patients will still have access to urgent, medically necessary procedures like those needed to preserve the patient's life or long-term health[.]" If additional information regarding the elective procedure ban is provided by the Governor's Office or the Bureau for Public Health, the Board will post the information on its COVID-19 webpage.

Thank you for your inquiry. Should you have additional questions regarding the applicability or interpretation of Executive Order 16-20, please consider reaching out to the West Virginia Bureau for Public Health.

For the Board,



Mark A. Spangler

EXHIBIT 4

P O Box 3952
Charleston WV 25339-3952

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April 1, 2020

Patrick Morrisey
State Capitol Complex, Bldg. 1, Room E-26
Charleston, WV 25305
sent via email: Patrick.J.Morrisey@wvago.gov; Vicki.L.Pendell@wvago.gov

Dear Attorney General Morrisey,

The ACLU of West Virginia represents Women's Health Center of West Virginia ("WHC"), a licensed outpatient clinic in Charleston providing a range of reproductive health services, including medication and procedural abortion care. We seek to confirm our understanding of the impact of Executive Order No. 16-20 (Mar. 31, 2020), on the clinic and its patients. As you know, this Order took effect a few hours ago, at midnight.

We note at the outset that WHC shares the Governor's commitment to reducing the spread of COVID-19 and protecting the health and safety of both patients and healthcare workers while continuing to ensure access to essential health services. To that end, WHC has already taken significant measures, consistent with public health guidelines, to mitigate this public health emergency—such as screening patients for COVID-19 upon arrival, imposing strict social distancing measures, and barring visitors.

We watched Governor Justice's media briefing on COVID-19 today, April 1, 2020. We agree with the statement you made during that briefing that Executive Order No. 16-20 applies to abortion facilities, as it applies to all health care facilities. The Executive Order bans "elective procedures," which it defines as "medical procedures that are not immediately medically necessary to preserve the patient's life or long term health." It specifies that "procedures that cannot be postponed without compromising the patient's long-term health, procedures that cannot be performed consistent with other law at a later date, or procedures that are religiously mandated shall not be considered 'elective.'"

We believe that the abortions WHC provides may continue under the Order. First, because medication abortions entail the prescription and dispensing of two medications and are thus not "procedures," they do not fall within the terms of the Order. Second, we believe that abortion procedures fall within the Order's exceptions. As you may know, the American College of Obstetricians and Gynecologists, along with numerous other well-respected medical associations, issued a statement on March 18, 2020, on Abortion Access During the COVID-19 Outbreak. The medical groups stated:

> To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure. It is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible. The consequences

of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.[1]

We further note that because West Virginia law severely restricts second-trimester abortion, *see* W. Va. Code §§ 16-2O-1, 16-2M-4, abortion is *always* a service that "cannot be performed consistent with other law at a later date," once a patient has been forced past a certain number of weeks of pregnancy.

Please confirm by 5:00 ET today that you agree that both medication abortions and procedural abortions may continue under the Order, and that you do not intend to enforce the Order against WHC based on its provision of abortion services.

Sincerely,

Loree Stark
Legal Director
ACLU of West Virginia
lstark@acluwv.org
cell: 914-393-4614

[1] Am. Coll. of Obstetricians & Gynecologists, Am. Board of Obstetrics & Gynecology, Am. Ass'n of Gynecologic Laparoscopists, Am. Gynecological & Obstetrical Soc'y, Am. Soc'y for Reprod. Med., Soc'y for Acad. Specialists in Gen. Obstetrics & Gynecology, Soc'y of Fam. Plan., and Soc'y for Maternal-Fetal Med., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

EXHIBIT 5

State of West Virginia
Office of the Attorney General

Patrick Morrisey
Attorney General

(304) 558-2021
Fax (304) 558-0140

April 1, 2020

Loree Stark
Legal Director
ACLU of West Virginia
PO Box 3952
Charleston, WV 25339
Via e-mail to lstark@acluwv.org

Dear Ms. Stark,

I am in receipt of your letter and will discuss it with the relevant regulatory agency tomorrow. We will respond by tomorrow at 3:00 p.m.

Sincerely,

Patrick Morrisey
Attorney General

EXHIBIT 6

State of West Virginia
Office of the Attorney General

Patrick Morrisey
Attorney General

(304) 558-2021
Fax (304) 558-0140

April 2, 2020

Loree Stark, Legal Director
ACLU of West Virginia
PO Box 3952
Charleston, WV 25339-3952

Dear Ms. Stark:

Our Office provides the following information in further response to your April 1, 2020 letter. After consultation with the Governor's office, as the office which issued Executive Order No. 16-20 ("Order"), the Order's reference to "procedures" does not exclude procedures that require prescribing and administering medication in a hospital or clinic setting. Further, we do not agree that all "medication abortions and procedural abortions may continue under the Order." The Order applies broadly to all procedures, and no procedure is subject to a blanket exemption. Rather, one or more of the exceptions in the Order must be demonstrated on a case-by-case basis.

Sincerely,

Patrick Morrisey
West Virginia Attorney General

State Capitol Building 1, Room E-26, 1900 Kanawha Boulevard East, Charleston, WV 25305

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

WOMEN'S HEALTH CENTER OF WEST VIRGINIA,

Plaintiff,

v.

PATRICK MORRISEY *et al.*,

Defendants.

Civil Action No.

Hon.

DECLARATION OF COY FLOWERS, MD, FACOG, IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Coy Flowers, MD, FACOG, declare and state as follows:

1. I am a board-certified obstetrician-gynecologist (Ob/Gyn) licensed to practice in West Virginia, with nearly 20 years' experience providing comprehensive reproductive health care to women, including referring patients for abortion care. I graduated from West Virginia University School of Medicine in 1998; completed my internship at the National Naval Medical Center in Bethesda, Maryland in 1999; and completed my residency at the National Capital Consortium Residency in Ob/Gyn at the National Naval Medical and Walter Reed Army Medical Centers in Bethesda, Maryland, and Washington, DC in 2002.

2. From 2002 to 2005, I was Lieutenant Commander & Staff Physician at the United States Naval Hospital in Camp Lejeune, North Carolina. From 2006 through 2019, I was in a private practice in Ronceverte, West Virginia. Over the last 15 years, I have held several faculty appointments at West Virginia medical schools.

3. I am a Fellow of, and am currently Chair of the West Virginia Section of, the American College of Obstetricians and Gynecologists ("ACOG"), the nation's pre-eminent authority on health care for women. I am also an ACOG delegate to the American Medical Association. From 2018–2019, I was President of the West Virginia State Medical Association. I have also served on the West Virginia Department of Health and Human Services Maternal-Infant Advisory Committee. I submit this declaration in my personal capacity, and not on behalf of any of the institutions with which I am affiliated. My *curriculum vitae*, which more fully sets forth my experience and credentials, is attached as Exhibit 1.

