IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

Pursuant to Civ.R. 65, Plaintiffs Planned Parenthood Southwest Ohio Region ("PPSWO"), Dr. Sharon Liner, Planned Parenthood of Greater Ohio ("PPGOH"), Preterm-Cleveland ("Preterm"), Women's Med Group Professional Corporation ("WMGPC"), and Northeast Ohio Women's Center ("NEOWC") (collectively "Plaintiffs") respectfully move this Court for a preliminary injunction to enjoin Defendants from enforcing Am.S.B. No. 27, 2020 Ohio Laws File 77 ("SB27").

As explained in the accompanying Memorandum in Support, its attached exhibits, the First Amended Complaint, and its attached exhibits, injunctive relief is necessary to prevent irreparable harm to Plaintiffs and their patients. Without relief from this Court, patients seeking procedural abortions in Ohio will either not be able to access that care at all or will be significantly delayed and otherwise severely burdened in doing so. This will result in irreparable injury and an unquestionable violation of Plaintiffs' and their patients' constitutional rights. Without relief from this Court, Plaintiffs will have to comply with SB27 by February 8, 2022. Plaintiffs request a hearing on this Motion.

A Proposed Order is filed separately.

Dated: January 7, 2022

Respectfully submitted,

/s/ Maithreyi Ratakonda

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PLAINTIFFS' MEMORANDUM IN SUPPORT OF SECOND MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs are health care providers who have been providing high-quality reproductive health care, including abortion, to patients in Ohio for decades. For years, the State of Ohio has taken action after action to make it more difficult, if not impossible, for Plaintiffs to provide and patients to obtain abortion, including by passing a law in 2019 banning abortion from the earliest days of pregnancy.[1] More recently, the State passed Am.S.B. No. 27, 2020 Ohio Laws File 77 ("SB27"), which imposes extremely onerous provisions that require a sea-change in how Plaintiffs dispose of embryonic and fetal tissue after a procedural abortion (sometimes called a surgical abortion). Despite Plaintiffs having consistently and scrupulously followed the applicable regulations to dispose of infectious waste, which have been in place for years, SB27 would require all such tissue to be either cremated or interred (buried).

SB27 serves no conceivable purpose except to further stigmatize abortion and severely burden patients who seek this care. SB27's mandates do not apply to providers who perform or patients who obtain other medical procedures, including identical procedures performed after a miscarriage, instead singling out abortion providers and abortion patients. Indeed, SB27 seems to apply more onerous requirements to the disposal of tissue from procedural abortion than apply to human remains. And SB27 will result in abortion patients, who already struggle to access this essential health care under the State's many unnecessary abortion restrictions, being even more burdened. Patients will face steep cost increases, will be delayed in accessing abortion until later in pregnancy, or will be prevented from obtaining this care altogether. Because of its interaction with other laws, SB27 will result in an effective total ban on abortion from 10 weeks of pregnancy

[1] This law was preliminarily enjoined by a federal court. *Preterm-Cleveland v. Yost*, 394 F.Supp.3d 796 (S.D.Ohio 2019).

until about 13 weeks of pregnancy. To avoid this clear violation of their and their patients' rights under the Ohio Constitution, Plaintiffs ask this Court to continue to enjoin Defendants from enforcing SB27.[2]

I. FACTUAL BACKGROUND

A. Abortion in Ohio

Plaintiffs provide reproductive health care, including procedural abortions, at licensed ambulatory surgical facilities ("ASFs") throughout the state. There are two main methods of abortion: medication abortion and procedural abortion. Both medication abortion and procedural abortion are effective in terminating a pregnancy. Second Affidavit of Sharon Liner, M.D. ("Liner Aff."), attached as exhibit No. 1, at ¶ 14–16.

Approximately one in four women in this country will have an abortion by age 45. *Id.* at ¶ 13. Patients seek abortion for a multitude of personal and complex reasons. Some patients have abortions because they conclude that it is not the right time to become a parent or have additional children, they desire to pursue their education or career, or they lack the financial resources or level of partner or familial support or stability they would want before having a child or additional children. *Id.* at ¶ 25. Other patients seek abortions because existing medical conditions put them at greater than average risk of medical complications. *Id.*

[2] This Court preliminarily enjoined Defendants from enforcing SB27 in April 2021 because compliance with the law was impossible without the law's implementing rules and forms. Implementing rules were finalized on December 30, 2021, a full year after SB27 was signed into law, and these rules will take effect on January 9, 2022. Under this Court's previous order, Defendants will continue to be enjoined from enforcing the law until 30 days after the implementing rules take effect—until February 8, 2022.

But patients seeking procedural abortions will be impacted well in advance of February 8th. Ohio law requires patients be given certain state-mandated information at least 24 hours before the abortion. R.C. 2317.56(B). However, because of delays in scheduling, patients usually have to obtain the state-mandated information around a week before the abortion procedure. Liner Aff. at ¶ 40 & fn.15. Plaintiffs therefore seek relief in advance of February 8th so as not to disrupt patient care.

Because Ohio law restricts medication abortion to the first ten weeks of pregnancy (or ten weeks LMP),[3] procedural abortion is the only method of abortion available after ten weeks LMP, and for some patients, it is the only method available at any gestation. *Id.* at ¶ 21. For example, a patient may be allergic to one of the medications used in medication abortion, or may have medical conditions that make procedural abortion relatively more safe. *Id.* Some patients also strongly prefer procedural abortion, including because they perceive it to be less painful or because it can be done quickly at the health center and generally allow them to return to work, childcare, or other responsibilities shortly afterward. *Id.* at ¶ 23. Additionally, having a medication abortion and having to pass the pregnancy at home may be an unsafe option, including for patients who are in abusive situations, where it could be dangerous for a partner or person in their home to know they are having an abortion. *Id.*

According to the latest data from the Ohio Department of Health ("ODH"), in 2019, more than 61 percent of abortions in the state were procedural abortions.[4] Plaintiffs provide procedural abortion up to maximum gestations between 16 weeks and 6 days LMP and 21 weeks and 6 days LMP. Liner Aff. at ¶ 16; Affidavit of Holly Myers ("Myers Aff."), attached as exhibit No. 2, at ¶ 6; Affidavit of Jennifer Moore Conrow ("Conrow Aff."), attached as exhibit No. 3, at ¶ 5;

[3] Pregnancy is commonly measured from the first day of a patient's last menstrual period ("LMP"). R.C. 2919.201 prohibits abortions after 22 weeks LMP. R.C. 2919.123 restricts Ohio abortion providers to prescribing the first drug used in medication abortion according to the federally approved label, which allows use of mifepristone only up to 10 weeks LMP. *See* U.S. Food & Drug Administration, *Mifeprex (mifepristone) Information* (last updated Dec. 16, 2021), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

[4] ODH, *Induced Abortions in Ohio, 2019*, at 23 (2020), https://bit.ly/386HyzK (accessed Jan. 4, 2022). In 2020, this number declined for reasons related to changes in service at the start of the COVID-19 pandemic, but still more than half of abortions in the state were procedural abortions. ODH, *Induced Abortions in Ohio, 2020*, at 23 (2021), https://bit.ly/3kZwzOX (accessed Jan. 4, 2022).

Affidavit of W.M. Martin Haskell, M.D. ("Haskell Aff."), attached as exhibit No. 4, at ¶ 5; Affidavit of David M. Burkons, M.D. ("Burkons Aff."), attached as exhibit No. 5, at ¶ 6.

B. Preexisting Laws Related to Disposition of Human Tissue

As part of their licensure requirements, Plaintiffs' ASFs must establish and follow written infection control policies and procedures that address the "disposal of biological waste." Ohio Adm.Code 3701-83-09(D)(3). Prior to SB27, the disposition of tissue following a procedural abortion was subject to regulation as infectious waste. *See* R.C. 3734.01(R) (defining "[i]nfectious wastes" to include "human blood and blood products" and all "[p]athological wastes"); Ohio Adm.Code 3745-27-01(I)(6)(c). Infectious waste must be treated by incineration, autoclaving, chemical treatment, or an alternative treatment technology approved by the director of the Ohio Environmental Protection Agency ("EPA") and then disposed of as solid waste. Ohio Adm.Code 3745-27-32(A) and (I)(18). Upon information and belief, neither cremation nor interment has been approved as an alternative treatment technology.[5]

After a procedural abortion, Plaintiffs safely dispose of embryonic and fetal tissue—along with other pregnancy tissue, such as placenta, gestational sac, and umbilical cord—through a licensed vendor who incinerates the tissue. Liner Aff. at ¶ 17; Myers Aff. at ¶ 6; Conrow Aff. at ¶ 6; Haskell Aff. at ¶ 6; Burkons Aff. at ¶ 7. This is in accordance with all laws and regulations that were in effect before SB27 was passed. Similarly, other medical facilities and hospitals in Ohio dispose of medical waste after a medical procedure (including after miscarriage or abortion) through one of the approved methods for disposal of infectious waste, such as incineration. Liner Aff. at ¶ 17. On the rare occasion a patient wishes to cremate or inter tissue following a procedural

[5] *See* Ohio EPA, *Currently Approved Infectious Waste Alternative Treatment Technologies*, https://epa.ohio.gov/wps/portal/gov/epa/divisions-and-offices/materials-and-waste-management/reports-and-data/facility-lists-and-other-general-documents (accessed Jan. 4, 2022).

abortion, they can do so. Liner Aff. at ¶ 42; Myers Aff. at ¶ 6; Affidavit of Suzanne Bertuleit ("Bertuleit Aff."), attached as exhibit No. 6, at ¶ 6; Conrow Aff. at ¶ 7; Haskell Aff. at ¶ 7; Burkons Aff. at ¶ 8.

There is no medical or public health reason to require embryonic and fetal tissue be disposed any differently from other tissue that is disposed following a medical procedure. Liner Aff. at ¶ 29. Incineration—the method currently used for disposal of embryonic and fetal tissue after both procedural abortions and miscarriage care—is a safe method to dispose of tissue. *Id.* Separate from the laws that govern tissue disposition, Ohio has laws that govern disposition of dead human bodies which are cremated or interred, including laws mandating certain forms that must be utilized when cremating or interring human remains and restricting when bodies may be cremated simultaneously.[6] *See generally* R.C. 4717 *et seq.* and R.C. 3705 *et seq.*

C. Senate Bill 27

SB27 drastically alters the disposition requirements for "fetal remains from a surgical abortion." R.C. 3726.02(A). SB27 does not apply to tissue from a miscarriage or medication abortion, although that tissue is identical to the tissue from a procedural abortion; nor does it apply to pre-implantation embryos collected for in vitro fertilization. Liner Aff. at ¶ 18–19, 28. SB27's requirements also do not apply to identical tissue that must be disposed after other medical procedures, including miscarriage management, where a provider utilizes a procedure identical to procedural abortion. *Id.* at ¶ 18, 28.

Under SB27, abortion facilities may no longer use the process that has been used throughout the state for decades for disposal of embryonic and fetal tissue, but rather must inform

[6] Dead human bodies can also be removed from the state, donated, or disposed of pursuant to other authorized means. R.C. 3705.01(J).

patients that the tissue will be disposed of by cremation or interment.[7] R.C. 3726.02(A). A patient who has a procedural abortion can choose interment or cremation but cannot request the tissue be disposed by other means. R.C. 3726.03(A). Currently, patients can choose to cremate or inter tissue after a procedural abortion, but are not required to do so and very few do. *See* above at Section (I)(B). SB27 therefore only serves to take away patient choice by limiting the options for disposal.

Before the procedural abortion, the patient must be provided with an ODH-prescribed "notification form." R.C. 3726.03(B). If the patient elects to determine the method of disposition (either interment or cremation), then that decision must be documented on an ODH-prescribed consent form. R.C. 3726.04(A)(1).[8] If the patient does not make an election under R.C. 3726.03, the abortion facility must determine the disposition (again by cremation or interment only). R.C. 3726.04(A)(2). A crematory operator may not cremate the embryonic or fetal tissue without first receiving a properly executed "detachable supplemental form." R.C. 4717.271(A)(1). SB27 expressly allows cremation without a death certificate, cremation authorization form, or burial permit, R.C. 4717.271(B); it is silent as to whether a death certificate or burial permit is required for interment.

Failure to comply with SB27 subjects Plaintiffs and their physicians to significant penalties, including criminal penalties. R.C. 3726.99. There are also severe noncriminal penalties that can apply to a violation of SB27, including physicians having their medical license limited,

[7] "Cremation" means "the technical process of using heat and flame to reduce human or animal remains to bone fragments or ashes or any combination thereof," R.C. 3726.01(B) and 4717.01(M), and "[i]nterment" means "the burial or entombment of fetal remains," R.C. 3726.01(D). Although incineration is generally the same process as cremation, incineration is not allowed in a crematory facility, *see* R.C. 4717.01(K), and SB27 requires cremation in a licensed crematory facility, R.C. 3726.02(B).

[8] If the patient is an unmarried, unemancipated minor, SB27 requires parental consent to the patient's disposition determination, unless the patient has obtained a judicial bypass order. R.C. 3726.04(B).

suspended, or revoked, and the ASFs facing licensure actions and other penalties. R.C. 2317.56(G)(2), 4731.22(B)(21) and (23); Ohio Adm.Code 3701-83-05(C) and 3701-83-05.1(C)(2). In addition, ODH may order the ASF to cease operations and obtain an injunction preventing the ASF from providing services. Ohio Adm.Code 3701-83-05.1; *see also* R.C. 3702.32(D)(3) and (E).

D. Adoption of SB27's Implementing Rules

SB27 requires ODH, within 90 days of its effective date (April 6, 2021), to adopt implementing rules. R.C. 3726.14. ODH had not begun the rulemaking process in advance of SB27's effective date and would not provide assurance to Plaintiffs that they would not be found in violation of the law prior to the rules being finalized and made effective—despite multiple attempts by Plaintiffs to receive that assurance and despite it being impossible for Plaintiffs to comply with the law prior to the rules and forms being issued. Plaintiffs therefore sued ODH in March 2021 to ensure that they would be able to continue providing procedural abortions. Entry Granting Plaintiffs' Motion for Preliminary Injunction at 4. This Court entered a preliminary injunction prohibiting Defendants from enforcing the law until 30 days after the rules and forms were adopted and became effective pursuant to the notice-and-comment rulemaking process. *See id*.

On October 25, 2021, ODH issued proposed rules to implement the law. Bertuleit Aff. at ¶ 37. These proposed rules were adopted on December 30, 2021, a full year after SB27 was signed into law, and they will become effective on January 9, 2022. *See* R.C. 119.04. Therefore, absent relief from this Court, Plaintiffs will have to come into compliance with SB27 on February 8, 2022 or stop providing procedural abortions. During the rulemaking process, Plaintiffs and others repeatedly raised several significant issues that made compliance with SB27 extremely onerous or

impossible. ODH did not address any of these issues, and the implementing rules instead introduce new burdens and ambiguities, as described below at Section (I)(E).

E. SB27's Ambiguities and Plaintiffs' Compliance Efforts

Recognizing that SB27 completely alters the way in which tissue from a procedural abortion may be disposed, after the bill passed, Plaintiffs began exploring whether compliance was feasible, contacting funeral homes, crematories, and cemeteries. Plaintiffs spent significant time contacting potential vendors, including entities with whom they have worked in the past. Bertuleit Aff. at ¶ 6–10; Myers Aff. at ¶ 8–11; Conrow Aff. at ¶ 9; Haskell Aff. at ¶ 9; Burkons Aff. at ¶ 10. However, providers of cremation and burial services are reluctant to work with Plaintiffs for a variety of reasons: some referenced opposition to abortion or religious beliefs (either their own or those of others); others are already operating at capacity or cannot accommodate the increase in volume; and several expressed concern about attracting protestors or being harassed by those opposed to abortion because of their affiliation with an abortion provider. Bertuleit Aff. at ¶ 11–12; Myers Aff. at ¶ 12–13; Haskell Aff. at ¶ 11; Conrow Aff. at ¶ 11; Burkons Aff. at ¶ 10. The vast majority of vendors also are unable or unwilling to enter into contracts with Plaintiffs, or determine whether they could provide services in compliance with the law, because of SB27's numerous, significant ambiguities—none of which were clarified by the implementing rules. Burkons Aff. at ¶ 10; Myers Aff. at ¶ 19–22; Bertuleit Aff. at ¶ 22–27; Haskell Aff. at ¶ 11; Conrow Aff. at ¶ 10–11. The ambiguities in the law also make it impossible for the Plaintiffs to understand how and whether they can comply with the law in certain circumstances.

First, SB27 does not address whether tissue from procedural abortions can be cremated simultaneously. Under Ohio law, simultaneous cremation is permitted in only certain limited circumstances. R.C. 4717.20(C), 4717.24(A)(7) and 4717.26(D). But having to individually cremate each embryo and fetus will be extremely time consuming, difficult, and costly. *See*

Affidavit of Poul Lemasters ("Lemasters Aff."), attached as exhibit No. 7, at ¶ 22, 25–26, 29; Bertuleit Aff. at ¶ 23; Myers Aff. at ¶ 19; Haskell Aff. at ¶ 11. While simultaneous cremation would reduce the cost, vendors are unwilling to risk severe penalties from running afoul of crematory regulations by simultaneously cremating tissue absent explicit approval from the state. Bertuleit Aff. at ¶ 24; Myers Aff. at ¶ 20; Conrow Aff. at ¶ 11; Lemasters Aff. at ¶ 18, 21; *see also* R.C. 4717.14.

SB27 does not address whether embryonic and fetal tissue can be sent to a crime lab, such as in response to a patient's request or in response to a warrant or subpoena in a sexual assault investigation. Plaintiffs cannot control how a crime lab will dispose of the tissue, and thus risk either violating SB27's requirements if the tissue is not cremated or interred, or have to refuse to comply with patients' requests, thereby violating bioethical principles of patient autonomy, Affidavit of Thomas V. Cunningham ("Cunningham Aff."), attached as exhibit No. 8, at ¶ 18, or even a warrant or subpoena. Liner Aff. at ¶ 32; Bertuleit Aff. at ¶ 26; Myers Aff. at ¶ 23. Similarly, SB27 does not address whether embryonic and fetal tissue can be sent to a pathologist for testing, which may be needed to diagnose conditions such as cancer. Liner Aff. at ¶ 31. Sending tissue to a pathologist is important for patient health, and it is the standard of care for medical providers to send tissue to a pathologist in certain circumstances. Liner Aff. at ¶ 31; Cunningham Aff. at ¶ 18. But because providers cannot control how the pathologist, who may be located out of state, *see* Myers Aff. at ¶ 23, will dispose of this tissue, they risk violating SB27 if they send tissue there. Liner Aff. at ¶ 31; Bertuleit Aff. at ¶ 26; Myers Aff. at ¶ 23.

SB27 also seems to conflict with infectious waste requirements, which mandate that pregnancy tissue, including uterine lining/decidua, umbilical cord, gestational sac, and placenta, be disposed of in certain specific ways, not including cremation and interment. *See* above at

Section (I)(B). Violating infectious waste requirements can result in providers facing severe, including criminal, penalties. *See* R.C. 3734.99. If this tissue does not fall within SB27's definition of "fetal remains," it cannot be cremated or interred. Lemasters Aff. at ¶ 31. But this other pregnancy tissue cannot always be physically separated from embryonic and fetal tissue, particularly at earlier gestational ages, Liner Aff. at ¶ 34, which means providers risk running afoul of either SB27's mandate that "fetal remains" be cremated or interred or the laws governing disposal of infectious waste, which includes the remainder of the pregnancy tissue. *See* Ohio Adm.Code 3745-27-32(A) and (I)(18); Liner Aff. at ¶ 34; Haskell Aff. at ¶ 14; Burkons Aff. at ¶ 12; Bertuleit Aff. at ¶ 27; Myers Aff. at ¶ 24. However, providers cannot know before beginning an abortion prior to around 13 weeks LMP whether they will be able to separate the tissue, and thus because of these conflicting obligations will be forced to stop providing procedural abortions before that point, which is when most patients currently obtain abortions. Liner Aff. at ¶ 35; Myers Aff. at ¶ 24; Conrow Aff. at ¶ 15; Haskell Aff. at ¶ 14; Burkons Aff. at ¶ 12; Bertuleit Aff. at ¶ 27.

Plaintiffs raised all of these issues with ODH on at least three separate occasions, but ODH has refused to provide any clarity in the rules. Bertuleit Aff. at ¶ 29, 36, 38. Instead, the rules only add to the confusion, and add more unnecessary and burdensome requirements. *Id.* at ¶ 32–34. The rules limit the locations for interment used by abortion providers to Ohio-registered cemeteries. Ohio Adm.Code 3701-46-01(B)(1)(b), attached as Exhibit B to Amended Complaint. Such a requirement is not present in SB27, and there is no such requirement in Ohio for the interment of human remains.[9] Lemasters Aff. at ¶ 39. Additionally, SB27 requires that the director of ODH prescribe rules for three separate forms to implement the law: the notification form, which must

[9] Similarly, while SB27 requires embryonic and fetal tissue be cremated in an Ohio-licensed crematory, R.C. 3726.02(B), there is no similar requirement in Ohio for cremation of human remains. Lemasters Aff. at ¶ 39. Human remains can be taken out of state for disposal, whether by interment, cremation, or otherwise. *See* R.C. 3705.01(J).

be provided to the patient; the consent form, which patients must complete; and the detachable supplemental form, which must be provided to a crematory operator, *see* R.C. 3726.14(A)–(C). But the rules appear to conflate the consent form with the detachable supplemental form, seeming to require that the patient complete the detachable supplemental form, which must then be provided to the crematory operator. *See* Ohio Adm.Code 3701-46-01(B).[10] Requiring that the patient complete the detachable supplemental form could result in identifying patient information being disclosed to the crematory operator. Bertuleit Aff. at ¶ 33; Myers Aff. at ¶ 26. Finally, while the rules "prescribe" the forms, they do not actually include any such forms. Plaintiffs, as well as crematories and funeral homes, who have requested to see the forms, are therefore still unsure what, if any, additional requirements the forms may contain. Bertuleit Aff. at ¶ 34; Myers Aff. at ¶ 26.

Given these ambiguities, many of the crematories and funeral homes Plaintiffs contacted stated they could not work with Plaintiffs, including because they were unable to determine if and how they could operationalize SB27's requirements. Bertuleit Aff. at ¶ 22–27; Myers Aff. at ¶ 19–22; Conrow Aff. at ¶ 10–11; Haskell Aff. at ¶ 11; Burkons Aff. at ¶ 10. After months of outreach, Plaintiffs were able to find only four vendors—three providing cremation services and one for interment—who were potentially willing to work with them. Bertuleit Aff. at ¶ 15; Conrow Aff. at ¶ 11. Due to capacity constraints, one vendor could not take much more than the embryonic and fetal tissue from procedural abortions at a single provider for individual cremation, and estimated a price of $95 per individual cremation for the tissue it was able to take. Bertuleit Aff. at ¶ 15. A second vendor only had capacity to take the embryonic and fetal tissue from one other provider,

[10] The rules do prescribe a consent form, but only for non-married or non-emancipated minors. *See* Ohio Adm.Code 3701-46-02, attached as Exhibit C to Amended Complaint. There were no rules prescribing consent forms for non-minors or married or emancipated minors.

and estimated a price of $117 per individual cremation. Conrow Aff. at ¶ 11. A third vendor had more capacity to individually cremate tissue and indicated they could take the tissue from the remaining providers, but was significantly more expensive, estimating $295 per individual cremation. Bertuleit Aff. at ¶ 15. The fourth vendor indicated it had capacity to inter tissue from procedural abortion from all providers and quoted a price of $75 per embryo or fetus. *Id*.

F. Impact of SB27 on Plaintiffs and Their Patients

Having to comply with SB27 will be extremely burdensome for Plaintiffs and their patients. First, because it creates conflicting obligations, *see* above at Section (I)(E), SB27 operates as an effective ban on procedural abortions until approximately 13 weeks LMP and a complete ban on abortions between 10 and 13 weeks LMP. The vast majority of procedural abortions are provided prior to 13 weeks LMP. Liner Aff. at ¶ 35; Myers Aff. at ¶ 15; Conrow Aff. at ¶ 15; Haskell Aff. at ¶ 14; Burkons Aff. at ¶ 12. Patients will be forced to delay their procedures until later in pregnancy, when abortion carries greater risks and is more expensive. Liner Aff. at ¶ 46. Additionally, because procedures later in pregnancy take longer to perform than procedural abortions in the first trimester, SB27 will likely result in a backlog of patients who will not be able to seek care right at around 13 weeks LMP—they will be pushed even later in pregnancy, when the expense and risk of the procedure increase even further. *Id.* at ¶ 35.

Second, requiring fetal tissue to be cremated or interred will substantially increase the cost of obtaining an abortion with devastating effect on Plaintiffs' patients. *See* above at Section (I)(E). Not only will the cost of the cremation or interment itself ($75–295) raise the cost of abortion care, but because SB27 effectively bans procedural abortion until around 13 weeks LMP patients will have to pay the increased costs associated with later abortions, *see* above at Section (I)(E). A procedural abortion in the second trimester is significantly more expensive than first-trimester procedures. Bertuleit Aff. at ¶ 21 & fn.2; Haskell Aff. at ¶ 15; *see also* Myers Aff. at ¶ 15 & fn.2;

Conrow Aff. at ¶ 16; Burkons Aff. at ¶ 13. Procedural abortion patients will therefore face substantial price increases because of this law, which many cannot afford.

Approximately 50 percent of abortion patients nationwide have a household income at or below the federal poverty level (classified as "poor"), and another 25 percent have incomes from 100 to 199 percent of the federal poverty level (classified as "low income").[11] Even 200% of the federal poverty line is not considered a living wage, and those who are not considered "low income" may still struggle to pay for basic living expenses. Affidavit of Carolette Norwood ("Norwood Aff."), attached as exhibit No. 9, at ¶ 15, 20. For patients who are poor or have low incomes, seemingly "minor" expenses or unexpected costs can be devastating. *Id.* at ¶ 12, 21. The price increases caused by SB27 will result in patients being delayed in accessing care, with corresponding additional risk to their health, as they struggle to raise the money needed for the procedure. Liner Aff. at ¶ 46–48; Bertuleit Aff. at ¶ 21 & fn.2; Haskell Aff. at ¶ 15; Burkons Aff. at ¶ 15; Conrow Aff. at ¶ 17. This can create a vicious cycle: patients are delayed because they need to raise additional funds; the delay means that the procedure is even more expensive; so patients must then delay again to raise more money to pay for the more expensive procedure. Norwood Aff. at ¶ 11, 25; Liner Aff. at ¶ 47; Haskell Aff. at ¶ 15; Conrow Aff. at ¶ 16. The law will result in patients having to make sacrifices that negatively affect themselves and their families, including forgoing other necessities, such as by not paying for rent or utilities, turning to predatory lenders, engaging in work outside of the mainstream economy in order to procure funds on an expedited basis, or having to borrow money from an abusive partner, further entrenching

[11] *See* Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. Journal of Pub. Health 1904, 1907 (2017), *available at* https://doi.org/10.2105/AJPH.2017.304042. For a family of three, the federal poverty level is $21,960. *See* U.S. Dept. of Health & Human Servs., *Federal Poverty Level (FPL)*, https://www.healthcare.gov/glossary/ federal-poverty-level-fpl/ (accessed Jan. 4, 2022).

themselves in a dangerous situation. Norwood Aff. at ¶ 26–30. Others will be prevented from obtaining an abortion entirely due to the increase in costs. Liner Aff. at ¶ 6, 39, 47, 49–50; Haskell Aff. at ¶ 15; Conrow Aff. at ¶ 14, 27; Burkons Aff. at ¶ 13–15; Norwood Aff. at ¶ 13; *see also* Myers Aff. at ¶ 15 & fn.2; Bertuleit Aff. at ¶ 21 & fn.2.

Additionally, as described above, most vendors were not willing to contract with Plaintiffs so that they could comply with SB27. Having very few vendors willing to partner with them puts Plaintiffs in a precarious position. Vendors expressed fear of harassment and negative consequences to their professional and personal lives if they are publicly associated with abortion providers. Bertuleit Aff. at ¶ 15 fn.1, 17–18; Conrow Aff. at ¶ 11; *see also* Myers Aff. at ¶ 12. The few vendors currently willing to work with Plaintiffs may refuse to do so if they become targets of harassment. Bertuleit Aff. at ¶ 18; *see also* Conrow Aff. at ¶ 11, 18; Myers Aff. at ¶ 17; Haskell Aff. at ¶ 16; Burkons Aff. at ¶ 19. This would result in Plaintiffs having to abruptly stop providing procedural abortions until they could secure another vendor—if that is even possible. Bertuleit Aff. at ¶ 18; Haskell Aff. at ¶ 16; *see also* Myers Aff. at ¶ 17; Conrow Aff. at ¶ 18; Burkons Aff. at ¶ 19.

If patients are not able to obtain an abortion from a licensed medical provider, they may seek to terminate their pregnancies outside the medical system, which can sometimes be dangerous. Liner Aff. at ¶ 49. Or, if they cannot do so and cannot afford the significant expense of traveling out of state to obtain an abortion, they will have to carry a pregnancy to term against their will. *Id.* at ¶ 47, 49.

Legal abortion is one of the safest medical procedures in the United States and is substantially safer than continuing a pregnancy through to childbirth. *Id.* at ¶ 13. The risk of death associated with childbirth is approximately 12 times higher than that associated with abortion, and

every pregnancy-related complication is more common among those giving birth than among those having abortions.[12] *Id.* at ¶ 52. Even for someone who is otherwise healthy and has an uncomplicated pregnancy, carrying that pregnancy to term and giving birth poses serious medical risk and can have long-term physical consequences. *Id.* These risks are greater for individuals with a medical condition caused or exacerbated by pregnancy. *Id.*

If an individual is forced to continue a pregnancy against their will, it can pose a risk to their physical, mental, and emotional health, as well as to the stability and wellbeing of their family, including existing children. *Id.* at ¶ 51; Cunningham Aff. at ¶ 22–23. The risk can be particularly severe for a patient who is pregnant as the result of sexual assault, a survivor of intimate partner violence, or who learns that the fetus has been diagnosed with a severe or lethal anomaly. Liner Aff. at ¶ 54. A child can place significant economic and emotional strain on a family and may disrupt an individual's life plans. *Id.* at ¶ 53. In addition, as most patients who seek abortion already have at least one child, forcing a person to have an additional child may interfere with their ability to care for the children they already have. *Id.*

Being prevented from having an abortion will have a disproportionate impact on the lives of Black people, other people of color, and people with low incomes in Ohio. *Id.* at ¶ 55. Recent ODH statistics show that Black women are 2.5 times more likely than white women to die of causes related to pregnancy in Ohio.[13] *Id.*

Being delayed in obtaining an abortion also results in significant harm. Although abortion is significantly safer than continuing pregnancy through childbirth, the risks associated with

[12] Natl. Academies of Sciences, Eng. & Medicine, *The Safety & Quality of Abortion Care in the United States,* at 74–75 (2018) available at https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states (accessed Jan. 4, 2022).

[13] ODH, *A Report on Pregnancy-Associated Deaths in Ohio 2008–2016*, at 19 (2019), https://bit.ly/3uZraej (accessed Jan. 4, 2022).

abortion increase as pregnancy advances. *Id.* at ¶ 46, 52. Therefore, the later in pregnancy a patient accesses a procedural abortion, the more likely she is to experience rare complications. *Id.* at ¶ 46. Later abortion procedures are also more complicated. *Id.* In the interim, these patients may also suffer from heightened emotional distress or anxiety, or other medical complications, especially if they face health issues with their pregnancies. *Id.*; Cunningham Aff. at ¶ 22–23.

By requiring tissue from procedural abortion to be cremated or interred and thereby equating this tissue with a deceased human body, *see* Affidavit of Reverend Terry Williams ("Williams Aff."), attached as exhibit No. 10, at ¶ 8–9; Cunningham Aff. at ¶ 16–17, 25–26. SB27 significantly adds to the harmful stigma that unnecessarily surrounds abortion, resulting in biopsychosocial suffering and other harm to Plaintiffs' patients.[14] Cunningham Aff. at ¶ 21, 24–29; Williams Aff. at ¶ 14; Liner Aff. at ¶ 43. Through SB27, the State inappropriately imposes one particular set of views of when life begins on all Ohioans, some of whom may not share this view—indeed, it may run directly counter to their deeply held religious and spiritual beliefs. Williams Aff. at ¶ 4, 10, 19; *see also id.* at ¶ 5–9, 11–12; Cunningham Aff. at ¶ 10, 16–17, 25–26. This will result in grave moral injury and psychological harm, and may be especially distressing to patients who have experienced intimate partner violence or sexual assault, who often experience shame after experiencing such trauma and will be further harmed by additional stigma and shame imposed by SB27. Williams Aff. at ¶ 14. SB27 similarly conveys a moral and social disapproval of health care professionals who provide abortion, perpetuating harmful stigma. Cunningham Aff. at ¶ 29.

[14] Patients rarely bring up the disposal of the tissue of their embryo or fetus. Liner Aff. at ¶ 42; Conrow Aff. at ¶ 7, 10; *see also* Burkons Aff. at ¶ 8. On the very rare occasion that they wish to dispose of tissue via cremation or interment, they are currently able to do so. Liner Aff. at ¶ 42; Conrow Aff. at ¶ 10; Haskell Aff. at ¶ 7; Burkons Aff. at ¶ 8. This current practice is in line with the bioethical principle of autonomy. Cunningham Aff. at ¶ 15.

SB27 also forces providers to violate basic bioethical principles. *See generally id.* For instance, SB27 violates patient autonomy by limiting patients' choice of disposal of their embryonic or fetal tissue from procedural abortions to only cremation or interment, thus restricting the extent to which patients can make decisions that conform to their values and needs. *Id.* at ¶ 14, 16–17. Additionally, any involuntary postponement of care and/or forced pregnancy as a result of SB27 likewise violates the foundational principles of bioethics, including justice and patient autonomy. *Id.* at ¶ 22–23, 31–32. Being forced to stop providing procedural abortions, forcing their patients to delay obtaining this care and/or having to significantly raise the price of procedural abortions, knowing that this will place this care out of reach for many patients, will also irreparably harm Plaintiffs' physicians and staff, many of whom have committed their professional careers to providing the full range of reproductive health care—of which procedural abortion is an essential part. Liner Aff. at ¶ 56–57; Myers Aff. at ¶ 32.

II. ARGUMENT

A. Standard of Review

A party seeking a temporary restraining order and/or preliminary injunction must demonstrate "that the moving party has a substantial likelihood of success in the underlying suit; that the moving party will suffer irreparable harm if the order does not issue; that no third parties will be harmed if the order is issued; that the public interest is served by issuing the order." *City of Cincinnati v. City of Harrison*, 1st Dist. Hamilton No. C-090702, 2010-Ohio-3430, ¶ 8, citing *Procter & Gamble Co. v. Stoneham*, 140 Ohio App.3d 260, 267–68, 747 N.E.2d 268 (1st Dist.2000). The purpose of a temporary restraining order and/or preliminary injunction is to preserve the status quo. *Martin v. Flick*, 150 N.E.2d 314, 316 (1st Dist.1958). For the reasons stated below, Plaintiffs meet the standard, and the grant of injunctive relief by this Court will

preserve the status quo and allow Plaintiffs to continue providing high-quality health care to their patients while ensuring the disposition of embryonic and fetal tissue in a safe manner, as they have been doing for decades.

B. Plaintiffs Have a Substantial Likelihood of Success on the Merits of Their Claims.

1. Plaintiffs have a substantial likelihood of success on the merits of their claim that SB27 violates the Ohio Constitution's guarantee of due process.

The Ohio Constitution's Due Course of Law Clause provides that:

> All courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, *shall have remedy by due course of law*, and shall have justice administered without denial or delay. . . . Suits may be brought against the state, in such courts and in such manner, as may be provided by law.

(Emphasis added). Ohio Constitution, Article I, Section 16. The Ohio Supreme Court has recognized that this provision protects substantive as well as procedural due process rights. *Stolz v. J & B Steel Erectors, Inc.*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶ 13, citing *Arbino v. Johnson & Johnson*, 116 Ohio St.3d 468, 2007-Ohio-6948, 880 N.E.2d 420, ¶ 48–49. Unlike procedural due process rights, substantive due process rights forbid the government from "infring[ing] certain 'fundamental' liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." (Emphasis sic.) *In re Raheem L.*, 2013-Ohio-2423, 993 N.E.2d 455, ¶ 7 (1st Dist.), quoting *Reno v. Flores*, 507 U.S. 292, 302, 113 S.Ct. 1439, 123 L.Ed.2d 1 (1993).

SB27 implicates a fundamental right and must be struck down under the strict scrutiny standard. Indeed, SB27 fails even if strict scrutiny does not apply, because it only serves to impose devastating burdens on patients without providing any benefits whatsoever. SB27 will result in patients having to pay significantly more money to obtain a procedural abortion, which many cannot afford, and will lead to patients being severely delayed or prevented entirely from obtaining

procedural abortions. Additionally, patients will be emotionally and psychologically harmed by the requirement that the tissue from their procedural abortion be cremated or interred.

a. Strict scrutiny applies to determine whether SB27 violates Plaintiffs' patients' substantive due process rights.

The Ohio Constitution's Due Course Clause is *at least* as protective of individual rights as the federal Due Process Clause, which protects a "liberty" interest in the right "to abortion," *State v. Lowe*, 112 Ohio St.3d 507, 2007-Ohio-606, 861 N.E.2d 512, ¶ 19; *see also Arnold v. City of Cleveland*, 67 Ohio St.3d 35, 42, 616 N.E.2d 163 (1993); *Werling v. Sandy*, 17 Ohio St.3d 45, 49, 476 N.E.2d 1053 (1985). In fact, Ohio case law demonstrates that the Ohio Constitution provides greater protections for the right of patients to access abortion than the U.S. Constitution. The Ohio Supreme Court has already recognized a fundamental substantive due process right to privacy, procreation, bodily integrity, and bodily autonomy under the Ohio Constitution. *Stone v. City of Stow*, 64 Ohio St.3d 156, 160–63, 593 N.E.2d 294 (1992); *State v. Aalim*, 150 Ohio St.3d 489, 2017-Ohio-2956, 83 N.E.3d 883, ¶ 18; *State v. Williams*, 88 Ohio St.3d 513, 530, 728 N.E.2d 342 (2000); *Holeton v. Crouse Cartage Co.*, 92 Ohio St.3d 115, 132–33, 748 N.E.2d 1111 (2001), *superseded by statute as stated in McKinley v. Ohio Bur. of Workers' Compensation*, 170 Ohio App.3d 161, 2006-Ohio-5271, 866 N.E.2d 527 (4th Dist.); *State v. Rohrer*, 2015-Ohio-5333, 54 N.E.3d 654, ¶ 36 (4th Dist.); *see also State v. Boeddeker*, 1st Dist. Hamilton No. C-970471, 1998 WL 57234, *2 (Feb. 13, 1998) (recognizing that substantive due process under the Ohio Constitution includes a right to privacy that, in the context of "sexual and reproductive matters," is "fundamental" and that triggers "a higher level of scrutiny" than rational-basis review). Because an abortion restriction impinges on the right to privacy, procreation, bodily integrity, and bodily autonomy, it implicates a fundamental right and triggers strict scrutiny review.

The textual differences between the federal and state constitutional provisions provide further support for broader protections under the Ohio Constitution than the U.S. Constitution. Where the Fourteenth Amendment of the U.S. Constitution forbids the government from "depriv[ing] any person of life, liberty, or property, without due process of law," the Ohio Constitution provides "remedy by due course of law" to "every person, for an injury done him in his land, goods, *person*, or reputation." (Emphasis added.) Ohio Constitution, Article I, Section 16. Deprivation of reproductive autonomy falls squarely within the meaning of an injury done to one's person.