4. The facts I state here are based on my personal experience, information, and the personal knowledge I have obtained in the course of my duties as Chair of the West Virginia Section of ACOG, President of the West Virginia State Medical Association, and in my private Ob/Gyn practice. The opinions in this declaration are my expert opinions as an Ob/Gyn. My expert opinions are based on my education, training, professional experience, and review of relevant medical literature. All of my opinions in this declaration are expressed to a reasonable degree of medical certainty. If called and sworn as a witness, I could and would testify competently thereto.

5. I submit this declaration in support of the motion of Plaintiff Women's Health Center of West Virginia ("WHC") for a temporary restraining order and preliminary injunction. I am familiar with the Order. Abortion qualifies as urgent, medically necessary care, and as care that cannot be postponed without compromising long-term health. Nonetheless, I understand that to comply with the Order, WHC must deny care to most patients seeking abortion unless and until the patient is nearing ineligibility for medication abortion (approximately 11 weeks in pregnancy) or procedural abortion (approximately 16 weeks in pregnancy). As a result, patients

will be forced to remain pregnant for up to six, or in some cases eleven, weeks, causing them serious and irreparable harm.

6. Moreover, because patients remain pregnant when they are denied timely abortion, prohibiting timely abortions runs contrary to the purpose the Governor stated in the Order: reducing transmission of the virus and preserving medical resources and equipment during the pandemic. That is because even though providing abortion care involves some risk of exposure to the virus and uses some medical resources, both of which providers take steps to minimize, this exposure and use is not reduced by forcing patients to remain pregnant. In fact, forcing patients to remain pregnant means that they will face increased exposure to the inherent risks of pregnancy complications, including miscarriage, which often can lead to the need for further medical care and hospital resources. Thus, prohibiting timely procedures will result in patients facing higher risk of virus exposure and using more medical resources than if the patient had obtained an earlier abortion. The result of delaying an abortion is not that the patient uses no medical resources, it is that the patient remains pregnant and potentially uses *more* medical resources.

Legal Abortion in the United States and West Virginia

7. Legal abortion is one of the safest medical procedures in the United States and is substantially safer than continuing a pregnancy through to childbirth.[1] Abortion-related emergency room visits constitute just 0.01% of all emergency room visits among women of

[1] Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77–78, 162–63 (2018).

reproductive age in the United States.[2] Abortion is also extremely common; approximately one in four women in this country will have an abortion by age forty-five.[3]

8. The risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion, and every pregnancy-related complication is more common among patients giving birth than among those having abortions.[4] Just as in many states throughout our country, West Virginia women experience a higher risk of both morbidity and mortality during pregnancy due to increased rates of chronic medical diagnoses such as diabetes and hypertension, as well as obesity.

9. There are two main methods of abortion: medication abortion and surgical (or procedural) abortion. Both methods are safe, effective means of terminating a pregnancy.[5] Medication abortion involves a combination of two pills: mifepristone and misoprostol.[6] The patient takes the mifepristone and then, typically 24 to 48 hours later, takes the misoprostol at a location of their choosing, most often at their home, after which they expel the contents of the uterus in a manner similar to a miscarriage. Medication abortion is neither a "surgery" nor a "procedure." Medication abortion is generally available up to 10–11 weeks, as measured from a patient's last menstrual period ("LMP").

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[2] Ushma Upadhyay et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16:88BMC Med. 1, 1 (2018).
[3] *See* Guttmacher Inst., *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (Oct. 19, 2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.
[4] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (Feb. 2012).
[5] Luu Doan Ireland *et al*., *Medical Compared With Surgical Abortion for Effective Pregnancy &*
[6] Nat'l Acads., *supra* note 1, at 51.

10. For some patients, medication abortion is contraindicated, and/or there are factors that counsel in favor of a procedural abortion, including patients with medical conditions that make procedural abortion a safer and/or more appropriate course.[7] Contraindications for medication abortion include confirmed or suspected ectopic pregnancy, intrauterine device in place, current long-term systemic corticosteroid therapy, chronic adrenal failure, known coagulopathy or anticoagulant therapy, and intolerance or allergy to mifepristone.[8] Most clinical trials also have excluded women with severe liver, renal or respiratory disease, or uncontrolled hypertension or cardiovascular disease (angina, valvular disease, arrhythmia, or cardiac failure).[9] Women are also not good candidates for medication abortion if they are unable or unwilling to adhere to care instructions, require quick completion of the abortion process, are not available for follow-up contact or evaluation, or cannot understand the instructions because of language or comprehension barriers.[10]

11. Surgical abortion, despite that name, is not what is commonly understood to be "surgery"—it involves no incision. For that reason, it is also called procedural abortion. In the first and early second trimester, procedural abortions are generally performed using the suction curettage technique, also called aspiration abortion, which involves using a curette connected to a suction apparatus to gently empty the contents of the uterus. This procedure typically takes five to ten minutes. My understanding is that in West Virginia, all outpatient abortion services are either medication abortion or aspiration procedures, and that there are no or almost no abortions are reported after 16–17 weeks LMP. Nationally, later in pregnancy, abortions are generally

[7] Nat'l Acads., *supra* note 1, at 51–52.
[8] ACOG, *Medical Management of First-Trimester Abortion* at 6, Practice Bulletin No. 143 (Mar. 2014).
[9] *Id.*
[10] *Id.*

performed using a method called dilation and evacuation ("D&E"), in which clinicians dilate the cervix further and use instruments as well as suction to empty the uterus.

12. In 2016, the latest year for which the CDC reports data, there were approximately 1400 abortions in West Virginia, of which 61% occurred at or before 8 weeks of pregnancy; 33% occurred at 9–13 weeks; 4% occurred at 14–15 weeks; 2% occurred at 16–17 weeks; and none were reported after 17 weeks.[11]

13. Over my many years of practice, I have routinely referred patients seeking abortion care to safe abortion providers, including WHC, the state's sole abortion clinic. I know that my patients have multiple reasons for deciding to end a pregnancy, and that they take the decision extremely seriously. They often speak of their careful consideration of how to proceed with the pregnancy, and the extreme stress and burdens that lead them to decide to have an abortion. They often include in their decision process not just me, but also their family and their pastor. Many tell me they have prayed on the issue. Many lack money and financial support of any kind. National statistics show that 75% of patients who seek abortions are poor or low-income.[12] Historically, half my patients have accessed health care through the Medicaid system. Patients who decide to have an abortion also often lack family and personal support systems to help them raise a child, or to expand their family with another child, at that time in their lives. They describe being at their limit in terms of the people they are already supporting, whether that means their existing children (a majority of women having abortions in the United States already

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[11] Tara C. Jatlaoui, Lindsay Eckhaus, Michele G. Mandel *et al.*, Abortion Surveillance — United States, 2016. MMWR Surveill. Summ Nov. 29, 2019; 68(No. SS-11): at 26 Table 7, https://www.cdc.gov/mmwr/volumes/68/ss/pdfs/ss6811a1-H.pdf.