Finally, Article I, Section 21 of the Ohio Constitution, the Health Care Freedom Amendment, confirms that freedom of choice in health care is a fundamental right in the state. This provision, not found in the U.S. Constitution, bars any law that "impose[s] a penalty or fine for the sale or purchase of health care." Ohio Constitution, Article I, Section 21(C). It defines penalty or fine to mean "any civil or criminal" sanction "that is used to punish or discourage the exercise of rights protected" by the Amendment. *Id.*, Article I, Section 21(E)(3). Here, SB27 imposes criminal and civil penalties on abortion providers for providing health care, and its restrictions serve to "punish" and "discourage" procedural abortion patients and their physicians from exercising rights protected by the Amendment, thereby violating Section 21 directly. But at a minimum, Section 21 establishes that the Ohio Constitution's protection for substantive-due-process rights extends to patients' fundamental rights to be free from government interference in personal health care decisions, and their doctor's corresponding right to provide that care to them, further affirming that abortion restrictions implicate fundamental rights and must be analyzed under the highest level of scrutiny.

Just last year, in determining whether an Ohio abortion restriction barring physicians from providing medication abortion via telemedicine was constitutional under the Ohio Constitution's substantive due process and equal protection provisions, this Court held that the abortion restriction "warrants strict scrutiny." *Planned Parenthood Southwest Ohio Region. v. Ohio Dept. of Health*, Hamilton C.P. No. A 2101148 (Apr. 19, 2021) ("PPSWO Telemedicine Op."), attached as exhibit No. 11, at 8. This Court explained this is so because the telemedicine ban "burdens a fundamental right to substantive due process in matters involving privacy, procreation, bodily autonomy, and freedom of choice in health care decision making." *Id.*, citing *Stone*, 64 Ohio St.3d at 160–63, 593 N.E.2d 294. Like the telemedicine ban, SB27 also burdens Plaintiffs' patients' fundamental rights to substantive due process in matters involving privacy, procreation, bodily autonomy, and freedom of choice in health care decision making, because it results in patients being significantly burdened, including being delayed in or prevented entirely from accessing procedural abortion. This Court's prior holding that an abortion restriction implicates fundamental rights, and that strict scrutiny review should apply in analyzing its constitutionality, is undoubtedly correct under Ohio case law and applies with equal force here.

b. SB27 fails strict scrutiny.

Under the strict scrutiny standard, the burden is on Defendants to show that SB27 is "narrowly tailored to serve a compelling state interest." *In re Raheem L.*, 2013-Ohio-2423, 993 N.E.2d 455, ¶ 7, quoting *Reno*, 507 U.S. at 302. They cannot meet this standard.

SB27 does not serve a compelling state interest. Plaintiffs have consistently and scrupulously followed the applicable regulations on the disposal of infectious waste, which have been in place for years, when disposing of embryonic and fetal tissue following a procedural abortion. Liner Aff. at ¶ 17; Myers Aff. at ¶ 6; Bertuleit Aff. at ¶ 5; Conrow Aff. at ¶ 6; Haskell Aff. at ¶ 6; Burkons Aff. at ¶ 7. And the infectious waste requirements still apply to disposal of

tissue removed from a patient's body after a medical procedure, including tissue from an identical procedure providers utilize to aid patients suffering a miscarriage. Liner Aff. at ¶ 18. There is no medical or public health reason to dispose of tissue from a procedural abortion any differently from this other tissue. *Id.* at ¶ 29. Incineration—the method currently used for disposal of embryonic and fetal tissue—is a safe method to dispose of tissue, *id.*, and the State can identify no compelling interest in public health or safety in imposing new, onerous requirements that will only serve to severely burden access.

The State also cannot claim that SB27 furthers any compelling interest in ensuring patients can choose how to dispose of tissue following a procedural abortion. Even before SB27 took effect, patients who wished to dispose of the tissue via cremation or interment could already do so. Liner Aff. at ¶ 42; Myers Aff. at ¶ 6; Bertuleit Aff. at ¶ 6; Conrow Aff. at ¶ 7; Haskell Aff. at ¶ 7; Burkons Aff. at ¶ 8. However, the vast majority of patients did not express a wish to cremate or inter this tissue. Liner Aff. at ¶ 42; Burkons Aff. at ¶ 8; *see also* Myers Aff. at ¶ 6; Bertuleit Aff. at ¶ 6; Conrow Aff. at ¶ 7, 10. SB27 only serves to *take away* patient choice, by limiting the methods of disposal and requiring patients to be told that the tissue can only be cremated or interred. Restricting the methods of disposing of tissue to those methods used for human bodies only entrenches the State's belief that life begins at conception, *see* Williams Aff. at ¶ 10–11, and to coerce and shame patients, many of whom may not share this belief, *see id.* at ¶ 14; Cunningham Aff. at ¶ 10, 14, 16–17, 21, 24–28; Liner Aff. at ¶ 43; Conrow Aff. at ¶ 19. This the State cannot do, and there is no compelling state interest furthered here. *Compare Humphrey v. Lane*, 89 Ohio St.3d 62, 67–68, 728 N.E.2d 1039 (2000) (stating the Ohio Constitution prohibits laws that interfere with the rights of conscience); *In re Landis*, 5 Ohio App.3d 22, 23–24, 448 N.E.2d 845 (10th Dist.1982) (stating the Ohio Constitution "require[s] governmental neutrality in religious

matters"); *see also Planned Parenthood of Southeastern Pennsylvania. v. Casey*, 505 U.S. 833, 852, 112 S.Ct. 2791, 120 L.Ed.2d. 674 (1992) (plurality opinion) (explaining that one's decision to become a parent "must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society"); *Lawrence v. Texas*, 539 U.S. 558, 562, 123 S.Ct. 2472, 156 L.Ed. 508 (2003) ("Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct."). A Texas district court considering a similar requirement that tissue from abortion procedures be cremated or interred found that, by requiring health care providers to ensure that "fetal tissue" be disposed of in ways normally associated with human remains, the State "appears to be inferentially establishing the beginning of human life as conception," which can undermine the constitutionally-protected interests at stake here. *Whole Woman's Health v. Hellerstedt*, 231 F.Supp.3d 218, 229 (W.D.Tex. 2017); *see also id.* (citing the "reserv[ation] to individuals [of] the right to define one's own concept of the mystery of human life" in *Casey*, 505 U.S. at 851); *id.* at 226–33 (citing bedrock constitutional principles concerning the impermissibility of government coercion in matters of personal belief and conscience).

Even if this Court finds that SB27 furthers a compelling state interest, it is certainly not narrowly tailored to serve that interest. Any supposed interest in ensuring patient choice is undermined by the fact that SB27 imposes its mandate on every patient who obtains a procedural abortion, regardless of that patients' wishes, beliefs, or circumstances. The disposal requirements apply even if a patient vehemently believes that embryonic and fetal tissue should not be treated as human remains and should instead be disposed like other medical waste. The State has made no attempt to accommodate patients who do not view an embryo or fetus as a person, or whose personal beliefs are that interment or cremation for a non-person would be inappropriate or wrong. Williams Aff. at ¶ 8 ("In most religious traditions, interment and cremation are rituals associated

with the death of human beings"); Cunningham Aff. at ¶ 14, 16–17. And any supposed interest in public health or safety do not explain why SB27 and its implementing rules do not explicitly allow embryonic and fetal tissue to be simultaneously cremated, and why they mandate that all tissue be cremated at Ohio-licensed crematories, R.C. 3726.02(B), and that abortion providers only provide options for interment at Ohio-registered cemeteries, Ohio Adm.Code 3701-46-01(B)(1)(b). SB27 and its rules only serve to significantly narrow the number of vendors Plaintiffs can contract with, burdening them further, and impose singularly onerous restrictions that do not even apply to the disposal of human bodies. *See* below at Section (II)(B)(2).

Devoid of any compelling justification to which it is narrowly tailored, SB27 can only be intended to prevent patients "from obtaining abortions and to punish and discriminate against those who do." *Cline v. Oklahoma Coalition for Reproductive Justice*, 2013 OK 93, 313 P.3d 253, ¶ 27 (Okla.2013) (overturned due to legislative action), quoting *Oklahoma Coalition for Reproductive Justice v. Cline*, Dist.Ct.Okla.Cty. No. CV-2011-1722, Slip Opinion, ¶ 7 (May 11, 2012). SB27 thus falls far short of strict scrutiny's demands.

c. SB27 would also fail under a less protective standard.

SB27 in fact violates Plaintiffs' patients' constitutional rights even if this Court does not apply strict scrutiny. The Ohio Supreme Court has explained that, at minimum, the Ohio Constitution is *at least* as protective of individual rights as the U.S. Constitution. *See Arnold*, 67 Ohio St.3d at 42, 616 N.E.2d 163. SB27 does not pass muster even under the federal "undue burden" standard.

Courts review federal constitutional challenges to abortion restrictions by applying the "undue burden" standard. *Preterm Cleveland v. Voinovich*, 89 Ohio App.3d 684, 704–05, 627 N.E.2d 570 (10th Dist.1993). As the U.S. Supreme Court concluded in *Casey*, 505 U.S. 833, 112 S.Ct. 279, 1120 L.Ed.2d 674, and further explained in *Whole Woman's Health v. Hellerstedt*, ___

U.S. ___, 136 S.Ct. 2292, 195 L.Ed.2d 665 (2016), an abortion regulation constitutes an undue burden if it has the purpose or effect of placing a substantial obstacle in the path of a woman's choice. *Whole Woman's Health* at 2312, quoting *Casey* at 877 (plurality opinion); *accord June Med. Servs., L.L.C. v. Russo*, ___ U.S. ___, 140 S.Ct. 2103, 2120, 2133, 207 L.Ed.2d 566 (2020) (plurality opinion); *id*. at 2135 (Roberts, C.J., concurring in the judgment). As this Court has held, where the test applies, a court must "'consider the burdens a law imposes on abortion access together with the benefits those laws confer' and 'weigh[] the asserted benefits against the burdens.'" PPSWO Telemedicine Op. at 11, quoting *Whole Woman's Health* at 2309. The more severe the burdens, the more robust the state interests must be. *Whole Woman's Health* at 2310; *see also, e.g.*, *Capital Care Network of Toledo v. State of Ohio Dept. of Health*, 2016-Ohio-5168, 58 N.E.3d 1207, ¶ 29 (6th Dist.) (considering a federal constitutional claim involving the right to abortion and applying the balancing described in *Whole Woman's Health*), *rev'd on other grounds*, 153 Ohio St.3d 362, 2018-Ohio-440, 106 N.E.3d 1209.[15]

As described above, SB27 provides no benefits whatsoever. *See Whole Woman's Health*, 231 F.Supp.3d at 232. Instead, it only imposes severe burdens on patients, including significantly delaying (for days or even weeks) or preventing them from obtaining care. *See* above at Section (I)(F); *see also, e.g.*, PPSWO Telemedicine Op. at 11 (striking down abortion restriction that resulted in patients being delayed or prevented in obtaining care); *Planned Parenthood of*

[15] Defendants may argue, as they previously did in the challenge to the telemedicine ban, that the balancing of benefits and burdens is no longer required after the Supreme Court's decision in *June Medical Services*, 140 S.Ct. 2103, 207 L.Ed.2d 566, and that the standard described in Chief Justice Roberts' concurrence in that case controls. But this Court previously recognized that Chief Justice Roberts' concurrence did not change the undue burden test as described in *Whole Woman's Health*. PPSWO Telemedicine Op. at 11. Moreover, even if it did, Plaintiffs would still prevail because SB27 is not rationally related to a legitimate state interest, *see* above at Section (II)(B)(1)(b), and it operates as a substantial obstacle to abortion for Plaintiffs' procedural abortion patients.

Wisconsin, *Inc. v. Schimel*, 806 F.3d 908, 916 (7th Cir.2015) ("[A] statute likely to restrict access to abortion with no offsetting medical benefit cannot be held to be within the enacting state's constitutional authority."). As major medical professional organizations, including the American College of Obstetricians and Gynecologists (ACOG), have concluded, 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." Liner Aff. at ¶ 46; *see also Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir.2013); *see also, e.g.*, *Schimel*, 806 F.3d at 918 (affirming injunction where law would delay access to abortion, causing some patients to need second-trimester abortions, "which are more expensive and present greater health risks"); *Planned Parenthood Southwest Ohio Region v. Hodges*, 138 F.Supp.3d 948, 960 (S.D.Ohio 2015); *Doe v. Barron*, 92 F.Supp.2d 694, 696–97 (S.D.Ohio 1999); *Planned Parenthood of Kansas v. Andersen*, 882 F.3d 1205, 1236–37 (10th Cir.2018), *cert. denied sub nom. Andersen v. Planned Parenthood of Kansas & Mid-Missouri*, ___ U.S. ___, 139 S.Ct. 638, 202 L.Ed.2d 503 (Mem.) (2018). SB27 is unconstitutional under either strict scrutiny or the federal constitutional standard.

2. Plaintiffs have a substantial likelihood of success on the merits of their claim that SB27 violates the Ohio Constitution's guarantee of equal protection.

The Ohio Constitution's equal protection provision is found in Article I, Section 2, which provides that:

> *All political power is inherent in the people. Government is instituted for their equal protection and benefit,* and they have the right to alter, reform, or abolish the same, whenever they may deem it necessary; and no special privileges or immunities shall ever be granted, that may not be altered, revoked, or repealed by the general assembly.

(Emphasis added). This provision "requires that the government treat all similarly situated persons alike." *Sherman v. Ohio Pub. Emps. Retirement Sys.*, 163 Ohio St.3d 258, 2020-Ohio-4960, 169

N.E.3d 602, slip op. at ¶ 14, citing *McCrone v. Bank One Corp.*, 107 Ohio St.3d 272, 2005-Ohio-6505, 839 N.E.2d 1, ¶ 6.

SB27 does not do so. Instead, it singles out patients who obtain and providers who perform procedural abortion for unnecessary restrictions that do not apply to similarly situated persons—including those who obtain or perform other medical procedures such as miscarriage management or in vitro fertilization. It imposes severe burdens on "pregnant wom[e]n" who need procedural abortions, R.C. 3726.03, without any countervailing benefit. And SB27 targets abortion providers with criminal penalties and draconian professional sanctions for violations of its requirements that do not apply to other medical providers, including providers who treat miscarriage using the same medical procedure. SB27's requirements violate the Ohio Constitution's equal protection guarantees and must be enjoined.

a. Strict scrutiny applies to determine whether SB27 violates Plaintiffs' and their patients' equal protection rights.

Strict scrutiny applies where a challenged classification implicates a fundamental right or protected class, meaning that the classification burdens that right or class in some non-trivial way. *See State ex rel. Brown v. Summit Cty. Bd. of Elections*, 46 Ohio St.3d 166, 169, 545 N.E.2d 1256 (1989); *City of Hamilton v. Fairfield Twp.*, 112 Ohio App.3d 255, 275–76, 678 N.E.2d 599 (12th Dist.1996); *United Auto Workers, Local Union 1112 v. Philomena*, 121 Ohio App.3d 760, 770–71, 773, 700 N.E.2d 936 (10th Dist.1998) (considering whether "the practical effect of a statute is to discourage" protected constitutional activity).

Strict scrutiny is warranted here because, as described in greater detail above, *see* above at Section (II)(B)(1), SB27 burdens the exercise of fundamental rights of privacy, procreation, bodily integrity and autonomy, and freedom of choice in health care decision making. *See, e.g.*, *Stone*, 64 Ohio St.3d at 160–63, 593 N.E.2d 294; *Aalim*, 150 Ohio St.3d 489, 2017-Ohio-2956, 83 N.E.3d

883, at ¶ 18. Strict scrutiny is also warranted because SB27 expressly discriminates against women and otherwise burdens them. Women constitute a suspect class because they have been subjected to "a history of purposeful unequal treatment," and historically "relegated to . . . a position of political powerlessness." *Williams*, 88 Ohio St.3d at 530, 728 N.E.2d 342, quoting *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 313, 96 S.Ct. 2562, 49 L.Ed.2d 520 (1976). SB27's discriminatory classification is clear from the law's face, *see* R.C. 3726.03 (requiring a "pregnant woman" to be notified that the embryonic or fetal tissue from her procedural abortion will be cremated or interred and limiting a "pregnant woman['s]" disposition options), and because it targets health care primarily used by women. Moreover, SB27 is clearly motivated by constitutionally impermissible sex stereotypes, imposing stigma and shame on a procedure commonly used by women, by forcing them to acknowledge that the tissue from their abortion will be treated like human remains. Williams Aff. at ¶ 8; Cunningham Aff. at ¶ 25–26. "By requiring the physician to confront the woman with a choice on the method of disposal, the state suggests to the woman that it equates abortion with the taking of a human life. Such a suggestion can only serve to increase the woman's feelings of guilt and impose a psychological burden on her." *Margaret S. v. Treen*, 597 F.Supp. 636 (E.D.La.1984) (striking down tissue disposal requirement—which did not require the tissue to be cremated or interred but only required providers to present patients with the option of cremation or interment—under the strict scrutiny framework).

b. SB27 fails strict scrutiny.

Under the strict scrutiny standard, it is the State's burden to advance a "compelling" reason for a challenged classification, and to demonstrate that the classification "is necessary to promote" that interest. *State ex rel. Brown*, 46 Ohio St.3d at 168, 545 N.E.2d 1256; *Conley v. Shearer*, 64 Ohio St.3d 284, 289, 595 N.E.2d 862 (1992). As explained above, SB27 furthers no compelling

state interest and, even if it does, it does not employ the least restrictive means to do so. *See* above at Section (II)(B)(1)(b). The fact that SB27's extreme restrictions apply only to patients who obtain and providers who provide procedural abortion, and not to those who obtain or provide other medical procedures, or those who seek to dispose of human remains, only serves to underscore this point.

SB27's cremation and interment requirements do not apply to identical tissue resulting from a medication abortion or from physician management of miscarriage, during which providers utilize a procedure identical to procedural abortion to remove embryonic or fetal tissue (and other pregnancy tissue) from a patient undergoing a miscarriage. Liner Aff. at ¶ 18, 28. In vitro fertilization ("IVF") clinics are not required to comply with SB27's mandates when they dispose of pre-implantation embryos either. *Id.* at ¶ 19, 28. Indeed, a Texas district court struck down similar tissue disposal requirements in Texas under the significantly less stringent rational basis standard, including because the court could "discern no legitimate state interests in distinguishing between identical tissue" from an abortion procedure and from an IVF procedure. *Whole Woman's Health v. Smith*, 338 F.Supp.3d 606, 641–42 (W.D.Tex.2018), *appeal filed,* No. 18-50730 (5th Cir. Sep. 7, 2018). And the law's requirements do not apply to human tissue that will need to be disposed following medical procedures, such as surgeries, other than procedural abortion. *See* Liner Aff. at ¶ 17. Instead, tissue from other medical procedures is disposed pursuant to the infectious waste disposal requirements—the same requirements Plaintiffs have been following for years to dispose of tissue from procedural abortion. There is no compelling reason for this differential treatment.

Indeed, SB27's requirements for embryonic and fetal tissue appear even more restrictive than pre-existing disposal requirements for human bodies under Ohio law. SB27 and its rules not

only limit disposal options to interment or cremation, but also require that cremation of tissue from a procedural abortion be at an Ohio-licensed crematory, R.C. 3726.02(B), and that locations for interring tissue provided by the abortion provider be at Ohio-registered cemeteries, Ohio Adm.Code 3701-46-01(B)(1)(b). But there is no requirement in Ohio law that human bodies only be cremated or interred or that they be cremated or interred in Ohio-licensed or -registered crematories or cemeteries. Human bodies can be disposed of by other means, not restricted to cremation or interment. *See* R.C. 3705.01(J) (stating dead human bodies can be interred or cremated, can be removed from the state, donated, or disposed of pursuant to "other authorized means"). And Ohioans—whether individuals or entities, like hospitals or state correctional institutions, that are charged with care of a body after death—can freely send human remains out of state. *Id.* There can be no compelling interest in imposing more onerous requirements on embryonic and fetal tissue than for human bodies, and this further demonstrates that, even if there were a compelling interest furthered by SB27, it does not employ the least restrictive means to do so.

Even if this Court finds that SB27 is a sex-based classification entitled to only intermediate scrutiny, it still cannot pass muster for the same reasons described above. There is no "exceedingly persuasive" justification for its requirements that is "substantially related" to the State's interests in the law. *United States v. Virginia*, 518 U.S. 515, 533, 116 S.Ct. 2264, 135 L.Ed.2d 735 (1996); *id.* at 585 (invalidating policy of excluding women under federal law's intermediate scrutiny standard and describing the "burden of justification" as "demanding" and "rest[ing] entirely on the State").

c. SB27 does not pass muster even under rational basis review.

In cases that do not involve a fundamental right or protected class, courts analyze an equal-protection claim under the Ohio Constitution using the rational-basis test. Under this test, the

State's interests must be "valid," and there must at least be some "rational" relationship between that interest and the means by which the State has chosen to advance it. *Conley*, 64 Ohio St.3d at 289, 595 N.E.2d 862; *Sherman*, 163 Ohio St.3d 258, 2020-Ohio-4960, 169 N.E.3d 602, slip op. at ¶ 15, quoting *McCrone*, 107 Ohio St.3d 272, 2005-Ohio-6505, 839 N.E.2d 1, at ¶ 9.

Although the rational-basis test is the least stringent form of constitutional review, it is not "toothless." *State v. Mole*, 149 Ohio St.3d 215, 2016-Ohio-5124, 74 N.E.3d 368, ¶ 28. Rather, rational-basis review stands as a bulwark to protect Ohioans from the government's "arbitrary exercise of power," *id.*, quoting *Conley* at 288, particularly where the stakes for disfavored groups—here, patients in need of access to procedural abortion and their doctors threatened with criminal penalties—are especially high. *See State v. Noling*, 149 Ohio St.3d 327, 2016-Ohio-8252, 75 N.E.3d 141, ¶ 21.

For all the reasons described in the previous section, SB27 bears no rational relationship to any conceivable state interest, and instead only serves to severely burden the provision of and access to abortion care. Ohio courts have not hesitated to strike down irrational and arbitrary state action under the rational basis standard, and this Court should do the same. *See Noling* at ¶ 22; *Mole* at ¶ 56–58, 60; *Holeton*, 92 Ohio St.3d at 132–33, 748 N.E.2d 1111; *State ex rel. Dayton Fraternal Order of Police Lodge No. 44 v. State Emp. Relations Bd.*, 22 Ohio St.3d 1, 488 N.E.2d 181 (1986), paragraph two of the syllabus; *see also, e.g.*, *Racing Assn. Of Cent. Iowa v. Fitzgerald*, 675 N.W.2d 1, 15–16 (Iowa 2004) (collecting rational-basis review cases from other states).[16]

[16] Indeed, a bare "desire to harm a politically unpopular group"—as Ohio politicians seem to view abortion patients and providers—"cannot justify disparate treatment of that group." *Noling* at ¶ 13; *see also, e.g.*, *Romer v. Evans*, 517 U.S. 620, 634–35, 116 S.Ct. 1620, 134 L.Ed.2d. 855 (1996); *Thompson v. KFB Ins. Co.*, 252 Kan. 1010, 1022–23, 850 P.2d 773 (1993); *Callaway v. City of Edmond*, 1990 OK CR 25, 791 P.2d 104, 107 (1990). The State's process in implementing the required rules for SB27 strongly supports that the requirements are based on animus, not policy. On April 6, 2021, the day SB27 was set to take effect, ODH issued emergency rules, despite there being no emergency and SB27 having been signed into law months earlier. Without the relief this

3. Plaintiffs have a substantial likelihood of success on the merits of their claim that SB27 is unconstitutionally vague.

SB27 should also be enjoined because it is impermissibly vague and thus violates due process guarantees under Article 1, Section 16 of the Ohio Constitution. *State v. Tanner*, 15 Ohio St.3d 1, 3, 472 N.E.2d 689 (1984). The void for vagueness doctrine is underpinned by three rationales:

> [F]irst, to provide fair warning to the ordinary citizen so behavior may comport with the dictates of the statute; second, to preclude arbitrary, capricious and generally discriminatory enforcement by officials given too much authority and too few constraints; and third, to ensure that fundamental constitutionally protected freedoms are not unreasonably impinged or inhibited.

Id., citing *Grayned v. City of Rockford,* 408 U.S. 104, 108–109, 92 S.Ct. 2294, 33 L.Ed.2d 222 (1972). Where, as here, "[u]ncertain meanings inevitably lead citizens to steer far wider of the unlawful zone . . . than if the boundaries of the forbidden areas were clearly marked," the third rationale is implicated. *Grayned*, 408 U.S. at 109, quoting *Baggett v. Bullitt*, 377 U.S. 360, 84 S.Ct. 1316, 12 L.Ed.2d. 377 (1964). And, where as here, a statute "'threatens to inhibit the exercise of constitutionally protected rights,' a more stringent vagueness test is to be applied." *Norwood v. Horney*, 110 Ohio St.3d 353, 2006-Ohio-3799, 853 N.E.2d 1115, ¶ 85, quoting *Village of Hoffman Estates v. Flipside, Hoffman Estates, Inc.,* 455 U.S. 489, 103 S.Ct. 1186, 71 L.Ed.2d. 362 (1982); *see also Akron v. Rowland*, 67 Ohio St.3d 374, 382, 618 N.E.2d 138 (1993); *Women's Med.*

Court awarded the day before, Plaintiffs would have had to stop providing procedural abortions entirely, as they had no warning of what the rules contained, despite asking ODH about the rules for months. Bertuleit Aff. at ¶ 28–29, 35–36, 38. Even after ODH initiated the notice-and-comment rulemaking process for the SB27 rules, they refused to engage with Plaintiffs' comments on the rules. *Id.* at ¶ 37 & fn.6. A Texas district court faced with an abortion restriction similar to SB27 found that the haphazard promulgation of the challenged law and its failure to consider how the law fits with the state's existing statutory schemes governing the disposition of "pathological waste" and "human remains" were "evidence [the state department of health's] stated interest is a pretext for its true purpose, restricting abortions," and struck down the law as irrational. *Whole Woman's Health*, 231 F.Supp.3d at 229. This Court should do the same.

Professional Corp. v. Voinovich, 130 F.3d 187, 197 (6th Cir.1997) (applying more stringent vagueness test to abortion restriction); *Belle Maer Harbor v. Charter Twp. of Harrison*, 170 F.3d 553, 557 (6th Cir.1999) (constitutionally protected conduct will survive vagueness challenge "only if it incorporates a high level of definiteness").[17] SB27 fails this standard.

SB27 and its implementing forms are impermissibly vague as to four key issues that make it impossible for "a reasonable individual of ordinary intelligence" to have "fair notice and sufficient definition and guidance to enable him to conform his conduct to the law." *Norwood* at ¶ 86. They will encourage "arbitrary, capricious and generally discriminatory enforcement," *Tanner* at 3, and force providers to "steer far wider of the unlawful zone . . . than if the boundaries of the forbidden areas were clearly marked," *Grayned*, 408 U.S. at 109, so as not to risk severe penalties, resulting in tremendous burden to Plaintiffs' patients.

First, the term "fetal remains" is vague because it does not specify whether it includes pregnancy tissue such as the placenta, gestational sac, and umbilical cord. The bill defines "fetal remains" as "the product of human conception that has been aborted." R.C. 3726.01(C). But it is unclear whether this *other* pregnancy tissue that is expelled during a procedural abortion is also "fetal remains" such that it can and should be cremated or interred, or whether it is infectious waste that must be disposed of by other means. R.C. 3734.01(R); Ohio Adm.Code 3745-27-32(A), (I)(18); *see also* above at Section (I)(B). Due to the size of the embryo or fetus prior to about 13 weeks LMP, it is impossible for physicians to be confident they can accurately separate embryonic

[17] Although "[t]he vagueness doctrine is usually applied in criminal law and First Amendment claims, . . . neither the rationale underlying the doctrine nor the case law interpreting it suggests that it should not be applied in any case in which the statute challenged substantially affects other fundamental constitutional rights." *Norwood* at ¶ 87 (applying vagueness framework in eminent domain case); *see also Akron v. Rasdan*, 105 Ohio App.3d 164, 167–68. 663 N.E.2d 947 (1995) (applying vagueness framework in the Second Amendment context).

and fetal tissue from other pregnancy tissue. *See* above at Section (I)(E). Without "fair warning" of whether it is permissible to cremate or inter the other pregnancy tissue under SB27, the only way for physicians to ensure compliance with the law is to avoid providing procedural abortions prior to approximately 13 weeks LMP. Liner Aff. at ¶ 35; Myers Aff. at ¶ 24; Haskell Aff. at ¶ 14; Burkons Aff. at ¶ 12; Bertuleit Aff. at ¶ 27. This is precisely the kind of chilling effect the void-for-vagueness doctrine is meant to prevent. *See, e.g.*, *Colautti v. Franklin*, 439 U.S. 379, 396, 99 S.Ct. 675, 58 L.Ed.2d. 596 (1979) (finding an abortion statute impermissibly vague where it "could have a profound chilling effect on the willingness of physicians to perform abortions . . . in the manner indicated by their best medical judgment").

Second, SB27 leaves providers unsure of whether they can send embryonic and fetal tissue from procedural abortion to third parties, such as pathologists and crime labs. SB27 states that the "[f]inal disposition of fetal remains from a surgical abortion at an abortion facility *shall* be by cremation or interment," (emphasis added) R.C. 3726.02(A), and imposes severe penalties on any "person [who] fail[s] to comply" with its requirements, R.C. 3726.99(A). Plaintiffs cannot control whether the pathologists (who are sometimes located in another state) and crime labs to whom they send tissue will cremate and inter the tissue, and it is unclear under the statute whether Plaintiffs will be subject to penalties if these third parties fail to do so. Plaintiffs thus risk "arbitrary, capricious and generally discriminatory enforcement." *Tanner*, 15 Ohio St.3d at 3, 472 N.E.2d 689; *see also Voinovich*, 130 F.3d at 205 ("In an area as controversial as abortion, . . . it is unlikely that the prosecution could not find a physician willing to testify that the physician did not act reasonably."). But sending tissue to these third parties may be essential for patients' health and safety, and providers can face civil suits and licensure actions for not doing so. Liner Aff. at ¶ 31.

Third, SB27 does not address whether embryonic and fetal tissue can be simultaneously cremated, or whether each embryo and fetus must be individually cremated. Without "fair warning" of whether they and their vendors risk penalties if they simultaneously cremate embryonic and fetal tissue, Plaintiffs will once again be forced to "steer far wider of the unlawful zone" by contracting with vendors to individually cremate tissue, thereby burdening their patients further, including because many vendors do not have capacity to individually cremate tissue and because individual cremation is necessarily more expensive. *Grayned*, 408 U.S. at 109, 92 S.Ct. 2294, 33 L.Ed.2d 222; *see also* above at Section (I)(E).

Fourth and finally, SB27 states that cremation must occur at Ohio-licensed crematories. R.C. 3726.02(B). And the law's implementing rules require that the interment options provided by abortion providers be at Ohio-registered cemeteries. Ohio Adm.Code 3701-46-01(B)(1)(b). But it is unclear whether this means that *all* tissue from procedural abortions must be disposed in state, or whether it requires only that the tissue that *is* disposed in state must be at a licensed or registered entity. Once again, because the law fails to provide "fair warning" and to avoid arbitrary and discriminatory enforcement, Plaintiffs have steered wide of the unlawful zone and only sought to partner with Ohio-based vendors. *See* Bertuleit Aff. at ¶ 7–9; Myers Aff. at ¶ 8–10, 14; Conrow Aff. at ¶ 9. Each of these ambiguities renders SB27 void for vagueness and it must be enjoined.

C. Plaintiffs and Their Patients Will Suffer Irreparable Harm Without Relief From This Court, and Preliminarily Enjoining Defendants Will Not Harm Third Parties.

Plaintiffs and their patients will suffer severe and irreparable harm unless Defendants continue to be enjoined from enforcing SB27. As stated above, without relief from this Court, if Plaintiffs have to comply with SB27, this will result in a violation of their and their patients' constitutional rights. Courts have long made clear that "[a] finding that a constitutional right has been threatened or impaired mandates a finding of irreparable injury as well." *Magda v. Ohio*

Elections Comm., 2016-Ohio-5043, 58 N.E.3d 1188, ¶ 38 (10th Dist.), citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir.2001); *see also Am. Civ. Liberties Union of Kentucky v. McCreary Cty.*, 354 F.3d 438, 445 (6th Cir.2003), citing *Elrod v. Burns*, 427 U.S. 347, 373, 96 S.Ct. 2673, 49 L.Ed.2d 547 (1976); *Michigan State A. Philip Randolph Inst. v. Johnson*, 833 F.3d 656, 669 (6th Cir.2016) ("[W]hen constitutional rights are threatened or impaired, irreparable injury is presumed." (Citation omitted.)); *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir.2012), citing *Am. Civ. Liberties Union of Kentucky* at 445 (same); *Taubman Co. v. Webfeats*, 319 F.3d 770, 778 (6th Cir.2003), citing *Connection Distrib. Co. v. Reno*, 154 F.3d 281, 288 (6th Cir.1998) ("[T]he loss of constitutional rights for even a minimal amount of time constitutes irreparable harm."). This Court has previously agreed. PPSWO Telemedicine Op. at 11–12. Because both Plaintiffs' and their patients' constitutional rights will be impaired without relief from this Court, they will suffer irreparable injury if Plaintiffs are forced to comply with SB27.

Moreover, severely burdening patients in obtaining procedural abortions—including significantly delaying them in accessing this care or forcing them to remain pregnant against their will—inflicts serious physical, emotional, and psychological consequences that alone constitute irreparable harm, as courts have recognized. *See* above at Section (I)(F); *see also e.g.*, *Planned Parenthood of Arizona, Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir.2014); *Van Hollen*, 738 F.3d at 795–96; *EMW Women's Surgical Ctr., P.S.C. v. Meier*, 373 F.Supp.3d 807, 825 (W.D.Ky.2019), *aff'd sub nom. EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785 (6th Cir.2020). This harm cannot be compensated once this challenge is concluded.

On the other hand, no third parties will be harmed if Defendants are enjoined. Plaintiffs have been providing health care safely and in accordance with all applicable laws, including infectious waste disposal laws, for decades. Defendants cannot claim any threat to public health or

safety. *See* above at Section (II)(B)(2)(b); *see also Van Hollen*, 738 F.3d at 793 (finding no harm to State in delaying implementation of new requirements where abortion providers had been safely providing care for decades). This is particularly so where the State waited a full year after SB27 was signed into law to finalize implementing rules. Finally, "the state cannot be harmed when an unconstitutional law does not go into effect." *Village of Newburgh Heights v. State*, 2021- Ohio-61, 166 N.E.3d 632, ¶ 76 (8th Dist.); *see also Chamber of Commerce of the United States v. Edmondson*, 594 F.3d 742, 771 (10th Cir.2010).

D. The Public Interest Will Be Served By Enjoining Defendants.

The public interest will be served by allowing Plaintiffs to continue providing, and their patients to continue accessing, essential and constitutionally protected health care. "[A] great[] public interest exists in ensuring governments and governmental officials operate within the confines of constitutional restrictions and prohibitions. Additionally, 'it is always in the public interest to prevent violation of a party's constitutional rights.'" *Lamar Advantage GP Co., LLC v. City of Cincinnati*, Hamilton C.P. No. A-18-04105, 114 N.E.3d 805, 829 (Oct. 17, 2018), quoting *Miller v. City of Cincinnati,* 709 F.Supp.2d 605, 627 (S.D.Ohio 2008); *see also Am. Civ. Liberties Union Fund of Michigan v. Livingston Cty.*, 796 F.3d 636, 649 (6th Cir.2015), quoting *Miller v. City of Cincinnati*, 622 F.3d 524, 540 (6th Cir.2010) ("[I]t is always in the public interest to prevent violation of a party's constitutional rights."); *Michigan State*, 833 F.3d at 669; *Am. Freedom Defense Initiative v. Suburban Mobility Auth. for Regional Transp.*, 698 F.3d 885, 896 (6th Cir.2012) ("[T]he public interest is promoted by the robust enforcement of constitutional rights * * *"); *G & V Lounge, Inc. v. Michigan Liquor Control Comm.*, 23 F.3d 1071, 1079 (6th Cir.1994).

E. A Bond Is Not Necessary.

This Court should use its discretion to waive the Civ.R. 65(C) bond requirement here, where the relief sought will result in no monetary loss to Defendants. *See Vanguard Transp. Sys., Inc. v. Edwards Transfer & Storage Co., Gen. Commodities Div.*, 109 Ohio App.3d 786, 793, 673 N.E.2d 182 (10th Dist.1996) (recognizing courts have discretion to issue preliminary injunctions without requiring bond); *see also Molton Co. v. Eagle-Picher Industries*, 55 F.3d 1171, 1176 (6th Cir.1995) (affirming decision to require no bond because of "the strength of [the plaintiff's] case and the strong public interest involved"); *Preterm-Cleveland*, 394 F.Supp.3d at 804 (waiving bond).

CONCLUSION

For the foregoing reasons, Plaintiffs ask this Court to issue a preliminary injunction, and continue to enjoin Defendants from enforcing SB27.

Dated: January 7, 2022

Respectfully submitted,

/s/ Maithreyi Ratakonda

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CERTIFICATE OF SERVICE

I hereby certify that on January 7, 2022, the foregoing was electronically filed via the Court's e-filing system.

/s/ Maithreyi Ratakonda
Maithreyi Ratakonda

EXHIBIT 1

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

SECOND AFFIDAVIT OF SHARON LINER, M.D., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Sharon Liner, M.D., being duly sworn on oath, do depose and state as follows:

1. I am the Medical Director of Planned Parenthood Southwest Ohio Region ("PPSWO"). I am also PPSWO's Director of Surgical Services. I have worked as a physician for PPSWO since 2004. Throughout that time, I have provided comprehensive sexual and reproductive health care, including abortion, to our patients.

2. The facts I state here and the opinions I offer are based on my education, years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, my review of PPSWO business records, information obtained through the course of my duties at PPSWO, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

3. I previously submitted an affidavit in this matter, and a copy of my *curriculum vitae* was attached to that affidavit as an exhibit. My *curriculum vitae* remains the same in all relevant respects.

4. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"), which regulates how embryonic

and fetal tissue will be disposed following a procedural abortion. SB27 requires this tissue to be cremated or interred.

5. I understand that SB27 imposes numerous penalties on physicians, like myself, and entities, like PPSWO, who provide procedural abortion for failure to comply with SB27, including criminal penalties.

6. If PPSWO is required to comply with SB27's requirements, my PPSWO colleagues and I will have no choice but to stop providing procedural abortions entirely in some circumstances, and, even if we are able to continue providing in other cases, significantly increase the cost of the procedure, resulting in patients being delayed or unable to access care. This will have a devastating impact on our patients and on providers, like myself, who have dedicated our careers to providing comprehensive reproductive health care. I am gravely concerned about the effect SB27 will have on Ohioans' emotional, physical, and financial wellbeing and the wellbeing of their families.

My Background

7. I am a board-certified family physician with 17 years of experience in women's health. I am licensed to practice medicine in the state of Ohio. I earned a B.S. in Medical Technology from Michigan State University and graduated from medical school at Michigan State University, College of Human Medicine. I completed my residency in Family Medicine at the University of Cincinnati.

8. Since 2002, I have provided abortions, including procedural abortions, in outpatient settings. In my current practice, I provide medication abortions up to 70 days (or 10 weeks) of

pregnancy as measured from the first day of a patient's last menstrual period ("LMP") and procedural abortions through 21 weeks, 6 days LMP.[1]

9. In my current roles as the Director of Surgical Services and Medical Director at PPSWO, I oversee all medical services that we provide, including abortion. My responsibilities include supervision of the physicians and clinicians who provide care and the development of PPSWO's medical policies and procedures.