[12] Jerman J, Jones RK and Onda T, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.

have at least one child[13]) and/or other family members, including parents. Still others choose abortion for medical reasons that would put their health in particular jeopardy were they to remain pregnant and give birth.[14]

14. Once they decide to seek abortion care, my patients try to access it as quickly as they can, but many of them, especially those with low incomes, face great obstacles in obtaining that care.

a. First, some patients do not discover they are pregnant until later in their pregnancies. Adolescent patients in particular often simply do not recognize the signs of pregnancy, and may deny the signs if their family circumstances lead them to feel ashamed. Some patients experience shame over the sexual assault through which they became pregnant—whether by a stranger, a date, or a family member—and their shame can obstruct their recognition of the pregnancy.

b. Second, many of my patients face logistical obstacles that can delay access to abortion care. Lack of money, transportation, and childcare are huge obstacles. West Virginia's road system is difficult even for patients with decent cars, but for patients with vehicles in poor condition, or no vehicle, having to travel many miles to WHC or an out of state clinic is daunting—

[13] Guttmacher Inst., Induced Abortions in the United States 1 (Sept. 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; *see also* Jenna Jerman *et al.* , *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. 6, 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[14] M. Antonia Biggs *et al.*, *Understanding Why Women Seek Abortions in the US*, 13:29 BMC Women's Health 1, 7 (2013).

and greatly delays their abortions—or even prohibitive. Adolescent patients may delay seeking care because they fear discovery and retribution, sometimes violent, by family members. Working poor patients, who lack access to Medicaid and cannot afford health insurance, often apply for Medicaid once pregnant, and are delayed as much as 4–8 weeks in obtaining their Medicaid cards. That card allows them to visit an Ob/Gyn when they can get a day off work (often without pay), but it does not cover abortion, which many of them do not realize. They are then in the position of having to take off another (often unpaid) day from work, and to raise funds to pay for a later, and therefore more expensive, abortion, and to pay for transportation to a distant clinic, as well as child care as needed.[15]

15. These obstacles are even greater during the COVID-19 crisis. So many West Virginians have lost their jobs or large portions of their paid work. Because schools are closed, school-hours childcare that patients had counted on is now gone. The crisis has also made it more difficult and riskier to access what little public transportation that exists in West Virginia.

16. As ACOG and other well-respected medical professional organizations have observed, abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the

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[15] Sarah E. Baum *et al.*, *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer *et al.*, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

risks [to patients] or potentially make it completely inaccessible."[16] That is why ACOG and other preeminent medical authorities advise: "To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure."[17] That statement is attached as Exhibit 2.

17. On April 4, 2020, the World Health Organization ("WHO") issued a similar statement concluding that "[a]bortion is considered an essential service during the corona virus pandemic" and that "services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak."[18]

18. The American Medical Association ("AMA")—the country's largest medical organization and one of its foremost authorities on medical and public health matters—concurs with this conclusion. The AMA's March 30, 2020 Statement on Government Interference in Reproductive Health Care disapproves of efforts "to ban or dramatically limit women's reproductive health care" during the COVID-19 outbreak by "labeling procedures as 'nonurgent.'"[19]

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[16] ACOG *et al.*, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak, attached as Exhibit 2.

[17] *Id.*

[18] Mary Margaret Olohan, *World Health Organization: Abortion Is 'Essential' During Coronavirus Pandemic*, Daily Caller, Apr. 4, 2020, https://dailycaller.com/2020/04/04/who-abortion-essential-coronavirus-covid-19/ (summarizing the WHO's statement).

[19] Am. Med. Ass'n, *AMA statement on government interference in reproductive health care*, Mar. 30, 2020, https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care.

Consequences of Delaying Abortion Care

19. For many patients and their families, at many times in their lives, a pregnancy is a profound joy and a blessing. Nonetheless, even an uncomplicated pregnancy poses challenges to a woman's entire physiology and stresses most major organs. From the onset of pregnancy, every patient is at risk of complications, which is why physicians encourage prenatal evaluation as early as possible.

20. During pregnancy, a woman's lungs must work harder to clear both the carbon dioxide produced by her own body and the carbon dioxide produced by the embryo or fetus. Yet her ability to breathe is hampered by the pregnancy growing in her abdomen, putting pressure on her lungs from below, leaving many, if not most, patients feeling chronically out of breath. If the shortness of breath or other pulmonary symptoms reach a certain level of severity, the patient may seek medical evaluation. Because such symptoms are not dissimilar from the symptoms of COVID-19, patients may be more likely to seek urgent or emergent care for these symptoms during the COVID-19 crisis and healthcare providers treating these patients will take the increased precautions, including use of increased personal protective equipment ("PPE"), that are necessary when treating suspected COVID-19 patients.

21. Pregnant patients are very likely to experience gastrointestinal symptoms like increased nausea and vomiting. These symptoms can occur throughout pregnancy, but often start early in pregnancy. In the most severe cases, patients can experience hyperemesis gravidarum, which occurs where the patient's nausea and vomiting are so severe that she becomes dehydrated. Patients experiencing this may require an IV to rehydrate and receive medication.

22. During pregnancy the patient's heart rate increases in order to pump 30–50% more blood. Starting in the second trimester and throughout the third, the heart is working 50%

harder than usual. Because of the increased blood flow, a woman's kidneys become enlarged and the liver must produce more clotting factors to prevent the woman from bleeding to death. However, this latter change increases the risks of blood clots or thrombosis. Patients may experience increased leg pain or leg swelling that leads them to seek medical evaluation.

23. Patients who suffer from chronic conditions including asthma, diabetes, hypertension, gallbladder disease, immunological conditions, thyroid disease, lung disease and diagnosed or undiagnosed cardiac conditions are more likely to experience symptoms that will lead them to seek medical evaluation early in pregnancy. While some patients might be aware of their preexisting conditions and seek nonurgent evaluation, other patients (particularly those who have never been pregnant) might not be aware that they have preexisting conditions and only seek care when their symptoms become urgent or emergent.

24. Although abortion is an extremely safe medical procedure, the health risks associated with it increase as pregnancy advances.[20] The risk of death associated with abortion increases as pregnancy progresses—increasing 38% each week.[21] The risk of death is lowest earlier in pregnancy: 0.3 per 100,000 abortions at eight weeks or less, 0.5 at 9–13 weeks, 2.5 at 14–17 weeks, and 6.7 at 18 weeks and greater. Thus, the mortality risk at 14–17 weeks is more than eight times greater than at eight weeks or less.[22] Delaying an abortion by a week in the second trimester significantly increases the mortality risk. Accessing abortion as early in pregnancy as possible is the single most important factor for ensuring the safety of abortion.

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[20] Nat'l Acads., *supra* note 1, at 77–78, 162–63.

[21] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 731 (2004).