PPSWO and Its Services

10. PPSWO and its predecessor organizations have provided care in Ohio since 1929. PPSWO is a nonprofit corporation organized under the laws of the State of Ohio and headquartered in Cincinnati, Ohio.

11. PPSWO provides affordable, respectful, and high-quality health care to tens of thousands of patients in southwest Ohio. PPSWO provides a broad range of medical services, including birth control; annual gynecological examinations; cervical pap smears; diagnosis and treatment of vaginal infections; testing and treatment for certain sexually transmitted diseases; HIV testing; pregnancy testing; miscarriage management; and abortion. We provide procedural abortions at our ambulatory surgical facility ("ASF") in Cincinnati.[2] PPSWO or a predecessor organization has provided procedural abortions in this location since 1974.

12. We strive to make our services as accessible as possible, particularly for patients in historically underserved communities who may not be able to reach us otherwise. The vast

[1] Pregnancy is commonly measured from the first day of a woman's last menstrual period or LMP. A full-term pregnancy is approximately 40 weeks LMP.

[2] Under Ohio law, all procedural abortions must occur in a licensed ASF or a hospital. The Cincinnati facility is PPSWO's only ASF.

majority—approximately 75%—of abortion patients nationwide are poor or have low incomes.[3] In calendar year 2020, 68% of our patients reported living at or below 110% of the federal poverty level.

Abortion Provision in Ohio

13. Legal abortion is one of the safest medical procedures in the United States.[4] It is also very common: Approximately one in four women in this country will have an abortion by age 45.[5]

14. There are two main methods of abortion: medication abortion and procedural abortion. Both methods are effective in terminating a pregnancy.[6]

15. Medication abortion involves a combination of two medications: mifepristone and misoprostol.[7] In Ohio, patients take the first medication in the health center and then, typically 24 to 48 hours later, take the second medication at a location of their choosing, most often at home, after which the contents of the pregnancy pass in a manner similar to a miscarriage. Medication abortion is available in Ohio in the first ten weeks of pregnancy.[8]

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[3] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 & Changes Since 2008*, at 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf (accessed Dec. 21, 2021).

[4] Natl. Academies of Sciences, Eng. & Medicine, *The Safety & Quality of Abortion Care in the United States*, at 77–78 and 161–62 (2018), available at https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states (accessed Dec. 21, 2021).

[5] *See* Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates & Lifetime Incidence of Abortion: United States, 2008–2014*, 107 Am. Journal of Pub. Health 1904, 1907 (2017).

[6] Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 Obstetrics & Gynecology 22 (2015).

[7] Natl. Academies of Sciences, Eng. & Medicine, *supra* note 4, at 51.

[8] Current medical evidence demonstrates that medication abortion is safe and effective through 11 weeks LMP. However, Ohio law, R.C. 2919.123, restricts the first drug used in medication abortion to use as described in the federally approved label, which is for pregnancies less than ten weeks. *See* U.S. Food & Drug Administration, *Mifeprex (mifepristone) Information*

16. While sometimes called "surgical abortion," procedural abortion is not what is commonly understood to be "surgery"; it involves no incisions. In a procedural abortion, clinicians use suction from a thin, flexible tube, and in some instances, other instruments, to empty the contents of the patient's uterus. PPSWO provides procedural abortion up to 21 weeks, 6 days LMP.

17. After a procedural abortion, PPSWO safely disposes of the products of conception—along with other pregnancy tissue, such as placenta, gestational sac, and umbilical cord—through a licensed vendor who incinerates the tissue. This is in accordance with all applicable laws and regulations prior to the enactment of SB27. Similarly, I understand that other medical facilities and hospitals in Ohio dispose of medical waste after a medical procedure (including after miscarriage or abortion) through one of the approved methods for disposal of infectious waste, such as incineration.

18. This is also the way that we dispose of tissue after treating a patient who has had a miscarriage. Dilation and curettage (D&C) is the standard treatment for a missed or incomplete miscarriage. This is the same procedure we use for a procedural abortion. Patients experiencing a miscarriage (like procedural abortion patients), have their cervix dilated and the contents of the uterus removed, generally using a suction curettage. These contents are then disposed of by incineration. The tissue disposed after a procedure used to treat miscarriage is identical to the tissue from a procedural abortion.

19. Similarly, pre-implantation embryos collected during in vitro fertilization ("IVF")—a method of assisted reproduction—are typically disposed of via incineration. During IVF, an egg and a sperm are combined in a laboratory dish to facilitate fertilization. A successfully

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(last updated Dec. 16, 2021), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

fertilized egg begins the process of cell division and results in an embryo. Embryos may then be transferred to a patient's uterus for implantation in the uterine lining, which begins a pregnancy. IVF providers typically attempt to fertilize more eggs than they will ultimately transfer. Embryos that are not immediately transferred are typically frozen and stored for possible future transfers. IVF patients may choose to use these frozen embryos or donate them; alternatively, they may direct providers to thaw and dispose of them. If this last option is chosen, IVF providers typically treat the pre-implantation embryos like other infectious waste and dispose of them via incineration.

20. Most people who have a medication abortion or who spontaneously miscarry (but do not need further medical care) often pass the pregnancy tissue in the privacy of their own homes, into the sewer.

21. Given the gestational age of their pregnancies, many patients—all those above 10 weeks LMP in Ohio—are only eligible for procedural abortion. Moreover, for some patients with pregnancies less than 10 weeks LMP, medication abortion is not available because it is medically contraindicated or there are other factors that necessitate a procedural abortion, such as where the patient has an allergy to the medications, or other medical conditions, such as a bleeding disorder or low hemoglobin, that make procedural abortion relatively more safe.[9]

22. Although medication abortion is safe and effective, in less than 1% of cases, it fails and the patient remains pregnant. In that circumstance, the patient has the option of repeating the medication-abortion process—if they remain eligible—or attempt a procedural abortion.

23. Some patients that have the option of choosing between a medication and procedural abortion (i.e. those who are less than 10 weeks LMP) strongly prefer procedural abortion. Although there are many reasons for this (and other patients have a strong preference for

[9] Natl. Academies of Sciences, Eng. & Medicine, *supra* note 4, at 51–52.

medication abortion), patients sometimes prefer the procedural option because they may perceive it to be less painful or because it can be done quickly at the health center and generally allow them to return to work, childcare, or other responsibilities shortly afterward. Additionally, there are numerous reasons that could make having a medication abortion an unsafe or less safe option. Some patients are in abusive situations, where it could be dangerous for a partner or person in their home to know they are having an abortion. Sadly, other patients may not have a residence at all, where they can pass the pregnancy in privacy.

24. In calendar year 2019, 77% of the abortions provided at PPSWO's ASF were procedural abortions. In calendar year 2020, this number declined for reasons related to the COVID-19 pandemic and 64% of abortions provided at PPSWO's ASF were procedural abortions.

25. Individuals seek abortion for a multitude of complicated and personal reasons, which may all be compounded by the current pandemic. By way of example, some patients have abortions because they conclude it is not the right time to become a parent or have additional children. In 2019, more than 62% of all abortions in Ohio were performed for patients who already had at least one child.[10] Others desire to pursue their education or career, or they lack the necessary financial resources or a sufficient level of partner or familial support or stability. Other patients seek abortions because continuing with the pregnancy could pose a significant risk to their health.[11]

26. Patients generally seek abortion as soon as they are able, but many face logistical obstacles that can delay access to abortion services. Patients will need to schedule an appointment,

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[10] Ohio Dept. of Health, *Induced Abortions in Ohio, 2019*, at 10 (2020), available at https://bit.ly/386HyzK (accessed Dec. 21, 2021); *see also* Jones & Jerman, *supra* note 5, at 1906 (in 2014, 59% of all abortions in the United States were performed for patients who already had at least one child).

[11] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC Women's Health 1, 7 (2013).

gather the resources to pay for the abortion and related costs,[12] and arrange transportation to a clinic, time off of work (often unpaid, due to a lack of paid time off or sick leave), and possibly childcare during appointments.[13]

SB27 Will Make Abortion Procedures Extremely Burdensome, or Impossible, to Obtain.

27. I understand that SB27 restricts the manner in which embryonic or fetal tissue from a procedural abortion can be disposed, requiring this tissue to be cremated or interred.

28. SB27's requirements do not apply to embryonic and fetal tissue from miscarriage, medication abortion, or IVF.

29. Embryonic and fetal tissue from a procedural abortion do not present any additional risk of infection than does any other form of tissue removed from a patient's body. There is no medical or public health reason to dispose of this tissue any differently from all of the other tissue that is disposed of after a medical procedure. Incineration, followed by depositing in a sanitary landfill—the method currently used for disposal of embryonic and fetal tissue—or another method of disposing of infectious waste, is a safe method to dispose of tissue.

30. After SB27 was passed, PPSWO immediately began determining whether we are able to comply with the law, including spending hours of staff time contacting funeral homes, crematories, and cemeteries. Our discussions with potential vendors surfaced a number of

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[12] Ohio prohibits public insurance, including Medicaid, and insurance purchased on the state health exchange from covering abortion services except in the very limited circumstances where a patient's physical health or life is at risk, or where the pregnancy is a result of rape or incest that has been reported to law enforcement. R.C. 9.04 and 3901.87; Ohio Adm.Code 5160-17-01.

[13] Guttmacher Inst., *Induced Abortion in the United States* (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states (accessed Dec. 21, 2021); 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, 341–42 (2006).

ambiguities in SB27, as described in greater detail in my colleague Suzanne Bertuleit's affidavit. These included whether SB27 allows embryonic or fetal tissue to be simultaneously cremated, what forms are needed to be completed prior to interment, and whether tissue can be sent to a pathologist or to a crime lab.

31. It is sometimes necessary to send tissue to a pathologist for testing for medical indications, such as suspected molar pregnancy, which if left undiagnosed or unmonitored can lead to a patient developing cancer and/or result in a hysterectomy. This testing can be essential for my patients' health, and it is the standard of care for medical providers to send tissue to a pathologist in certain circumstances. But we cannot control how the pathology labs will dispose of the tissue we send them, and whether they will ensure it is cremated or interred in accordance with SB27. Additionally, in some cases the pathology lab we work with will need to send tissue to another lab, perhaps one out of state, for further evaluation. There is no way of knowing in advance where or even to what state the tissue will ultimately be taken to be analyzed. The only way to avoid exposing ourselves to liability for pathology labs' actions is to stop sending tissue to pathology labs, but this would be a threat to our patients' health, and can expose the provider to civil suit and licensure consequences.

32. Similarly, it is very important that we be able to continue sending tissue to a crime lab in certain circumstances, such as when there has been a sexual assault. But we also cannot control how the crime lab will dispose of the tissue, and thereby expose ourselves to liability by sending tissue there.

33. SB27 also seems to conflict with infectious waste requirements, with which abortion providers are required to comply. Infectious waste requirements mandate that pathological waste, which includes pregnancy tissue such as uterine lining/decidua, umbilical cord,

gestational sac, and placenta, be treated by incineration, autoclaving, chemical treatment, or an alternative treatment technology approved by the Ohio Environmental Protection Agency, and then disposed as solid waste. R.C. 3734.01(R); Ohio Adm.Code 3745-27-32(A) and (I)(18). To my knowledge, neither cremation nor interment has been approved as an alternative treatment technology.[14] Under Ohio law, abortion providers are required to separate infectious from noninfectious waste, R.C. 3734.021, Ohio Adm.Code 3745-27-30, and can face severe, including criminal, penalties for not complying with disposal requirements, R.C. 3734.10 and 3734.99.

34. While SB27 requires "the product of human conception" to be cremated or interred, Ohio's infectious waste requirements generally require tissue and blood, which can include the other pregnancy tissue, such as the uterine lining, to be disposed of in other ways. However, early in pregnancy, it can be extremely difficult or even impossible to separate embryonic and fetal tissue from the other pregnancy tissue described above due to the size of the embryonic and fetal tissue. In these circumstances, I and other providers run the risk of running afoul of either SB27 or the laws related to disposal of infectious waste—a risk we cannot afford to take.

35. I and other providers at PPSWO cannot determine with confidence that we will be able to separate embryonic and fetal tissue from other pregnancy tissue until around 13 weeks LMP. This means that if we have to comply with SB27, we will not be able to provide procedural abortions until around 13 weeks LMP. In 2020, 73% of the procedural abortions provided at PPSWO were provided prior to 13 weeks LMP, and in 2019 75% were prior to 13 weeks LMP. Because medication abortion is only available until 10 weeks LMP, SB27 will result in an effective

[14] *See* Ohio Environmental Protection Agency, *Currently Approved Infectious Waste Alternative Treatment Technologies*, https://epa.ohio.gov/wps/portal/gov/epa/divisions-and-offices/materials-and-waste-management/reports-and-data/facility-lists-and-other-general-documents (accessed Dec. 21, 2021).

total ban on abortion from 10 weeks until about 13 weeks of pregnancy LMP. Having to delay all of our patients until around 13 weeks LMP will be hugely burdensome, including because procedures around 13 weeks or later take longer to perform than procedural abortions during the first trimester. This will likely result in a backlog of patients who will not be able to seek care right at around 13 weeks LMP—they will be pushed even later in pregnancy. Procedures later in pregnancy are also significantly more expensive.

36. Despite PPSWO and other abortion providers reaching out to the Ohio Department of Health ("ODH") several times to ask for clarity around the ambiguities inherent in the law, including asking ODH to address the conflicts between SB27 and the infectious waste requirements, ODH has refused to address any of these issues in the implementing rules they are required to issue.

37. In light of this, I and other providers at PPSWO have no choice but to stop providing procedural abortions until around 13 weeks LMP, forcing the vast majority of patients seeking procedural abortions to either delay their abortion until later in pregnancy, obtain a medication abortion when they may strongly prefer a procedural abortion or it may be the safer option, or to continue a pregnancy to term.

38. For medication-abortion patients who experience a failed abortion but are past the gestational age limit to attempt another medication abortion, SB27 will force them to wait several weeks to obtain a procedural abortion in Ohio, or travel out of state to obtain a procedural abortion.

39. Even if we can provide procedural abortions in compliance with the law after 13 weeks LMP, I understand that the costs imposed by SB27's requirements will result in significant burdens on our patients, which many of them will not be able to afford.

40. I understand that without relief from this Court, PPSWO will have to be in compliance with SB27 within 30 days after the implementing rules issued by ODH are made effective. ODH adopted the rules on December 30, 2021, and they will become effective on January 9, 2022. This gives PPSWO until February 8, 2022 to be in compliance with the law.[15]

SB27 Will Have a Devastating Impact on Us and Our Patients.

41. If we have to comply with SB27's requirements, this will have a devastating impact on our patients. Many patients seeking procedural abortions will be severely burdened in accessing that care.

42. In my almost 20 years of providing abortions, I have spoken to countless patients about the circumstances of their lives, their decision to have an abortion, any questions or concerns they have regarding the procedure, and their hopes and dreams for the future. Patients rarely bring up the disposal of the tissue of their embryo or fetus. On the very rare occasion that they do ask about this, I and our staff say that we dispose of the tissue like all other human tissues removed in medical procedures, such as an appendix. This makes perfect sense to them. And in the rare circumstances when patients ask about the possibility of a funeral, almost invariably in the case of the diagnosis of a fetal anomaly in the second trimester of pregnancy, we always provide them with a referral to a funeral home. But patients' primary concern is always to have a safe abortion. Their main desire is to be treated with respect and receive good care.

[15] As explained above, without relief, PPSWO's providers will have to stop providing procedural abortions prior to around 13 weeks LMP on February 8, 2022. But in fact, we may be forced to stop counseling patients for procedural abortions well ahead of February 8th. Ohio law requires patients be given certain state-mandated information at least 24 hours before their abortion. R.C. 2317.56(B). But because of delays in scheduling, patients usually have to obtain the state-mandated information around a week before the abortion procedure. Therefore, without relief, our patients seeking procedural abortions will be impacted well in advance of February 8th.

43. With the new regulation in place, we will have to present patients with forms notifying them that the State requires fetal and embryonic tissue to be cremated or interred. From my years of speaking with abortion patients, I know that many will be extremely upset and angry, because this law is yet another instance of the State imposing unnecessary abortion restrictions designed to shame and burden patients. In my experience, patients have different beliefs about whether a fetus is a person and should be afforded rituals customarily reserved for human remains, such as burials and cremations. These beliefs are often grounded in religious, spiritual, and cultural views. But SB27 imposes a funeral ritual on every patient, and is therefore completely disrespectful of patients' agency. Forcing patients to grapple with the knowledge that their tissue will be cremated or interred will only add to the harmful stigma that unnecessarily surrounds abortion care.

44. Complying with SB27 will also raise ethical concerns for me and our staff. Providers must respect patient autonomy.[16] Of course, personal autonomy is not an absolute right, but it should not be overridden without sound ethical justification. By requiring medical professionals to treat patients' embryonic and fetal tissue like human remains, SB27 forces the State's beliefs about personhood on a patient who may not share them, forcing providers to violate the patient's autonomy. I cannot identify a single ethical reason that would justify supplanting a patient's beliefs and desires about whether to treat their embryonic and fetal tissue like human remains with the State's beliefs about personhood.

45. Moreover, due to the ambiguities in SB27 and its apparent conflict with infectious waste requirements, we will be forced to stop providing procedural abortions until around 13

[16] *See e.g.*, Am. College of Obstetrics & Gynecologists Commt. Opinion No. 6, *Ethical Decision Making in Obstetrics and Gynecology* (Dec. 2007).

weeks LMP. Patients who seek abortion prior to this time in pregnancy—the vast majority of procedural abortion patients, *see* above—may have to substantially delay their care.

46. While abortion is generally safe throughout pregnancy, the risks of the procedure increase with gestational age.[17] The ability to access abortion even one week earlier reduces health risks, including the (already extremely low) risk of death.[18] The later in pregnancy a patient accesses a procedural abortion, the more likely they are to experience rare complications like hemorrhage, uterine perforation, cervical laceration or retained products of conception. These pregnant patients may also suffer from heightened emotional distress or anxiety, especially if they face health issues with their pregnancies. Later procedural abortion procedures are also more complicated. For example, the dilation and evacuation techniques used later in pregnancy require more time in the clinic (some even require an extra day) and a larger number of staff than aspiration abortion, which is used earlier in pregnancy. Accordingly, medical professional organizations have observed that 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."[19]

47. Abortion later in pregnancy is also more expensive. Some patients will not be able to afford the increased cost if they are forced to carry a pregnancy for longer before they are able to get care. Patients can be caught in a vicious cycle of delaying care to raise additional money, only to find that the price has increased and they once again cannot afford the procedure. Some of

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[17] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).

[18] *Id.*

[19] Am. College of Obstetricians & Gynecologists 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 (accessed Dec. 21, 2021).

these patients, including those eventually foreclosed from accessing abortion at all given their stage of pregnancy, will be forced to carry to term against their will.

48. Having to comply with SB27's requirement that all fetal and embryonic tissue from a procedural abortion be cremated or interred (when we are able to do so) will result in significant costs—both because of the cremation or interment costs and because abortions later in pregnancy are necessarily more expensive. These additional costs will result in many patients being delayed in accessing care as they struggle to raise the money needed for the procedure.

49. The increase in costs will also result in some patients simply not being able to afford to obtain an abortion from a licensed medical provider. This may lead to patients seeking care outside the medical system, which can sometimes be dangerous, being forced to travel hundreds of miles out of state if they are able to do so, or being forced to carry their pregnancies to term.

50. It is important to remember that most of our patients are poor or have low incomes. *See* above at ¶ 12. We have abortion patients who are students, who are only able to work part time, or who have lost their jobs during the COVID-19 pandemic. Patients struggle to provide for the children they already have: one patient had six children, all under the age of ten. Another was a minor, whose mother was working extra shifts to pay for the procedure. And another was caring for a sick relative, but would not be able to pay for the relative's medical bills because of the cost of obtaining an abortion. For these patients, even marginal increases in medical costs can put care out of reach.

51. If an individual is forced to continue a pregnancy against their will, it can pose a risk to their physical, mental, and emotional health, as well as to the stability and wellbeing of their family, including that of existing children.

52. Abortion is substantially safer than continuing a pregnancy through to childbirth. The risk of death associated with childbirth is approximately 12 times higher than that associated with abortion, and every pregnancy-related complication is more common among women giving birth than among those having abortions.[20] Even for a patient who is otherwise healthy and has an uncomplicated pregnancy, carrying that pregnancy to term and giving birth poses serious medical risks and can have long-term medical and physical consequences. These risks are greater for individuals with a medical condition caused or exacerbated by pregnancy, or for some who learn that the fetus has been diagnosed with a severe or lethal anomaly.

53. Preventing an individual who wants an abortion from having one can place economic and emotional strain on a family and may interfere with their life goals. As most patients who seek abortion already have at least one child, families must consider how an additional child will impact their ability to care for the children they already have.

54. Pregnancy, childbirth, and an additional child may exacerbate an already difficult situation for those who have suffered trauma, such as sexual assault or domestic violence.

55. Inability to access procedural abortion will have a disproportionate impact on the lives of Black people, other people of color, and people with low incomes in Ohio.[21] Recent ODH statistics show that Black women are 2.5 times more likely than white women to die of causes related to pregnancy.[22]

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[20] Natl. Academies of Sciences, Eng. & Medicine, *supra* note 4, at 74–75.

[21] In 2019, Black people made up only 13.4% of Ohio's population but over 46% of people who obtained abortions in Ohio. *See* ODH, *Induced Abortions in Ohio, 2019*, *supra* note 10, at 3; U.S. Census Bureau, *Quick Facts: Ohio*, https://www.census.gov/quickfacts/oh (accessed Dec. 21, 2021).

[22] Ohio Dept. of Health, *A Report on Pregnancy-Associated Deaths in Ohio 2008–2016*, at 19 (2019), https://bit.ly/3uZraej (accessed Dec. 28, 2021).

56. Being forced to stop providing some procedural abortions and greatly burden our patients in providing others will also have a detrimental impact on me and the other staff at PPSWO.

57. Many of our staff, including myself, have committed our professional careers to providing the full range of reproductive health care—of which procedural abortion is an essential part—to all patients who needs this care. Early in my medical career, I felt compelled to learn to provide abortions and safeguard patient access to abortion after the murder of Dr. Barnett Slepian, who was killed in his home by an anti-abortion extremist. Since then, I have spent significant time ensuring I am providing the highest-quality care. Having to scale back my provision of this necessary health care, and knowing that this unnecessary disposal requirement is imposing burdens that are greatly delaying or even preventing patients from obtaining care, will be devastating.

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58. For all of these reasons, if PPSWO has to comply with SB27, it will have a harmful impact on PPSWO and our patients.

FURTHER AFFIANT SAYETH NAUGHT

Sharon Liner, M.D.

Signed before me this 5 day of January, 2022

Notary Public

EXHIBIT 2

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF HOLLY MYERS IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Holly Myers, being duly sworn on oath, do depose and state as follows:

1. I am the Director of Compliance, Risk & Quality Management of Planned Parenthood of Greater Ohio ("PPGOH"). PPGOH is a not-for-profit organization with headquarters in Columbus. I am over the age of eighteen, competent to testify, and make this affidavit based on personal knowledge.

2. In my role as Director of Compliance, Risk & Quality Management, I am responsible for all compliance efforts, quality assurance, and risk management, including compliance with SB27.

3. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"), which regulates how "fetal remains" will be disposed following a procedural abortion. SB27 requires "fetal remains" to be cremated or interred.

4. Through spearheading and coordinating PPGOH's outreach efforts to attempt to comply with SB27, I've learned that PPGOH cannot comply with this law without placing a significant burden on our patients seeking abortion in the state. SB27 also contains numerous

ambiguities that make compliance impossible in certain circumstances. Having to comply with this law will thus have a devastating effect on our patients and on PPGOH. Relief from this Court is necessary to prevent serious harm.

Provision of Health Care, Including Abortion, at PPGOH

5. PPGOH was formed in 2012 through a merger of several local and regional Planned Parenthood affiliates that had served patients in Ohio for decades. PPGOH serves patients in northern, eastern, and central Ohio, and provides a broad range of medical services, including birth control, gynecological examinations, cervical pap smears, diagnosis and treatment of vaginal infections, testing and treatment for sexually transmitted infections, HIV testing, pregnancy testing, and abortions.

6. PPGOH provides procedural abortions until 19 weeks and 6 days of pregnancy at our ambulatory surgical facilities ("ASFs") in East Columbus and Bedford Heights. After a procedural abortion, we safely dispose of the products of conception—along with other pregnancy tissue, such as placenta, gestational sac, and umbilical cord—through a licensed vendor who incinerates the tissue. This is in accordance with applicable laws and regulations, and, I understand, is consistent with the methods used by other medical facilities and hospitals in Ohio who dispose of medical waste. On the rare occasion a patient wants to bury or cremate the tissue from her abortion procedure, they are able to do so.

7. In calendar year 2019, 60% of the abortions provided at PPGOH's ASFs were procedural abortions. In calendar year 2020, this number declined for reasons related to the COVID-19 pandemic and 51% of abortions provided were procedural abortions.

PPGOH's SB27 Compliance Efforts and Outcomes

8. PPGOH began to diligently explore compliance with the new law soon after Governor DeWine signed the bill on December 30, 2020, because we recognized that it would be a seachange in how we dispose of tissue from procedural abortions, and that the process to contact potential vendors, explain the law's requirements, obtain and evaluate proposals, and implement a new disposal process would be lengthy. I oversaw a team that made outreach efforts to 140 crematories and funeral homes to see if they would work with us. In total, these outreach efforts took multiple staff members hours of work each.

9. We obtained a list of all crematories and funeral homes licensed by the Ohio Board of Embalmers and Funeral Directors from Ohio's License Look-Up website, https://elicense.ohio.gov/oh_verifylicense. But because this website does not have contact information for these entities, we had to perform internet searches to obtain this information.

10. We began by calling crematories and funeral homes nearest to our East Columbus and Bedford Heights health centers, working our way out to cast a wide net. This was an extremely time-intensive process because of the time it takes to find their telephone numbers and to actually make all those calls. Most did not respond or return our messages. Of the few that expressed some interest, we explained what SB27 requires and our needs; these calls took over an hour each. In total, we made 63 calls to crematories and funeral homes.

11. We also sent 77 emails with a Request for Proposal ("RFP") to crematories and funeral homes. This, too, was difficult and time consuming because we had to find each individual entity's email address through internet searches. For those that did not have an email address available online, we called them to obtain one; some refused to provide an email address.

12. Nearly all of the crematories and funeral homes we contacted did not respond to our requests. Some responded to explain why they were declining to work with us, including because of capacity, because they did not want to be associated with an abortion provider, for religious reasons, and because of ambiguities in the law.

13. Only two indicated an interest in continuing conversations with us, by submitting proposals. But further conversations with one crematory vendor revealed that it did not have the capacity to individually cremate all of the tissue from procedural abortions provided at PPGOH's health centers. The other vendor also did not have capacity to individually cremate tissue from us and the cemetery that they worked with would not allow them to contract with us to inter tissue there.

14. There is one crematory in the state that can individually cremate the embryonic and fetal tissue from procedural abortions at our health centers and is willing to work with us. This vendor has stated that it will cost $295 for cremation of tissue from each embryo or fetus. There is also one vendor who can inter embryonic and fetal tissue, and interment will cost $75 for each embryo or fetus.

15. Passing these costs on to our patients by raising the price of procedural abortions will have a devastating effect on their ability to access this care. The cost of this increase will be significant. Not only will we have to raise prices based on the cost of the cremation or interment ($75–295), but patients will also face a price increase because SB27 will effectively eliminate the provision of procedural abortion until around 13 weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"), *see* below at ¶ 24. About 67% of our procedural abortion patients obtained their abortion prior to 13 weeks LMP in 2020 and about 80% did so in

2019.[1] A procedural abortion after 13 weeks is *at least* around $150 more expensive than a procedural abortion before 13 weeks. Therefore, most of our patients will face significant price increases because of this law.[2] Many of our patients, most of whom are poor or have low incomes, cannot afford such an increase in price.

16. Having to delay all of our patients until around 13 weeks LMP will also result in severe burdens, including because procedures around 13 weeks or later take longer to perform than procedural abortions during the first trimester, and some of our providers do not provide procedural abortions much past the first trimester. This will likely result in a backlog of patients who will not be able to seek care right at around 13 weeks LMP—they will be pushed even later in pregnancy.

17. I am also concerned that being tied to at most two vendors for disposal of tissue from procedural abortions would put us in a precarious position. Anti-abortion activists regularly harass our vendors, and we lose vendors from time to time because of this. In fact, this has happened with multiple waste disposal vendors in the past, and I am afraid it may very well happen again. Even our current waste disposal vendor regularly experiences harassment from protestors. We have also had other contractors refuse to continue working with us, due to the harassment they have experienced for their willingness to contract with an abortion provider, including a fencing company who received terrible fake reviews online once protestors discovered they installed a fence for us. I fear that if these two vendors are similarly targeted and harassed, they will decide that they can no longer work with us, and we may have to suddenly stop providing procedural

[1] Due in part to temporary changes in service at the start of the COVID-19 pandemic, the 2019 numbers better reflect the percent of early procedural abortions typically provided at PPGOH.

[2] Patients may be further delayed as they struggle to raise the funds necessary to obtain care. But the cost of a procedural abortion becomes more and more expensive later in pregnancy. For example, an abortion at 14 weeks LMP is $300 more than an abortion prior to 13 weeks LMP. One at 16 weeks LMP is $525 more, one at 18 weeks LMP is $600 and one at 19 weeks is $750 more.

abortions altogether. This uncertainty is difficult not only for our patients, but also for our staff and professionals, and we may encounter problems retaining staff who see our workplace as unstable. Having to comply with this law will therefore significantly burden our patients seeking to access abortions, that is if we are able to navigate SB27's ambiguities and come into compliance at all.

SB27 and the Implementing Rules' Ambiguities

18. SB27 contains numerous ambiguities. While we and the other procedural abortion providers in Ohio repeatedly raised these issues during the rulemaking process in attempt to get some clarity, the Ohio Department of Health ("ODH") refused to address the ambiguities, and instead introduced more confusion in their implementing rules.

19. For instance, SB27 does not address whether embryonic and fetal tissue can be cremated simultaneously, or instead whether each fetus and embryo must be individually and separately cremated. Many crematories we spoke to do not have the capacity to individually cremate all tissue from procedural abortions performed at PPGOH. Crematories also indicated that individual cremation would be extremely difficult, if not impossible, due to the very small size of the fetus or embryo, and the fact that there would be no cremains to dispose of after the cremation process.

20. While simultaneous cremation may be more feasible, it is our understanding that crematories will not be able to simultaneously cremate tissue from procedural abortions without explicit guidance from the state allowing this.

21. I understand that cremation is a highly regulated field, and the crematory operators wanted to fully understand their operational responsibilities before they committed to this work.

22. For similar reasons, burial is not a feasible alternative to cremation. Indeed, the only funeral home that was willing to continue conversations with us indicated they needed clarity from ODH on the forms that were needed before burial of embryonic and fetal tissue in order to provide exact prices or enter into a contract. And clarity is also needed to determine whether forms used for interring embryonic and fetal tissue would compromise patient-identifying information.

23. Other ambiguities in the law make it difficult for us to determine how to comply at all. SB27 and the implementing rules are unclear as to whether we can continue sending embryonic and fetal tissue to a crime lab. We sometimes receive law enforcement requests, including warrants or subpoenas, to turn over tissue as evidence as part of, for example, a sexual assault investigation. We may also need to send tissue to a pathology lab, if there are medical indications for doing so. Because we cannot control how the crime or pathology labs will dispose of the tissue, and whether they will do so in compliance with SB27, we risk SB27's severe penalties by continuing to send tissue to these labs despite the very important health and safety reasons to do so. In fact, the pathology labs we work with are part of national chains, and the tissue we send to them is frequently taken out of state to be analyzed.

24. It is also unclear what our providers should do in the event they cannot separate a fetus or embryo from other pregnancy tissue, as is often the case for pregnancies earlier in gestation. Being unable to separate fetal and embryonic tissue from other pregnancy tissue may result in our providers either violating SB27 or Ohio's infectious waste disposal laws. Because of this ambiguity in the law, PPGOH's providers will have to stop providing procedural abortions before around 13 weeks LMP—because they cannot be confident they can separate fetal and embryonic tissue from other pregnancy tissue before that point—so as not to risk severe penalties. The majority of procedural abortions performed by PPGOH are early in pregnancy—

approximately 67% to 80%, based on the year, are before 13 weeks LMP. Additionally, because procedures around 13 weeks or later take longer to perform than procedural abortions during the first trimester, having to delay patients until at least 13 weeks LMP will likely result in a backlog, pushing patients even later in pregnancy.

25. PPGOH, as well as the other providers of procedural abortion in Ohio, repeatedly raised these issues with ODH during the rulemaking process, through which ODH drafted rules to implement SB27. We submitted three rounds of comments—two sets of written comments in response to "draft" rules issued by ODH, and comments during a public hearing, after ODH issued "proposed" rules. But ODH refused to engage with our comments and implement any clarifying changes. Instead, the implementing rules only introduce further restrictions and confusion.

26. For instance, ODH added a requirement that the locations for interment of embryonic and fetal tissue provided by the abortion providers must be Ohio-registered cemeteries. This restriction does not exist in SB27. Additionally, while SB27 requires ODH to prescribe rules relating to three forms to be utilized when cremating tissue, ODH seemingly conflated rules for two of the forms—one to the filled out by the patient and one to be given to a crematory operator—which can result in the patient-identifying information to be disclosed to the crematory operator. Finally, ODH has refused to issue the actual forms that must be utilized by us, our patients, and the crematories and funeral homes, leaving everyone in the dark as to what the forms we must incorporate into the disposal process contain. Once again, despite PPGOH and other providers raising these issues repeatedly with ODH, it has refused to implement necessary changes.

The Impact of Having to Comply with SB27

27. If PPGOH has to comply with SB27, this will be terrible for our patients. All of our patients seeking procedural abortions will be either be prevented from accessing that care or, if we are able to comply with the law in limited circumstances, severely burdened in doing so.

28. Forcing patients to acknowledge that the tissue from their abortion will be cremated or interred will significantly add to the stigma surrounding abortion. Patients already have to walk through a gauntlet of protestors, who attempt to disparage and shame them, before entering the health center. Many patients enter the health center shaking or crying after going through this experience. Then they have to be given a litany of state-mandated information, including about the "anatomical and physiological characteristics" of the embryo or fetus. *See* R.C. 2317.56(B)–(C). Ohio law also requires providers to determine whether there is a fetal heart tone, and to tell patients they can view or hear the heart tone. R.C. 2919.192(A). If a heart tone is detected, the patient must be informed that the fetus has a "fetal heartbeat," be told the probability of bringing the fetus to term, and sign a form acknowledging that they have been provided this information. R.C. 2919.194(A)(1)–(2). If an ultrasound is performed, the provider must offer the patient the opportunity to view the ultrasound. R.C. 2317.561. Providers are also prohibited from performing abortions where they know the patient's reason for the abortion is related, in whole or in part, to Downs Syndrome. R.C. 2919.10(B). All of these requirements severely harm patients by shaming them for having an abortion. Having to then read a form stating that the tissue from their abortion procedure will be treated as a human body will be extremely distressing to patients. I do not know what the purpose of this requirement is other than to burden and shame our patients.

29. As I explained above, even if we can comply, PPGOH's providers will have to stop providing procedural abortions before around 13 weeks LMP, due to the ambiguities in the law.

Indeed, SB27 will result in an effective total ban on abortion from 10 weeks until around 13 weeks LMP. Patients who seek procedural abortion prior to 13 weeks—the vast majority of our patients, as reflected above—will have to delay their care for days or weeks. Abortions later in pregnancy are more expensive as explained above, and some patients may not be able to access this care at all due to the increase in price.

30. Of course, having to inter or cremate fetal and embryonic tissue will also significantly add to the price of the abortion procedure, as described above at ¶ 15. Many of our patients are poor or have low incomes. They simply cannot afford such an increase in price to obtain this procedure.

31. I fear that SB27 will result in many of our patients being forced to turn to methods of ending their pregnancy outside of the medical system, which can be dangerous, being forced to travel hundreds of miles out of state, or having to carry a pregnancy to term against their will.

32. Having to comply with SB27 will also have a devastating impact on our staff. Many of our staff have committed their professional careers to providing the full range of reproductive health care—of which procedural abortion is an essential part—to *all* of our patients, no matter their income or means. Being forced to significantly raise the price of procedural abortions, knowing that many of our patients cannot afford such an increase, when we are able to provide this care at all, will be heartbreaking for our staff.

33. SB27's onerous and ambiguous requirements will result in serious harm to PPGOH and our patients seeking procedural abortions. It will force us to stop providing procedural abortions entirely in some circumstances, or to otherwise impose tremendous burdens on our patients if we can comply with the law, resulting in our patients being significantly delayed in seeking this care, if they are able to obtain it at all.

FURTHER AFFIANT SAYETH NAUGHT

Holly Myers

Signed before me this 6 day of January, 2022

Notary Public

VALORIE E. CLEVENGER
Notary Public, State of Ohio
My Comm. Expires 04/14/2024
Recorded in Stark County

EXHIBIT 3

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF JENNIFER MOORE CONROW IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Jennifer Moore Conrow, being duly sworn on oath, do depose and state as follows:

1. I am the Executive Director of Preterm-Cleveland ("Preterm"), a nonprofit corporation organized under the laws of the State of Ohio, which is a plaintiff in this case. I have held this position since June 2021.

2. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Ohio Senate Bill 27 ("SB27"), which regulates how "fetal remains" will be disposed of following a procedural abortion. In particular, SB27 requires cremation or interment of "fetal remains." I am over the age of eighteen, I am competent to testify, and I make this affidavit based on personal knowledge.

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

4. Compliance with SB27 will result in heavy burdens on our patients, including significantly delaying them in obtaining care, and preventing some patients entirely from

accessing abortion care. Indeed, because of its interaction with other laws, compliance with SB27 will result in an effective total ban on abortion from about 10 weeks of pregnancy until 13 weeks of pregnancy. Without relief from this Court, SB27 will cause severe harm to Preterm and our patients.

Abortion Services at Preterm

5. Preterm provides procedural abortion until the legal limit in Ohio, which is 21 weeks, 6 days of pregnancy, as measured from the first day of a patient's last menstrual period, or LMP. Preterm also provides medication abortion until 10 weeks LMP, which is the legal limit in Ohio for that method of abortion.

6. SB27 would fundamentally alter our process for managing medical waste from procedural abortion, because we currently use a licensed vendor who incinerates the tissue, as permitted for decades under Ohio law. That tissue includes both fetal or embryonic tissue and other pregnancy tissue such as placenta, gestational sac, uterine lining, and umbilical cord. To my knowledge, other facilities in Ohio, including hospitals, similarly dispose of tissue following medical procedures (including miscarriage and abortion) using one of the methods for disposal of medical waste, such as incineration, that have long been deemed acceptable under Ohio law.

7. In those rare instances in which a patient wishes to ensure that tissue from an abortion is handled in a different manner, such as through cremation or burial, we work with that patient and with local service providers to facilitate that disposition.

8. In calendar year 2019, Preterm performed 4953 abortions, of which 3,638 (or approximately 73%) were procedural abortions. In 2020, approximately 3,430 out of 4364 abortions at Preterm (79%) were procedural abortions.

Preterm's Efforts to Comply with SB27

9. Preterm began to diligently explore compliance with the new law soon after Governor DeWine signed the bill on December 30, 2020. Preterm staff promptly reached out to local funeral homes, funeral industry groups and associations, and crematories about potential compliance. We also asked our board members for suggestions and solicited one of our board members in particular who, because of her profession, works closely with members of the funeral services industry, to reach out to her contacts on our behalf.