[22] Suzanne Zane et al., *Abortion-Related Mortality in the United States 1998–201*0, 126(2) Am. J. Obstetrics & Gynecology 258, Table 2 (2015)

25. Complications from abortion are likewise rare, but the risks of complications increase as pregnancy advances. When complications do occur, they can usually be managed in an outpatient clinic setting, most likely at the time of the abortion, or, if not then, in a follow-up visit. Complications occur in 1.26% of first-trimester surgical abortions and 1.47% of second-trimester cases.[23] Major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester in-clinic abortion cases, and in 0.41% of in-clinic cases in the second trimester or later.[24] Major complications occur nearly twice as frequently in second-trimester abortions as in first-trimester abortions.

26. While the risk of abortion-related mortality and morbidity is very low, there is no way to know in which patients those risks will materialize and cause harm. Because, statistically, the risks associated with abortion increase with each week of pregnancy, a provider forced to select certain patients to delay would be needlessly increasing the risks to patients' physical safety.

27. Health care providers must be able to use their medical judgment to determine whether a patient's abortion can be delayed. Indeed, even prior to the pandemic, we use our medical training, experience, and professional guidance, as well as patient-specific considerations—including not only her physical health but also psychosocial factors—to inform our recommendations to patients. The same is no less true during this crisis.

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[23] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecol. 177 (2015).

Lack of Medical Justification for the Order

28. There is no medical justification for the assertion that delaying abortions will minimize COVID-19 transmission or preserve medical resources including PPE. That is because a patient who desires an abortion but cannot get one remains pregnant, and will thus require much more contact with the health care system and use of many more medical resources, including PPE.

29. The vast majority of abortions take place in outpatient settings. Abortion care in general does not require a sterile field and does not use extensive PPE, and that is certainly true of the early medication abortions and aspiration abortions available at WHC.

30. Neither medical nor procedural abortion preformed at the clinic requires extensive PPE. Medication abortion requires almost no PPE at all and administering the medication requires minimal clinician-patient contact. Aspiration abortions requires some PPE and greater patient contact, but still far less than the patient would need if the patient needed pregnancy-related or emergency medical care.

31. I am familiar with the PPE protocol for abortion treatments because I have long provided the same treatments for patients suffering from early uncomplicated miscarriage: prescribing a patient pills to empty the uterus, or performing a suction curettage (aspiration). In either scenario—abortion or miscarriage—the use of PPE is the same. Although treating miscarriage uses greater medical resources than an induced abortion, under the standard of care across West Virginia, N-95 masks would not be used for either abortion or miscarriage. It is the N-95 masks that are in critically short supply right now. In addition, WHC services are all outpatient and use no hospital resources, staff, supplies, or beds, and certainly no intensive care unit (ICU) beds. They use no ventilators.

32. An abortion at WHC requires a single in-person visit to the clinic. Patients with continuing pregnancies require *significantly* more interaction with the health care system and more PPE. Pregnant patients routinely go to the hospital for evaluation multiple times. Each time they do, they interact with hospital staff and increase the use of PPE.

33. A substantial proportion of pregnant women present to the emergency department at least once before delivery.[25] In one recent study of young, low-income pregnant women, 49% visited the emergency department at least once, and 23% visited twice or more.[26] Patients with comorbidities, such as asthma, obesity, or diabetes, are significantly more likely to seek emergency care.[27] West Virginians experience increased rates of chronic medical diagnoses such as diabetes, hypertension, and obesity. Patients with unplanned pregnancies or without an obstetrician are more likely to present to the emergency department for urgent and non-urgent care.[28]

34. ACOG and the Society for Maternal Fetal Medicine recommend that pregnant patients who are at "elevated risk"—that is, those who have severe symptoms consistent with COVID-19—should immediately seek care in the emergency department or an equivalent unit that treats pregnant women.[29] When seeing these patients in the emergency department, health care providers will use the appropriate amount of PPE for a suspected COVID-19 patient.

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[25] Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 26 Acad. Emergency Med. 940, 942 (2017).
[26] *Id.* at 941.
[27] *Id.* at 942.
[28] Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, 216 Am. J. Obstetrics & Gynecology 181.e1 at 5 (2017).
[29] ACOG & Soc'y for Maternal Fetal Med., *Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Apr. 10, 2020),

35. Pregnant patients also commonly miscarry at various points in pregnancy. Approximately 17% of pregnancies end in miscarriage.[30] Treatment for uncomplicated miscarriage is similar to abortion care but becomes much more involved the later in pregnancy the miscarriage occurs, which would require more intensive care and, therefore, more interaction with the medical system and consumption of resources, including PPE. Patients miscarrying regularly seek hospital care and often make multiple visits to hospitals, as, for example, they bleed outside office hours, get sent home, return if their symptoms worsen, and so forth.

36. Patients who carry to term and deliver will require extensive PPE. Pregnancy generally lasts 38 weeks (40 LMP). Though providers are encouraged to maximize the use of telehealth appoints during the COVID-19 pandemic, an *uncomplicated* pregnancy generally requires at least one prenatal appointment per month, and additional appointments for laboratory tests and ultrasounds. Any in-person encounter with a medical provider entails the use of gloves, a face mask, and other PPE. For a complicated or high-risk pregnancy, the number of visits can double. During each visit, the clinician will wear at least gloves and, during the COVID-19 crisis, may also wear a mask. During an actual birth, almost all of which occur in hospitals in West Virginia, multiple medical providers attend the patient, including nursery personnel, a labor and delivery nurse, an OB tech, a physician, and an anesthesiologist. That care requires *multiple* gowns, masks, and sterile gloves. A patient with an uncomplicated pregnancy remains in the

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https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf.

[30] Stephanie J. Ventura et al., Estimated Pregnancy Rates and Rates of Pregnancy Outcomes for the United States, 1990–2008, National Vital Statistics Reports, National Vital Statistics Reports Vol. 60, No. 7 at 2 & 4 (June 20, 2012), available at https://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf. ("The proportion of pregnancies ending in fetal losses [as opposed to live births or induced abortions] was 17 percent in 2008 compared with 15 percent in 1990").

hospital 24–48 hours for a vaginal birth and 72–96 hours for a cesarean section ("c-section"). Vaginal deliveries are safer than c-sections, but can nonetheless lead to injuries, such as injury to the pelvic floor. One third of West Virginia births are c-sections, a significant abdominal surgery that carries risks of hemorrhage, infection, and injury to internal organs. A patient who goes into labor with an already complicated pregnancy may remain in the hospital even longer—requiring yet more time in a hospital bed, more attention of hospital staff, and more PPE.

37. My career involves prenatal and labor and delivery care, and during this time, we must provide that care to patients who are pregnant and give birth. But for patients who are desperate *not* to be pregnant, we need to respect their decisions. We must not pretend that forcing them to remain pregnant in any way mitigates COVID-19 transmission or preserves medical resources and PPE. On the contrary, forcing patients who want an abortion to remain pregnant would increase their health risks—from unwanted pregnancy and from increased exposure to the risk of COVID-19 in hospital visits.[31] It would also greatly expand demands on clinicians and PPE.