10. Because we already facilitate burial or cremation on a case-by-case basis for those patients who wish to pursue this option (which happens very rarely and generally in the case of later pregnancies where there are fetal anomalies), Preterm staff began by reaching out to a funeral home and crematory that Preterm has worked with in the past. The owner did not offer burial as an option, but he was open to having further conversations about cremation. However, he said that he needed to understand the logistics first. Over the course of several conversations, he raised questions about documentation, whether simultaneous cremation was permitted, and other related issues, many of which the law simply does not address.

11. Ultimately, after several months, he produced a proposal that includes a price of $117 per fetus or embryo for individual cremation. This particular vendor stated that he could likely cremate all of the tissue from Preterm, but he would need to increase his present capacity, including by adding to his physical plant, in order to serve other abortion providers. He stated that he did not feel comfortable doing simultaneous cremation without explicit guidance from the state. In addition, this vendor wanted to keep his identity from being publicly disclosed if he were to work with us because of concerns about harassment from anti-abortion activists. But the requirements of SB27 may make this anonymity impossible, because according to SB27, the forms to be signed by patients must indicate the location of final disposition.

12. We spoke to another vendor who indicated a willingness to work with us to inter embryonic and fetal tissue and stated that interment would cost $75 per embryo or fetus.

13. We also received an unsolicited call from an individual who claimed to be associated with a particular funeral home in the Columbus area. This individual claimed he could work with us to comply with the law and that he had already been speaking with another provider in the state. We initially responded, but then learned that this individual was actually a journalist and did not appear to be affiliated with a funeral home. This individual did not try contacting us again. None of our other outreach—including through our board members and industry groups and associations—yielded any other names of funeral homes or crematories that were willing and able to work with us, except for one crematory that quoted an even higher price of $295 per fetus or embryo.

Impact on Preterm's Patients

14. The additional costs associated with complying with SB27 would delay many patients in getting care and put an abortion entirely out of reach for many others. The vast majority of our patients are poor or low-income, and many struggle to afford their care. Some are forced to delay their abortion as they struggle to acquire the necessary funds; some even forgo groceries or other necessities in order to pay for abortion care. Thus, the increased costs associated with burial or cremation would likely put abortion out of reach for many of them (especially since, as noted below, the price of the abortion procedure increases later in pregnancy, and the subsequent reduction in services that Preterm would incur could ultimately force Preterm to close.)

15. On top of the struggles patients already face to raise the funds for their care, they will now have to come up with additional funds to pay the higher cost for the abortion procedure due to this law. In addition, because we cannot reliably separate fetal or embryonic tissue from

other pregnancy tissue before around 13 weeks LMP—which we will need to do under this law, as it appears that other pregnancy tissue likely *cannot* be cremated or interred—patients who are beyond 10 weeks of pregnancy and all those who need a procedural abortion would also be forced to wait until around 13 weeks LMP to obtain the procedure, at which point it becomes more expensive. Currently, about 80% of our procedural abortions occur before 13 weeks LMP, so this change would shift a large number of abortions later in pregnancy.

16. Beginning at 13 weeks LMP, the cost of a procedural abortion increases by $90. If a patient requires more time to raise the additional funds, the procedure might become even more expensive, as the cost increases by another $100 between 15 and 16 weeks LMP—creating a vicious cycle whereby the delay causes the price of the procedure to increase, leading to more delay as the patient has to acquire additional funds. A procedural abortion between 17 and 18 weeks costs $450 more than an abortion before 13 weeks.

17. Along with concerns regarding the cost of the procedure increasing throughout pregnancy, there is also an increased risk of complication for the patient if they are forced to delay an abortion procedure until later in pregnancy. Although procedural abortion is extremely safe, the health risks of both pregnancy and abortion increase later in pregnancy, so forcing patients to undergo later abortion procedures would also increase the risks to their health. I find the idea of forcing patients to seek care later in pregnancy, thereby increasing the risks to their health without any offsetting benefit, to be deeply unethical.

18. I am also concerned that having only a small number of possible vendors available for disposal of tissue from procedural abortions will make us vulnerable to uncertainty and possible closure. As our potential cremation vendor recognized, anti-abortion activists regularly target for harassment vendors who work with abortion clinics. In my years of working with abortion clinics,

I have personally witnessed refusals by contractors, hotels, and car services to work with abortion clinics due to concerns over harassment. For example, one clinic where I worked had contracted with a local hotel to provide a negotiated rate for patients traveling from out of state for abortion care. Within three days of negotiating this contract, the hotel pulled out because of constant phone calls and emails from anti-abortion activists. I have also worked with clinics that have been unable to hire contractors to do basic maintenance or upkeep of their facilities due to fear of, or past experience with, harassment by anti-abortion activists. This includes at least two clinics that lost medical waste disposal vendors due to harassment. I fear that if the only two vendors we were able to find are similarly targeted, they will decide that they no longer wish to work with us, which could force us to stop providing procedural abortions altogether.

19. In addition, forcing the state's views about the nature and status of fetal tissue onto patients is offensive and demeaning. I believe that our patients should not be forced to accept the state's view on this personal matter and instead should be permitted to act in accordance with their own moral, spiritual, and philosophical views. SB27 takes away our patients' ability to decide for themselves how to treat their pregnancies and instead forces them to treat the tissue in the manner the state prescribes.

25. Moreover, if Preterm has to stop providing procedural abortions until around 13 weeks LMP, this will cause emotional distress for patients who wish to terminate their pregnancies earlier but who are not eligible for medication abortion. When a patient contacts our clinic, she has already decided to end her pregnancy and may have already spent significant time raising money and making arrangements for the abortion. It will be extremely distressing for those patients who must be told that they are required to remain pregnant for several more weeks or even months.

26. In addition, having to stop providing procedural abortions until around 13 weeks LMP would create an enormous scheduling challenge. We would have to change both our physician and patient schedules to make this happen—not just for scheduling appointments, but also for ensuring that there is an appropriate amount of time in the day for each procedure. Scheduling more people later in pregnancy means that procedures take longer, so there will be fewer available time slots for them each day. This will result in patients being prevented from obtaining abortions until later and later in pregnancy, as there are fewer and fewer appointments available.

27. I am concerned that some of our patients, if unable to access legal abortions because they are pushed too late in pregnancy or they cannot afford the increased cost of this care, may turn to other methods of ending their pregnancies, which may be dangerous. Some may be able to travel out of state if they have the means to do so, but others will be forced to carry unwanted pregnancies to term, causing them great harm.

FURTHER AFFIANT SAYETH NAUGHT.

Jennifer Moore Conrow

Signed before me this 5 day of January, 2022

aimee l maple
Notary Public

EXHIBIT 4

Haskell Affidavit.pdf

DocVerify ID:	9E253969-98B8-4CD1-8DA9-B2E0F35BCCFE
Created:	January 06, 2022 07:56:52 -8:00
Pages:	7
Remote Notary:	Yes / State: OH

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E-Signature Summary

E-Signature 1: W M Martin Haskell, MD (WMH)
January 06, 2022 08:03:36 -8:00 [96A1AB412938] [66.161.150.106]
martyh@fortemgt.com (Principal) (Personally Known)

E-Signature Notary: Theresa M Sabo (TMS)
January 06, 2022 08:03:36 -8:00 [5D575472B8E4] [23.28.168.121]
tess.sabo@gmail.com
I, Theresa M Sabo, did witness the participants named above electronically sign this document.

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

SUPPLEMENTAL AFFIDAVIT OF W.M. MARTIN HASKELL, M.D. IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, W.M. Martin Haskell, M.D., being duly sworn on oath, do depose and state as follows:

1. I am the sole shareholder and Medical Director of Women's Med Group Professional Corporation ("WMGPC"), which has owned and operated a clinic known as Women's Med Center of Dayton ("WMCD") in Kettering, Ohio since 1983.

2. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Ohio Senate Bill 27 ("SB27"), which regulates how "fetal remains" will be disposed of following a procedural abortion. In particular, SB27 requires cremation or interment of "fetal remains." I am over the age of eighteen, I am competent to testify, and I make this affidavit based on personal knowledge.

3. As Medical Director of WMCD, I supervise physicians and clinicians and provide reproductive health care to patients. I also supervise and manage the provision of all abortion care at WMGPC facilities and am responsible for developing and approving WMGPC's policies and procedures.

4. As explained below, compliance with SB27 would delay WMCD's patients in obtaining care and prevent some of our patients entirely from accessing abortion care. Indeed, because of its interaction with other laws, compliance with SB27 will result in an effective total ban on abortion from about 10 weeks of pregnancy until 13 weeks of pregnancy.

Abortion Services at WMCD

5. WMCD provides procedural (sometimes called "surgical") abortion until the legal limit in Ohio, which is 21 weeks, 6 days, as measured from the first day of a patient's last menstrual period, or LMP. WMCD provides medication abortion until 10 weeks LMP, which is the legal limit in Ohio for that method of abortion.

6. SB27 would fundamentally alter our process for managing medical waste following a procedural abortion, because we currently use a licensed vendor who incinerates the tissue, as permitted for decades under Ohio law. That tissue includes both fetal or embryonic tissue and other pregnancy tissue that is removed during a procedural abortion, such as placenta, gestational sac, uterine lining, and umbilical cord. To my knowledge, this is similar to the methods of disposal of medical waste, including embryonic and fetal tissue, used by other medical facilities, including hospitals, in Ohio.

7. If a patient wishes to ensure that tissue from an abortion is handled in a different manner, such as through cremation or burial, we work with that patient and with local service providers to facilitate that disposition.

8. In calendar year 2019, WMCD performed 2,745 abortions, of which 1,892 (or approximately 69%) were procedural abortions. In 2020, we provided fewer procedural abortions for reasons related to the COVID-19 pandemic, and approximately 1,570 out of 2,695 abortions at WMCD (58%) were procedural abortions.

WMCD's Efforts to Comply with SB27

9. WMCD began to diligently explore compliance with the new law soon after Governor DeWine signed the bill on December 30, 2020. We promptly reached out to contacts within the funeral industry, including funeral homes and crematories that we sometimes work with when we assist the handful of patients, approximately six per year, who choose to arrange for burial or cremation after an abortion. (Generally these patients are ending a wanted pregnancy due to a fetal anomaly discovered in the second trimester of pregnancy.)

10. Despite the prior relationships and our best efforts, finding potential vendors for burial or cremation services that would allow us to comply with SB27 has proven to be extremely difficult.

11. Potential partners have expressed concern about the lack of clarity in the rules. Others have said that individual cremation, which appears to be required, would be impracticable because the crematory facilities are not designed for cremating extremely small amounts of tissue and, even if it were possible, some crematories explained that they would not have the capacity to handle the number of cremations we would require.

12. In the end, we were left with only two vendors who were potentially willing and able to work with us. One vendor stated he had capacity to inter tissue from procedural abortion and that interment of each embryo or fetus would cost $75.

13. The second vendor stated that individually cremating embryonic and fetal tissue would cost $295 per fetus or embryo.

14. However, SB27 fails to address how we should handle other pregnancy tissue, including umbilical cord, gestational sac, uterine lining/decidua, or placenta, which may not fall within the definition of "fetal remains" and which may be impossible to physically separate out

from fetal or embryonic tissue earlier in pregnancy. Because of this ambiguity, WMCD may be at risk of violating either SB27 or Ohio's infectious waste disposal laws, which may apply to this other pregnancy tissue, unless it halts all procedural abortions until around 13 weeks LMP, at which point we can be confident that we can identify and separate the embryonic and fetal tissue from the other pregnancy tissue. Yet, the overwhelming majority (77-80%) of procedural abortions performed by WMCD are prior to 13 weeks LMP.

Impact on WMCD's Patients

15. The additional costs imposed by SB27 would likely put abortion out of reach for many of our patients. Most of WMCD's patients are poor or low-income; in 2021, approximately 61% of our patients had incomes at or below 120% of the poverty line. In addition to the direct costs associated with cremation and interment, compliance with SB27 would force patients to delay procedural abortions until after about 13 weeks of pregnancy because until that point we cannot reliably separate fetal or embryonic tissue from other pregnancy tissue before around 13 weeks LMP, which we will need to do under this law as it seems other pregnancy tissue cannot be cremated or interred. This will force patients to incur additional costs as well. Beginning at 14 weeks LMP, the cost of a procedural abortion increases by $150, and due to scheduling logistics and individual patient circumstances it will not be possible to schedule every patient for surgery before the 14-week mark. If a patient requires additional time to raise the additional funds, the procedure becomes even more expensive, as the cost increases by another $350 between 16 and 17 weeks LMP. A procedural abortion between 18 and 19 weeks costs $1,000 more than an abortion before 13 weeks. This can create a cycle in which the patient must delay her procedure in order to raise additional funds, and then the delay causes the cost of the procedure to increase,

requiring further delay in order to raise even more money. This cycle can even result in the abortion becoming altogether unaffordable for some patients.

16. I am also concerned that having only two possible vendors available for disposal of tissue from procedural abortions will make us more vulnerable and could result in us having to suddenly stop providing care. Anti-abortion activists regularly target for harassment vendors and others who work with us. For example, several years ago, our medical waste disposal company was bought out by a larger company, which then stopped accepting fetal tissue after its involvement with abortion clinics became publicly known. Thus, I fear that these two vendors may decide that they no longer wish to work with us. That could force us to stop providing procedural abortions altogether, which in turn would make it impossible for WMCD to remain open and cause a sudden loss of services for our patients.

17. In addition, forcing patients to accept that embryonic and fetal tissue will be interred or cremated is offensive and stigmatizing. It forces upon patients the State's apparent belief that fetal or embryonic tissue must be treated like the body of a deceased human person–a belief that many of our patients disagree with. Indeed, WMCD currently works with the few patients who wish to have their embryos or fetuses cremated or buried to ensure their wishes can be carried out; however, SB27 takes away patients' choice in the matter and forces them to treat the tissue in the manner the State prescribes.

18. Moreover, having to stop providing procedural abortions before around 13 weeks LMP will cause emotional distress for patients who wish to terminate their pregnancies earlier but are not eligible for medication abortion. When a patient arrives at our clinic, she has already decided to end her pregnancy and may have already spent significant time raising money and making arrangements for the abortion. It will be extremely distressing for those patients to be told

that they are required to remain pregnant for several more weeks or even months. And while abortion is safe, abortions later in pregnancy are more complex and carry higher risk than those earlier in pregnancy.

19. I am concerned that some of our patients, if denied legal abortions, may turn to methods of ending their pregnancies outside of the medical system, which may be dangerous. Some may be able to travel out of state if they have the means to do so, but others will be forced to carry unwanted pregnancies to term.

FURTHER AFFIANT SAYETH NAUGHT.

W M Martin Haskell, MD
Signed on 2022/01/06 08:03:36 -8:00

W.M. Martin Haskell, M.D.

01/06/2022

Signed before me this ___ day of January, 2022

Signed on 2022/01/06 08:03:36 -8:00

Notary Public

NOTARY PUBLIC STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2022/01/06 09:03:36 PST 5D575472B8E4

Notarial act performed by audio-visual communication

EXHIBIT 5

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

SUPPLEMENTAL AFFIDAVIT OF DAVID M. BURKONS, M.D. IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, David M. Burkons, M.D., being duly sworn on oath, do depose and state as follows:

1. I am the Medical Director of the Northeast Ohio Women's Center ("NEOWC"), which operates an Ambulatory Surgical Facility in Cuyahoga Falls, Ohio, and a medication-only abortion facility in Shaker Heights, Ohio.

2. As NEOWC's Medical Director, I supervise physicians and clinicians and provide reproductive health care, including medication and procedural abortions, to patients. I also oversee the provision of all abortion services at NEOWC, and I am responsible for developing and approving NEOWC's policies and procedures.

3. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"), which requires that "fetal remains" from procedural abortions, defined as "the product of human conception that has been aborted," must be cremated or interred. I previously submitted an affidavit in support of the Plaintiffs' first Motion for a Temporary Restraining Order in this case.

4. The facts I state here are based on my experience, information obtained in the course of my duties at NEOWC, and personal knowledge that I have acquired through my role at NEOWC. If called and sworn as a witness, I could and would testify competently thereto.

5. As explained below, without relief from this Court, SB27 will cause severe harm to NEOWC and our patients. Indeed, because of its interaction with other laws, compliance with SB27 will result in an effective total ban on abortion from about 10 weeks of pregnancy until 13 weeks of pregnancy.

6. NEOWC provides procedural abortion until 16 weeks, 6 days, as measured from the first day of a patient's last menstrual period, or LMP. NEOWC also provides medication abortion until 10 weeks LMP, which is the legal limit in Ohio for that method of abortion.

7. SB27 would fundamentally alter our process for managing medical waste, because we currently use a licensed vendor who incinerates the tissue, as permitted for decades under Ohio law. That tissue includes both fetal or embryonic tissue and other pregnancy tissue such as placenta, gestational sac, uterine lining, and umbilical cord. To my knowledge, other facilities in Ohio, including hospitals, similarly dispose of tissue following medical procedures (including miscarriage and abortion) using one of the methods for disposal of medical waste, such as incineration, that have long been deemed acceptable under Ohio law.

8. If a patient wishes to arrange for cremation or burial of fetal tissue, they may do so; however, in my experience, patients generally seek to dispose of fetal or embryonic tissue in this way only in cases of fetal anomalies that are discovered in the second trimester of pregnancy.

9. In calendar year 2019, NEOWC performed 1,886 abortions, of which 1,136 were procedural abortions (60%). In 2020, the number of procedural abortions we provided was lower, partly for reasons related to the COVID-19 pandemic, and approximately 1,275 out of 2,941

abortions at NEOWC (43%) were procedural abortions.

10. Soon after Governor DeWine signed SB27 at the end of 2020, we began to diligently explore compliance options. Despite multiple attempts to secure concrete proposals, none of the vendors we contacted were willing or able to work with NEOWC to provide services that would comply with SB27, citing a range of concerns relating to the lack of clear guidance as to what SB27 requires and difficulties providing individual cremations of embryos.

11. After the proposed implementing rules were issued, we again began to explore options for compliance. We eventually found one vendor that stated that they could inter tissue from procedural abortion at a cost of $75 per embryo or fetus and another vendor that quoted a price for cremation of $295 per fetus or embryo.

12. However, SB27 fails to address how we should handle other pregnancy tissue, including umbilical cord, gestational sac, uterine lining/decidua, or placenta, which may not fall within the definition of "fetal remains" and which may be impossible to physically separate out from fetal or embryonic tissue earlier in pregnancy. Because of this ambiguity, NEOWC may be at risk of violating either SB27 or Ohio's infectious waste disposal laws, which may apply to this other pregnancy tissue, unless it halts all procedural abortions until around 13 weeks LMP, at which point we can be confident that we can identify and separate the embryonic and fetal tissue from the other pregnancy tissue. Yet, the overwhelming majority of procedural abortions performed by NEOWC are prior to 13 weeks LMP, and approximately 400 of those abortions are between 10 weeks (the legal limit for medication abortion) and 13 weeks.

13. Beginning at 13 weeks LMP, the cost of a procedural abortion at NEOWC increases by $50, and by another $50 at 14 weeks LMP. If a patient requires additional time to raise the additional funds, the procedure might become even more expensive, as the cost increases

by another $50 at 15 weeks LMP and another $125 at 16 weeks LMP. Thus, a procedural abortion between 16 weeks LMP and 16 weeks, 6 days LMP costs $275 more than an abortion before 13 weeks LMP.

14. The increase in price of procedural abortions due to the cost of cremation or interment and due to forcing patients to obtain the procedure later in pregnancy would likely put abortion out of reach for many of our patients. Nearly half of our patients have incomes at or under 120% of the poverty line. Thus, they already struggle to pay for their abortions, and may forgo other necessities in order to do so.

15. Therefore, if NEOWC has to comply with SB27, it will seriously harm and burden our patients, many of whom will be significantly delayed in obtaining a procedural abortion or unable to access procedural abortion care at all because they are delayed beyond the gestational age at which abortion care is available, or because the procedure becomes too expensive for them to afford.

16. In addition, forcing patients to acknowledge that the embryonic or fetal tissue from their procedural abortion will be cremated or interred is offensive. It forces upon patients the idea that fetal or embryonic tissue must be treated like the body of a deceased human person—a view that conflicts with many of our patients' religious or spiritual beliefs.

17. Having to stop procedural abortions until around 13 weeks LMP will also cause emotional distress for patients who wish to terminate their pregnancies earlier but who are not eligible for medication abortion. When a patient contacts our clinic, they have already decided to end their pregnancy and may have already spent significant time raising money and making arrangements for the abortion. It will be extremely distressing for those patients who must be told that they are required to remain pregnant for several more weeks or even months.

18. I am concerned that some of our patients, if unable to access legal abortions due to financial constraints, may turn to other methods of ending their pregnancies, some of which may be dangerous. Some may be able to travel out of state if they have the means to do so, but others will be forced to carry unwanted pregnancies to term.

19. I am also concerned that having only two possible vendors available for disposal of tissue from procedural abortions will make us vulnerable to sudden interruptions in providing care. Anti-abortion activists regularly target for harassment vendors and others who work with us, and I have had many vendors decline to work with us due to concerns about harassment. In fact, one clinic in Ohio where I have worked was unable to get mail delivery for a period of time because of harassment from anti-abortion activists. I fear that if these two vendors are similarly targeted, they will decide that they no longer wish to work with us. That could force us to stop providing procedural abortions altogether. Of course, operating under this kind of uncertainty is very problematic for our patients—who might face sudden loss of services—as well as for our staff and physicians.

FURTHER AFFIANT SAYETH NAUGHT.

David M. Burkons, M.D.

Signed before me this 10 day of January, 2022

Notary Public

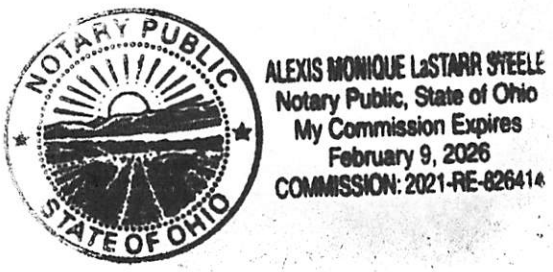

EXHIBIT 6

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF SUZANNE BERTULEIT IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Suzanne Bertuleit, being duly sworn on oath, do depose and state as follows:

1. I am the Chief Operating Officer ("COO") of Planned Parenthood Southwest Ohio Region ("PPSWO"). I am over the age of eighteen, competent to testify, and make this affidavit based on personal knowledge.

2. In my role as COO, I am responsible for all patient services, quality assurance, and risk management work at PPSWO, as well as overseeing IT, security, facilities, contract management and certain business projects, including compliance with Senate Bill 27 ("SB27").

3. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of SB27, which regulates how "fetal remains" will be disposed following a procedural abortion. SB27 requires "fetal remains" be cremated or interred.

4. Through overseeing our extensive outreach efforts to attempt to comply with SB27, I have learned that SB27 contains significant ambiguities that make compliance impossible in some circumstances. Even if PPSWO is able to comply with SB27, this law will tremendously burden our patients' access to procedural abortions.

PPSWO diligently explored compliance options.

5. For years, PPSWO has arranged for the pathological waste from its health centers to be incinerated, and then deposited in a sanitary landfill. Until SB27, this method fully satisfied all laws and regulations governing treatment and disposition of tissue following a procedural abortion, including Ohio's requirement that tissue from an abortion procedure "shall be disposed of in a humane manner." Ohio Adm.Code 3701-47-05(A).

6. PPSWO recognized SB27 would fundamentally alter how we manage medical waste because our current methods do not comply with SB27's requirements. Therefore, we began to diligently explore compliance with the new law even before Governor DeWine signed the bill into law on December 30, 2020. We understood that the process of reaching out to local funeral homes, cemeteries, and crematories about potential compliance would entail many hours over many months. We would have to contact area crematories and funeral homes, solicit proposals, evaluate those proposals, ensure the suitability of the new partner, and enter into a contract—all before the law took effect.

7. I oversaw, and was part of, a team that has contacted 160 Ohio crematories and funeral homes to see if they would contract with us, as SB27 requires.

8. To start, we reached out to about one dozen local crematories and funeral homes that we identified from an internet search. We called each of these crematories and funeral homes. This was a time-intensive process because many did not answer even after repeated attempts to contact them. Even when we were able to make contact, most did not take our subsequent calls after we described SB27's requirements; this was true even for those who committed to follow up with us.

9. We then obtained a list of all crematories and funeral homes licensed by the Ohio Board of Embalmers and Funeral Directors from Ohio's License Look-Up website,

https://elicense.ohio.gov/oh_verifylicense. Because the online license registry does not contain any contact information, we then performed internet research to obtain that information for each crematory and funeral home in the Southwest Ohio region. This proved difficult—and time consuming—because some entities did not have a website at all and some had a website that did not include contact information. Contact information was not available for some even after thorough searching. Of the 175 unique crematories and funeral homes in our region, after hours of research, we found contact information for most of them. For some, their website did not list contact information but allowed us to submit a request for them to contact us back.

10. In total, we were able to contact 128 funeral homes and 32 crematories. Nearly all did not respond to our requests.

11. Even of those who responded, most were not interested in or willing to work with us. Some provided a reason for this. For example, several stated that they did not want to partner with an abortion provider. Others were already operating at capacity.

12. Some entities also expressed concern with working with us due to the real risk of protestors or other demonstrations. Several even said they would only work with us if they could remain anonymous to the public. But SB27 requires us to provide all patients obtaining procedural abortions with a "notification form" which lists "available options for locations . . . for the disposition of fetal remains." R.C. 3726.14(A)(2). Because the Ohio Department of Health ("ODH") has refused to provide us with this "notification form"—despite us asking repeatedly for access to this form—we are unsure what information must be included on the form and therefore cannot assure the crematories and funeral homes that they can remain anonymous to the public. Not knowing what information must be listed on this form raises another significant concern. For our patients' privacy and comfort, we must ensure that the precise location where cremated

remains or tissue for interment is disposed is not made public. But because we have not been able to review the ODH forms, we do not know what level of detail must be included regarding the location of final disposition.

13. We sent a Request for Proposal ("RFP") to all the crematories and funeral homes that responded to us and indicated they were interested in working with us—eleven entities in total. *See* Ex. A. The RFP sought detailed information on their capacity and willingness to work with us to comply with SB27, as well as the cost of such compliance.

14. Of the eleven, only six submitted proposals. Lengthy and numerous follow-up conversations with these entities revealed that several of these vendors did not have capacity to, or otherwise could not commit to, interring or individually cremating tissue from the procedural abortions we provide every year. Others simply could not give us sufficient cost estimates for cremation or interment and/or could not provide us with annual capacity estimates for interring or cremating tissue, including because of ambiguities in the law.

15. In the end, two vendors indicated they had capacity to take tissue from PPSWO for individual cremation. One vendor, Vendor A,[1] quoted us a price of $95 per individual cremation, and indicated that due to capacity constraints, they could not take on much more than PPSWO's embryonic and fetal tissue from procedural abortions. Vendor B had more capacity, indicating they could individually cremate the embryonic and fetal tissue from the other providers in the state, but were significantly more expensive, quoting us a price of $295 per individual cremation. A third vendor, Vendor C, indicated it had capacity to inter tissue from procedural abortion and quoted us a price of $75 per embryo or fetus.

[1] I am using pseudonyms to indicate the identity of the vendors, due to the vendors' real fear of harassment and other negative consequences if it becomes publicly known that they are willing to work with abortion providers. *See* below at ¶ 17–18.

16. These vendors were only able to provide us cost *estimates* and their proposals could not include precise costs of cremation or interment of embryonic and fetal tissue because of the lack of clarity around many aspects of compliance, which are detailed below at ¶ 22–27.

PPSWO cannot comply with SB27 without imposing tremendous burdens on our patients.

17. Being forced to dispose of fetal or embryonic tissue with very few vendors willing to partner with us puts PPSWO in a precarious position. As discussed above, some vendors expressed fear of harassment and negative consequences to their professional and personal lives if they are publicly associated with abortion providers. These fears are not unfounded. Anti-abortion groups have a history of exerting political and economic pressure on key vendors not to work with abortion providers. This has been a particular challenge in the area of waste management. PPSWO has previously had a waste management vendor withdraw from working with us due to pressure from anti-abortion protestors. I know this is the case for other abortion providers across the country as well. Other vendors we work with have lost clients once it became known that they are working with us. One electrical contractor refused to work with us after consulting with his priest; after he suddenly withdrew from the contract, we were delayed for several months in remodeling our health center, which severely affected our operations and resulted in significant cost. Other staff affiliated with PPSWO have experienced significant harassment from anti-abortion protestors, including protestors showing up at their homes.

18. I am very concerned that if we were tied to just two or three vendors, these vendors may refuse to continue working with us if they become targets of harassment. This would mean that we would have to stop providing procedural abortions until we could secure another vendor—if that were even possible. This is already a serious concern with the sole vendor who has stated it has capacity to inter embryonic and fetal tissue. The cemetery this vendor works with is very

concerned about publicity—and resulting harassment—from being associated with an abortion provider. This tenuous position makes it difficult to keep clinic doors open and ensure continuous care to our patients.

19. Requiring another vendor relationship also provides yet another opportunity for ODH to investigate us or even shut us down for compliance missteps (which seems to be the very purpose of SB27, given its many uncertainties and ODH's refusal to provide necessary guidance, as detailed below). Regardless of whether we are ultimately successful in these disputes with ODH, professionals like licensed sonographers, registered nurses, and physicians are reluctant to work in an environment that they see as unstable, which may contribute to staffing issues and curtail services beyond procedural abortions.

20. Even if we are able to secure stable vendor relationships, SB27 imposes significant financial challenges. The estimates submitted by the two crematories, Vendors A and B, ranged from $95 to $295 for cremation of tissue from each embryo or fetus. According to Vendor C's estimate, interment will cost $75 for each embryo or fetus.

21. Passing these costs on to our patients by raising the price of procedural abortions will have a devastating effect on their ability to access this care. The cost of this increase will be significant. Not only will we have to raise prices based on the cost of the cremation or interment ($75–95), but patients will also face a price increase because SB27 will effectively eliminate the provision of procedural abortion until around 13 weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP"). *See* below at ¶ 27. The vast majority of our patients obtain abortions prior to 13 weeks LMP. A procedural abortion after 13 weeks is *at least* $150 more expensive than a procedural abortion before 13 weeks. Therefore, most of our patients

will face significant price increases because of this law.[2] Many of our patients simply cannot afford such an increase in price. Having to comply with this law will therefore severely burden our patients seeking to access abortions.

SB27 contains numerous, significant ambiguities.

22. As I mentioned, SB27 contains numerous ambiguities that make it impossible for crematories and funeral homes to give us precise costs for cremation or interment of embryonic and fetal tissue. Other ambiguities in the law make it impossible for us to understand how and whether we can comply in many circumstances, even if we were able to find a vendor whose services are not cost prohibitive.

23. First, SB27 does not address whether tissue from procedural abortions can be cremated simultaneously. Based on the information we obtained from the crematories we spoke to, it appears that individually and separately cremating tissue from each fetus or embryo would be extremely difficult for several reasons. Because individual cremation is a lengthy and time-intensive process, many crematories cannot meet PPSWO's needs due to lack of capacity. The crematory operators also expressed concern with the impracticality of individual cremation, given the small size of the tissue from procedural abortion. For example, while the law requires remains after tissue is cremated be disposed in certain prescribed ways, *see* R.C. 4717.271, there will likely be no remains to dispose of if tissue is required to be individually cremated. Moreover, it would

[2] In fact, they may face even higher costs, because SB27 will likely result in further operational costs to PPSWO, including requiring additional staff time to supervise workflow and to monitor the crematory and funeral home vendors.

Patients may be further delayed as they struggle to raise the funds necessary to obtain care. But the cost of a procedural abortion becomes more and more expensive later in pregnancy. An abortion at 16 weeks LMP is $330 more than an abortion prior to 13 weeks LMP. One at 18 weeks LMP is $950 more, and one at 20 weeks is $1,750 more.

be exceedingly difficult to physically cremate the products of procedural abortion, given the small size at earlier gestations.

24. While simultaneous cremation may be more feasible, crematories who could work with us were not willing to enter into a contract for simultaneous cremation absent explicit guidance permitting this from the State.[3]

25. Additionally, SB27 does not address what forms are required when interring fetal and embryonic tissue. I understand that this results in two significant problems: 1) certain forms required to inter human bodies, if used for fetal and embryonic tissue disposal, can result in the disclosure of patient-identifying information; and 2) the number and types of forms required can significantly affect the cost of interment. Without knowing which forms are required by the law, some funeral homes could not give us accurate cost estimates for interment. We also could not determine whether our patients' privacy would be compromised.

26. SB27 also does not address whether fetal and embryonic tissue subject to SB27's requirements can be sent to a crime lab in compliance with the law. From time to time, we get law enforcement requests, including warrants or subpoenas, to turn over tissue as evidence as part of, for example, a sexual assault investigation, and we are uncertain how to respond to these requests under SB27. In addition, the law is unclear whether we may continue sending tissue to a pathologist for testing, which is the medical standard of care if there are certain medical indications warranting this. While sending tissue to a crime lab or to a pathologist is essential for patient health and safety, because we cannot control how the crime lab or pathologist will dispose of this tissue, we are

[3] Even if the State provided guidance stating that simultaneous cremation is permissible for embryonic and fetal tissue, our conversations with crematory operators indicate that this would still be very costly (although not as costly as individual cremation). Moreover, having to simultaneously cremate tissue can raise informational privacy concerns, as certain authorization forms required for simultaneous cremation can compromise patient privacy.

unsure if we risk violating SB27 (or otherwise face the consequences of disregarding a warrant or subpoena or the medical standard of care) if we continue sending the tissue to crime labs and pathologists.

27. SB27 also seems to conflict with infectious waste requirements, with which abortion providers are required to comply. Infectious waste requirements mandate that pregnancy tissue, including uterine lining/decidua, umbilical cord, gestational sac, and placenta, be disposed of in certain specific ways, not including cremation and interment. If this tissue does not fall within SB27's definition of "fetal remains," it cannot be cremated or interred. But it is sometimes impossible to physically separate out this other pregnancy tissue from fetal or embryonic tissue, particularly at earlier gestational ages. If our providers are not able to separate fetal or embryonic tissue from other pregnancy tissue, which they may not be able to do prior to around 13 weeks LMP, they risk running afoul of either SB27's mandate that "fetal remains" be cremated or interred or the laws governing disposal of infectious waste, which includes this other pregnancy tissue. *See* Ohio Adm.Code 3745-27-32(A), (I)(18). The risk engendered by this conflict in the laws will result in our providers not being able to provide procedural abortion until around 13 weeks LMP.

SB27's implementing rules do not address any of these ambiguities.

28. I understand that under SB27, ODH is required to issue implementing regulations, including rules that prescribe three forms that are to be used by patients, providers, and crematories under this law. *See* R.C. 3726.14. PPSWO contacted ODH several times asking them to address ambiguities—including all of the issues listed above—in the implementing rules, but ODH has refused to do so.

29. PPSWO and other abortion providers were contacted by ODH in early July 2021 and asked to submit comments to draft rules related to SB27. On July 20, 2021, Plaintiffs together timely submitted one set of comments ("First Round Comments") describing several aspects of

SB27 and the draft rules that were ambiguous and/or onerous, and which ODH could address in future iterations of the rules. *See* Ex. B.

30. For instance, the First Round Comments pointed out that because SB27 is silent on whether simultaneous cremation is permitted, crematories were not willing to simultaneously cremate embryonic and fetal tissue despite individual cremation being extremely difficult and cost prohibitive. The First Round Comments also asked ODH to create an exception for embryonic and fetal tissue sent to a pathologist or crime lab, list the forms necessary for interring tissue and ensure patient privacy would be protected, and make clear that pregnancy tissue that cannot be separated from embryonic and fetal tissue be allowed to be cremated or interred.

31. In addition to the ambiguities in SB27, described above at ¶ 22–27, the First Round Comments also described further unnecessary requirements and ambiguities introduced by the draft rules.

32. The draft rules contained a requirement that interment occur in an Ohio-registered cemetery. Such a requirement is not present in SB27, and ODH did not provide any explanation why further restrictions beyond the scope of the statute were necessary.

33. Additionally, SB27 mandated that the director of ODH prescribe rules for three separate forms to implement the law: the notification form, which must be provided to the patient; the consent form, which patients must complete; and the detachable supplemental form, which must be provided to a crematory operator. *See* R.C. 3726.14(A)–(C). But the draft rules seemed to conflate the consent form with the detachable supplemental form.[4] Requiring that the patient complete the detachable supplemental form, rather than the consent form, could result in protected

[4] The draft rules did prescribe a consent form, but only for non-married or non-emancipated minors. There were no rules related to a consent form for non-minors or married or emancipated minors.

patient information being disclosed to the crematory operator. The First Round Comments therefore asked ODH to prescribe the consent form and make clear that it is separate from the detachable supplemental form.

34. Finally, while the draft rules "prescribed" the forms, they did not actually attach any such forms, so that we or the crematories and funeral homes could review them. We have repeatedly received requests from crematories and funeral homes to review the forms that they must use under SB27, as these forms may resolve some of the ambiguities listed above, or they may introduce new ambiguities. We therefore requested ODH issue forms for our review.

35. We did not hear any response from ODH with regard to the First Round Comments.

36. On August 19, 2021, ODH issued a second set of draft rules to implement SB27, and provided a one-month public comment period. This set of draft rules were almost identical to the rules circulated by ODH in July, and ODH did not adequately address *any* of the issues raised in the First Round Comments.[5] On September 17, 2021, PPSWO and the other abortion providers once again submitted comments ("Second Round Comments") re-raising the issues initially described in the First Round Comments. *See* Ex. C. ODH perfunctorily responded to the Second Round Comments, indicating that they would not meaningfully address the comments, including by disclaiming authority to address the issues raised.

37. On October 25, 2021, ODH issued proposed rules, along with a notice for public hearing on the rules, to be held on December 2. The proposed rules were identical to the draft rules

[5] The only change made in the second set of draft rules was to allow a patient to choose to inter embryonic and fetal tissue in a non-Ohio registered cemetery. However, the rules mandated that locations for interment provided by the abortion facility be limited to Ohio-registered cemeteries.

issued in August and thereby did not address any of the issues raised in the Second Round Comments.[6]

38. Representatives from PPSWO and the other providers raised the issues from the First and Second Round Comments a *third* time, during the public hearing on the proposed rules, on December 2. But the final rules issued by ODH were identical to the proposed rules, and again did not address the issues we raised.

[6] ODH's refusal to engage with our comments is representative of their other interactions with PPSWO and the other Plaintiffs in relation to SB27. Prior to SB27 taking effect, ODH refused to reassure Plaintiffs that we would not be penalized for violating the law, despite the fact that compliance was impossible prior to implementing rules and forms being issued. We were forced to sue ODH to obtain relief. Then, without warning, on April 6, 2021, the day SB27 was set to take effect, ODH issued emergency rules despite there being no emergency and SB27 having been signed into law months earlier. Without the relief this Court awarded, Plaintiffs would have had to stop providing procedural abortions entirely as they had no warning of what the rules contained, despite asking ODH about the rules for months.