Harms to Patients

38. The Order has no end date and will apply throughout the COVID-19 emergency.

39. Under the Order, the vast majority of patients will be forced to wait weeks, some months, to obtain an abortion in West Virginia. In addition to the increased medical risks of remaining pregnant described above, remaining pregnant will entail increased financial costs and stress.

[31] Nat'l Acads., *supra* note 1, at 77–78; Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women* (last updated Mar. 16, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html.

40. Forcing patients who want abortions to remain pregnant would cruelly impose even greater anxiety on patients during the COVID-19 crisis. They may, with justification, fear that their hospital visits and other pregnancy-related medical care will expose them to COVID-19, which they would then bring home to their children, parents, and other family members.

41. Forcing a patient to remain pregnant will cause emotional and psychological harm to patients. Once a patient has decided to terminate her pregnancy, being forced to wait an unknown period of time can be stressful. This is especially true for patients who lack social support or have underlying psychosocial conditions.

42. For patients whose pregnancies are the result of episodes of violence, including those who have been raped or assaulted, being forced to carry an unwanted pregnancy for weeks is an unconscionable burden.

43. Prohibiting timely abortion care may also compromise the patient's privacy. As described above, patients will most likely be experiencing increased nausea and vomiting as the pregnancy progresses. These symptoms are difficult to hide, especially if they become severe enough to result in dehydration. Patients might experience symptoms of miscarriage, which can also be difficult to hide. Further, at about ten to twelve weeks of pregnancy, the uterus goes from being a pelvic organ to an abdominal organ, thus around this time the pregnancy will start showing.

44. Further, limiting abortion to two small windows will likely result in some patients being denied care entirely. As I described above, many patients, especially those with low incomes, already face extreme difficulty in accessing care. The constellation of obstacles that are inherent to poverty in West Virginia—including lack of transportation, support, and childcare—make it difficult for patients to access care at any point in pregnancy. Restricting access to

abortion to two very specific points in pregnancy adds yet another hurdle that some patients will not be able to overcome.

45. Even if the COVID emergency ends sooner than expected, patients will have suffered greatly increased health risks and much added psychological distress from the weeks of pregnancy they were forced to endure.[32] Further, because WHC is the only clinic in the state, patients will be delayed in obtaining care after the Order is lifted because one clinic will simply not have the capacity to immediately meet the pent-up demand that accrued while the Order was in place.

46. The vast majority of patients seeking timely abortion care will be forced to travel out of state, if they have the resources to do so. As described above, travel is always a great burden, especially to patients with low incomes, and those burdens are heightened because of COVID-19. Today, travel is harder, is more expensive, takes longer, and entails the risk of exposure to the virus. Travel will also delay care, pushing some patients past point at which they can have a suction aspiration abortion. Those patients, if they can access care at all, would have to have a more complicated procedure, a D&E, which carries a higher risk than an aspiration abortion, and is often a two-day procedure; it would therefore entail greater risk of transmission of the virus and use of more medical resources.

47. Those patients who are unable to travel out of state and are unable to obtain care at WHC in the narrow windows imposed by the Order may remain pregnant against their will, as discussed above, or may seek to end their pregnancies outside the regulated medical setting, which can result in serious complications that necessitate urgent or emergent medical care. It is unthinkable that West Virginia would deny patients safe, legal care. The need for urgent hospital

[32] Nat'l Acads., *supra* note 1, at 77–78 (2018).

care for some of these patients will likewise increase pressure on our overburdened health care system.

48. Forcing patients to remain pregnant for of weeks, and in some cases months, is unconscionably cruel and unconscionably profligate with our medical resources during this COVID-19 crisis.

I declare under penalty of perjury that the foregoing is true and correct.

Executed April 24, 2020

/s Coy Flowers
Coy Flowers, MD, FACOG

EXHIBIT 1

COY A. FLOWERS, MD, FACOG

EMPLOYMENT

NOV 2006 – DEC 2019:	Greenbrier Physicians Inc., Obstetrics & Gynecology
NOV 2006 – Present:	West Virginia School of Osteopathic Medicine, Clinical Assistant Professor
JAN 2017 – Present:	Lincoln Memorial University-DeBusk College of Osteopathic Medicine, Clinical Assistant Professor
AUG 2005 – OCT 2006:	West Virginia University-Charleston Division, Department of Obstetrics & Gynecology, Assistant Professor Director, Women's Urinary Continence Center
JUL 2002 – AUG 2005:	United States Navy, Naval Hospital Camp Lejeune, North Carolina Lieutenant Commander & Staff Physician Division Head, The Women's Health Center for Cervical Dysplasia Division Officer, Outpatient Clinic Administration OBGYN GME Coordinator for Family Medicine Residency Program

EDUCATION

Residency	National Capital Consortium Residency in Obstetrics & Gynecology National Naval Medical Center, Bethesda, Maryland Walter Reed Army Medical Center, Washington, DC July 1999 – June 2002
Internship	National Naval Medical Center, Categorical Obstetrics & Gynecology Bethesda, Maryland July 1998 – June 1999
M.D.	West Virginia University School of Medicine Morgantown, West Virginia May 1998
B.A.	West Virginia University Eberly College of Arts & Sciences Summa Cum Laude & University Honors Scholar Graduate Major: Biology Minors: Chemistry & Spanish May 1994

PROFESSIONAL ORGANIZATIONS & COMMITTEES

Fellow, American College of Obstetrics & Gynecology (ACOG), 2005-Present
- ACOG AMA Delegate 2019-Present
- District IV, West Virginia Section 2008-Present
  - WV Section Chair, 2019-Present
  - WV Section Vice Chair, 2016-2019
  - WV Section Legislative Chair, 2014-Present
  - District IV PSQI Committee, 2016-2019
  - District IV Legislative Committee, 2016-Present
  - Congressional Leadership Conference, 2015/2016/2017/2018/2020

Armed Forces District 2005-2008
Junior Fellow, ACOG, Armed Forces District, 2002-2004, Secretary-Treasurer, 2003-04
American Medical Association
West Virginia State Medical Association
President, 2018-2019
President-Elect, 2017-2018
Vice President, 2016-2017
Legislative Affairs Committee, 2006-Present
Greenbrier Valley Medical Society, President, 2008-Present
Greenbrier Valley Medical Center
Chair, Department of Surgery, 2010-2011, 2018-Present
Medical Executive Committee, 2010-2011, 2018-Present
Maternal/Infant Service Improvement Committee, 2006-Present
Peer Review Committee, 2007-2013
Graduate Education Committee, 2008-2012
Safety & Infection Control Committee, 2015-Present
Community Health Systems OB Collaborative Committee, 2017-Present
West Virginia State Perinatal Partnership
Chair, Maternity Care Shortage Committee, 2010-2012
Telecommunications in Rural Medicine Committee, 2007-2013
AIM Safety Bundles State Co-Chair, 2017-Present
West Virginia Department of Health and Human Services Maternal-Infant Advisory Committee