FURTHER AFFIANT SAYETH NAUGHT

Suzanne Bertuleit

Signed before me this 6th day of January, 2022

Notary Public

STEVEN JAMES ROLFES
Notary Public, State of Ohio
My Commission Expires
June 23, 2026

EXHIBIT A

Planned Parenthood
Care. No matter what.
Planned Parenthood Southwest Ohio Region

Request For Proposal

Compliance with Ohio SB 27 "Regards disposition of fetal remains from surgical abortion"

Company Name: Planned Parenthood Southwest Ohio Region
Address: 2314 Auburn Avenue, Cincinnati, OH 45219
Contact Person: Suzanne Bertuleit, Director of Quality & Risk Management
Telephone Number: [redacted]
Email Address: [redacted]
Fax Number: [redacted]

1. Background/Introduction

For 90 years, Planned Parenthood Southwest Ohio Region (PPSWO) has been the leading reproductive health care provider, educator, and advocate for southwest Ohio and northern Kentucky communities. Our mission is to provide access to high quality health care and education that empower people to make informed private decisions about their reproductive lives and sexual health. To achieve our mission, we provide essential reproductive health services at five health centers, including the Mt. Auburn Surgery Center in Cincinnati, to over 20,000 people annually. These services include annual exams, cancer screenings, family planning and contraception, STI testing and treatment, abortion and miscarriage management, and more.

2. Project Goals and Scope of Services

PPSWO is seeking the services of a crematory or funeral home to provide cremation and/or burial services to our patients. The selected firm(s) will be responsible for complying with SB27 "Regards disposition of fetal remains from surgical abortion" and the resulting Ohio statutes and regulations. At this time, the SB27 implementing regulations have not been promulgated.

Tasks include but may not be limited to the following criteria:

- Transportation of products of conception to your facility in an unmarked vehicle.
- Individual or simultaneous cremation or burial of 2,600 - 3,600 products of conception.
- Final disposition of the remains to be anonymous to the public.
- If required, processing fetal death certificates, burial transit permits, and cremation authorization forms.
- Other requirements as specified by the law.

3. Anticipated Selection Schedule

The Request for Proposal (RFP) timeline is as follows:

- **Proposal submission deadline: February 19, 2021**
- Selection of top bidders / notification to unsuccessful bidders: February 26, 2021
- MOU signed: March 5, 2021
- Contract award / notification to unsuccessful bidders: March 19, 2021
- Project test run/soft launch: March 29, 2021
- SB27 goes into effect: April 6, 2021

4. Time and Place of Submission of Proposals

This RFP will be e-mailed to licensed crematories and funeral homes throughout southwest Ohio.

Respondents to this RFP must e-mail their submission in a Word or PDF file to:

- Suzanne Bertuleit, Director of Quality & Risk Management ([redacted])
- Vanessa Hinsdale, Administrative Director of Surgery ([redacted])

Responses received by **February 19, 2021** will be prioritized for first-round consideration. Proposals may be considered after that date. Responses should be clearly marked in the subject line "RFP-SB27" and e-mailed to the people listed above.

5. Timeline

This project will be ongoing.

6. Elements of Proposal

A submission must, at a minimum, include the following elements:

- General overview of your firm.
- Names, credentials and contact information of the team members assigned to this project.
- Crematory/funeral home license numbers.
- Provide price information for both simultaneous and individual cremation and for burial in the following table.

The expected annual volume is: 2,600 – 3,600.

Planned Parenthood
Care. No matter what.
Planned Parenthood Southwest Ohio Region

Request For Proposal

Compliance with Ohio SB 27 "Regards disposition of fetal remains from surgical abortion"

Please provide cost (per product of conception) and capacity data in this chart:

	Simultaneous Cremation	Individual Cremation	Burial
Your facility's annual capacity			
Transportation			
Frequency of pick-up			
Transportation costs			
Cremation • Cremation boxes • Operational costs • List other costs			
Burial • Urn/vault • Grave/crypt/niche • Opening vault (per opening)			
Processing permits and paperwork (if required) • Fetal death certificate • Burial transit permit • Cremation authorization form • New form required by SB27			
Total Cost (per product of conception)			

Please describe any other items or costs:

Is your firm willing to have its name known to patients and the State of Ohio? ☐Yes ☐No

Are you able to work with facilities in Columbus and Bedford Heights, Ohio? ☐Yes ☐No

If you must subcontract with another entity (e.g., to provide cremation services or disposition services for cremains), please provide the name of the other entity, its general duties under the subaward, credentials and other contact information, license number(s).

7. Evaluation Criteria

The successful respondent will:

- Have current licensure with no actions.
- Be competitively priced.
- Have the capacity to fulfill the contract.
- Preferred: Currently work with a medical facility in a similar arrangement (miscarriage management, etc.)

Thank you for your quick response to this RFP. We recognize that the response time is tight. Please note that the implementing regulation may not be available until after the law goes into effect on April 6, 2021. Please contact Suzanne Bertuleit with any questions you may have.

Suzanne Bertuleit
Director of Quality & Risk Management
e-mail: [redacted]
Office: [redacted]

Vanessa Hinsdale
Administrative Director of Surgery
[redacted]

EXHIBIT B

Stephanie McCloud
Director
Ohio Department of Health

Submitted electronically to ODHrules@odh.ohio.gov

July 20, 2021

RE: Comments on Draft Rules Related to Senate Bill 27

Dear Director McCloud:

Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Preterm, Women's Med Group Professional Corporation, and Northeast Ohio Women's Center (collectively "Providers") submit these comments to the two draft administrative rules ("Draft Rules") related to Am.S.B. No. 27, 2020 Ohio Laws File 77 ("SB27"), which were circulated via email by the Ohio Department of Health ("ODH").[1]

The Providers have been providing high-quality reproductive health care, including abortions, to patients in Ohio for decades. Together, they represent all providers of procedural (or "surgical") abortions in the state of Ohio. The Providers have consistently abided by the applicable regulations on the disposal of infectious waste, which includes disposal of embryonic and fetal tissue from a procedural abortion.

In the 2019–2020 legislative session, the Ohio legislature passed SB27, which requires cremation or interment (burial) of embryonic and fetal tissue after a procedural abortion. R.C. 3726.02(A). SB27 also states that the director of ODH "shall adopt rules necessary to carry out" provisions of SB27, "including rules that prescribe" certain forms necessary to implement the law. *Id.* 3726.14.

Since SB27 was signed into law, the Providers have made significant efforts to determine compliance with the law. Despite extensive outreach to funeral homes and crematories, the

[1] It is the Providers' understanding that the circulation of the Draft Rules via email did not commence the notice and comment rulemaking process under Ohio law. *See* R.C. 119.03(A)–(F). To the Providers' knowledge, as of the date of this letter, the Draft Rules have not been published in the Ohio Register, nor has a hearing date on the Draft Rules been scheduled. *See id.* 119.03(A) (requiring "[r]easonable public notice . . . in the register of Ohio at least thirty days prior to the date set for a hearing"); *see id.* 119.03(B) (requiring "[t]he full text of the proposed rule . . . accompanied by the public notice required under division (A)" to be filed "at least sixty-five days prior to the date on which the agency, in accordance with division (E) of this section, issues an order adopting the proposed rule"). If it is the position of ODH that the notice and comment rulemaking process has in fact commenced, the Providers request to be notified immediately.

Providers are not at this time able to determine whether and how they can comply with the law's requirements, including because of several critical ambiguities in SB27. The Draft Rules fail to address any of these ambiguities. They are also inconsistent with the law's requirements and introduce further confusion.

I. The Draft Rules Do Not Address SB27's Ambiguities.

As the Providers learned through their compliance efforts and outreach to funeral homes and crematories, SB27 leaves many crucial compliance-related questions unanswered. The Draft Rules do not address any of these issues, but should do so.

A. Simultaneous cremation

The Draft Rules do not address whether tissue from procedural abortions can be cremated simultaneously. The Providers understand, based on their outreach to funeral homes and crematories, that if simultaneous cremation is not permitted, and each "zygote, blastocyte, embryo, or fetus" must be cremated separately and individually, compliance with the law is extremely onerous and likely impossible. Because individual cremation is a lengthy and time-intensive process, crematories are unlikely to be able to work with Providers due to lack of capacity and safety concerns. Crematories also expressed concern with the impracticality of individual cremation, given the small size of the tissue from procedural abortion. Most procedural abortions in Ohio occur during the first trimester. While individually cremating tissue from a procedural abortion is likely to result in no cremated remains, under SB27, crematory operators are required to dispose of cremated remains in certain prescribed ways. *See id.* 4717.271(A)(2). They are unable to do so if individual cremation is required. And even if crematories were able to individually cremate tissue from procedural abortions, the cost is likely to be prohibitive.[2] Because SB27 is silent on the issue of simultaneous cremation, and preexisting law suggests simultaneous cremation is not permitted, crematories are not willing to risk penalties by simultaneously cremating tissue from procedural abortions unless ODH expressly addresses this issue. In fact, in a memo addressed to ODH dated February 16, 2021, the Ohio Funeral Directors Association ("OFDA") explained the impossibility of complying with the statute if ODH does not explicitly permit simultaneous cremation in the promulgating rules. *See* Ex. A, attached (stating: "it will be *necessary* to conduct simultaneous cremations of multiple zygotes, blastocytes, embryos and/or fetuses" (emphasis added)); *see also id.* ("OFDA is asking that the proposed regulations issued by ODH specifically provide for simultaneous cremation . . . .").

[2] The Providers are continuing to determine compliance and are currently unable to determine whether the cost of simultaneously cremating tissue from procedural abortions is also prohibitive; however, their outreach so far indicates it is less costly than requiring individual cremation.

B. Tissue sent to a crime lab or pathologist

The Draft Rules also do not address what is required of the Providers when tissue from a procedural abortion must be sent to a crime lab, such as in the case of a sexual assault investigation. Similarly, they do not address what must happen when a health care provider determines that tissue from a procedural abortion must be sent to a pathologist for testing for medical indications, such as a suspected molar pregnancy (which, if left undiagnosed or unmonitored, can lead to a patient developing cancer and/or result in a hysterectomy). Sending tissue from a procedural abortion to a crime lab or pathologist when necessary is of the utmost importance, and abortion providers must be able to continue doing so without risking severe civil and criminal penalties. Therefore, the Providers ask that rules implementing SB27 create an exception for embryonic or fetal tissue that is sent to a pathologist or crime lab.

C. Documentation for interment and protected patient information

While SB27 lists the types of documents that are *not* necessary for crematory operators to secure when cremating tissue from procedural abortions, *see* R.C. 4717.271(B), it contains no such provisions regarding necessary (or unnecessary) documentation if tissue is interred. The Draft Rules do not address this either. This results in at least two significant problems. First, certain documentation that is required for interring human bodies, if required for interring embryonic and fetal tissue, can result in the disclosure of protected patient information.[3] Second, the amount and type of documentation required can significantly affect the cost of interring embryonic and fetal tissue, and therefore may affect whether it is possible for the Providers to comply with the law. The Providers request implementing rules list the forms necessary for interment and ensure patient confidentiality will be protected.

D. Disposal of other pregnancy tissue

The Draft Rules also fail to address how the new requirements under SB27 interact with the requirements for disposing of infectious waste. For example, under existing requirements for disposing of infectious waste, pregnancy tissue that does not appear to fall within the definition of "fetal remains," including uterine lining/decidua, umbilical cord, gestational sac, and placenta, cannot be cremated or interred. However, it is often impossible to physically separate this other

[3] For example, before interment can occur, the funeral director must obtain a burial permit from the local registrar, and in order to obtain a burial permit, a death certificate needs to have been completed and registered. R.C. 3705.17. These documents contain individually identifying information, including names of "decedent[s]" and manner of death, that may become public. *Id.* 3705.23. Burial of a "decedent" also requires identification, by "[a]ffix[ing] to the ankle or wrist of the deceased a tag enclosed in a durable and long-lasting material that contains the name, date of birth, date of death, and social security number of the deceased," or placing "in the casket a capsule containing a tag bearing [the name, date of birth, date of death, and social security number of the deceased]." *Id.* 4717.13(B)(1)–(2).

pregnancy tissue from fetal or embryonic tissue—once again leaving abortion providers to risk severe penalties without adequate guidance. The Providers ask that rules promulgating SB27 make clear that, in the event other pregnancy tissue cannot be separated from embryonic and fetal tissue, the other pregnancy tissue can also be cremated or interred.

II. The Draft Rules Are Inconsistent with the Requirements of SB27.

The Draft Rules create inconsistencies with SB27 by adding a new and unnecessary requirement, omitting required rules, and creating further ambiguities in the law.

A. Cemetery registration requirement

The Draft Rules require that interment occur "in a cemetery registered pursuant to Chapter 4767 of the Revised Code." Draft Rule 3701-46-01(A); *see also id.* 3701-46-01(B)(1)(a). However, SB27 does not require interment be limited to cemeteries registered pursuant to Chapter 4767 of the Ohio Revised Code. The Draft Rules therefore unnecessarily add a restriction not present in the statute. No similar requirement exists for interring human remains in Ohio. Indeed, Ohio citizens can currently choose to inter remains of loved ones wherever they choose, and are not required to do so at a cemetery registered under Ohio law. This requirement therefore unduly and singularly restricts the options available to abortion patients.

B. Patient consent form

The Draft Rules also omit rules to prescribe a patient consent form, as required under SB27. The Draft Rules include rules prescribing a patient consent form for patients who are under 18 years of age, unmarried, and unemancipated, as required by R.C. 3726.04(B). *See* Draft Rule 3701-46-02. But they do not contain rules prescribing a consent form for a patient who is over 18 years of age, or otherwise does not need parental consent under the law, as required by R.C. 3726.04(A). *See also id.* 3726.14(B). Instead, the Draft Rules seem to conflate a separate form—the detachable supplemental form, which under SB27, should be completed by the abortion provider and provided to the crematory operator, *see id.* 3726.14(C) and 3726.15(B)—with the patient consent form, which the patient must complete, *see* Draft Rule 3701-46-01(B) ("The detachable supplemental form will be *used by a pregnant woman* to exercise her rights under division (A) of section 3726.03 of the Revised Code." (emphasis added)). Requiring that the patient complete the detachable supplemental form, rather than the consent form, is not only contrary to the language of SB27, but could also result in protected patient information being disclosed to the crematory operator, who must receive the detachable supplemental form. The Providers therefore request the implementing rules prescribe the patient consent form and make clear it is separate from the detachable supplemental form.

C. No forms

Finally, while the Draft Rules "prescribe" the forms—or at least, two of the forms—required by SB27, they do not have the forms attached, and the Providers have not been able to review the forms, which the Providers and patients must complete. Review of these forms well before the rules are adopted is necessary for the Providers (and funeral homes and crematories) to determine whether and how compliance is possible with SB27 and its rules. The forms may resolve some of the ambiguities listed above, or they may introduce new ambiguities. The Providers therefore respectfully request ODH issue draft forms for themselves and for funeral homes and crematories to review.

* * * *

The Providers request ODH address and resolve the above issues. Otherwise the Providers may not be able to determine whether and how they can comply with the law, which will result in them being unable to continue providing, and patients from accessing, essential reproductive healthcare.

Thank you for the opportunity to comment on the Draft Rules.

Sincerely,

/s/ Kersha Deibel_____
Kersha Deibel, CEO
Planned Parenthood Southwest Ohio Region

/s/ Iris Harvey_____
Iris Harvey, CEO
Planned Parenthood of Greater Ohio

/s/ Jennifer Moore Conrow_____
Jennifer Moore Conrow, Executive Director
Preterm

/s/ Martin Haskell, M.D._____
Martin Haskell, M.D., Medical Director
Women's Med Group Professional Corporation

/s/ David Burkons, M.D._____
David Burkons, M.D., Medical Director
Northeast Ohio Women's Center

EXHIBIT C

Bruce Vanderhoff
Director
Ohio Department of Health

Submitted electronically to ODHrules@odh.ohio.gov

September 17, 2021

RE: Comments on Draft Rules Related to Senate Bill 27

Dear Director Vanderhoff:

Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Preterm, Women's Med Group Professional Corporation, and Northeast Ohio Women's Center (collectively "Providers") submit these comments to the two draft administrative rules ("Draft Rules") related to Am.S.B. No. 27, 2020 Ohio Laws File 77 ("SB27"), which were posted on the Ohio Department of Health ("ODH") website on August 19, 2021.

The Providers have been providing high-quality reproductive health care, including abortions, to patients in Ohio for decades. Together, they represent all providers of procedural (or "surgical") abortions in the state of Ohio. The Providers have consistently abided by the applicable regulations on the disposal of infectious waste, which includes disposal of embryonic and fetal tissue from a procedural abortion.

In the 2019–2020 legislative session, the Ohio legislature passed SB27, which requires cremation or interment (burial) of embryonic and fetal tissue after a procedural abortion. R.C. 3726.02(A). SB27 also states that the director of ODH "shall adopt rules necessary to carry out" provisions of SB27, "including rules that prescribe" certain forms necessary to implement the law. *Id.* 3726.14.

Since SB27 was signed into law, the Providers have made significant efforts to determine compliance with the law. Despite extensive outreach to funeral homes and crematories, the Providers are not at this time able to determine whether and how they can comply with the law's requirements, including because of several critical ambiguities in SB27. The Draft Rules fail to address any of these ambiguities. They are also inconsistent with the law's requirements and introduce further confusion.[1]

I. The Draft Rules Do Not Address SB27's Ambiguities.

[1] On July 20, 2021, the Providers submitted comments to ODH on a previous iteration of the Draft Rules, which were circulated to the Providers via email. The current version of the Draft Rules does not address any of the issues raised in the Providers' previous comments.

As the Providers learned through their compliance efforts and outreach to funeral homes and crematories, SB27 leaves many crucial compliance-related questions unanswered. The Draft Rules do not address any of these issues, but should do so.

A. Simultaneous cremation

The Draft Rules do not address whether tissue from procedural abortions can be cremated simultaneously. The Providers understand, based on their outreach to funeral homes and crematories, that if simultaneous cremation is not permitted, and each "zygote, blastocyte, embryo, or fetus" must be cremated separately and individually, compliance with the law is extremely onerous and likely impossible. Because individual cremation is a lengthy and time-intensive process, crematories are unlikely to be able to work with Providers due to lack of capacity and safety concerns. Crematories also expressed concern with the impracticality of individual cremation, given the small size of the tissue from procedural abortion. Most procedural abortions in Ohio occur during the first trimester. While individually cremating tissue from a procedural abortion is likely to result in no cremated remains, under SB27, crematory operators are required to dispose of cremated remains in certain prescribed ways. *See id.* 4717.271(A)(2). They are unable to do so if individual cremation is required. And even if crematories were able to individually cremate tissue from procedural abortions, the cost is likely to be prohibitive.[2] Because SB27 is silent on the issue of simultaneous cremation, and preexisting law suggests simultaneous cremation is not permitted, crematories are not willing to risk penalties by simultaneously cremating tissue from procedural abortions unless ODH expressly addresses this issue. In fact, in a memo addressed to ODH dated February 16, 2021, the Ohio Funeral Directors Association ("OFDA") explained the impossibility of complying with the statute if ODH does not explicitly permit simultaneous cremation in the promulgating rules. *See* Ex. A, attached (stating: "it will be *necessary* to conduct simultaneous cremations of multiple zygotes, blastocytes, embryos and/or fetuses" (emphasis added)); *see also id.* ("OFDA is asking that the proposed regulations issued by ODH specifically provide for simultaneous cremation . . . .").

B. Tissue sent to a crime lab or pathologist

The Draft Rules also do not address what is required of the Providers when tissue from a procedural abortion must be sent to a crime lab, such as in the case of a sexual assault investigation. Similarly, they do not address what must happen when a health care provider determines that tissue from a procedural abortion must be sent to a pathologist for testing for medical indications, such as a suspected molar pregnancy (which, if left undiagnosed or unmonitored, can lead to a patient developing cancer and/or result in a hysterectomy). Sending tissue from a procedural abortion to

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a crime lab or pathologist when necessary is of the utmost importance, and abortion providers must be able to continue doing so without risking severe civil and criminal penalties. Therefore, the Providers ask that rules implementing SB27 create an exception for embryonic or fetal tissue that is sent to a pathologist or crime lab.

C. Documentation for interment and protected patient information

While SB27 lists the types of documents that are *not* necessary for crematory operators to secure when cremating tissue from procedural abortions, *see* R.C. 4717.271(B), it contains no such provisions regarding necessary (or unnecessary) documentation if tissue is interred. The Draft Rules do not address this either. This results in at least two significant problems. First, certain documentation that is required for interring human bodies, if required for interring embryonic and fetal tissue, can result in the disclosure of protected patient information.[3] Second, the amount and type of documentation required can significantly affect the cost of interring embryonic and fetal tissue, and therefore may affect whether it is possible for the Providers to comply with the law. The Providers request implementing rules list the forms necessary for interment and ensure patient confidentiality will be protected.

D. Disposal of other pregnancy tissue

The Draft Rules also fail to address how the new requirements under SB27 interact with the requirements for disposing of infectious waste. For example, under existing requirements for disposing of infectious waste, pregnancy tissue that does not appear to fall within the definition of "fetal remains," including uterine lining/decidua, umbilical cord, gestational sac, and placenta, cannot be cremated or interred. However, it is often impossible to physically separate this other pregnancy tissue from fetal or embryonic tissue—once again leaving abortion providers to risk severe penalties without adequate guidance. The Providers ask that rules promulgating SB27 make clear that, in the event other pregnancy tissue cannot be separated from embryonic and fetal tissue, the other pregnancy tissue can also be cremated or interred.

II. The Draft Rules Are Inconsistent with the Requirements of SB27.

[3] For example, before interment can occur, the funeral director must obtain a burial permit from the local registrar, and in order to obtain a burial permit, a death certificate needs to have been completed and registered. R.C. 3705.17. These documents contain individually identifying information, including names of "decedent[s]" and manner of death, that may become public. *Id.* 3705.23. Burial of a "decedent" also requires identification, by "[a]ffix[ing] to the ankle or wrist of the deceased a tag enclosed in a durable and long-lasting material that contains the name, date of birth, date of death, and social security number of the deceased," or placing "in the casket a capsule containing a tag bearing [the name, date of birth, date of death, and social security number of the deceased]." *Id.* 4717.13(B)(1)–(2).

The Draft Rules create inconsistencies with SB27 by adding a new and unnecessary requirement, omitting required rules, and creating further ambiguities in the law.

A. Cemetery registration requirement

The Draft Rules require that interment occur in "cemeteries registered pursuant to Chapter 4767 of the Revised Code." Draft Rule 3701-46-01(B)(1)(b). However, SB27 does not require interment be limited to cemeteries registered pursuant to Chapter 4767 of the Ohio Revised Code. The Draft Rules therefore unnecessarily add a restriction not present in the statute. No similar requirement exists for interring human remains in Ohio. Indeed, Ohio citizens can currently choose to inter remains of loved ones wherever they choose, and are not required to do so at a cemetery registered under Ohio law. This requirement therefore unduly and singularly restricts the options available to abortion patients.

B. Patient consent form

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Finally, while the Draft Rules "prescribe" the forms—or at least, two of the forms—required by SB27, they do not have the forms attached, and the Providers have not been able to review the forms, which the Providers and patients must complete. Review of these forms well before the rules are adopted is necessary for the Providers (and funeral homes and crematories) to determine whether and how compliance is possible with SB27 and its rules. The forms may resolve some of the ambiguities listed above, or they may introduce new ambiguities. The Providers

therefore respectfully request ODH issue draft forms for themselves and for funeral homes and crematories to review.

* * * *

The Providers request ODH address and resolve the above issues. Otherwise the Providers may not be able to determine whether and how they can comply with the law, which will result in them being unable to continue providing, and patients from accessing, essential reproductive healthcare.

Thank you for the opportunity to comment on the Draft Rules.

Sincerely,

/s/ Kersha Deibel_____
Kersha Deibel, CEO
Planned Parenthood Southwest Ohio Region

/s/ Iris Harvey_____
Iris Harvey, CEO
Planned Parenthood of Greater Ohio

/s/ Jennifer Moore Conrow_____
Jennifer Moore Conrow, Executive Director
Preterm

/s/ Martin Haskell, M.D._____
Martin Haskell, M.D., Medical Director
Women's Med Group Professional Corporation

/s/ David Burkons, M.D._____
David Burkons, M.D., Medical Director
Northeast Ohio Women's Center

EXHIBIT 7

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF POUL LEMASTERS IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Poul Lemasters, J.D., being duly sworn on oath, do depose and state as follows:

1. I am a licensed funeral director and embalmer in the state of Ohio. I have been a funeral director and embalmer for over 20 years. I have also been a lawyer licensed by the Ohio Supreme Court since May 2004.

2. I regularly work with crematory operators and funeral directors in Ohio and across the country to assist them in complying with legal requirements. I regularly provide training and advice on licensing, form and contract review, compliance with regulations, valuations, policies and procedures, operational audits, and buying and selling deathcare-related businesses. I represent funeral and cremation providers on state issues, including in front of the Ohio Board of Embalmers and Funeral Directors (the "Board"). I have served as an expert witness on various deathcare topics, including funeral and cremation issues. I also serve as General Counsel to the International Cemetery, Cremation and Funeral Association ("ICCFA"), and have also served as Cremation Coordinator for ICCFA for the past ten years, where I oversee and provide cremation training across the United States, all pursuant to best practices as well as state-required training standards.

3. I attach my curriculum vitae as Exhibit A.

4. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"). I have read SB27 and its implementing rules, and I understand that it regulates how "fetal remains" will be disposed following a procedural abortion. SB27 requires "fetal remains" to be cremated or interred.

5. I am over the age of eighteen, competent to testify, and make this affidavit based on personal knowledge, my review of documents, and, where noted, information provided by Plaintiffs' counsel.

Cremation Under Current Ohio Law

6. Cremation is a highly regulated field. Ohio law defines "cremation" as "the technical process of using heat and flame to reduce human or animal remains to bone fragments or ashes or any combination thereof," and includes "processing and may include the pulverization of bone fragments." R.C. 4717.01(M).

7. Under existing law, cremation must occur in a crematory facility. *See* R.C. 4717.01(K).[1] Crematory facilities must be licensed by the Board, R.C. 4717.06, and obtain permits from the Ohio Environmental Protection Agency ("EPA"), R.C. 3734.05. In addition, crematory operators must obtain a permit from the Board after completing the required certificate program and other coursework. R.C. 4717.051; Ohio Adm.Code 4717-15-01.

8. There are many forms required for cremation. Ohio law requires the crematory operator to have a death certificate, a burial or burial-transit permit, and a completed cremation authorization form before a cremation may occur. R.C. 4717.23.

9. Ohio law requires that a body be cremated in the casket or alternative container in which it arrived and prohibits the crematory facility from removing the body from the casket or

[1] Cremation may not occur in an infectious waste incineration facility or a solid waste incineration facility. R.C. 4717.01(K).

container. R.C. 4717.26(C). That means the container must be combustible, leak proof, and sufficiently rigid. *See* R.C. 4717.20(A) (defining "alternative container").

10. The law also requires an unembalmed body be held in a refrigeration facility if the body is held for eight hours or longer before the cremation. R.C. 4717.26(B)(1).

11. Generally speaking, the cremation process involves both a funeral home as well as a crematory facility, as there are parts of the cremation process that can only be done by a licensed funeral home and other parts that can only be done by a licensed crematory facility. The initial part of the cremation process, done by the funeral home, includes receiving the deceased and making proper identification. The funeral home would then complete any paperwork, typically including the burial permit, death certificate, and cremation authorization form. Following all needed documentation, the funeral home would be responsible for transferring the deceased to the required cremation container. At this point, the deceased would be transferred to the crematory facility. The crematory facility would make sure all proper documentation is received, confirm required identification of the deceased, and then store the deceased until the time of cremation.

12. The actual cremation process would start by preheating the crematory chamber—typically to at least 800°F, or as high as 1400°F, depending on the manufacturer. For the first cremation of the day, preheating the chamber can take up to 2 hours. Once temperature is reached, then the first cremation can be done. Depending on the size of the container and deceased, it can take up to 3 hours for the average adult to be cremated. When the cremation is complete, there is a cool down period that must be implemented, allowing the crematory to go from approximately 1500°F down to 700°F, which can take 30 minutes to 1 hour, after which it is safe to remove the cremated remains. At this point, the cremated remains can be handled and the processing of the cremated remains can begin.

13. Ohio law requires individual cremation except in three circumstances: blood relatives, cohabiting partners, and body parts. Under these three exceptions, consent to simultaneous cremation must be provided on a cremation authorization form for each decedent. R.C. 4717.24(A)(7) and 4717.25(A)(4). The body parts exception applies to: "limbs or other portions of the anatomy that are removed from a living person for medical purposes during biopsy, treatment, or surgery" as well as "dead human bodies that have been donated to science for purposes of medical education or research and any parts of such a dead human body that were removed for those purposes." R.C. 4717.20(C). As the definition suggests, and as understood by crematory operators, crematory facilities can simultaneously cremate limbs or other portions of the anatomy that have been amputated—or bodies donated to science. This body-parts exception also requires a statement from the authorizing agent on a cremation authorization form that authorizes such simultaneous cremation. R.C. 4717.25(A)(4).

14. After the cremation, the operator must remove all the cremated remains that can practically be recovered and place them in an urn (or a temporary container). R.C. 4717.26(G). The processing of the cremated remains includes sweeping out the cremated remains from the retort (also known as the cremation chamber), and then processing them into a fine powder, what is typically thought of as ashes. These cremated remains, or "ashes," are then packaged into a required urn or temporary container, which is identified with a tag that contains the name, date of birth, date of death, and social security number of the deceased. R.C. 4717.13(B)(3). The ashes are then returned to the funeral director or other legally appropriate person, as identified in the cremation authorization form, for final disposition. Generally, cremated remains may be disposed by interment in a grave, crypt, or niche, or by scattering them in a memorial garden, scattering grounds, at sea, or by air. R.C. 4717.27(C). Commingling of cremated remains from more than

one decedent is not allowed, unless each decedent (or authorizing agent) authorizes such on the cremation authorization form. R.C. 4717.24, 4717.25, 4717.27(D).

15. Crematories must have a system to accurately identify each body (or body parts) the crematory facility has in its possessions throughout the entire cremation process. R.C. 4717.26(J). This entails significant paperwork and policies. It is common practice, and considered a best practice, to only handle human remains of one deceased at a time to limit the possibility of cremating the wrong deceased or mixing the cremated remains of any one deceased with another. Overall, the process of handling a cremation is meant to be slow and deliberate, as any mistake can not only be costly in the form of liability, but also to allow an opportunity to correct a mistake made in the cremation process.

16. The actual cremation process, including preheating the retort, placing the cremated remains inside, the actual cremation of the deceased, cooling down the retort, collecting the cremated remains, processing the cremated remains, packaging the cremated remains into the required urn or temporary container, and completing all associated paperwork, can take, on average, 3 hours for the cremation of an adult and, on average, 2 hours for an infant or stillborn.

17. The average range for the cost of cremation for an adult in Ohio ranges from approximately $1000 to $3000. This cost includes all aspects of the cremation, from picking up the deceased, filing all necessary paperwork, the cremation process, crematory fee, and returning the cremated remains to the family. Some funeral homes will offer a small discount for handling the cremation of an infant or stillborn, but this is a compassion discount, and is based on the infrequency of having to provide such a discount.

18. Violating any statute or rule related to cremation, including the prohibition on simultaneous cremation, puts crematory facilities and crematory operators at risk of discipline,

including license and permit suspension, revocation, or denial by the Board, R.C. 4717.14—as well as by the Ohio EPA, which also permits crematories.[2] Indeed, I have had clients in other states lose their EPA permits for violating cremation laws. In addition, there are criminal penalties associated with these laws, including the restrictions on simultaneous cremation. R.C. 4717.99. A funeral home or crematory facility could also face civil lawsuits for improper cremation of a deceased. *See* R.C. 4717.30.

Cremation Under SB27

19. SB27 requires cremation at a crematory facility in compliance with Chapter 4717 of the Revised Code, including the licensing and permitting requirements, as well as the restrictions relating to simultaneous cremation and commingling of remains, that I have discussed above. R.C. 3726.02(B).

20. SB27 does not alter the general restrictions on simultaneous cremation. Consistent with my understanding of the relevant law and practice (although it is not entirely clear, as Ohio has never required cremation of embryonic and fetal tissue before), tissue from procedural abortions would not be considered a "limb[] or other portion[] of the anatomy," or body parts "of such a dead human body that were removed for [the purposes of medical education or research]."[3] R.C. 4717.20(C). Thus, absent clarification from the state, crematory facilities and operators risk criminal, civil, and professional penalties if they simultaneously cremate tissue from procedural abortion.

[2] *See* Ohio EPA, Air Pollution Control, *General Permit Program*, https://epa.ohio.gov/wps/portal/gov/epa/divisions-and-offices/air-pollution-control/permitting/general-permit-program (accessed Dec. 20, 2021).

[3] Ohio law does not allow tissue from an abortion to be donated for research. R.C. 2919.14.

21. Therefore, if a crematory facility reaches out to me requesting guidance on how to comply with the bill, I would advise them that, as the bill is currently written and without further guidance, simultaneous cremation is not permitted.

22. But this makes compliance with SB27 nearly impossible. Indeed, the Ohio Funeral Directors Association ("OFDA") sent a memo to ODH and the Board explaining just that:

> According to data reported by Planned Parenthood, approximately 65% of abortions occur when the embryo is 8 weeks or less in gestational age. At 8 weeks, an embryo is approximately 1/2 inch in length and about 1/2 ounce in weight. The embryo at this stage is described as about the size of a kidney bean and no bone has yet formed. It is not until 10 weeks that bone cells start to form.
>
> Because of the extremely small size of embryos that will be cremated, it will be necessary to conduct simultaneous cremations of multiple zygotes, blastocytes, embryos and/or fetuses in order to properly carry out the cremation and to have cremated remains. If embryos are cremated on an individual basis, there will be no cremated remains to bury or scatter as provided for by amended Section 4717.271(A)(2). Additionally, it will be nearly impossible to carry out individual cremations of zygotes and blastocytes which are not visible to the naked eye or small embryos which may weigh only a few grams and be difficult to see and place in a large cremation retort designed for the cremation of a regular size adult.[4]

23. The OFDA memo thus further states that because SB27 "does not address simultaneous cremation in any respect, OFDA is asking that the proposed regulations issued by ODH specifically provide for simultaneous cremation of multiple zygotes, blastocytes, embryos and fetuses."[5]

24. I concur wholeheartedly with the OFDA's conclusions. According to ODH's recent Induced Abortion Reports, there were 12,299 procedural abortions in Ohio in 2019 and 10,792

[4] Memorandum from Ohio Funeral Directors Association to Ohio Department of Health regarding "Fetal Remains Law" 1 (Feb. 16, 2021), attached as Ex. B.

[5] *Id.*

procedural abortions in Ohio in 2020.[6] The vast majority of abortions occur early in pregnancy; the ODH report for 2019 shows that 61% occurred at less than 9 weeks of pregnancy and another 26.5% occurred between 9 to 12 weeks. Only 12.6% occurred in the second trimester.[7] In 2020, 61.8% of abortions in Ohio occurred at less than 9 weeks of pregnancy, while 25.3% occurred between 9 and 12 weeks, and only 13% occurred in the second trimester.[8]

25. Given their small size, it would be exceedingly difficult to individually cremate the overwhelming majority of remains from procedural abortions because it would be very challenging to place them in the cremation chamber and there would likely be no ashes to recover. Because of the small size, it would be impractical from a business standpoint to operate a crematory in this manner. A crematory is set to run at a set temperature and for a set duration. A crematory retort cannot function optimally at a lower temperature. Heating the chamber to the correct temperature, and then cooling to a set temperature takes time, and to handle such a small quantity of cremated remains in each cycle is contrary to the intended use of a retort. Indeed, it could cause damage to the retort.

26. Moreover, given the time it takes to cremate one dead body, it will be very difficult to find a crematory that can individually cremate the tissue from all the procedural abortions in the state. Crematories will have to operate around the clock to accommodate this volume, but such full-time operation is unsafe and impractical, since most crematories are not meant to run every day, non-stop. Not only is the equipment not built to run non-stop; most crematory businesses are not staffed to accommodate 24-hour operations either.

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[6] Ohio Dept. of Health, *Induced Abortions in Ohio, 2019*, at tbl.7 (2020), https://bit.ly/386HyzK (accessed Dec. 20, 2021); Ohio Dept. of Health, *Induced Abortions in Ohio, 2020*, at tbl. 7 (2021), https://bit.ly/3xDuqxk (accessed Dec. 20, 2021).

[7] *Induced Abortions in Ohio, 2019*, at tbl.8a.

[8] *Induced Abortions in Ohio, 2020*, at tbl.8a.

27. This also assumes the crematory facilities have no other clients. However, there were approximately 143,661 deaths in Ohio in 2020, up from 123,705 in 2019 (an increase of over 14%).[9] And over half of deaths are cremated in Ohio and in the United State more broadly.[10] Due in part to the ongoing COVID-19 pandemic, Ohio crematory facilities are already stretched thin. And due to the pandemic, there is greater interest in cremation than burial.

28. Ohio's crematory facilities cannot rely on out-of-state crematories to come to their aid, because SB27 seems to prohibit cremation except at a facility in compliance with Ohio law and licensed by the Board.

29. Individual cremation would also be prohibitively expensive. It is reasonable for crematories and funeral homes to charge the same crematory fee for tissue from abortion procedures as infants or stillborns, because of the similar time and expense of operating the crematory and for the administrative requirements associated with cremation. The crematory fee, which averages between $300 and $500 is the actual fee the crematory charges for each cremation. This is different from the total cremation cost at the funeral home (referenced above as ranging from $1,000 to $3,000 on average).

30. Even if simultaneous cremation were allowed, the patient's identity could be compromised. SB27 is silent on whether a cremation authorization form is needed in order to authorize both simultaneous cremation and commingling of cremated remains. This form requires the name of the decedent, the authorizing agent, and the name of the person from whom the body

[9] Ohio Dept. of Health, *Ohio Public Health Information Warehouse: Mortality*, http://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality (accessed Dec. 20, 2021).

[10] Cremation Assn. of N. Am., *Annual Statistics Report* (2020), www.cremationassociation.org/resource/resmgr/members_statistics/StatisticsReport2021-short.pdfm (accessed Dec. 20, 2021).

part was removed. R.C. 4717.24 and 4717.25. As a result, the form could result in the disclosure of the abortion patient's identity.

31. There are other ambiguities that the ODH rules do not resolve and which make compliance practically impossible. SB27 and its implementing rules do not seem to authorize the cremation of pregnancy tissue other than embryonic and fetal tissue. I understand from Plaintiffs' counsel that along with the embryo or fetus, the products of a procedural abortion may include uterine tissue, umbilical cord, gestational sac, and placenta, and that these tissue are difficult or impossible to separate from the embryo or fetus, particularly earlier in pregnancy. Under existing law, a crematory facility may not cremate infectious waste, which includes this other pregnancy tissue if it does not fall within SB27's definition of "fetal remains."

32. As another example, SB27 assumes crematory operators will arrange for final disposition of the cremated remains. But the responsibility to do so falls under the duties of funeral directors, meaning that a funeral director through a licensed funeral home—not a crematory—would have to produce and execute the contract for cremation services. It is unprofessional conduct, subject to discipline, for a crematory operator to undertake funeral directing duties (unless they are dually licensed and working for a licensed funeral establishment). *See* R.C. 4717.01(C).

Burial Under Current Law

33. When a body is not cremated, Ohio law requires earth burial or entombment. R.C. 3705.01. Earth burial means burial in a grave, and entombment means placement in a crypt or niche.

34. Generally speaking, burial requires working with a funeral director to purchase a casket, transport the body, store the body until time of interment, place the body into the casket, then transport the casketed remains to the cemetery. The funeral director may also work with the family to purchase a cemetery plot and the vault within the grave for an earth burial, or a crypt or

niche for an entombment. Alternatively, the cemetery can work directly with the family, but this presents yet another party to coordinate with, as well as fees to incur. Additionally, the cemetery, on its own, may not handle the disposition of the deceased as they are not permitted to handle human remains for disposition; this activity falls under the licensed activity of a funeral director.