COMMUNITY & STATE ORGANIZATIONS

Fairness West Virginia - Founder, Board Member, Treasurer, and President
Greenbrier Valley Theatre - Board Member & Strategic Planning Committee
The Tutoring Center Foundation - Capital Campaign Committee, Chairman
G.R.O.W: Greenbrier Residents Outreach to the World - Board Member

AWARDS & HONORS

Robert C. Cefalo National Leadership Institute/ACOG, UNC Chapel Hill, March 2018
West Virginia Free Helaine Rotkin "Champion of Choice" 2014
West Virginia State Journal 2012 Generation Next Honoree, "Forty Under 40"
West Virginia Executive 2013 Young Gun
Uniformed Services University of the Health Sciences
Adjunct Instructor, 2003-2005
Clinical Teaching Fellow, 1999-2002
Outstanding Resident Teaching Award, 2000
Wyeth-Ayerst Resident Reporter Program, 2001
West Virginia University International Health Medicine Award, Zimbabwe, Africa
West Virginia University School of Medicine Class Officer, 1994-1996
West Virginia University Foundation Scholar & Honors Program
Phi Beta Kappa
Howard Hughes Research Fellow

EXHIBIT 2

Clinical | Mar 18, 2020

Joint Statement on Abortion Access During the COVID-19 Outbreak

The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, released the following statement:

“As hospital systems, clinics, and communities prepare to meet anticipated increases in demand for the care of people with COVID-19, strategies to mitigate spread of the virus and to maximize health care resources are evolving. Some health systems, at the guidance of the CDC, are implementing plans to cancel elective and non-urgent procedures to expand hospitals’ capacity to provide critical care.

“While most abortion care is delivered in outpatient settings, in some cases care may be delivered in hospital-based settings or surgical facilities. To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure. Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being.

“The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, do not support COVID-19 responses that cancel or delay

abortion procedures. Community-based and hospital-based clinicians should consider collaboration to ensure abortion access is not compromised during this time."

Topics Coronavirus COVID-19 Delivery of health care Health services accessibility Induced abortion Medical societies Obstetric surgical procedures Organizations Virus diseases Women's health services

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Apr 20, 2020

ACOG Releases Updated Guidance on Exercise in Pregnancy and Postpartum, Includes Recommendations for Athletes

Mar 26, 2020

Joint Statement on Elective Surgeries

Mar 16, 2020

ACOG Updates on Novel Coronavirus Disease 2019 (COVID-19)

Mar 6, 2020

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EXHIBIT C

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION**

WOMEN'S HEALTH CENTER OF WEST VIRGINIA,

Plaintiff,

v.

PATRICK MORRISEY *et al*.,

Defendants.

Civil Action No.

Hon.

**DECLARATION OF KATIE QUINONEZ
IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION FOR
A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION**

I, Katie Quinonez, declares as follows:

1. I am the Executive Director of Women's Health Center of West Virginia ("WHC"), a nonprofit corporation organized under the laws of the State of West Virginia, which is the plaintiff in this case. I have held this position since January 2, 2020. Prior to becoming Executive Director at WHC, I was the Development Director of WHC. I held that position from September 5, 2017 to January 1, 2020.

2. WHC is the only outpatient abortion clinic in West Virginia. It was also the first abortion clinic in West Virginia and has been providing safe, legal abortion in Charleston since 1976. WHC sues on behalf of itself, its staff, its physicians, and its patients.

3. As Executive Director, I am ultimately responsible for WHC's administrative, financial, and clinical operations. Thus, I am responsible for developing and implementing WHC's policies and procedures.

4. I submit this declaration in support of Plaintiff's motion for a temporary restraining order and a preliminary injunction.

5. Under Defendants' interpretation of the Governor of West Virginia's Executive Order 16-20 (the "Order"), abortions are only permitted when the patient is at or near the legal limit for obtaining medication abortion or at or near the limit for obtaining procedural abortion at WHC. Because abortion is time-sensitive care that cannot be delayed, in many cases even for a few days or weeks, this severe restriction is causing our patients irreparable harm.

6. The facts I state here are based on my experience, my review of WHC's business records, information obtained in the course of my duties at WHC, and personal knowledge that I have acquired through my service at WHC. If called and sworn as a witness, I could and would testify competently thereto.

WHC's Provision of Abortion Care

7. WHC performs medication abortion from 28 days (4 weeks) through 77 days (or 11 weeks) of pregnancy,[1] as measured from the first day of a patient's last menstrual period ("LMP") and procedural abortion from 4 weeks and 0 days through 16 weeks and 0 days LMP. WHC provides abortion services three days per week: Mondays, Wednesdays and Thursdays. On Mondays we provide only medication abortion. On Wednesdays and Thursdays we provide both medication abortions and procedural abortions. Under normal circumstances, patients who are

[1] WHC began providing medication abortion through 77 days or 11 weeks in October of 2019; prior to this date we provided medication abortion through 70 days or 10 weeks.

eligible for medication or procedural abortion can choose the procedure they prefer, but there are several reasons that a patient at or before 11 weeks may not be eligible for medication abortion. All procedural abortions at WHC use the aspiration abortion method. WHC does not use general anesthesia for any abortions.

8. WHC performed 1,144 total abortions in 2019. Of those, 466 were medication abortion and 678 were procedural abortion.

9. In the first three months of this year (January 1 through March 31, 2020), WHC has performed 283 abortions. Of those, 121 were medication abortions and 162 were procedural abortions.

10. WHC does not use and does not have in supply any N-95 masks. WHC does not use or possess any disposable protective eyewear.

11. Abortion care requires minimal use of personal protective equipment ("PPE"). For procedural abortions, only a small number of staff are in the procedure room and therefore in need of PPE. WHC clinicians use surgical masks, gowns, reusable protective eyewear, gloves, and shoe coverings. Only the physician uses sterile gloves. Consistent with current CDC guidelines, gloves are changed between patients; all other PPE is reused unless soiled.

12. Medication abortion requires even less PPE. Only two clinicians are involved in the administration of medication abortion and each uses only non-sterile gloves and masks. Consistent with current CDC guidelines, the gloves are changed between patients and the masks are reused unless soiled.

13. WHC patients seek abortion for a multitude of complicated and personal reasons. For example, some patients decide that it is not the right time in their life to have a child or to expand their family. Others desire more financial, professional, or familial stability before

having a child or additional children. Still others may have preexisting medical conditions that put them at higher than average risks of complications from continuing a pregnancy.

14. While our patients generally seek abortion as soon as they are able, many face logistical obstacles that can delay access to care. Some patients may not discover they are pregnant until later in their pregnancies, others may experience difficulties navigating the medical system, including finding a provider and scheduling an appointment.[2] Many WHC patients are also struggling financially, indeed approximately 40% have Medicaid as their health insurance. which covers the cost of abortion only under extremely limited circumstances.