35. Before an interment can take place, the funeral director must obtain a burial permit from the local registrar, and in order to obtain a burial permit, a death certificate needs to have been completed and registered. R.C. 3705.17. These documents contain individually identifying information, including names of decedents and manner of death, that may become public. R.C. 3705.23. Burial of a decedent also requires identification, by "affix[ing] to the ankle or wrist of the deceased a tag enclosed in a durable and long-lasting material that contains the name, date of birth, date of death, and social security number of the deceased," or placing "in the casket a capsule containing a tag bearing [the name, date of birth, date of death, and social security number of the deceased]." R.C. 4717.13(B)(1) and (2).

Burial Under SB27

36. SB27 is largely silent on interment. Indeed, although the bill does not require a death certificate or burial permit for *cremation*, it is silent on the need for such forms for interment. And as I discuss above, these forms are otherwise needed before an interment and could contain patient-identifying information. Additionally, most cemeteries have rules and regulations that require some form of identification before allowing the burial of remains in their property.

37. ODH's implementing rules do not address these issues.

38. Abortion providers would have to purchase a grave site, vault, and a container (such as a casket) in order to inter, which could easily amount to over $3000. This does not include the high costs of opening and reopening crypts, niches, or columbariums to place the remains. It also does not include the cost of storage prior to burial. Almost all cemeteries do not offer storage prior

to burial, and therefore a licensed funeral home would be needed for this as well, adding to expense.

39. The implementing rules for SB27 contain an additional requirement—not present in SB27—that seems to limit locations for interment provided by the abortion facility to cemeteries registered under Ohio law. And the law itself seems to limit locations for cremation to Ohio-licensed crematories. No such requirements apply to disposal of human remains in Ohio, and I do not understand why such requirements would be necessary for embryonic and fetal tissue.

FURTHER AFFIANT SAYETH NAUGHT

Poul Lemasters

Signed before me this 4th day of January, 2022

Notary Public

EXHIBIT A

Poul H. Lemasters

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Professional Experience

Lemasters Consulting, LLC, Cincinnati, OH — October 2009—Present
Owner / Attorney / Consultant
Lemasters Consulting is a company formed exclusively to serve the needs of the funeral profession, including funeral homes, funeral directors, cemeteries, cemeterians, crematories, and others. Lemasters Consulting provides various services in such areas as: Government Compliance; Policy and Procedures; Risk Management; Litigation; Valuation; Market Analysis; Buy/Sell; Forms Management; and Next of Kin Disputes.

Frank B. Rosenacker Co., L.P.A, Rosenacker & Associates, Cincinnati, OH — August 2006—September 2009
Attorney / Consultant
Provided Legal and Consulting services to funeral industry firms throughout United States including:

- Appraisals and valuations of business
- Succession and Estate Planning
- Interpretation of Funeral Industry Regulations
- Mergers and Acquisitions
- Compliance with Funeral Industry Regulations
- Legal assistance in business litigation

Alderwoods Group, Inc., Cincinnati, OH — November 2005—August 2006
Corporate Counsel
Executed forms management for the second largest operator of funeral homes and cemeteries in North America to determine state/federal compliance, internal standardizing, and form/contract approval. Tracked legislative and regulatory issues on a state and federal level to determine appropriate action including lobbying, interpretation, and internal communication throughout Alderwoods Group. Provided interpretations and explanations of laws, policies, and procedures to locations. Oversaw litigation matters encompassing contract, corporate, regulatory, employment, and liability. Evaluated and monitored internal policies and procedures to ascertain necessary updates and additions.

Freund, Freeze & Arnold, LPA, Cincinnati, OH — March 2004—November 2005
Attorney
Provided civil defense litigation for clients in the areas of personal injury, premises liability, workers' compensation, insurance, construction, and municipality law. Independently managed a caseload of up to one hundred files while also working as part of a team with partners and associates on projects and cases.

Radel Funeral Home, Cincinnati, OH — 1998—2004
Funeral Director / Embalmer / Manager
Conducted initial family conferences to help families understand, prepare for, and plan funeral arrangements. Managed two separate funeral homes fulfilling State Board requirements and OSHA certification. Acted as mediator for families and staff during conflicts and helped achieve resolution. Oversaw three apprentices as Master Embalmer/Funeral Director during a three-year period. Developed an after-care program that increased family satisfaction and market share.

Baker Stephens Funeral Home, Middletown, OH — 1997—1998
Funeral Director / Embalmer

Vorhis Funeral Home, Cincinnati, OH — 1996—1997
Apprentice Funeral Director / Embalmer

William McCulla Funeral Home, Morgantown, WV — 1993—1995
Apprentice Funeral Director / Embalmer

Professional Representation

2019 – Present	General Counsel - International Cemetery Cremation & Funeral Association
2013 – Present	General Counsel - National Concrete Burial Vault Association
2017 – Present	Special Counsel - Catholic Cemetery Conference
2010 – Present	Special Counsel - Pet Loss Professional Alliance

Education

Salmon P. Chase College of Law, Highland Heights, KY — Juris Doctor - December 2003
Cumulative G.P.A. 3.49 - Class Rank of 2 out of 39

- Northern Kentucky Law Review
- Chase Moot Court Team Member, Ethics Advisor
- Winner: 2001 W. Jack Grosse Moot Court Competition
- Competitor: 2002 Wagner Labor & Employment Law Moot Court
- Semi-Finalist: 2003 Giles Sutherland Intellectual Property Moot Court
- Dean's List: 2001, 2002, Spring 2003
- CALI Excellence Award
- Asst. Adv. Appellate Advocacy, Chase College of Law
- Chase College of Law Reciprocity Scholarship
- Raymond P. Hutchens Scholarship
- John R. Heflin Memorial Scholarship
- Chase Excellence Scholarship

Cincinnati College of Mortuary Science, Cincinnati, OH Bachelor of Mortuary Science — December 1996
Cumulative G.P.A. 3.63 - Graduated cum laude
Class President, Member of Alpha Tau Epsilon, Professional & Educational Fraternity

West Virginia University, Morgantown, WV — 1989-1991
Courses in Chemical Engineering and Business Administration
Founding President Phi Sigma Pi, Co-Ed Honor Fraternity; Vice President, Li Toon Awa

Professional Memberships and Involvement

2004 – Present	Admitted to practice law in the State of Ohio
2006 – Present	Admitted to practice law in Commonwealth of Kentucky
2006 – Present	Admitted to practice law in Southern District of Ohio - Federal
1997 – Present	Licensed Funeral Director / Embalmer in the State of Ohio
1997 – Present	Licensed Funeral Director / Embalmer in the State of West Virginia
2006 – 2012	Adjunct Professor at Cincinnati College of Mortuary Science Business Law Legal Issues in Funeral Service
2006 – Present	Member International Cemetery Cremation & Funeral Association Government and Legal Affairs Committee Cremation Counsel to ICCFA Members GPL Compliance Cremation Coordinator
1997 – Present	Member Ohio Funeral Director's Association Legislative Committee (1997 - 2005) Education Committee (1997 – 2021)

Publications

Oct 2021	*We're Holding Your Graves Hostage! Ransomware In Deathcare*	ICCFA
Aug 2021	*The cremation Dilemma - No Patience, Nos Satisfaction. The Battle Between Immediate Gratification & Instant Dissatisfaction*	ICCFA
Jul 2021	*The Body Broker Bill - 3 Things You Should Know About Whole-Body Donation*	CCC
Jul 2020	*Mr. Cemetery - Tear Down This Monument! A Legal Look at Monument Laws and Removals*	CCC
May 2020	*Questions and Answers on Business Liability and COVID-19*	NCBVA
Apr 2020	*Signatures, Witnesses, and Notaries In the Virtual World*	The Funeral Chronicle
Apr 2020	*"Streaming Graveside Services Online" What Cemeteries Need to Know*	CCC
Feb 2020	*Identification at the Cemetery "The Importance of Recording Identification"*	CCC
Jan 2020	*Just Trying To Help - The Cemetery Side*	The Funeral Chronicle
Nov 2019	*Can You Just Tell Me…? How To Handle 3 Common Requests For Information*	CCC
Jul 2019	*Stop Thief! How To Protect Yourself From Stealing From The Dead*	The Funeral Chronicle
Apr 2019	*Offering DNA Services? Put the Paperwork In Place First*	ICCFA
Mar 2019	*No One Wants Mom Anymore? A How-to On Handling Unclaimed Cremated Remains*	ICCFA
Jan 2019	*Some Things To Consider When A Family Turns To Crowdfunding*	ICCFA
Dec 2018	*Wisdom on Improving Your Cremation Authorization*	Funeral Service Insider
Nov 2018	*Online Cremation Arrangements: Not As Easy As 'Just Click Here'*	ICCFA
Oct 2018	*You Want Me To Do What? From gold fillings to hip replacements, funeral directors are being asked to remove non-organic material from the deceased.*	Canadian Funeral News
Oct 2018	*It's All in The Details: Getting Online Arrangements Right*	ICCFA
Oct 2018	*How One Blank Line Can Help Make You Money*	The Funeral Chronicle
Aug 2018	*Do You Know What's in Your Food: Your Food Release Form, That Is*	The Funeral Chronicle
July 2018	*Seeing Through the Haze of Marijuana in the Workplace*	NCBVA
Jun 2018	*How to Collect Money—Yep, There's a Form for That*	The Funeral Chronicle
Apr 2018	*The Silica Standard | A Dusty Proposition That May Affect You*	NCBVA
Apr 2018	*3 Items That Can Breathe New Life into Your Embalming Authorization Form*	The Funeral Chronicle
Mar 2018	*When Your Basic Service + Direct Cremation = Confusion*	ICCFA
Feb 2018	*Form Versus Function: Perfecting Your Forms with Function*	The Funeral Chronicle
Feb 2018	*To DNA or Not to DNA, That is the Question*	The Funeral Chronicle
Oct 2017	*Identification: The First, Last, and Every Step in Between—Returning Cremated Remains*	The Funeral Chronicle
Aug 2017	*Identification: The First, Last, and Every Step in Between—Storage of Human Cremated Remains*	The Funeral Chronicle
Jun 2017	*Identification: The First, Last, and Every Step in Between—The Arrangement Conference*	The Funeral Chronicle
May 2017	*A Couple Times You May Want to Call an Attorney, and A Couple Times You Can Just DIY*	NCBVA
Mar 2017	*Product Liability: When A Product Breaks, Whose Wallet Breaks?*	NCBVA
Apr 2017	*Identification: The First, Last, and Every Step in Between—The First Call*	The Funeral Chronicle
Mar 2017	*It's Just a Phone Call: What the Funeral Rule Requires*	ICCFA
Feb 2017	*Some Good Things about Identification (and a Few Not so Good Too)*	The Funeral Chronicle
Jan 2017	*When You May Want to Call an Attorney, and When You Can Do It Yourself*	NCBVA
Jan 2017	*3 Times to Call an Attorney & 3 Times You Don't Have To*	ICCFA
Oct 2016	*Dust Off Your Cremation Authorization Form Today*	ICCFA
Jan 2016	*Do's and Don'ts of Landscaping— But Really for Cremation*	ICCFA
Dec 2015	*Deathcare Business Basics: Insurance, Hiring and Firing*	ICCFA
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Jun 2015	*Another Wrongful Cremation*	ICCFA
Feb 2015	~~*Changes. Addendums.*~~ *Changes. What To Do (& Not Do) When Family Members Change Their Minds*	ICCFA
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Feb 2008	*Safely and Respectfully Dealing With Unclaimed Cremated Remains*	ICCFA
Jan 2008	*Why Pre-Arranged Cremation Authorizations Need to be Confirmed*	ICCFA

Parliament

Parliament is a quarterly journal focusing on the deathcare profession published by Poul Lemasters; it focuses on issues relevant to deathcare professionals (funeral homes, crematories, cemeteries) and each publication contains articles on how certain issues affect the profession as a whole. It is released quarterly on March 13, June 13, September 13, and December 13.

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Issue 45, Autumn 2021	*Immediate Gratification, Instant Dissatisfaction: 3 Ways ALL Disposition Providers can Help Prevent Issues* *"What if we just hide the body?" A Case Analysis on Insurance Coverage*
Issue 44, Summer 2021	*Covid-19 Funeral and Cemetery Assistance: How Families are Getting Money for Covid-19 Deaths* *"Don't Worry, the Estate will Pay the Bill" A Case Analysis on Accounts Receivable and Collections*
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Just Trying To Help - The Cemetery Home Side
Just Trying To Help - The Crematory Home Side
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Legal Point | Legacy Touch

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Three Trends that Could Affect the Future of State and Federal Deathcare Regulation

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~~*Changes. Addendums.*~~ *Changes. What To Do – and Not Do – When Family Members Change Their Mind During Cremation*
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Case Analysis | If You Can't Beat'em—Just Change the Law

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Some Good Things About Identification (and a Few Not So Good, Too)
Case Study | A Wrongful Cremation and the Funeral Home Wins

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Personnel Files | 5 Things That Are In & 4 Things That Stay Out (& 3 Others You Should Just Know)

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Issue 16, Summer 2014 *Shipping Cremated Remains |A Change in the Law Means a Change in Your Policy*
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"But You Never Made Me Pay Before..." | A Case Analysis
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"What Do You Mean I'm Not Covered!?" | A Case Analysis

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Social Media | The Ultimate Hiring & Firing Tool?
Case Analysis | "You're Fired!"

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"But I Didn't Know the Law" | A Case Study

Issue 11, Spring 2013 *5 Issues When Your Family Members Work For You*
"It's My Name, So I Will Use It Anyway I Want—Right?" A Case Analysis
3 Things To Do When You WISH Your Employees Were Your Family

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A Case Analysis | "Yes...We are Still Married—Sort Of. So, Can I Sign?"
Families and Forms | A Little Protection Goes a Long Way

Issue 9, Autumn 2012 *An External Voice to Internal Procedures: Having the Funeral Home Review The Cemetery Rules and Regulations*
The Right Forms | A Positive Spin on a Negative Idea
Identification: The First, Last and Every Step In Between
I Didn't Think of That One | 3 Commonly Missing Policies and Procedures for Your Funeral Business

Issue 8, Summer 2012 *Identification—How Do We Know Who We Are Dealing With?*
Case Study | I Love Rock-n-Roll, So Put Another $6,000 in the Jukebox, Baby
Copyrights—New Ways to Print and Old Ways to Get Sued

Issue 7, Spring 2012 *Pet Cremations Policies | 3 Common Mistakes*
Pet Parents—What's in a Name?
Case Study | Perpetual Care and One Pet Cemetery

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Issue 5, Autumn 2011	*The Risks Associated with Pre-Need Sales: A Due Diligence Checklist for all Pre-Need Providers* *Case Study | Heavy-Handed Sales—How Far is Too Far?*
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Issue 3, Spring 2011	*A Case Study On Immunity: Thompson v. City of Calhoun* *Cremation Liability: I Have Insurance For That, So Why Worry?* *Identification: The First, Last and Every Step In Between*
Issue 2, Winter 2010	*Bereaved Consumer Rights Bill: A Proactive or Reactive Solution for Families?* *A Case Study on Rudeness | Habersham Memorial Park, Inc. v. Moore* *The Right Forms | A Positive Spin on a Negative Idea*
Issue 1, Autumn 2010	*Funeral Homes & Cemeteries: Friends or foes?* *Graveside Services | Who is Responsible?*

Presentations

May 2021	*Cocktails & Laws*	ICCFA Virtual Annual Convention
May 2021	*The Winding Road of FTC Compliance; The Crossroads of Laws & Cocktails*	Iowa Funeral Director's Association
Apr 2021	*The Nuts and Bolts of the Things We Do: Cemetery Legal Awareness*	Catholic Cemetery Conference
Mar 2021	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	CCMS Masters Training Program
Mar 2021	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Jan 2021	*Cocktails & Communications*	Monument Builders of North America
Dec 2020	*Digging into Disinterment and Other Cemetery Issue*	Wilbert Funeral Services, Inc.
Dec 2020	*Covid-19: What is has Taught Deathcare (The Legalities)*	Funeral Director's Association of Kentucky
Dec 2020	*FTC & Legal Update*	Funeral Director's Association of Kentucky
Dec 2020	*Cremation Embalming Liability: How to CYA*	Funeral Director's Association of Kentucky
Nov 2020	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Nov 2020	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Oct 2020	*The Era of CYA: New Cemetery Issues*	Catholic Cemetery Conference
Oct 2020	*FTC Funeral Rule Update*	Iowa Funeral Director's Association
Oct 2020	*Communication Cocktail Hour*	OACFP Annual Conference
Oct 2020	*Virtual Emcee*	OACFP Annual Conference
Sept 2020	*Cremation Operator Liability*	CCMS/ICCFA Cremation Certification
Sept 2020	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Sept 2020	*The Do's and Don'ts of Hiring New Employees*	NCBVA
Sept 2020	*Update on Federal Deathcare Legislation*	ICCFA Government and Legal Luncheon
Sept 2020	*Leadership Cocktail Hour*	ICCFA Executive Leadership Summit
Sept 2020	*Cremation Cocktail Hour*	OACFP Cremation Certification & Training
Sept 2020	*Cremation Liability: Is Anyone Really Getting Sued?*	OACFP Cremation Certification & Training
May 2020	*COVID-19: How to Handle Employment Issues*	ICCFA COVID-19 Resources
May 2020	*COVID-19: How to Handle the Deceased Part 2*	ICCFA COVID-19 Resources
Apr 2020	*COVID-19: How to Handle the Deceased*	ICCFA COVID-19 Resources
Feb 2020	*Navigating the Cemetery and Funeral Home Relationship: Why Can't We All Get Along?*	Alliance of Illinois Cemeterians
Feb 2020	*I Never Thought About That: How to Document & Protect Yourself from Things You Don't Even Know Exist*	Alliance of Illinois Cemeterians
Feb 2020	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Jan 2020	*DEADTalks: Emcee*	ICCFA Wide World of Sales
Dec 2019	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Dec 2019	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Nov 2019	*The Future of Deathcare: Are We Creating the Worst Funeral Ever*	Casket Funeral Suppliers Assoc. Fall Conf.
Oct 2019	*I Never Thought About That: How to Document & Protect Yourself from Things You Don't Even Know Exist*	Indiana Cemetery Association Annual Conv.
Oct 2019	*Navigating the Cemetery and Funeral Home Relationship: Why Can't We All Just Get Along?*	Minnick Services CEU Class
Oct 2019	*The Laws of Funeral Profession in Ohio - Including the Revised*	ODFA Masters Training Program

	Code, Regulations, and the FTC	
Sept 2019	*Cremation Operator Liability*	OFDA/ICCFA Cremation Certification
Sept 2019	*Tackling the Dreaded "C-Word" in Deathcare: Communication for Funeral Homes*	New York State Association of Cemeteries
Sept 2019	*Cremation CYA*	Kates-Boylston
Sept 2019	*Cemetery and Funeral Home Communication: Why we can't seem to get along!*	Western Canada Cemetery Assoc. Conf.
Sept 2019	*Top Ten Cemetery Mistakes: Little mistakes that turn into grave problems*	Western Canada Cemetery Assoc. Conf.
Sept 2019	*Cemetery 101: The nuts and bolts of what we do*	Western Canada Cemetery Assoc. Conf.
Aug 2019	*Tackling the Dreaded "C-Word" in Deathcare: Communication for Funeral Homes*	New York State Funeral Directors Assoc.
July 2019	*Cemetery Liability Issues*	ICCFA University
July 2019	*Arranger Curriculum: Reducing Your Liability to Add to Your Bottom Line*	ICCFA University
July 2019	*Hospitality Isn't Just About Being Nice: The Legal Liabilities and Risk Management in Hospitality Service*	ICCFA University
July 2019	*The Legal Aspects of Funeral Service*	ICCFA University
July 2019	*Cremation Operator Liability*	ICCFA Cremation Certification Program
July 2019	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
July 2019	*The Laws of Funeral Profession in Ohio: Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
June 2019	*Tackling the Dreaded "C-Word" in Deathcare: Communication*	Funeral Directors Assoc. of Kentucky Conv.
May 2019	*Cremation Operator Liability*	ICCFA Cremation Certification Program
May 2019	*That's the Way Everyone Does It: Funeral Ethics and Law*	OFDA Annual Convention
May 2019	*Tackling the Dreaded "C-Word" in Deathcare: Communication*	Southern Cemetery, Cremation, and Funeral Association Annual Conference
Apr 2019	*Legal Cemetery Issues: The Nuts and Bolts*	CCC Smaller Cemetery Conference
Apr 2019	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Apr 2019	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Apr 2019	*Government, Legal & State Association Leadership Luncheon*	ICCFA Annual Convention and Expo
Apr 2019	*Cremation Authorization Form Pitstop*	ICCFA Annual Convention and Expo
Mar 2019	*Tackling the Dreaded "C-Word" in Deathcare: Communication*	ODFA Young Funeral Directors Seminar
Mar 2019	*The Laws of Funeral Profession in Ohio: Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Mar 2019	*Graveside Liability*	NCBVA
Feb 2019	*Cremation Operator Liability*	CCMS/ICCFA Cremation Certification
Feb 2019	*Complete First-Call Training Session*	OFDA Annual Education Conference
Jan 2019	*DEADTalks: Click, Click, Boom! The Online Funeral World*	ICCFA Wide World of Sales
Dec 2018	*Cremation Operator Liability*	ICCFA Live Stream Cremation Certification
Dec 2018	*Cremation Arranger Liability*	ICCFA Live Stream Cremation Certification
Dec 2018	*Little Mistakes that Turn into Grave Problems*	NECA 49th Annual Frederick R. Laffond Seminar
Nov 2018	*Cremation Operator Liability*	OFDA/ICCFA Cremation Certification
Nov 2018	*So You Think It's Tough Now: 5 Cremation Issues Affecting Funeral Homes and Cemeteries*	Mid-Atlantic States Cemetery and Funeral Conference
Nov 2018	*The First Call: DO you Really Have them at "Hello"?*	Mid-Atlantic States Cemetery and Funeral Conference

Oct 2018	*Cremation Operator Liability*	CCMS/ICCFA Cremation Certification
Oct 2018	*Cremation Liability*	Turner Vault Company
Oct 2018	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Oct 2018	*Communication & Relationship Between Cemetery and Funeral Homes*	Catholic Cemeteries of Ohio Conference
Oct 2018	*The Dreaded "C-Word" in the Funeral Profession: Communication*	Fall Cities Funeral Director Meeting
Oct 2018	*LemastersPiece Theatre—The Blueprint for Consent*	Ontario Association of Cemetery and Funeral Professionals Annual Crematorium Operator Training
Sept 2018	*It's Not Just Hiring and Firing Anymore— Some Do's and Don'ts of HR*	National Catholic Cemeteries Conference
Sept 2018	*Covering Your Assets - A Look at Cremation and Embalming Liability*	The Independent Funeral Group
Sept 2018	*The Future of Deathcare - The Worst Funeral Ever*	The Independent Funeral Group
Sept 2018	*Funeral Home Regulation: Implementing Procedural Requirements of Ohio's Preneed Recovery Fund*	Ohio State Bar Association
Aug 2018	*Cremation Arranger Liability*	OFDA/ICCFA Cremation Certification
Aug 2018	*Cremation Operator Liability*	OFDA/ICCFA Cremation Certification
July 2018	*Cemetery Liability Issues*	ICCFA University
July 2018	*Arranger Curriculum: Reducing Your Liability to Add to Your Bottom Line*	ICCFA University
July 2018	*Hospitality Isn't Just About Being Nice: The Legal Liabilities and Risk Management in Hospitality Service*	ICCFA University
July 2018	*Business Law: Funeral Home & Cemetery Legal Outlook*	ICCFA University
July 2018	*The Legal Aspects of Funeral Service*	ICCFA University
July 2018	*Cremation Operator Liability*	ICCFA Cremation Certification Program
July 2018	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
July 2018	*The Phone Call: Do You Really Have Them at "Hello?"*	Michigan Cemetery Assoc. Annual Conv.
July 2018	*Cemetery Mistakes: As People Change, So Do the Risks*	Michigan Cemetery Assoc. Annual Conv.
July 2018	*The Future of Deathcare: The Worst Funeral Ever*	Michigan Cemetery Assoc. Annual Conv.
June 2018	*Cremation–The Struggle is Real: Pitfalls You Can Avoid*	Florida Cemetery, Cremation, & Funeral Association
June 2018	*Legal Issues in the Funeral Profession: What We Don't Know Can't Hurt Us?*	Funeral Service Association of Canada
May 2018	*Cremation Arranger Liability*	CCMS/ICCFA Cremation Certification
May 2018	*Cremation Operator Liability*	CCMS/ICCFA Cremation Certification
May 2018	*That's How Everyone Does It: Funeral Ethics & Law*	OFDA Annual Convention
May 2018	*Futurama of Deathcare*	Iowa Funeral Directors Association Conf.
May 2018	*FTC and Legal Update*	Iowa Funeral Directors Association Conf.
May 2018	*Cremation Operator Liability*	ICCFA Cremation Certification Program
May 2018	*Deathcare Wake Up Call*	British Columbia Funeral Assoc. Annual Conf.
Apr 2018	*Legal Cemetery Issues: The Nuts and Bolts*	CCC Smaller Cemetery Conference
Apr 2018	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Apr 2018	*The Cents and Sense of Cremation Metal Recycling*	ICCFA Annual Convention and Expo
Mar 2018	*Cremation Liability & Best Practices*	Ontario Association of Cemetery and Funeral Professionals Annual Crematorium Operator Training
Mar 2018	*Cremation Operator Liability*	CCMS/ICCFA Cremation Certification

Feb 2018	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Feb 2018	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Feb 2018	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Feb 2018	*Cremation Operator Liability*	OFDA/ICCFA Cremation Certification
Feb 2018	*The Burning Issue of Cremation & Cemeteries: As Choices Change so do Your Liabilities*	Ohio Township Association Winter Conf.
Jan 2018	*5 Issues That Are Changing Death Care*	Catholic Cemeteries of the West Conv.
Jan 2018	*Top 10 Cemetery Mistakes*	Metropolitan Cemetery Association Expo
Jan 2018	*5 Things a Lawyer can Teach Me about Sales — There's a Reason some Lawyers are Called Rainmakers*	ICCFA Wide World of Sales
Dec 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Dec 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Nov 2017	*What You Can Learn From Consumers on Funerals*	Funeral Director's Association of Kentucky
Nov 2017	*Recent challenging Issues and Where Cremation Liability is Heading*	Funeral Director's Association of Kentucky
Nov 2017	*Kentucky Laws: The Updated Funeral Declaration Law*	Funeral Director's Association of Kentucky
Oct 2017	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Oct 2017	*Cremation Liability & Best Practices*	Ontario Association of Cemetery & Funeral Professionals Annual Education Conference
Oct 2017	*Comastery Program*	Wilbert Continuing Education Seminar
Sept 2017	*Cemetery Legal Issues, Trends, and their Ramifications*	National Catholic Cemeteries Conference
Sept 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Sept 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
July 2017	*Cemetery Liability Issues*	ICCFA University
July 2017	*Arranger Curriculum: Reducing Your Liability to Add to Your Bottom Line*	ICCFA University
July 2017	*Doing the Right Things for the Right Reasons*	ICCFA University
July 2017	*The Legal Aspects of Funeral Service; Business Law: Funeral Home and Cemetery Legal Outlook*	ICCFA University
July 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
July 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
July 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
July 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
June 2017	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
June 2017	*Cremation Headaches: How to Handle the Families, the Regulations, & Yourself*	Western Pennsylvania Funeral Director Assoc.
June 2017	*Cemetery Liability: Little Mistakes that Turn into Grave Problems*	Notre Dame Leadership College
June 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
June 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
May 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
May 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
May 2017	*FTC, Technology, Copyright, Music Licensing*	Iowa Funeral Directors Association Conf.
May 2017	*Conflict Resolution with Families*	Iowa Funeral Directors Association Conf.
May 2017	*The Future of Cremation*	British Columbia Funeral Association Conf.
Apr 2017	*Navigating the Cemetery & Funeral Home Relationship*	Catholic Cemeteries of the West Convention

Apr 2017	*What's New That Can Get You Sued*	Iowa Western Community College
Apr 2017	*Cremation Liability*	Iowa Western Community College
Apr 2017	*Cremation Liability*	Manitoba Funeral Service Association
Apr 2017	*Embalming Liability*	Manitoba Funeral Service Association
Apr 2017	*The Science of Forms*	Manitoba Funeral Service Association
Apr 2017	*Has Deathcare Gone to the Dogs?*	Massachusetts Cemetery Assoc. Annual Mtg.
Apr 2017	*iCremation - Selling Cremation in the Mobile World*	ICCFA Annual Convention and Expo
Apr 2017	*Anatomy of a First Call*	ICCFA Annual Convention and Expo
Apr 2017	*Crisis Communication Management: What to Do When Your Brand or Profession Becomes Headline News*	ICCFA Annual Convention and Expo
Mar 2017	*Cremation Liability & Best Practices*	Ontario Association of Cemetery and Funeral Professionals Annual Crematorium Operator Training
Mar 2017	*Indiana Cremation Law*	Minnick Services
Feb 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Feb 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Feb 2017	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Jan 2017	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Jan 2017	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Dec 2016	*Forms: The Biggest Thief at Your Business*	Funeral Service Business Plan Conference
Nov 2016	*If cremation is so simple…Why do they sue everyone?*	Multicultural Symposium of Cemeteries and Funeral Homes
Oct 2016	*Legal Soup for the Corporation Soul*	National Catholic Cemeteries Conference
Sept 2016	*Cremation Issues that Affect Cemeteries*	Catholic Cemeteries of Ohio Conference
Sept 2016	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Aug 2016	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Aug 2016	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Jul 2016	*Cemetery Liability Issues*	ICCFA University
Jul 2016	*Arranger Curriculum: Reducing Your Liability to Add to Your Bottom Line*	ICCFA University
Jul 2016	*Doing the Right Things for the Right Reasons*	ICCFA University
Jul 2016	*The Legal Aspects of Funeral Service;* *Business Law: Funeral Home and Cemetery Legal Outlook*	ICCFA University
Jun 2016	*Cremation Legal Pitfalls*	SCCFA Annual Convention
Jun 2016	*Cremation Issues for Cemeteries*	Mt. Elliott Cemetery Assoc. Summer Conf.
May 2016	*Cremation Operator Liability*	ICCFA Cremation Certification Program
May 2016	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
May 2016	*Copyright and Music Licensing*	Iowa Funeral Directors Annual Conference
May 2016	*FTC & Legal Update*	Iowa Funeral Directors Annual Conference
May 2016	*21st Century Lawsuits*	Funeral and Cremation Services Council of Saskatchewan Convention
May 2016	*Cremation & Embalming Liability*	Funeral and Cremation Services Council of Saskatchewan Convention
Apr 2016	*Cremation Operator Liability*	ICCFA Cremation Certification Program

Apr 2016	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Apr 2016	*Cemetery 101: Everything from HR to Operations*	Catholic Cemeteries Smaller Cemetery Conf.
Apr 2016	*Cremation Operator Liability*	OACFP Crematorium Trainer Program
Feb 2016	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Feb 2016	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Feb 2016	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	ODFA Masters Training Program
Feb 2016	*The Science, Legalities and Marketing of Forms*	Indiana Funeral Directors Mid-Winter Conf.
Feb 2016	*Cremation Liability and Lawsuits— Learning Through the Eyes of Consumer*	CANA Cremation Symposium
Nov 2015	*Embalming Liability: Making Sure You Cover Your Assets*	Funeral Directors Association of Kentucky Mid-Winter Conference
Nov 2015	*Cremation Issues for Cemeteries: Making Sure You Cover Your Assets*	Funeral Directors Association of Kentucky Mid-Winter Conference
Nov 2015	*Kentucky Legal Update*	Funeral Directors Association of Kentucky Mid-Winter Conference
Nov 2015	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Nov 2015	*Cremation Arranger Liability*	CANA & ICCFA Cremation Certification
Oct 2015	*Pet Owners v. Pet Parents: Defining and Understanding Pet Cremation*	International Association of Animal Hospice and Palliative Care
Oct 2015	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Oct 2015	*Cremation Issues for Cemeteries: Making Sure You Cover Your Assets*	Indiana Cemetery Association
Oct 2015	*Cremation Isn't 'Quick, Simple and Easy': Helping the Bereaved Understand a Difficult Process*	15th Clinical National Hospice and Palliative Care Organization Conference
Sept 2015	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Sept 2015	*Cremation Arranger Liability*	CANA & ICCFA Cremation Certification
Sept 2015	*Disinterment Liability: A Grave Decision; HR Issues: Making Sure You Cover Your Assets*	Doric Products Annual Dealer's Meeting
Sept 2015	*Not Just a Form: The Science, Legality & Marketing of Forms for Cemeteries; Cremation Panel*	Catholic Cemetery Conference
Aug 2015	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Jul 2015	*Cemetery Liability Issues*	ICCFA University
Jul 2015	*Arranger Curriculum: Reducing Your Liability to Add to Your Bottom Line*	ICCFA University
Jul 2015	*Doing the Right Things for the Right Reasons*	ICCFA University
Jul 2015	*Business Law: Funeral Home and Cemetery Legal Outlook*	ICCFA University
Jul 2015	*The Legal Aspects of Funeral Service*	ICCFA University
Jun 2015	*Not Just a Form: The Science, Legality and Marketing of Forms*	Texas Funeral Director Convention
Jun 2015	*Not Just a Form: The Science, Legality and Marketing of Forms for Cemeteries*	Wisconsin Cemetery Association
Jun 2015	*Cremation Liability: Covering Your Assets*	Kentucky Association of Morticians
Jun 2015	*Not Just a Form: The Science, Legality and Marketing of Forms*	Funeral Directors Association of Kentucky
Jun 2015	*Not Just a Form: The Science, Legality and Marketing of Forms for Cemeteries*	New England Cemetery Association
May 2015	*Top 15 Issues of 2015*	Illinois Funeral Directors Association
May 2015	*Cremation Liability: Covering Your Assets*	Funeral and Cremation Services Council of Saskatchewan
May 2015	*It's Not Just A Form: The Art, Science, & Legality of your Forms & Contracts*	Kansas Funeral Director's Association

Apr 2015	*Five Legal Issues Affecting Every Pet Business*	ICCFA Annual Convention
Apr 2015	*Cremation Hotline Calls: Learning about Cremation from a Consumer's Perspective*	ICCFA Annual Convention
Apr 2015	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Apr 2015	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Apr 2015	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Apr 2015	*Cremation Arranger Liability*	CANA & ICCFA Cremation Certification
Apr 2015	*Cremation Operator Liability*	OFDA, CANA & ICCFA Cremation Cert.
Apr 2015	*Cremation Arranger Liability*	OFDA, CANA & ICCFA Cremation Cert.
Mar 2015	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Mar 2015	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Mar 2015	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Mar 2015	*Cremation Arranger Liability*	CANA & ICCFA Cremation Certification
Mar 2015	*Panel Discussion*	OACFP Cremation Training
Mar 2015	*Cremation Liability: Covering Your Assets*	OACFP Cremation Training
Mar 2015	*Cremation Liability – Crossing American Borders*	Ontario Association of Cemetery and Funeral Professionals
Mar 2015	*A Cremation Primer For Funeral Directors - Liability*	Southern Funeral Directors Assoc. Conv.
Feb 2015	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Feb 2015	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Feb 2015	*Disinterment Liability – A Grave Decision*	National Concrete Burial Vault Assoc. Conf.
Jan 2015	*Cremation Paperwork and Forms As Sales Tools. No Really!*	ICCFA Wide World of Sales
Nov 2014	*Why Do I Need A Signature? Due Diligence In the Pet Deathcare Profession*	Illinois State Veterinarian Medical Assoc.
Nov 2014	*Pet Scandals In the News: What We Can Learn From Recent Events*	Illinois State Veterinarian Medical Assoc.
Nov 2014	*Pet Owners Versus Pet Parents: Defining & Understanding Pet Cremation Issues*	Illinois State Veterinarian Medical Assoc.
Nov 2014	*The Laws of Funeral Profession in Ohio - Including the Revised Code, Regulations, and the FTC*	OFDA Masters Training Program
Nov 2014	*Cremation Operator Liability*	CANA & ICCFA Cremation Certification
Nov 2014	*Cremation Arranger Liability*	CANA & ICCFA Cremation Certification
Oct 2014	*Cremation Operator Liability*	OFDA, CANA & ICCFA Cremation Cert.
Oct 2014	*Cremation Arranger Liability*	OFDA, CANA & ICCFA Cremation Cert.
Oct 2014	*Cremation, Cemeteries, and the Catholic Church*	Annual Catholic Cemeteries Conference
Jul 2014	*Doing the Right Things for the Right Reasons*	ICCFA College of Sales and Marketing
Jul 2014	*Cemetery Liability Issue*	ICCFA College of Land Management
Jul 2014	*What's New That Can Get You Sued: Update on Funeral Profession Liabilities*	ICCFA Embalming & Restorative Arts College
Jul 2014	*Social Media: Welcome to the Dark Side*	ICCFA College of Leadership Admin & Mgmt.
Jul 2014	*The Legal Aspects of Funeral Service*	ICCFA College of Funeral Home Management
Jul 2014	*Embalming Liability –Is Anyone Really Getting Sued*	ICCFA Embalming & Restorative Arts College
Jul 2014	*Avoiding Cremation Liability*	ICCFA Cremation College
Jun 2014	*Cremation Liability – Pursuant to the Ohio Revised Code and Administrative Code*	OFDA Masters Training Program
Jun 2014	*What Every Cemetery Needs to Know*	Wisconsin Cemetery Association
May 2014	*FTC – Update; Cremation Liability; Embalming Liability; Women In the Funeral Profession*	Iowa Funeral Director's Association
May 2014	*Cemetery Legal Update; 3 Things That Always Go Wrong*	Pennsylvania Cemetery, Cremation and Funeral