15. The COVID-19 pandemic has exacerbated these constraints. As a result of COVID-19, and associated social distancing measures, patients have been laid off work or faced other work disruptions, placing them in precarious financial situations that make it even harder to afford an abortion and associated costs, on top of their cost of living. This crisis has also resulted in the closing down of schools in West Virginia and has imposed restrictions on childcare facilities which will make it even harder to arrange childcare and may make it more difficult or risky to access public transportation in order to travel to the clinic.

WHC's Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

16. WHC is committed to doing its part to reduce the spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

17. Since the COVID-19 outbreak, WHC has taken steps consistent with CDC and National Abortion Federation guidelines to preserve much-needed medical resources, including

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[2] Navigating this system is particularly confusing in West Virginia, where there is only one abortion provider and new federal law prohibits family planning providers in the Title X program (a federal program for those with low incomes) from helping their patients identify abortion providers.

PPE, that are in short supply during the pandemic and help prevent the spread of COVID-19 in our state. We are only offering time-sensitive and medically necessary care and have cancelled all routine appointments, including annual gynecological exams and pap smears, until further notice.

18. On March 12, I distributed a memo to all staff outlining the proactive steps WHC would take to reduce the risk of spread of COVID-19 among patients and staff. The memo is attached hereto as Exhibit 1.

19. Since then, we have taken several additional steps to reduce the spread of COVID-19. Although in normal times we welcome support people accompanying patients, we have decided not to allow such companions (except a parent or legal guardian accompanying a minor) to enter our health center in order to reduce the number of people in the clinic during the pandemic. We have also suspended our clinic escort program—through which volunteers help secure patient privacy and provide support and affirmation to patients as they navigate to the entrance of our clinic, which is often, even during this crisis, surrounded by anti-abortion protestors—to reduce, to the extent we can, the number of people in and around the clinic.

20. Patients are screened by phone for symptoms of COVID-19. If patients answer yes to any screening questions, they are referred to the West Virginia Department of Health or their primary care physician before they can schedule an appointment. At check-in, our staff again screens patients for symptoms and check them for fever.[3] Staff screening patients use gloves and a surgical mask. Only those individuals whose screen as negative can receive

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[3] Additionally, staff must report if they experience any symptoms of COVID-19. Consistent with CDC guidelines, staff experiencing symptoms must not return to work until 3 days after improvement in respiratory symptoms and the resolution of any fever (without the use of fever-reducing medications) and 7 days after the first appearance of symptoms.

services. We have also increased the frequency of sanitation of high touch areas and put up signage about how to decrease the spread of COVID-19.

21. We have made changes to the flow of patient care. While we normally have capacity to see up to 20 abortion patients per day, we have reduced the maximum number of abortions per day to 14, so that we can enforce social distancing.[4] We have rearranged the chairs in our waiting room to ensure appropriate space between patients and have made hand sanitizer, tissues, and trash cans readily available to patients in locations throughout the clinic.

WHC Compliance with Executive Order 16-20

22. Once aware of the Order—which became effective just hours after being released—WHC immediately began to assess how to best comply.

23. Because abortion is not an "elective procedure" and "cannot be postponed without compromising the patient's life or long-term health," our understanding was that they should continue under this Order. Further, because West Virginia restricts second-trimester abortion, abortion is a "procedure[] that cannot be performed consistent with other law at a later date." In addition, a medication abortion is not a "procedure" at all, and so our understanding was that it should continue under the Order for that reason as well.

24. To confirm our understanding of the Order, WHC sent letters to the Director of the West Virginia Department of Health and Human Resources ("DHHR"), the President of the Board of Medical Licensure, and the Attorney General, by and through our attorney Loree Stark,

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[4] Although WHC has decreased the number of abortions per day, the demand on WHC providers had actually increased prior to the Order. Normally, WHC has one physician who travels in from out of state to provide abortion care. Because of the increased risk of travel due to COVID-19, that provider is unable to travel to provide care and WHC's two remaining physicians were increasing their hours to compensate for the loss.

stating our intention to continue to perform abortions and our reasoning for why such procedures would be permitted under the Order.

25. The only responsive reply we received came from the Attorney General on April 2. He informed us of his position that medication abortions are "procedures" for the purposes of the Order and that some, if not most, abortions are prohibited under the Order.

26. It is well known that the West Virginia Attorney General is hostile towards abortion. Since the start of this public health crisis, he has signed on to several amicus briefs in support of states that have attempted to use the public health crisis to ban abortion. I understand that the Attorney General has enforcement authority over the Order. When asked about how the Order would impact the provision of abortion care in West Virginia, Governor Justice referred the question to the Attorney General.

27. Based on the Attorney General's response and in consultation with our medical director, WHC adopted a policy that conformed to the Attorney General's interpretation of the Order. Under this policy, abortion procedures can be performed when (1) the abortion is immediately medically necessary to preserve the patient's life or long-term health; (2) when the physician determines that a procedure cannot be postponed without compromising the patient's long-term health; (3) when the procedure cannot be performed consistent with law at a later date or (4) when the procedure is religiously mandated.

28. Because WHC typically does not perform abortions that are immediately medically necessary to preserve the patient's life or health or abortions that are religiously mandated, WHC has restricted abortion care to those patients who are at or near the legal limit for obtaining abortion in West Virginia and those patients for whom the Attorney General would deem unable to be postponed without compromising the patient's long-term health.

29. Medication abortion cannot be performed consistent with West Virginia law after 11.0 weeks (i.e., 11 weeks 0 days) LMP. W. Va. Code Ann. § 30-3-14(c)(13). Thus, WHC is currently providing medication abortion care to eligible patients who are at or nearing 11.0 weeks in pregnancy.

30. Our physicians evaluate each patient on a case-by-case basis to determine whether the patient's abortion will meet the Attorney General's interpretation of the Order's exception for procedures that cannot be postponed without compromising the patient's long-term health.

31. Because being forced to carry an unwanted pregnancy to term and give birth will compromise a patient's long-term health, WHC has provided procedural abortion care to patients who are at or nearing 16.0 weeks in pregnancy, which is the latest point at which WHC can provide procedural abortion care.

32. Thus, in practice, patients who seek care before 11.0 weeks LMP cannot access it for up to 6 weeks (the gap between 4 weeks LMP and 10 weeks LMP), and patients who seek care after 11.0 weeks LMP cannot access it for up to 4 weeks (the gap between 11 weeks LMP and 15 weeks LMP). Patients who have contraindications for medication abortion cannot access any abortion care for up to 11 weeks (the gap between 4 weeks LMP and 15 weeks LMP).

33. On April 16, about two weeks after the new policy went into effect, I received a call from representatives of DHHR asking about WHC's compliance with the Order. I told them that WHC was delaying patients as long as possible. When I asked the representatives what prompted the call, they said that the Governor's office had requested the inquiry. When I asked what would be done with the information I had shared, they said they would be sharing it with the Governor.

Harm to WHC Patients

34. I am concerned that WHC could lose its license, our staff could face civil penalties, and our physicians could lose their licenses and face civil penalties for providing abortion care. Although we have adopted an extremely restrictive policy that we believe complies with the Attorney General's interpretation of the Order, the Governor's inquiry into our clinic and the Attorney General's continued public statements indicate that WHC will be subject to increased scrutiny and our provider's decisions will not be treated with the same respect as other providers operating under the Order. Under these circumstances, WHC is at risk for even providing the small number of abortions we are currently providing. We certainly cannot take the risk of providing any abortions beyond these limits, even for patients in desperate circumstances and who face serious irreparable harm if denied timely abortion care.

35. Because most of our patients schedule procedures as early as possible in pregnancy (as health professionals recommend), the Order prohibits the vast majority of our patients from receiving timely care. For patients who are ineligible for medication abortion, the delay could be up to over two months.

36. Most patients recognize that they should schedule an abortion as early as possible. Because only a very small number of patients schedule their abortions at or near the limit for obtaining care, we had to reschedule approximately 45 of the 49 abortion appointments that patients had schedule before the Order was enacted. Before the Order, WHC had 27 patients scheduled for abortions the weeks of April 6, 12 medication abortions and 15 procedural abortions. As a result of the Order, we only saw three medication abortion patients that week. Similarly, out of all the patients who had abortion appointments scheduled last week (the week of April 13), we only saw four medication abortion patients and two procedural abortion patients.

Upon hearing that they would be denied timely care, patients were angry, confused, and upset. Some were devastated.

37. In addition to the patients we had to contact to cancel, and, if tenable, reschedule, their care since the Order went into effect, our phone counselors have spoken to approximately 46 patients attempting to schedule new appointments in April. These patients were equally distressed to learn they would be denied timely care.

38. Many patients said they believed that delaying their abortion would compromise their long-term health, but none so far have had medical conditions that, given the climate in West Virginia and the Attorney General's interpretation, our physicians felt safe asserting would fall under the Order's long-term health exception. Many patients identified economic, social and logistical reasons that they could not access care if delayed, but our clinicians do not feel safe taking these factors into account when performing the patient's case by case assessment.

39. A significant number of patients expressed the desire to seek care out of state, even though such travel can be difficult and, in current times, risky, rather than remain pregnant for weeks.

40. Based on the average number of abortion patients in April of 2017, 2018, and 2019, we would expect to provide abortion care to 105 patients this month. The vast majority of these patients—those who have been denied timely care, those who are attempting to travel out of state to obtain timely care, and those who have yet to attempt to schedule appointments—are or will be seriously and irreparably harmed by the Order.

41. The Order is indefinite; thus, we are unable to tell patients whether they might obtain care sooner than expected. However, even if the Order were lifted in May, it would be impossible for WHC to provide care for all the patients who were prevented from obtaining care

in April *and* all the patients needing new appointments in May. With our schedule reduced to allow for social distancing, we are only able to provide care to a maximum of 133 abortion patients in May 2020. If April's abortion patients—those who were not past 16 weeks—were forced to wait until May, we would expect a demand of approximately 200 patients needing care. Many of them will be further along in pregnancy and thus face higher medical costs, and therefore greater burdens. Additionally, there will be a number of patients we will have to refer out of state because they will be too far along to receive care at WHC.

42. Patients who are forced to remain pregnant against their will while the Order is in place face emotional, mental and financial distress, and medical risks. The costs of abortion increase as patients are pushed later into pregnancy. Moreover, since WHC is the only clinic in West Virginia, those patients who have the means to travel will necessarily be forced to travel out of state in the midst of a global pandemic. Many patients are unable to manage such travel under normal circumstances, but now patients face decreased travel options due to reduced transit schedules and increased risk to their health because of COVID-19.

43. For other patients, travel out of state will simply not be possible, particularly during the pandemic. Most WHC patients have low incomes and already struggle to raise the money to afford an abortion and related costs like travel and childcare. Some have been forced into even more precarious situations as the result of layoffs or reduced hours associated with COVID-19.

44. Some of these patients will not be able to overcome the obstacles imposed by the Order. Patients who have last minute changes in childcare or travel arrangements may be prevented from obtaining abortion at WHC. For patients with extremely limited means, being denied abortion in West Virginia will mean being denied abortion altogether.

45. In sum, the Order's requirement that, until further notice, the vast majority of abortion patients must remain pregnant against their will for weeks, and in some cases months, before obtaining an abortion will not only inflict extreme and irreparable harm on our patients, it will also risk exacerbating the COVID-19 crisis—by forcing patients to either remain pregnant or travel out of state for timely abortion care, thus exposing themselves and their families to increased risk of COVID-19—thereby undermining the stated purpose of the Order.

I declare under penalty of perjury that the foregoing is true and correct.

Executed April 23, 2020

s/ Katie Quinonez
Katie Quinonez,
Executive Director
Women's Health Center of West
Virginia

EXHIBIT 1

Women's Health Center of West Virginia

M E M O R A N D U M

To: All WHC Staff

From: Katie Quiñonez, Executive Director

RE: COVID-19

Date: March 12, 2020

As the COVID-19 outbreak evolves, Women's Health Center of West Virginia (WHC) aims to reduce exposure risks to patients and staff. Given the uncertainty of the virus, and the fact that the seasonal influenza (flu) virus is also widespread, we are taking proactive steps to address a number of concerns. First and foremost, we want to maintain a safe workplace and encourage practices of protecting the health of employees and patients.

We ask all employees to cooperate in taking steps to reduce the transmission of communicable diseases in the workplace. Please be reminded of the following:

1. Stay home if you are sick and only return to work when you are free of symptoms for 24 hours.
2. Wash hands frequently with warm, soapy water for at least 20 seconds.
3. Exercise proper cough and sneezing etiquette by coughing or sneezing into your elbow or a tissue. Discard used tissues in the trash. Tissues are available to you at your desk.
4. Clean and disinfect high touch areas frequently. Waiting room and patient areas should be disinfected more frequently than at the end of the day.
5. Clinical staff must wear gloves for all patient interactions. Change gloves and wash hands between patients.
6. Front office staff can wear gloves while taking payment or exchanging clipboards and pens with patients. Utilize alcohol-based hand sanitizer and wipes, and take time to use them between patient check-ins.
7. Ensure there are boxes of tissues in the waiting room and a bottle of hand sanitizer at the check-in window for patient use.

WHC will provide alcohol-based hand sanitizers throughout the workplace. Cleaning sprays and wipes will also be provided to clean and disinfect frequently touched objects and surfaces such as telephones and keyboards.

It is critical that employees do not report to work while they are experiencing respiratory symptoms such as fever, cough, shortness of breath, sore throat, runny or stuffy nose, body aches, headache, chills or fatigue. Currently, the Centers for Disease Control (CDC) recommends that employees remain at home until at least 24 hours after they are of free of a fever (100 degrees F) or signs of a fever without the use of fever-reducing medications. Employees who report to work ill will be sent home in accordance with these health guidelines.