		Association
Apr 2014	*What You Can Learn From Recent Events*	PLPA / ICCFA Annual Convention
Apr 2014	*Five Cremation Issues That Are Affecting All of Us*	ICCFA Annual Convention
Feb 2014	*Cremation Liability – Is Anyone Really Getting Sued?*	Indiana Funeral Directors Annual Conv.
Feb 2014	*Employment Issues*	National Concrete Burial Vault Assoc. Conf.
Feb 2014	*Cremation Arranger Liability*	ICCFA Cremation Certification Program
Feb 2014	*Cremation Operator Liability*	ICCFA Cremation Certification Program
Jan 2014	*Limiting Liability for Cremation Salespeople*	ICCFA Wide World of Sales
Jan 2014	*Cemetery Liability*	Michigan Cemetery Assoc. Mid-Winter Conf.
Jan 2014	*Cemetery 101*	Michigan Cemetery Assoc. Mid-Winter Conf.
Jan 2014	*Cemetery Rules and Regulations*	Michigan Cemetery Assoc. Mid-Winter Conf.
Oct 2013	*Pulling the Weeds - Employment Issues*	Annual Catholic Cemeteries Conference
Oct 2013	*The Case of the Botched Cremation*	Ontario Association of Cemetery and Funeral Professionals
Sept 2013	*FTC Update, Liability, and Changes*	North American Cemetery Regulators Assoc.
Sept 2013	*If You Don't Pull the Weeds, They'll Take Over the Garden*	Catholic Cemetery Conference Annual Conv.
Sept 2013	*The Case of the Botched Cremation*	Colorado Funeral Directors Association
Jul 2013	*Doing the Right Things for the Right Reasons*	ICCFA College of Sales and Marketing
Jul 2013	*Cemetery Liability Issue*	ICCFA College of Land Management
Jul 2013	*What's New That Can Get You Sued: An Update on Funeral Prof Liabilities*	ICCFA Embalming & Restorative Arts College
Jul 2013	*Social Media: Welcome to the Dark Side*	ICCFA College of Leadership Admin & Mgmt.
Jul 2013	*The Legal Aspects of Funeral Service*	ICCFA College of Funeral Home Management
Jul 2013	*Embalming Liability –Is Anyone Really Getting Sued*	ICCFA Embalming & Restorative Arts College
Jul 2013	*Avoiding Cremation Liability*	ICCFA Cremation College
Jun 2013	*Cemetery Liability and 101 Employment Liability*	Wisconsin Cemetery Association
Apr 2013	*The $10,000 Cremation: A Legal Look at the Real Cost for Cremation*	ICCFA Annual Convention
Apr 2013	*The Case of the Botched Pet Cremation*	PLPA Annual Convention
Apr 2013	*How Traditional Is Cremation? A Look at Recent Changes in the Market*	ICCFA Annual Convention
May 2013	*FTC – Update; Cremation Liability; Embalming Liability*	Iowa Funeral Director's Association
May 2013	*Cremation Liability – Is Anyone Really Getting Sued*	Kansas Funeral Director's Association
Feb 2013	*What's New That Can Get You Sued – Social Media*	Ohio Funeral Director's Association
Feb 2013	*Cremation Liability and the Laws of Ohio*	Ohio Funeral Director's Association
Feb 2013	*Embalming Liabilities*	Ohio Funeral Director's Association
Nov 2012	*Cremation Legal Update*	Kates-Bolyston Seminar
Nov 2012	*Hiring and Firing – And a Few Things In Between*	Kates-Bolyston Seminar
Oct 2012	*Pet Cremation Liability for Vets*	Illinois State Veterinarian Medical Association
Sept 2012	*Pet's and Potential Liability: Cremation, Cemeteries, and Providers*	Int'l Assoc. of Pet Cemeteries & Crematories
Aug 2012	*Cemetery Liability – Top 10 Mistakes*	Colorado Funeral Directors Association
Jul 2012	*Doing the Right Things for the Right Reasons*	ICCFA College of Sales and Marketing
Jul 2012	*Cemetery Liability Issue*	ICCFA College of Land Management
Jul 2012	*The Legal Aspects of Funeral Service*	ICCFA College of Funeral Home Management
Jul 2012	*Avoiding Cremation Liability*	ICCFA Cremation College
Jun 2012	*Cremation Liability – Is Anyone Getting Sued?*	Texas Cemeteries Association, Annual Conv.
May 2012	*FTC – Update; Cremation Liability; Embalming Liability*	Iowa Funeral Director's Association
May 2012	*Embalming Liability – Myths Revealed*	Ohio Embalmer's Association

Mar 2012	*The Case of the Botched Cremation*	ICCFA Annual Convention
Mar 2012	*Pet Owners vs. Pet Parents: The Liability Implications*	PLPA Annual Convention
Mar 2012	*Kentucky Funeral Law Review*	Funeral Director's Association of Kentucky
Mar 2012	*Embalming and Cremation Liability – Myths and Mania*	Pittsburgh Institute of Mortuary Science
Feb 2012	*Liability and the Cemetery Profession*	Ohio Cemetery Association
Nov 2011	*Ethics in the Funeral Profession*	Ohio Funeral Director's Association
Oct 2011	*Pet Cremation Liability*	PLPA College
Jul 2011	*Are You Priced Right? Examining Your Financials*	ICCFA Administration College
Jul 2011	*Avoiding Cremation Liability*	ICCFA Cremation College
May 2011	*FTC – Update; Cremation Liability; Embalming Liability*	Iowa Funeral Director's Association
Apr 2011	*Cremation Liability – Is Anyone Getting Sued*	Oklahoma Funeral Director's Association
Mar 2011	*Alkaline Hydrolysis Summit*	ICCFA Annual Convention
Mar 2011	*Pet Cremations: A Blueprint for Limiting Liability*	PLPA Annual Convention
Mar 2011	*The Cremation Case: A Step-by-Step Guide to Avoiding Liability*	ICCFA Annual Convention
Mar 2011	*Cemetery Liability*	Ohio Monument Builder's Association
Mar 2011	*Embalming Liability – An Update*	Ohio Embalmer's Association
Nov 2010	*Cemetery Liability: 3 Prevalent Problems – 3 Simple Solutions*	Tri-State Cemetery and Funeral Assoc. Conv.
Oct 2010	*Alkaline Hydrolysis Legal Update*	ICCFA Fall Management Conference
Sept 2010	*Embalming Liability – Traditional Dispositions and Non-Traditional Lawsuits*	Ohio Embalmer's Association
Sept 2010	*Embalming Liability – Traditional Dispositions and Non-Traditional Lawsuits*	Iowa Funeral Directors Assoc. Annual Conv.
Sept 2010	*Cremation News – An Update for Cremation Providers*	Wilbert Burial Vault Annual Seminar
Jul 2010	*Are You Priced Right? Examining Your Financials*	ICCFA Administration College
Jul 2010	*Avoiding Cremation Liability*	ICCFA Cremation College
Jul 2010	*Current Cemetery Legal Issues and Legislation*	New England Cemetery Association
May 2010	*Cremation Strategies*	Kates-Bolyston Seminar
May 2010	*Cremation Issues Today*	Iowa Funeral Directors Association
May 2010	*FTC – Legal Overview*	Iowa Funeral Directors Association
May 2010	*Cremation Issues Today*	Iowa Funeral Directors Association
May 2010	*Cremation Training*	Virginia
Apr 2010	*Direct Cremation and a Direct Lawsuit*	Ohio Funeral Directors Assoc. Annual Conv.
Apr 2010	*Cemetery Legal Update – From the Laws to the Lawsuits*	Texas Cemeteries Association, Annual Conv.
Apr 2010	*Cremation Liability*	Texas Cemeteries Association, Annual Conv.
Dec 2009	*Business and Health Insurance For Your Business*	Young Funeral Directors of Ohio
Dec 2009	*Show Me the Money – Getting Paid for your AR*	Young Funeral Directors of Ohio
Sept 2009	*RICO and the Cemetery Industry*	North American Cemetery Regulators Assoc.
Jul 2009	*Are You Priced Right? Examining Your Financials*	ICCFA Administration College
Jul 2009	*Avoiding Cremation Liability*	ICCFA Cremation College
Apr 2009	*Insurance Primer for the Industry*	ICCFA Annual Convention
Apr 2009	*Pre-Need Due Diligence*	ICCFA Annual Convention
Mar 2009	*Cremation Liability*	Kentucky State District Meetings
Mar 2009	*GPL Compliance v. Marketing*	Kentucky State District Meetings
Mar 2009	*Pre-Need Due Diligence*	Kentucky State District Meetings
Jan 2009	*Cremation Law in Ohio and Liability*	Ohio District 8, 12
Dec 2008	*Cremation Liability*	Dodge Chemicals
Nov 2008	*Cremation Liability*	Kentucky State District Meetings

Nov 2008	*GPL Compliance v. Marketing*	Kentucky State District Meetings
Nov 2008	*Pre-Need Due Diligence*	Kentucky State District Meetings
Aug 2008	*Cremation Liability for Operators and Providers*	Virginia
Mar 2008	*The Fall of the Preneed Giants*	ICCFA Annual Convention
Mar 2008	*Form Management –Making Sense of the Alphabet Soup*	ICCFA Annual Convention
Feb 2008	*Show Me the Money – Getting Paid for Your AR*	Funeral Directors Association of Kentucky Mid-Winter Conference
Nov 2007	*RICO and the Funeral Industry*	ICCFA Fall Management Conference

EXHIBIT B

M E M O R A N D U M

TO: Ohio Department of Health

FROM: Ohio Funeral Directors Association

DATE: February 16, 2021

RE: **Fetal Remains Law**

Ladies and Gentlemen:

On behalf of the Ohio Funeral Directors Association (OFDA) and its funeral home members, OFDA requests that the Ohio Department of Health (ODH) consider the following issues when promulgating the regulations to carry out the changes that S.B. 27 (the "Fetal Remains Law") made to the applicable sections of the Ohio Revised Code:

1. **Simultaneous Cremation**. The Fetal Remains Law requires that following a surgical abortion, all zygotes, blastocytes, embryos or fetuses must be either buried or cremated. It is anticipated that the overwhelming majority of zygotes, blastocytes, embryos and fetuses will be cremated.

According to data reported by Planned Parenthood, approximately 65% of abortions occur when the embryo is 8 weeks or less in gestational age. At 8 weeks, an embryo is approximately ½ inch in length and about ½ ounce in weight. The embryo at this stage is described as about the size of a kidney bean and no bone has yet formed. It is not until 10 weeks that bone cells start to form.

Because of the extremely small size of embryos that will be cremated, it will be necessary to conduct simultaneous cremations of multiple zygotes, blastocytes, embryos and/or fetuses in order to properly carry out the cremation and to have cremated remains. If embryos are cremated on an individual basis, there will be no cremated remains to bury or scatter as provided for by amended Section 4717.271(A)(2). Additionally, it will be nearly impossible to carry out individual cremations of zygotes and blastocytes which are not visible to the naked eye or small embryos which may weigh only a few grams and be difficult to see and place in a large cremation retort designed for the cremation of a regular size adult.

Due to the practical problems of cremating extremely small zygotes, blastocytes and embryos, and to produce any cremated remains from the cremation process, it is necessary to allow simultaneous cremations of multiple zygotes, blastocytes, embryos and fetuses. Because the Fetal

Remains Law does not address simultaneous cremation in any respect, OFDA is asking that the proposed regulations issued by ODH specifically provide for simultaneous cremation of multiple zygotes, blastocytes, embryos and fetuses.

2. **Burial**. If an abortion provider elects to bury zygotes, blastocytes, embryos and fetuses instead of cremating them, it will again be necessary from a practical standpoint to conduct joint burials of multiple zygotes, blastocytes, embryos and fetuses.

3. **Irrevocable Disposition Election**. Section 3726.04 provides that the pregnant woman will be presented with a form developed by ODH on which she will document in writing her choice to bury or cremate the embryo, or if she wishes the abortion provider to carry out the cremation or burial on its own.

   OFDA would request that the language of the form specify that the pregnant woman's choice regarding disposition is irrevocable and not subject to modification if she were to later have a change of heart. Funeral homes and crematories are concerned about possible liability claims if the pregnant woman changes her choice, but the cremation or burial has already been carried out. To clear up any possible claim and to reinforce to the pregnant woman that her choice may not be modified at a later date, the form should plainly spell out that the disposition choice is irrevocable and not subject to change.

OFDA and its membership respectfully request that ODH address the Association's concerns stated above in promulgating the regulations. If you have any questions, please contact Melissa Sullivan, OFDA Executive Director, at (614) 486-5339 or Melissa@ofdaonline.org. Thank you.

cc. William Wappner, President, Ohio Board of Embalmers and Funeral Directors
Cheryl Grossman, Executive Director, Ohio Board of Embalmers and Funeral Directors

EXHIBIT 8

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, Plaintiffs, v. OHIO DEPARTMENT OF HEALTH, *et al.*, Defendants.	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF THOMAS V. CUNNINGHAM, PH.D., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Thomas V. Cunningham, Ph.D., M.A., M.S., being duly sworn on oath, do depose and state as follows:

Background and Expert Qualifications

1. I am the Director of Bioethics at Kaiser Permanente West Los Angeles Medical Center and faculty member at Loyola Marymount University Bioethics Institute.

2. I have a Ph.D. in the History and Philosophy of Science from the University of Pittsburgh, a Master's degree in Bioethics and Health Law from the University of Pittsburgh, and a Master's degree in Biology from the University of California at San Diego.

3. I specialize in theoretical and clinical bioethics and the philosophy of medicine. Currently, my work involves: A) clinical work, including consulting on ethical issues involved in difficult medical cases; B) educational work, including teaching on various topics in bioethics; C) scholarship, including publishing my own research in clinical ethics and ethical decision making; and D) managing a hospital ethics committee and contributing to Kaiser Permanente's Southern California Bioethics Program.

4. My clinical work in my position as Director of Bioethics is particularly relevant to the issues presented in this case. I have extensive clinical experience working with hundreds of patients and their families who face challenging ethical questions or dilemmas that arise in the health care setting. In these cases, I generally review the patient's medical condition, prognosis, and the range of likely outcomes, and work with the patient and their family to help determine the best medical decisions for the patient, using bioethical theories and methods. This often involves incorporating patients' religious, moral, and cultural beliefs into their medical decision making, even where those beliefs may conflict with or complicate their course of treatment, to ensure that every patient's autonomy is respected appropriately by their medical team. I have worked with pregnant patients, including those considering abortion or experiencing miscarriage, and patients of diverse faiths, including Catholics, Christian Scientists, Muslims, Hindus, Jehovah's Witnesses, and Orthodox Jews, where such difficult issues have arisen.

5. Additionally, I have published and taught extensively on both theoretical and clinical bioethics, including mentoring post-graduate students in medical ethics and philosophy, teaching graduate courses in medical ethics, regularly presenting at the American Society for Bioethics and Humanities, and teaching undergraduate classes in ethics and society as well as morality and medicine. My research includes work on the ethics of parental decision making for severely ill neonates, fetal tissue research, and cloning for research purposes. My publications on those and other topics have appeared in dozens of peer-reviewed journals, including *Journal of Medical Ethics* and *American Journal of Bioethics*.

6. My *curriculum vitae*, which more fully sets forth my education, credentials, experiences, and publications, is attached hereto as Exhibit A.

7. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Ohio Senate Bill 27 ("SB27"). I am over the age of eighteen, competent to testify, and make this affidavit based on personal knowledge; my background and experience in the field of bioethics, as described above; my review of the challenged law; and, where noted, information provided by Plaintiffs' counsel.

Statement of Opinions

8. I have reviewed the enrolled version of SB27 and the associated Ohio regulations governing the disposal of embryonic and fetal tissue from procedural abortions. I understand the law to require health care facilities to ensure the disposal of all embryonic and fetal tissue from procedural abortions by either interment or cremation, regardless of patients' individual beliefs or desires. I further understand that the law prohibits health care facilities from disposing of their patients' embryonic and fetal tissue through any other means, including medical methods of disposal approved by Ohio for other biological tissue.

9. I understand that Ohio abortion providers currently dispose of pregnancy tissue from procedural abortions, including embryonic and fetal tissue, in the same manner as biological tissue from other medical procedures. I understand that this practice is in conformity with current Ohio law but would no longer be allowed under SB27.

10. It is my opinion that SB27 violates basic bioethical principles and inappropriately imposes the State's value judgments onto patients' medical decision-making process in a manner that would cause harm to those seeking abortion in Ohio.

SB27 Violates the Foundational Principles of Bioethics

11. Modern bioethical theory has developed out of legal precedent and philosophical scholarship over the twentieth century.[1] There are four interrelated principles, shared across different moral frameworks, that provide the foundation for bioethics: respect for patient autonomy, beneficence, nonmaleficence, and justice.[2] Each is afforded equal priority, and must be specifically addressed and balanced in a particular case or policy question.[3]

12. Respect for autonomy counsels that adult persons should be supported in making un-coerced, authentic, and voluntary choices after having been provided material information regarding the decision at issue to achieve the best health outcomes. Beneficence is the notion that medical interventions should aim to benefit the patient, and, accordingly, health care professionals should act with the intent of benefiting patients. Nonmaleficence is the notion that medical interventions should minimize treatment burdens, or harms, and accordingly, health care professionals should act with the intent of reducing harms to patients. In practice, since medical interventions are often burdensome, ethical medical practice requires balancing the aim of benefitting patients while reducing treatment burdens as much as possible.[4] Finally, the principle of justice conveys the view that medical interventions ought to be equally accessible to those who need them.

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[1] Faden, Ruth R. & Beauchamp, Tom L. (1986). *A History and Theory of Informed Consent*. New York: Oxford University Press.

[2] Beauchamp, Tom L. & Childress, James F. (2019). *Principles of Biomedical Ethics*, 8th Ed. Oxford: Oxford University Press.

[3] Richardson, Henry S. (1990). "Specifying Norms as a Way to Resolve Concrete Ethical Problems." *Philosophy & Public Affairs*. 19(4): 279–310; Richardson, Henry S. (2000). "Specifying, Balancing, and Interpreting Bioethical Principles." *Journal of Medicine and Philosophy*. 25(3): 285–307.

[4] Beauchamp & Childress, *supra* note 2.

13. SB27 inserts the State into medical decision making in ways that contravene all four foundational principles of bioethics. The law violates patient autonomy, is more likely to harm than benefit the patient, and is contrary to justice principles.

SB27 Violates the Ethical Principle of Patient Autonomy

14. SB27 is inconsistent with the principle of respect for patient autonomy because it limits patients' choice of disposal of their embryonic or fetal tissue from procedural abortions to only cremation or interment, thus restricting the extent to which patients can make decisions that conform to their values and needs.

15. Ohio abortion providers' current practices align with principles of respect for patient autonomy. I understand that patients rarely ask about how the tissue of the embryo or fetus will be disposed but that, on the infrequent occasion that a patient does inquire, clinic staff explain that embryonic or fetal tissue is typically disposed of in the same manner as other human tissues removed in medical procedures. I also understand that in the even rarer circumstances when a patient wants to bury or cremate the tissue, they may do so. I further understand that when patients request the tissue be sent to a pathologist or crime lab, abortion providers honor that request. These practices demonstrate respect for patient autonomy by providing material information to patients based on the values they express in the setting of a patient-provider relationship, which honors patients' different, individual requests for specific disposition options consistent with their personal moral values.

16. In contrast, SB27 disempowers abortion patients from making their own, authentic judgments about how to understand embryonic and fetal tissue from their procedural abortions and, based on this, what the morally appropriate disposal methods are for those patients. Although the law purports to provide patients with a choice for tissue disposal, the options are improperly

limited to cremation or interment. Even if the patient declines to select cremation or interment, the law still requires the tissue be disposed of only by one of those two methods. The law thus coerces patients by mandating fetal or embryonic tissue from procedural abortions be disposed of differently than tissue from other medical procedures and by restricting embryonic and fetal tissue disposal to the manners in which human remains are typically handled. Such a limitation signals to abortion patients that the tissue from their abortions is, and should be treated as equivalent to, a human being. By sending this message to patients, the law imposes upon them a moral framework for understanding embryonic and fetal tissue, which circumvents patients' native capacity for formulating personal, moral judgments about such matters and, consequently, making decisions that align with those personal, moral values.

17. In our diverse and pluralistic society, there is no universal agreement regarding the moral status of embryos and fetuses, because some traditions believe a developing embryo or fetus is worthy of the same reverence as a person, while others do not.[5] Some believe that an embryo—even at the earliest moment of conception—is morally equal to all other human beings and, consequently, that embryonic and fetal tissue ought to be treated the same as at other developmental stages of human life.[6] Other beliefs and religious traditions counsel that a human being does not come into existence until birth, making rituals related to death for people (like burial and cremation) inappropriate because performing the ritual logically entails a moral commitment that is inconsistent with their traditions. For patients with these beliefs, requiring the

[5] Connolly, William E. (2005). *Pluralism*. Duke University Press.

[6] *See* President's Council on Bioethics. (July 2002). *Human Cloning and Human Dignity: An Ethical Inquiry*, available at https://bioethicsarchive.georgetown.edu/pcbe/reports/cloningreport/; Meilaender, Gilbert & George, Robert P. (Feb. 21, 2006). "That Thing in a Petri Dish." *National Review*, available at https://www.nationalreview.com/2006/02/thing-petri-dish-gilbert-meilaender-robert-p-george/.

cremation or interment of their embryonic or fetal tissue prohibits them from making an authentic decision consistent with their values and preferences. This violates the principle of respect for autonomy. This likewise violates nonmaleficence, because the restrictions to autonomy also promote a harm unto patients who are compelled to act contrary to their considered moral judgments.

18. I also understand that SB27's mandate that embryonic and fetal tissue be disposed of by cremation or interment could impair abortion providers' ability to send the tissue to a pathologist for testing, as might be medically indicated, or to a crime lab for preservation as evidence, as might be needed for a criminal investigation. Patients who have medical indications or who are survivors of sexual assault are likely to form sincere moral beliefs about the rightness of sending such tissue to a pathologist or crime lab, so that necessary testing can occur for their health or in the pursuit of justice. They also may seek evaluation of the tissue for the benefit of their emotional and physical health, to seek knowledge about their medical condition, facilitate future reproductive decision making, or in support of their understanding of personal trauma. But these patients will not be able to have this decision effectuated because of SB27. This restriction on patient choice violates respect for patient autonomy and entails harms for patients.

19. It is also remarkable that SB27 gives the State more authority over patients' decisions than bioethical theory conveys even to parents of minor children. Respect for parental decision making in ethics includes the parents' ability to make decisions for their children based on their cultural or religious beliefs. Parents may sometimes make choices for their children that others might see as causing harm, but their authority to do so is awarded respect because they are recognized as uniquely suited to assess how the burdens for their children relate to their future benefits. Only when good scientific research shows that their chosen course of action is patently

and disproportionally likely to be harmful, and society is widely in agreement, are parents prevented from acting in accordance with their personal values and religious or moral beliefs.[7] In contrast, SB27 takes a stance that is not widely agreed upon and does not permit patients to act on their values. The law thus creates a category of people—those who seek procedural abortion—who are uniquely deprived of the ability to fully exercise values-based judgment, even though their autonomy must otherwise be respected both before and after pregnancy.

20. In sum, SB27 is strikingly at odds with the foundational principle of autonomy and the respect that medical ethics requires be granted to patients' beliefs and preferences.

SB27 Violates the Ethical Principles of Beneficence and Nonmaleficence

21. SB27 is inconsistent with the principles of beneficence and nonmaleficence because it imposes health risks and stigmatic harms on abortion patients without countervailing beneficial effects.

22. I understand that because there is a potential conflict between SB27 and laws governing the disposal of infectious waste, which includes pregnancy tissue other than embryonic and fetal tissue, SB27 could make procedural abortion unavailable prior to around 13 weeks of pregnancy. In making procedural abortion inaccessible during early pregnancy, when most patients obtain this care, SB27 could force many to postpone care until later in pregnancy when the procedure is both riskier and more expensive. This creates risks to patients' physical and mental health without any countervailing benefits, in direct violation of the ethical principles of beneficence and nonmaleficence.

[7] Diekema, Douglas S. (2004). "Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention." *Theoretical Medicine*. 25: 243–264.

23. I also understand that the costs associated with interment and cremation, as well as the additional costs of later abortion, could foreclose access to abortion for some patients and force some abortion seekers to carry their pregnancies to term. Forcing a patient to continue a pregnancy and bear a child against her will, and to endure all of the profound physical and emotional consequences that come along with that, violates the ethical principles of beneficence and nonmaleficence. Any involuntary postponement of care or forced pregnancy would likewise violate the ethical principle of autonomy.

24. SB27 also harms abortion patients by exacerbating the stigmas associated with seeking or having an abortion. Stigma is conceptualized as an attribute that marks individuals as different or "other" than their fellow community members and, consequently, as less valuable people.[8] Such moral devaluation can be conveyed through various social interactions, including when individuals deny services or treat certain people differently due to the individual's perception of the other's lack of value or a belief that the other is unworthy of human dignity. Stigma may also be communicated through the enactment of social norms via public policy or legislation, which may impose restrictions on the liberties of some based on the perception by policymakers, legislators, or powerful interest groups that members of a population should have their liberties restricted because their actions or identities are disvalued.[9] Research on abortion care shows that stigma is primarily experienced in two ways: as something perceived to emanate from others and as something that a person self-imposes as a negative self-assessment. These two notions are

[8] Abrams, Paula. (2015). "The Bad Mother: Stigma, Abortion and Surrogacy." *The Journal of Law, Medicine & Ethics*. 43(2): 179–191.

[9] *Id.*

described as "felt" stigma and "internalized" stigma, respectively.[10] A 2010 study reports that two in three women who received an abortion experienced stigma.[11]

25. Where the State mandates that embryonic and fetal tissue not be treated like other medical waste and instead forces disposal via cremation or interment, patients will likely understand the State to be signaling that such tissue is equivalent to human remains. Furthermore, this also signals that those who receive abortion care are morally corrupt because they are harming a human being with their actions. In this way, the State mandate imposes a moral position—that embryos and fetuses are morally equivalent to an infant—onto patients who otherwise do not hold this view, whether such moral views were derived from religious or secular ethical commitments. This stigmatizes abortion and people who have them.

26. In insisting on treating this tissue as equivalent to human remains, SB27 conveys a moral and social disapproval of abortion and people who have abortions that is likely to influence patients' experiences of both internalized and felt stigma. The law also harms some patients by forcing them to treat the embryonic or fetal tissue in ways that are inconsistent with their religious or moral traditions. In limiting the methods of disposal so that they will not be aligned with some patients' religious or moral convictions on abortion and when human life begins, the law will perpetuate the stigma that is conveyed by legislation that imposes restrictions on liberty and choice. In perpetuating this stigma, the law contributes to the growth of stigma against patients who adopt religious and moral views that are inconsistent with the view that a developing embryo or fetus is morally equivalent to a living person.

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[10] Cockrill, Kate & Nack, Adina. (2013). "'I'm Not That Type of Person': Managing the Stigma of Having an Abortion." *Deviant Behavior.* 34: 973–990.

[11] Shellenberg, K.M. (2010). "Abortion Stigma in the United States: Quantitative and Qualitative Perspectives from Women Seeking an Abortion." (Doctoral Dissertation). Baltimore, Maryland: The Johns Hopkins University.

27. The stigmatization of abortion may cause unnecessary biopsychosocial suffering. In my professional practice, I have participated in medical care as an ethicist where patients' values deviate from the values expressed by the State, and seen first-hand the burdens this creates for patients and their families. For example, when I worked at the University of Arkansas for Medical Sciences, a young, pregnant woman suffered an anoxic brain injury that caused irreversible neurological damage from which she could not recover; she would never regain consciousness or be able to live off life support. The woman had expressed that in such a situation she would not want to be kept alive, and she reiterated this view even after she intentionally became pregnant. Her family knew she did not want to be kept on life support merely so that the fetus could develop and they conveyed these wishes to the doctors; however, Arkansas law cast doubt on whether physicians could honor pregnant patients' wishes to be taken off life support. As the ethicist in the case, I facilitated a resolution to the conflict between the patient's values and preferences and the implications of Arkansas law by meeting with the family, the medical team, the hospital ethics committee, the hospital risk manager, and the hospital legal counsel. The process of legal and ethical review took multiple days, during which the patient's and family's suffering were prolonged as they continued to experience her lifelessness and the feeling of being restricted in expressing their liberties to make autonomous choices in the setting of profound, traumatic circumstances. Once we concluded our analysis, the family was finally able to follow the woman's wishes and she was taken off life support while being comforted by medical professionals and attended to by her loved ones. In my opinion, the patient's husband and parents displayed early signs of prolonged grief and anxiety associated with traumatic surrogate decision making.[12] In

[12] *See* Anderson, Wendy G., et al. (2008). "Posttraumatic Stress and Complicated Grief in Family Members of Patients in the Intensive Care Unit." *Journal of General Internal Medicine*. 23(11): 1871–1876; Wendler, David & Rid, Annette. (2011). "Systematic Review: The Effect on

prolonging their experience by many days, the burdens of decision making on this family, and the harms to the patient associated with extended suffering and being treated discordantly from her end-of-life preferences while dying, were increased.

28. Though in a different medical context, SB27 will have the same negative effects on some Ohioans as the restrictive Arkansas laws had on this woman and her family: it will profoundly impact some abortion patients whose choices are restricted as they do the difficult work of assimilating deeply personal, moral, and religious convictions into their health care decisions.

29. Internalized and felt stigma also affect health care professionals participating in providing abortions.[13] By requiring that embryonic and fetal tissue from procedural abortions be disposed of as human remains, SB27 conveys a moral and social disapproval of health care professionals who provide abortion. This perpetuates the effects of stigma on health care professionals and harms them by imposing a reduced sense of self, identity, and character that follows from both internalized and felt stigma.

SB27 Violates the Ethical Principle of Justice

30. The ethical principle of justice conveys the view that medical interventions ought to be equally accessible to those who need them. SB27 is inconsistent with this principle because of the burdens it will impose on patients' access to care.

31. I understand that SB27, as discussed above, could make procedural abortion unavailable prior to around 13 weeks of pregnancy, forcing some to postpone care until later in pregnancy and forcing others to carry their pregnancies to term against their will. This violates the

Surrogates of Making Treatment Decisions for Others." *Annals of Internal Medicine*. 154(5): 336–346.

[13] Norris, Alison, Bessette, Danielle, Steinberg, Julia R., Kavanaugh, Megan L., De Zordo, Silvia, & Becker, Davida. (2011). "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences." *Women's Health Issues*. 21(3): s49–s54.

ethical principle of justice by making abortion care more, or completely, inaccessible to those who need them, when they need them.

32. I further understand that SB27 will result in a significant increase in the cost of procedural abortions, making it more difficult or impossible for patients to raise the funds needed to obtain this health care. This further violates the ethical principle of justice by making procedural abortion—the only method available for some abortion patients—less accessible.

FURTHER AFFIANT SAYETH NAUGHT.

Thomas V. Cunningham
Signed on 2022/01/06 11:29:19 -8:00

Thomas V. Cunningham, Ph.D.

01/06/2022

Signed before me this ___ day of _____, 2022.

Signed on 2022/01/06 11:29:19 -8:00

Notary Public

NOTARY PUBLIC
STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2022/01/06 12:29:19 PST E9760CB39314

Notarial act performed by audio-visual communication

EXHIBIT A

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Thomas V. Cunningham

Current Positions

Bioethics Director, Kaiser Permanente West Los Angeles Medical Center
Faculty (part-time), Loyola Marymount University Bioethics Institute, Los Angeles
Covering Bioethics Director, Kaiser Permanente Baldwin Park Medical Center

Areas of Specialization

Philosophy of Medicine, Theoretical and Clinical Bioethics

Areas of Competence

Philosophical Ethics, Philosophy of Science

Previously Held Positions

Assistant Professor, Division of Medical Humanities, University of Arkansas for Medical Sciences (UAMS) College of Medicine (2013-2016)
Assistant Professor, Internal Medicine, UAMS College of Medicine (2013-2016)
Clinical Ethicist, UAMS and Arkansas Children's Hospital (2013-2016)
Adjunct Faculty, University of Arkansas at Little Rock (2015)

Education

PhD. History and Philosophy of Science, University of Pittsburgh **2005-2013**
Socializing Medical Practice: A Normative Model of Medical Decision-Making
Committee: Kenneth Schaffner, MD, PhD (co-director; Pittsburgh, HPS)
Peter Machamer, PhD (co-director; Pittsburgh, HPS)
Sandra Mitchell, PhD (Pittsburgh, HPS)
Edouard Machery, PhD (Pittsburgh, HPS)
Robert Arnold, MD (University of Pittsburgh Medical School)

M.A. Bioethics and Health Law, University of Pittsburgh **2008-2013**
Philosophy and Science Policy in the American Cloning Debate
Committee: Mark Wicclair, PhD (director; University of Pittsburgh Medical School, Center for Bioethics and Health Law)
Douglas White, MD, MAS (Pittsburgh, Medical School and CHBL)
Alex London, PhD (Carnegie Mellon University)

M.S. Biology, University of California at San Diego **2001-2004**
Genetic Analysis of Endoplasmic Reticulum Plasticity
Committee: Randolph Hampton, PhD (director; UCSD, Biology)
Laurraine Pillus, PhD (UCSD, Biology)
Douglass Forbes, PhD (UCSD, Biology)

B.S. Biology, University of California at San Diego **1999-2003**

B.A. Philosophy, University of California at San Diego **1999-2003**

Publications

Peer Reviewed Publications

1. NR Van Buren, E Weber, MJ Bliton, and TV Cunningham (In Press). "In This Together: Navigating Ethical Challenges Posed by Family Clustering During the COVID-19 Pandemic." *Hasting Center Report*.

2. TV Cunningham (In press). "A Feminist Defense of Fetal Tissue Research," In J Schoen (ed), *Abortion Care as Moral Work* [working title], Rutgers University Press.

3. TV Cunningham (Forthcoming in 2021). "Surrogate Decision Making," In DM Hester and T Schonfeld (eds.), *Guidance for Healthcare Ethics Committees*, Cambridge University Press.

4. KW Harris, TV Cunningham, DM Hester, K Armstrong, A Kim, FR Harrell, and JB Fanning (2020). "Comparison is Not a Zero-Sum Game: Exploring Advanced Measures of Healthcare Ethics Consultation" *AJOB Empirical Bioethics*. https://doi.org/10.1080/23294515.2020.1844820

5. AC Glover, TV Cunningham, EW Sterling, and J Lesandrini (2020), "How Much Volume Should Healthcare Ethics Consult Services Have?" *The Journal of Clinical Ethics*, 31(2): 158-172.

6. MM Feinstein, JD Niforatos, I Hyun, TV Cunningham, A Reynolds, D Brodie, and A Levine (2020). "Considerations for Ventilator Triage During the COVID-19 Pandemic." *The Lancet Respiratory Medicine*. Available online April 28, 2020.

7. RS Purvis, CR Long, LR Eisenberg, DM Hester, TV Cunningham, A Holland, HE Chatrathi, and PA McElfish (2020). "First Do No Harm: Ethical Concerns of Health Researchers That Discourage the Sharing of Results with Research Participants." *AJOB Empirical Bioethics*, 11(2): 104-113

8. E Gilmore-Szott and TV Cunningham (Forthcoming). "How Do People Make Moral Medical Decisions?" In M Trachsel, S Tekin, NB Andorno, J Gaab, and JZ Sadler (eds.), *The Oxford Handbook of Psychotherapy Ethics*, Oxford University Press.

9. TV Cunningham, A Chatburn, C Coleman, E DeRenzo, K Furfari, J Frye, AC Glover, M Kenney, N Nortje, J Malek, M Repenshek, F Sheppard, and JS Crites (2019). "Comprehensive Quality Assessment in Clinical Ethics." *The Journal of Clinical Ethics*, 30(3): 284-296.

10. L Low, RS Purvis, TV Cunningham, A Chughati, R Garner, and PA McElfish (2019). "Ethical Dilemmas Encountered by Health Care Providers Caring for Marshallese Migrants in Northwest Arkansas." *Narrative Inquiry in Bioethics* 9(1):53-62.

11. TV Cunningham, LP Scheunemann, RM Arnold, and DB White (2018). "How Do Clinicians Prepare Family Members for the Role of Surrogate Decision Maker?" *Journal of Medical Ethics,* 44(1):21-26.

12. R Green, A Merrick, TV Cunningham, LR Eisenberg, and DM Hester (2017). "The Curricular Ethics Bowl: Answering Pedagogical Challenges." *Teaching Ethics,* 17(2):151-166.

13. TV Cunningham (2017). "Health, Disease, and the Basic Aims of Medicine." In U Feist, Z Biener, J Sullivan, and M Adams (eds.), *Doing History and Philosophy of Science with Peter Machamer*. Dordrecht: Springer International Publishing, pp. 141-162.

14. CR Long, MK Stewart, TV Cunningham, TS Warmack, and PA McElfish (2016). "Health Research Participants' Preferences for Receiving Research Results." *Clinical Trials* 13(6): 582-591.

15. TV Cunningham (2016). "A Life Below the Threshold? Examining Conflict Between Ethical Principles and Parental Vales in Neonatal Treatment Decision Making." *Narrative Inquiry in Bioethics* 6(1):63-71.

16. A Merrick, R Green, TV Cunningham, LR Eisenberg, and DM Hester (2016). "Introducing the Medical Ethics Bowl." *Cambridge Quarterly of Healthcare Ethics* 25(1):141-149.

17. ML Schwarze, TC Campbell, TV Cunningham, DB White, and RM Arnold (2016). "You Can't Get What You Want: Innovation for End-Of-Life Communication in the ICU." *American Journal of Respiratory and Critical Care Medicine* 193(1):14-16.

18. LP Scheunemann, TV Cunningham, RM Arnold, P Buddadhumaruk, and DB White (2015). "How Clinicians Discuss Critically Ill Patients' Preferences and Values with Surrogates: An Empirical Analysis." *Critical Care Medicine* 43(4):757-764.

19. TV Cunningham (2015). "Objectivity, Scientificity, and the Dualist Epistemology of Medicine." In P. Huneman et al. (eds.), *Classification, Disease and Evidence: New Essays in Philosophy of Medicine*. Dordrecht: Springer Science+Business Media, pp. 1-18.

20. TV Cunningham (2013). "What Justifies the Ban on Federal Funding for Nonreproductive Cloning?" *Medicine, Health Care, and Philosophy,* 16:825-841.

Other Publications

21. J Lesandrini, L Guidry-Grimes, J Crites, and TV Cunningham (2021). "160: A Survey of Ethical Views and Experiences During a Pandemic: A Critical Care Perspective." *Critical Care Medicine* 49(1): 65. [Annual Conference Abstracts]

22. E Weber, S Gray, M Applewhite, and TV Cunningham (2021). "Surrogate Decision-Making for Incarcerated Patients: A Pandemic-Inspired Call to Action." *Hastings Center Bioethics Forum* (blog), 03/24/2021, available at: https://www.thehastingscenter.org/surrogate-decision-making-for-incarcerated-patients-a-pandemic-inspired-call-to-action/

23. TV Cunningham (2019). "The Methods of Bioethics: An Essay in Meta-Bioethiocs, by J. McMillan" [Book Review]. *Notre Dame Philosophical Reviews*.

24. AL Scott and TV Cunningham (2016). "The Problems of Half-Hearted Inderdisciplinarity." *AJOB Neuroscience* 27(2): 108-109.

25. TV Cunningham (2016). "Power and Limits in Medical Decision Making." *American Journal of Bioethics* 16(1):56-58.

26. TV Cunningham (2015). "A Multidisciplinary Approach to Ensure Scientific Integrity in Clinical Research: How expensive is sustained moral commitment?" *The Annals of Thoracic Surgery* 100:1534.

27. LR Eisenberg, TV Cunningham, and DM Hester (2015). "Closure But No Cigar." *American Journal of Bioethics* 15(1):44-46.

28. PK Machamer and TV Cunningham (2015). "Mechanisms." In R. Gunstone (editor-in-chief), *Encyclopedia of Science Education*. Dordrecht: Springer Science+Business Media, pp. 625-628.

29. TV Cunningham (2014). "Philosophy, Neuroscience and Consciousness, by Rex Welshon." [Book Review], *Quarterly Review of Biology* (89):256.

30. TV Cunningham (2014). "Non-Reductive Moral Classification and the Limits of Philosophy." *American Journal of Bioethics* 14(2):22-24.

31. TV Cunningham (2013). "Critical Decisions: How You and Your Doctor Can Make the Right Medical Choices Together, by Peter Ubel." [Book Review], *Theoretical Medicine and Bioethics* 34:505-509.

32. TV Cunningham (2013). "Skepticism About the 'Convertibility' of Induced Pluripotent Stem Cells." *American Journal of Bioethics* 13(1):40-42.

33. TV Cunningham (2013). "The Principle of Charity and Non-inferential Coding in Interdisciplinary Behavioral Research." *Proceedings and Addresses of the American Philosophical Association* 86(4):174.

34. LP Scheuenemann, TV Cunningham, M Crankovic, and DB White (2012). "How do Clinicians Elicit Values from Surrogate Decision-Makers of Critically Ill Patients: A Pilot Study" *Proceedings of the American Thoracic Society* A5219.

35. TV Cunningham (2008). "Scientific Pluralism [Book Review]." *The Pluralist* 3:132-137.

36. RY Hampton, O Bazirgan, SR Cronin, TV Cunningham, J Defries, C Federovitch, I Flury, R Garza, T Lam, and E Quan (2002). "Using the ER Quality Control Pathway for Regulation of the Sterol Synthesis." *The Journal of General Physiology* 120(1):3A-3A.

Healthcare Policy

37. TV Cunningham (2020). "MP Score Triage Committee." Available at: https://www.researchgate.net/publication/340135577_MP_Score_Triage_Committee

38. TV Cunningham (2020). "Pandemic Triage Committee Draft Policy." Available at: https://www.researchgate.net/publication/340022240_Pandemic_Triage_Committee_Draft_Policy

39. TV Cunningham and KL Watson (2017). "Recognition of Conscience in Health Care Draft Policy." Available at: https://www researchgate net/publication/320402513_Recognition_of_Conscience_in_Health_Care_Draft_Policy

Work in Progress

i. "Distributed Cognition in Critical Care Medicine" (draft available)

ii. "Ethical Medical Decision Making for Incapacitated, Hospitalized Inmates" (research in progress)

iii. "Against Hospital Ethics Committees" (research in progress)

Presentations

2021: F Cohn, NR Van Buren, and TV Cunningham, "Wave After Wave: Bioethics and Distress in the Pandemic Hospital Setting." Loyola Marymount University Bioethics Institute Annual Lecture Series, November 5, 2021. Online.

J Gaffigan, D Chavira, M Haddah, N Austriaco, T Heyne, NH Heyne, and TV Cunningham, "Vaccination is a Life Issue." Loyola Marymount University Center for Religion and Spirituality, August 31, 2021. Online panel discussion.

TV Cunningham, "Measuring Ethics Consultation: Innovation in Quality Assessment and Improvement through and EMR-Integrated Approach." Geisenger Health System. June 24, 2021. Online

J Lesandrini, A Muster, N Gin, and TV Cunningham, "Partnering Together for Ethical Planning: A Conversation between Hospital Leaders and Ethics Directors." American College of Healthcare Executives (AHCE) 2021 Annual Meeting March 22-25, 2021. Online.

TV Cunningham, "Conscientious Objection & Abortion Care." Kaiser Permanente San Bernardino Service Area, March 4, 2021. Online.

J Lesandrini, L Guidry-Grimes, J Crites, and TV Cunningham, "A Survey of Ethical Views and Experiences During the COVID-19 Pandemic: A Critical Care Perspective." Society for Critical Care Medicine 2021 Annual Meeting, January 31-February 12, 2021. Online.

2020: TV Cunningham, "Nine Months Yet No Delivery in Sight: Doing Ethics on the Frontline of COVID-19." National Institute of Health Bioethics Interest Group, December 7, 2020. Online.

TV Cunningham, "Clinical Ethics: A 'Philosophy Job' Outside of Academia." Georgetown University Philosophy Department Workshop. October 30, 2020. Online.

L Guidry-Grimes, J Crites, J Lesandrini, and TV Cunningham, "A Survey of Ethical Views and Experiences During the COVID-19 Pandemic." American Society for Bioethics and Humanities (ASBH), October 15, 2020. Online

A Kondrat, S Finder, V Bartlett, and TV Cunningham, "Ethics and Epidemics: Caring in the Time of COVID-19." Harvard University Medical School Webinar Series, May 28, 2020.

TV Cunningham, A Kon, and K Michelson, "The Ethics of COVID-19: Some Initial Reflections." Loyola University Chicago Webinar, April 1, 2020.

2019: TV Cunningham, "Clinical Ethics in a Learning Health System: A Vision." Kaiser Permanente Bernard J. Tyson School of Medicine, November 22, 2019.

MJ Bliton and TV Cunningham, "Moral Significance in ELO Work." Kaiser Permanente Southern California End of Life Option Act 2019 Education Event, Anaheim, CA, October 29, 2019.

R Mishra, J Crites, TV Cunningham, and J Lesandrini, "What's the Problem with Tracking Ethics Consultations?" American Society for Bioethics and Humanities (ASBH), Pittsburgh, PA, October 24-27, 2019.

SR Gray, E Weber, TV Cunningham, and M Applewhite, "Surrogate Decision Making in Schackles: Finding a Voice for the Hospitalized Inmate." American Society for Bioethics and Humanities (ASBH), Pittsburgh, PA, October 24-27, 2019.

TV Cunningham "HCEC Charting, Tracking, and Quality Assessment: A Vision for the Future." Kaiser Permanente Inter-Regional Medical Ethics Committee (IRMEC), Portland, OR, October 3, 2019.

K Wollenburg-Harris, TV Cunningham, M Hester, and J Fanning, "Why Share Data in Health Care Ethics Consultation?" International Conference on Clinical Ethics Consultation, Vienna, Austria, May 22-25, 2019.

TV Cunningham, "Black Birth Matters: What Happens When We Think About Beneficence from a Multi-Level Perspective?" Northwestern University School of Medicine, Chicago, IL, May 2, 2019

TV Cunningham, "Serving the Common Good in the Context of Clinical Care." Loyola Marymount University, Los Angeles, CA, April 2, 2019.

SR Gray, E Weber, M Applewhite, and TV Cunningham, "Surrogacy in Shackles: Finding a Voice for the Hospitalized Inmate." 6th Annual National Nursing Ethics Conference, Los Angeles, CA, March 21-22, 2019.

TV Cunningham, "Conscientious Objection & Abortion Care." Kaiser Permanente Baldwin Park Medical Center, February 28, 2019.

2018: TV Cunningham, "Clinical Ethics and Advanced Care Planning: Supporting Patient-Centered, Values-Based Care." Panelist for the "Conversations in Medical Ethics" panel at the North American Imamia Medics International (IMI) Annual Meeting, Anaheim, CA, December 14-16, 2018.

TV Cunningham, "Ethical Research and Medical Decision Making in the Pediatric Setting." Research Week Grand Rounds, Children's Hospital of Orange County, Orange, CA, November 14, 2018.

TV Cunningham, "Being an Expert Witness." JCEPHS Learning Forum at the Philosophy of Science Association Biennial Meeting, Seattle, WA, November 1-4, 2018.

AC Glover, TV Cunningham, and J Lesandrini, "National Benchmarks for the Growth of Clinical Ethics Consultation Services." American Society for Bioethics and Humanities (ASBH), Anaheim, CA, October 18-21, 2018.

SK Shah, TS Huddle, and TV Cunningham, "Autonomy: It's Time to Set New Priorities." ASBH Medical Decision Making Affinity Group Annual Meeting, Anaheim, CA, October 18-21, 2018.

AC Glover, TV Cunningham, and J Lesandrini, "National Benchmarks for the Growth of Clinical Ethics Consultation Services." European Association of Centers of Medical Ethics Annual Conference, Amsterdam, The Netherlands, September 6-8, 2018.

J Crites and TV Cunningham, "Continuous Quality Improvement [Whitepaper Workshop]." Innovations in Clinical Ethics: A Working Un-Conference, Cleveland, OH, August 27-28, 2018.

TV Cunningham and J Crites, "Tracking Healthcare Ethics Consult Service Activities Minimally, Meaningfully, and Efficiently." Innovations in Clinical Ethics: A Working Un-Conference, Cleveland, OH, August 27-28, 2018.

AC Glover, TV Cunningham, and J Lesandrini, "National Benchmarks for Clinical Ethics Consultation Services." Innovations in Clinical Ethics: A Working Un-Conference, Cleveland OH, August 27-28, 2018.

2017: TV Cunningham and D Cruze, "Did You Know That in California You're My Relative?" Kaiser Permanente National Bioethics Symposium, Berkeley, CA, November 2-4, 2017.

TV Cunningham, K Mutcherson, J Schoen, and K Watson, "Taking Care: How Can Secular Healthcare Systems Accommodate the Wide Spectrum of Patient and Provider Views on Abortion?" (Panel Presentation). American Society for Bioethics and Humanities (ASBH), Kansas City, MO, October 19-22, 2017.

TV Cunningham, K Mutcherson, J Schoen, and K Watson, "Abortion Care as Moral Work" (Plenary). Forum on Family Planning National Meeting, Atlanta, GA, October 14-16, 2017.

K Watson, J Chor, TV Cunningham, and D Stulberg, "Difficult Ethical Cases in Abortion Care" (Invited Panel Presentation). National Abortion Federation (NAF), Montreal, Québec, April 22-25, 2017.

TV Cunningham, "On Getting By With the Help of Your Friends: How Multidisciplinary Team Meetings Can Resolve Clinical Ethics Dilemmas." Cook Children's Hospital PICU/CICU Meeting, Forth Worth, TX, February 12, 2017.

TV Cunningham, "From Medical School Curriculum to Clinical Practice: How to Approach Ethical Dilemmas with GRACE." Cook Children's Hospital Pediatric Grand Rounds, Forth Worth, TX, February 13, 2017.

TV Cunningham, "Sometimes it Takes More than Two to Tango: From Parental Authority to Shared Decision Making." Cook Children's Hospital Neonatal Grand Rounds, Forth Worth, TX, February 13, 2017.

TV Cunningham, "Working the Hard Cases: Tools for the Ethics Committee." Cook Children's Hospital Ethics Committee, Forth Worth, TX, February 12, 2017.

2016: TV Cunningham, M Kuczewski, H Lipman, and R McKinney, "From "Meh" to MEB: Innovative Ethics Education in Medical School" (Panel Presentation). American Society for Bioethics and Humanities (ASBH), Washington, DC, October 6-9, 2016.

TV Cunningham, "Epic Ethics: Measuring Clinical Ethics Consultation Using the Epic Electronic Health Record System." Vanderbilt University Medical Center, Nashville, TN, July 15, 2016.

TV Cunningham, "Distributed Cognition in Critical Care Medicine." Society for Philosophy of Science in Practice, Glassboro, NJ, June 17-19, 2016.

TV Cunningham, "Philosophical Perspectives on Fetal Tissue Research." Rutgers Workshop on Fetal Tissue Ethics, New Brunswick, NJ, June 10-12, 2016.

TV Cunningham, K Armstrong, and J Fanning, "Integrating Quality Improvement Measures into Ethics Consultation." Pre-Conference Workshop at the International Conference on Clinical Ethics Consultation, Washington, DC, May 19-22, 2016.

TV Cunningham, "Distributed Cognition in Critical Care Medicine." Medical Knowledge in a Social World, Irvine, CA, March 28-29, 2016.

TV Cunningham, "Introduction to the UAMS/ACH Clinical Ethics Consult Service" and "Decision Making in Developmental Pediatrics: Ethical and Legal Considerations." Developmental Pediatrics Lecture Series, Little Rock, AR, March 03 & 10, 2016.

2015: TV Cunningham, LR Eisenberg, and DM Hester, "From "Meh" to MEB: A Novel Curriculum for Overcoming Challenges in Undergraduate Medical Ethics Education." AAMC Medical Education Meeting, Baltimore, MD, November 10-12, 2015.

K Armstrong, J Fanning, and TV Cunningham, "Find Meaning: Evidence Based Practice in Clinical Ethics Consultation." American Society for Bioethics and Humanities (ASBH), Houston, TX, October 22-25, 2015.

TV Cunningham, A Merrick, R Green, LR Eisenberg, and DM Hester, "The Curricular Ethics Bowl: Answering Pedagogical Challenges." Society for Ethics Across the Curriculum, Greenville, SC, October 8-10, 2015.

TV Cunningham, "Guardianship, Capacity, and Decision Making for Incapacitated Loved Ones." Department of Geriatrics Grand Rounds, Little Rock, AR, July 29, 2015.

M Jaffar and TV Cunningham, "Controversies in Critical Care." White Paper Workshop at ICARE (Improving Critical and Acute Care Through Regional Education), Rodgers, AR, July 10-12, 2015.

A Jones, H Moseby, D Jordan, and TV Cunningham, "Controversies in Critical Care." Panel Discussion at ICARE (Improving Critical and Acute Care Through Regional Education), Rodgers, AR, July 10-12, 2015.

TV Cunningham, "Research Misconduct in Light of RCR." UAMS Research Education, Little Rock, AR, May 29, 2015.

TV Cunningham, "Decision Making for Children and Incapacitated Adults: Educating Institutional Stakeholders About Ethical Differences." UAMS IWHE (Intensive Workshop in Healthcare Ethics), Little Rock, AR, May 7-8, 2015.

L Viscioni, M Pippenger, SB Harrington, E Price, TV Cunningham, and LJ Greenfield, "Psychology of Pain" Panel Discussion at Neurology Update 2015, Little Rock, AR, April 11, 2015.

A Merrick, R Green, TV Cunningham, LR Eisenberg, and DM Hester, "On the Uses of the Intercollegiate Ethics Bowl Model for Professional Students' Education in Healthcare Ethics." Association for Practical & Professional Ethics (APPE), Costa Mesa, CA, February 19-22, 2015.

TV Cunningham, A Merrick, R Green, LR Eisenberg, W Ward, and DM Hester, "Introducing the Medical Ethics Bowl" [Poster]. UAMS 1st Annual Educators' Academy Teaching and Learning Symposium: Education Scholarship," Little Rock, AR, January 22, 2015.

2014: TV Cunningham and E Gilmore-Szott, "Debating the Ethics of Embryo Research: The Language from 'Making Babies' to 'Cloning-for-Biomedical-Research." American Society for Bioethics and Humanities (ASBH), San Diego, CA, October 16-19, 2014.

LR Eisenberg and TV Cunningham, "Ethics and Decisionmaking at the End of Life." Hospice & Palliative Care Association of Arkansas Partners in Care Conference, Little Rock, AR, October 2-3, 2014

TV Cunningham, "A Criticial Assessment of Patient- and Family-Centered Care." Department of Surgery Grand Rounds, Little Rock, AR, September 16, 2014.

TV Cunningham, "The Role of an Ethicist in Pediatric Medicine." Arkansas Childrens' Hospital Pastoral Staff Education & Training, Little Rock, AR, June 12 and August 14, 2014.

TV Cunningham, "What is Narrative Medicine? A Deflationary Account for Psychiatry." Association for the Advancement of Philosophy and Psychiatry, New York, NY, May 3-4, 2014.

TV Cunningham, "Rawlsian Reflective Equilibrium." American Philosophical Association Pacific Division, San Diego, CA, April 16-19, 2014.

2013: TV Cunningham, "Is Patient-Centered Care Possible? The Case of Hereditary Breast and Ovarian Cancer." Department of Obstetrics and Gynecology Grand Rounds, UAMS, Little Rock, AR, November 13, 2013.

TV Cunningham, "Concepts of Health and Disease: Who Needs Them? Recent Progress on a Vexing Debate." Philosophy of Medicine Affinity Group, American Society for Bioethics and Humanities (ASBH), Atlanta, GA, October 24-27, 2013.

TV Cunningham, "Surrogate Decision-Making: The Liger of Bioethics?" Arkansas Children's Hospital, Little Rock, AR, September 3, 2013.

TV Cunningham, "The Principle of Charity and Non-Inferential Coding in Interdisciplinary Behavioral Research" [Poster]. American Philosophical Association Pacific Division, San Francisco, CA, March 27-30, 2013.

TV Cunningham, "Objectivity, Scientificity, and the Dualist Epistemology of Medicine." Department of Bioethics, Cleveland Clinic, February 4, 2013.

TV Cunningham, "Objectivity, Scientificity, and the Dualist Epistemology of Medicine." Division of Medical Humanities, University of Arkansas for Medical Sciences, February 1, 2013.

TV Cunningham, "Objectivity, Scientificity, and the Dualist Epistemology of Medicine." Department of Philosophy and Religion, Northeastern University, January 29, 2013.

2012: TV Cunningham, LP Scheunemann, M Crankovic, and DB White "How Informed are Surrogate Decision Makers About the Principles of Surrogate Decision-Making? Preliminary Data from ICU Family Conferences" [Paper]. American Society of Bioethics and Humanities (ASBH), Washington, D.C., October 18-21, 2012.

TV Cunningham, "The Principle of Charity and Non-Inferential Coding in Interdisciplinary Behavioral Research" [Poster]. American Society of Bioethics and Humanities (ASBH), Washington, D.C., October 18-21, 2012.

2011: TV Cunningham, "What Justifies the Ban of Federal Funding of Somatic Cell Nuclear Transfer for Research Purposes?" International Society for the History, Philosophy, and Social Studies of Biology (ISHPSSB), Salt Lake City, UT, July 10-15, 2011.

TV Cunningham, "What is 'Group Decision-Making'? The case of shared decision-making as a normative model of medical choice." Three Rivers Philosophy Conference: Science, Knowledge, & Democracy, University of South Carolina, Columbia, SC, April 1-3, 2011.

TV Cunningham, "Our Unjustified Regulation of Stem Cell Research: What HPS Can teach about how politics influences scientific research." History and Philosophy of Biology in the Desert, Arizona State University, Tempe, AZ, February 1-3, 2011.

2009: TV Cunningham, "To Save the Semantic View." Models and Simulations 3, University of Virginia, Charlottesville, VA, USA, March 6-8, 2009.

2008: TV Cunningham, "J. B. S. Haldane's Intellectual Heritage." History of Science Society, Pittsburgh, PA, USA, November 6-8, 2008.

TV Cunningham, "Natural Selection, Adaptation, and Fitness: On the illusion of perspectively neutral explanatory roles." Institut d'Histoire et de Philosophie des Sciences et Techniques (IHSPT), Paris, France, June 4-5, 2008.

2007: TV Cunningham, "A Reply to Naïve Mechanicism: J. S. Haldane's Shift from Vitalism to Holism, and its Effects on his Philosophy of Biology." International Society for the History, Philosophy, and Social Studies of Biology (ISHPSSB), Exeter, UK, July 25-29, 2007.

TV Cunningham, "Science, Policy, & Politics: How distortion and bias on the President's Council on Bioethics generated the moratorium on cloning for biomedical research." 7th Annual University of Pittsburgh Graduate Student Expo, Pittsburgh, PA, USA, March 1, 2007.

Research, Educational Leadership, & Funding

2020: Co-Investigator, "Prospective Descriptive Study of Bioethics Case Consultation in a Large Health Maintenance Organization." Kaiser Permanente Southern California (PI: Bates Moses, MD)

2015: UAMS TRI Pilot Award: "Participant Preferred Dissemination Methods." Intramural funding for a T4 phase pilot study investigating community and research participant perceptions and preferences regarding the dissemination of research results. **Co-Investigator (**PI: Scott Warmack, PharmD). Total award: **$50,000**. **No salary coverage.**

UAMS Division of Medical Humanities Bruce and Brandon Lee Scholarship: "Bridging the Gap – An Exploration of the Climate of Mental Health in Rural Costa Rica." Intramural funding for a mixed methods investigation of Costa Rican perspectives on mental health. **Co-Investigator and Mentor** for Matthew Kern (PI and 4th year medical student); Total award: **$3,000**. **No salary coverage.**

2014: UAMS Department of Pediatrics Innovation in Pediatric Education Grant: "Fourth Year Reflection Rounds." Intramural funding to institute interdisciplinary, spiritual competency curriculum in fourth year acting internships in pediatrics at UAMS and to perform a mixed methods evaluation of program efficacy. **Co-Principal Investigator**, with Rebecca Latch, MD. Total award: **$25,000. 3% salary coverage for 2014-15**.

George Washington Institute for Spirituality and Health (GWish)-John Templeton Foundation: "Reflection Rounds: Sustaining Spirituality-Based Competencies in Medical Education" (GTRR). Extramural funding to institute interdisciplinary, spiritual competency curriculum in third year clinical clerkships at UAMS. **Co-Principal Investigator** for UAMS site, with Wendy Ward, PhD. Total award: **$25,000. 4% salary coverage, 2014-15**.

UAMS Department of Pediatrics Summer Science Student Research Grant. Mentee: Jackson Bridges. Extramural funding (by the Stella Boyle Smith Foundation) to educate and oversee a summer mentee from July-August 2014. **Principal Investigator. $2,500.**

Honors & Awards

Visiting Lecturer (Invited), Cook Children's Hospital, Forth Worth, TX, February 2017.

Early Career Advisee, American Society for Bioethics and Humanities Meeting, October 2014. Advisors: Mark Yarborough, PhD and Alex Rajczi, PhD

Graduate Student Stipend, American Philosophical Association, to present at the 87th Annual American Philosophical Association Pacific Division Meeting, March 2013: $300.

Travel Award, National Science Foundation, to attend the Philosophy of Science Association Annual Meeting, November 2012: $410.

Early Career Scholar Award, American Society for Bioethics and Humanities, October 2012: $500.

Travel Award, Center for Bioethics & Health Law, November 2012: $725.

Travel Award, International Society for the History, Philosophy, and Social Studies of Biology, July 2011: $150.

Travel Award, University of Pittsburgh Graduate and Professional Student Assoc., May 2011: $200.

Housing Assistance Award, University of Arizona History and Philosophy of Biology in the Desert, February 2011: $100.

Travel Award, Center for Bioethics & Health Law, November 2010: $825.

Travel Award, Univ. of Pittsburgh Graduate and Professional Student Assoc., March 2009: $200.

Travel Award, International Society for the History, Philosophy, and Social Studies of Biology, July 2007: $900.

Travel Award, University of Pittsburgh Graduate and Professional Student Association, November 2006: $100.

Departmental Fellowship, University of Pittsburgh: 2005-2006, 2007-2008, 2009-2010

Teaching Experience

Mentees:

Eleanor Gilmore-Szott, PhD, current Clinical Ethics Fellow, Baylor School of Medicine

Cheyenne Ford, MA, current PsyD candidate, Psychology, Alliant University Los Angeles

Sonya Ringer, current PhD candidate, Philosophy, Johns Hopkins University

Lauren Sankary, JD, MA, current Assoc. Director, Neuroethics Program, Cleveland Clinic

Course Coordinator:

History of American Medicine [M4 elective], Fall 2014 (UAMS)

Art & Medicine [M4 elective], Spring 2015 (UAMS)

Course Co-Coordinator:

Genetic Counselor Ethics, Fall 2015

Medical Ethics for Physicians Assistants, Summer 2014 (UAMS)

Biomedical Ethics [M4 elective], Spring 2014 (UAMS)

Instructor

Foundations of Philosophical Ethics (for Graduate Students), Fall 2021 (LMU)

Clinical Bioethics (for Graduate Students), Summer 2021 (LMU)

Life Care Planning Trainer Certification, March 6, 2019 (KP Southern California)

Clinical Bioethics (for Graduate Students), Spring 2020 (LMU)

KP Advanced Steps Instructor, Winter 2019 training

Introduction to Bioethics (for Graduate Students), Fall 2019 (LMU)

Introduction to Bioethics (for Graduate Students), Fall 2018 (LMU)

Research Ethics, Summer 2018 (LMU)

Ethics and Society, Fall 2015 (UALR)

Medical Ethics for Physicians Assistants, Summer 2016 (UAMS)

Medical Ethics for Physicians Assistants, Summer 2015 (UAMS)

Teaching Facilitator (co-taught):

Practice of Medicine 1 [for M1 students], 2015-2016 (UAMS)
with Professor D. Micah Hester

Practice of Medicine 1 [for M1 students], 2014-2015 (UAMS)
with Professor D. Micah Hester

Practice of Medicine 2 [for M2 students], 2015-2016 (UAMS)
with Professor D. Micah Hester

Practice of Medicine 2 [for M2 students], 2014-2015 (UAMS)
with Professor D. Micah Hester

Pediatric Reflection Rounds [for M3 and M4 students], 2015-2016 (UAMS)
with Professor Rebecca Latch

Pediatric Reflection Rounds [for M3 and M4 students], 2014-2015 (UAMS)
with Professor Rebecca Latch

Medical Ethics [for M2 students], 2013-2014 (UAMS)
with Professor D. Micah Hester

Clinical Clerkship Ethics Conference [for M3 students], Spring 2011 (Pitt)
with Professor David Barnard

Ethics, Law, and Professionalism [for M1 students], Fall 2011 (Pitt)
with Professor David Barnard

Clinical Clerkship Ethics Conference, Fall 2011 (Pitt)
with Professor David Barnard

Teaching Fellowship (independently taught):

Morality and Medicine [Bioethics], Summer 2011 (Pitt)

Morality and Medicine [Bioethics], Spring 2011 (Pitt)

Morality and Medicine [Bioethics], Fall 2010 (Pitt)

Myth and Science, Spring 2009 (Pitt)

Morality and Medicine [Bioethics], Fall 2008 (Pitt)

Teaching Assistantship:

Explanations of Humans and Society, Spring 2007 (Pitt)
for Professor Peter Machamer

Darwin and His Critics, Fall 2006 (Pitt)

for Visiting Professor Laura J. Snyder

Introduction to Human Nutrition, Spring 2003 (UCSD)

Metabolic Biochemistry, Winter 2002 (UCSD)

Administrative Experience

Director, Bioethics, Kaiser Permanente West Los Angeles Medical Center	**2016-present**
Administrative Assistant, University of Pittsburgh Graduate and Professional Student Government Association	**2011-2013**
Administrative Assistant for Adolf Grunbaum, PhD.	**2007-2008**
Department Representative, University of Pittsburgh Arts & Sciences Graduate Student Council	**2006-2008**

Professional and Community Service

Community Service

Panel Reviewer, Department of Defense Peer Reviewed Orthopaedic Research Program, 2020-2021

Panel Reviewer, Armed Forces Institute of Regenerative Medicine Network, 2019-2020

Expert Witness, Center for Reproductive Rights, Virginia TRAP Laws (2019)

Expert Witness, Center for Reproductive Rights, Texas Senate Bill 08 (2017)

Taskforce, Conference, and Journal Service

Member, ASBH Core Competencies 3rd Edition Task Force, 2021-present

Chair, ASBH Clinical Ethics Consultation Affinity Group (CECAG), 2020-present

Member, ASBH National Conference Programming Committee, 2019 and 2021

Chair, ASBH National Conference Programming Committee, 2020

Referee for *Social Theory & Practice*, 2021-present

Referee for *Clinical Ethics*, 2019-present

Referee for *Palliative Care: Research and Treatment*, 2019-present

Referee for *AJOB Empirical Bioethics*, 2018-present

Referee for *Journal of Evaluation in Clinical Practice*, 2016-present

Referee for *Medicine, Health Care, and Philosophy*, 2016-present

Referee for *Journal of Medical Ethics*, 2016-present

Referee for *American Society of Bioethics and Humanities*, 2014-2018

Referee for *Philosophy of Science*, 2010-present

Judge, University of Arkansas, Little Rock High School Ethics Bowl, January 25, 2014

Chair, Contributed Papers: Values, Interests, and Motivations, Philosophy of Science Association 2012, San Diego, CA.

Session Co-organizer, Meeting of the History of Science Society, Pittsburgh, PA, USA, November 6-9, 2008.

Conference Co-organizer, 9th and 10th annual Pittsburgh-Carnegie Mellon Graduate Student Conferences, Pittsburgh, PA, USA, March 2007 and 2008.

Session Chair and Co-organizer, Meeting of the International Society for the History, Philosophy, and Social Studies of Biology, Exeter, UK, July 25-29, 2007

University and Hospital Service

Covering Bioethics Director, KP Baldwin Park Medical Center, 2021 (6 month term)

Covering Bioethicist On-Call, KP Los Angeles Medical Center, 2020-present (periodic)

Covering Bioethicist On-Call, KP San Bernardino Area, 2020-present (periodic)

Logistics Chief, KP West Los Angeles COVID-19 Incident Command Center, 2020-2021

Member, KP West LA Blood Management Committee, 2018-present

Member, KP West LA Neonatal ICU Mortality and Morbidity Committee, 2018-present

Co-Chair, Life Care Planning Committee, KP West LA Medical Center, 2018-2019

Co-Chair, Bioethics Committee, KP West LA Medical Center, 2016-present

Member, Senior Leadership Team, KP West LA Medical Center, 2016-present

Member, KP West LA Critical Care Committee, 2016-present

Member, Compliance Committee, KP West LA Medical Center, 2016-2018

Member, Kaiser Permanente Southern CA Regional Bioethics Committee, 2016-present

Member, UAMS Multidisciplinary Critical Care Committee, 2015-2016

Member, UAMS College of Medicine Curriculum Committee, 2015-2016

Member, UAMS Arts Council, 2015-2016

Chair, Bruce and Brandon Lee Medical Scholarship Committee, 2014-2016

Member, UAMS Institutional Review Board, 2013-2016.

Member, UAMS Medical Ethics Advisory Committee, 2013-2016

Member, UAMS Planned Emergency Research Committee, 2013

Member, Arkansas Genetic Health Committe (ARGHC), 2013-2015.

Member, ARGHC Newborn Screening Subcommittee, 2013-2015.

Member, Children's Hospital of Pittsburgh (UPMC) Ethics Committee, 2012-2013.

Member, University of Pittsburgh Provost's Advisory Committee for Planning and Budget, 2012-2013.

Member, Univ. of Pittsburgh Univ. Senate Child and Dependent Care Subcommittee, 2012-2013.

Member, Univ. of Pittsburgh University Senate Commonwealth Relations Committee, 2012-2013.

Attendee, UPMC Presbyterian Ethics Committee, 2012-2013.

Member, University of Pittsburgh GPSG Executive Committee, 2012-2013.

Chair, University of Pittsburgh GPSG Student Affairs Committee, 2012-2013.

Lead, GPSG Pittsburgh Public Schools Fund Raiser: The Represent PITT! Art Initiative, 2012.

Member, University of Pittsburgh Board of Trustees Affirmative Action Commitee, 2011-2013.

Member, University of Pittsburgh University Review Board, 2011-2013

Project Leader, GPSA Alliance for Infants and Toddlers Toy Drive & Fund Raiser, 2011.

Professional Memberships

Since 2010:	American Society for Bioethics and Humanities
2011-2019:	American Philosophical Association
2015-2016:	Association for Practical and Professional Ethics
2006-2020:	Philosophy of Science Association
2006-2014:	History of Science Society; International Society for History, Philosophy, & Social Studies of Biology

Media Coverage

Medical Ethics Advisor: "Ethics Services Want to Know How Consult Data Compare to Other Hospitals." March 2021. https://www.reliasmedia.com/articles/147625-ethics-services-want-to-know-how-consult-data-compare-to-other-hospitals

Medical Ethics Advisor: "Many Ethics Services Need Better Information on Volume." October 2020. https://www.reliasmedia.com/articles/146894-many-ethics-services-need-better-information-on-volume

WIRED, "In Crowded Hospitals, Who Will Get Life-Saving Equipment? As health care workers prepare for surges of Covid-19 patients, they must grapple with the ethics of rationing critical medical gear." March 2020: https://www.wired.com/story/in-crowded-hospitals-who-will-get-life-saving-equipment/

LMU Magazine's Off Press Podcast, March 30, 2020: https://magazine.lmu.edu/podcasts/thomas-v-cunningham/

Medical Ethics Advisor, "Fresh Approaches for Quality Assurance: Hot Topic in Ethics Field." February 2020: https://www.reliasmedia.com/articles/145653-fresh-approaches-for-quality-assurance-hot-topic-in-ethics-field

Medical Ethics Advisor, "Ethical Controversy Erupts Over Human-animal Embryo Research." October 2016: https://www.reliasmedia.com/articles/138800-ethical-controversy-erupts-over-human-animal-embryo-research

Dissertation Abstract

Socializing Medical Practice: A Normative Model of Medical Decision-Making.

My dissertation is about the way people *should* and *do* make medical choices. It defends the claim that medical decisions should be made by groups of persons acting together, not by individuals acting alone. I begin by arguing that prominent models of medical decision-making are problematic, because they fail to be both *descriptively* and *normatively adequate*, which I argue any account of choice in medicine should be. The remainder of the work articulates a model that meets these two criteria. First, I justify an account of the uniquely medical context my model is designed to apply to by distinguishing *two basic aims of medicine*: (i) to fully understand patients in personal and scientific terms; and, (ii) to intervene upon patients' health states in ways that are consistent with this understanding. Then, I take two chapters to develop a descriptive account of medical decision-making. In them, I introduce a close study of the case of hereditary breast and ovarian cancer decision-making, which I argue shows choices are made by groups of interacting persons over extended spatiotemporal and social dimensions. So, I appeal to the theory of *distributed cognition* to describe this collection of persons processing information together when making choices. Having defended a descriptive account of medical choice, I then take two more chapters to propose a normative account, based on a modified version of Rawlsian reflective equilibrium that I call *medical reflective equilibrium*. On my account, medical choices should be made by searching for, selecting, and integrating the right kind and amount of information, which requires considering sufficient information to meet the basic aims of medicine. Given that the basic aims are defined in terms of an epistemic distinction between *subjective* and *objective knowledge*, I argue that performing the medical reflective equilibrium procedure adequately requires multiple participants in decision-making. Consequently, I conclude that medical choices are and should be social.

My dissertation may be accessed here: http://d-scholarship.pitt.edu/20142/

EXHIBIT 9

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF CAROLETTE NORWOOD, PH.D., IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Carolette Norwood, Ph.D., being duly sworn on oath, do depose and state as follows:

1. I am a Professor and the Department Head of Sociology and Criminology at Howard University in Washington, DC. My areas of expertise include gender, race, poverty, and access to sexual and reproductive health care.

2. I received my Ph.D. in Sociology with concentrations in Demography (the statistical study of populations) and International Development from the University of Nebraska-Lincoln in December 2004. I also have an M.A. in Liberal Arts with a concentration in African and African American Studies, which I received from Louisiana State University in Baton Rouge, Louisiana, in 1999, and B.A. degrees in Sociology and French, also from Louisiana State University.

3. I joined the faculty at Howard University in August 2021. Before that, from September 2006 to August 2021, I was an Associate Professor of Women's, Gender, and Sexuality Studies at the University of Cincinnati in Cincinnati, Ohio ("UC"). From 2004 to 2006, I was an Assistant Professor in the Department of Sociology at St. Mary's College in Notre Dame, Indiana. From 2002 to 2003, I was an Andrew W. Mellon Fellow in Demography at the

University of Montreal in Quebec.

4. My current research lies at the intersection of poverty, gender, race, and disparities in sexual and reproductive health. My work has spanned various geographic settings, including in Ohio. I have published on these topics in peer-reviewed journals, and I am finishing a book manuscript on my research in this area, tentatively entitled *Jim Crow Geography: Mapping the Intersection of Gender, Race, and Sexuality in Cincinnati Urban Space*. I was awarded a $20,000 Provost award from UC in support of my work on this book.

5. I have presented my research at numerous professional conferences and have been invited to lecture on my research at numerous academic institutions and community events. I have also served as a reviewer for the National Science Foundation, as well as for various peer-reviewed journals, including *Gender and Society*, *African Journal of Reproductive Health*, *Social Science Quarterly*, *World Medicine & Health Policy*, and *Journal of Family Issues*. I have also served as a book reviewer for Vanderbilt University Press.

6. In 2017, I was awarded a three-year renewable grant from the Ohio Policy Evaluation Network to support my reproductive justice and health policy work, together with other researchers from UC, Case Western Reserve University, and the Ohio State University. I was named a Taft Center Fellow from 2017 to 2018, and I have received funding for my research from The Cincinnati Project, an organization based at UC that supports research aimed at understanding and reducing economic, racial, gender, and health inequalities in Cincinnati. In 2020, I was also awarded a $30,000 grant from the Greater Cincinnati Women's Fund to study the economic mobility of Black women in Cincinnati.

7. In my current research, I explore the lived experiences of Black women at the intersection of gender, race, sexuality, social class, and geography, and how these experiences

affect sexual health and overall well-being. I combine rigorous analysis of statistics, which I learned through my training in sociology and demography, with in-depth face-to-face interviews of women who are living in impoverished neighborhoods in Ohio. This work focuses largely on urban Black communities in Southwest Ohio. Using this methodology, I have gained a profound understanding of the lived experiences of poor women in Ohio.

8. My curriculum vitae, which sets forth my experience and credentials in greater detail and contains a full list of my publications, is attached as Exhibit A to this declaration.

9. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"). The opinions stated in this report are based on my knowledge and experience as a sociologist and demographer, including my research, writing, review of the relevant literature, and oral interviews with women living in poverty.

I. Impact of SB27 on Women in Ohio

10. I understand that SB27 requires embryonic and fetal tissue from a procedural abortion be cremated or interred. My opinion as discussed below assumes that Ohio abortion clinics will be able to comply with SB27's requirements and does not reflect the catastrophic burdens that patients would face if clinics could not comply and were forced to stop providing procedural abortion entirely. I understand that cremating or interring embryonic and fetal tissue will result in an increase in the price of the abortion procedure by $75-$295. I further understand that clinics will not be able to comply with this requirement during the early stages of pregnancy and will not be able to provide procedural abortion care until around 13 weeks of pregnancy and any abortion care at all between 10 weeks of pregnancy and 13 weeks of pregnancy. I further understand that starting at around 13 weeks of pregnancy, the cost of an abortion in Ohio increases

by approximately $100 and continues to rise as the pregnancy advances. Therefore, if Ohio abortion providers have to comply with this requirement, the cost of a procedural abortion is likely to increase significantly.

11. I also understand that the cost of an abortion procedure continues to increase as the pregnancy advances. This can create a vicious cycle: women's abortions are delayed because they need to raise additional funds; the delay means that the procedure is more expensive; women must then delay again to raise more money to pay for the more expensive procedure; and so on. SB27 will exacerbate this cycle because abortion clinics cannot provide procedural abortions earlier in pregnancy, and women seeking abortion will rush to come up with more money to pay for abortion care.

12. As I discuss below, poverty itself is a vicious cycle. People who are poor or low-income, even when they are making ends meet, are just one unexpected expense away from a major financial crisis that can result in eviction, hunger, or escalating medical problems that go untreated because of economic hardship. Seemingly "minor" expenses or small emergencies can be devastating for poor or low-income women's safety and ability to meet their basic needs for months and years to come.

13. Through my research, I am familiar with the immense barriers that women in Ohio already face in attempting to find the funds to pay for a first-trimester procedure. If SB27 goes into effect, I believe that a cost increase of even $100-$200 will delay numerous poor, low-income and cost burdened women in obtaining an abortion, and for many, push care entirely out of reach.

II. Poverty in Ohio

14. In the United States, poverty is defined by income thresholds. The United States

Department of Health and Human Services ("HHS") defines the 2021 federal poverty level as a single person who makes less than $12,880 per year, and up to $21,960 for a family of three — *e.g.*, a single mother and two children.[1] People who make less than the federal poverty level are classified in the academic literature as "poor," "impoverished," or living "in poverty."[2] Poverty rates vary by gender and race. Women have a higher poverty rate than men in Ohio (14.3% compared to 11.7%).[3] And approximately 27.3% of Black Ohioans but only 10.4% of white Ohioans live at or below the poverty level.[4]

15. Poverty rates do not tell the full story, however. It is well-accepted that the federal poverty level is out of date and that people with incomes at the poverty level lack the means to support themselves in today's economy. Recognizing that people who are low income (but are not classified as poor) may need assistance in meeting basic needs, federal, state, and local social programs thus set eligibility requirements for public assistance to encompass people who are above the federal poverty level. According to the National Center for Childhood Poverty,

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[1] U.S. Dep't of Health & Human Servs., *U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs* (2021), https://aspe.hhs.gov/poverty-guidelines. This figure uses the federal poverty "guidelines" rather than the federal poverty threshold, because the federal poverty guidelines are simpler and more current.

[2] *See, e.g.*, Ctr. for Poverty & Inequality Research, University of California, Davis, *How Is Poverty Measured in the United States?*, https://poverty.ucdavis.edu/faq/how-poverty-measured-united-states.

[3] U.S. Census Bureau, *American Community Survey S1701: Poverty Status in the Past 12 Months,* https://data.census.gov/cedsci/table?t=Income%20and%20Poverty&g=0400000US39_400C000US22528&tid=ACSST1Y2019.S1701. These data are from 2019, the most recent year for which they are available.

[4] *Id*.

"[r]esearch suggests that, on average, families need an income of about twice the federal poverty threshold [200% of the federal poverty line] to meet their most basic needs."[5] Families earning below 200% of the federal poverty line are generally classified as "low income."[6] In Ohio, more than 23% of families meet this criteria and are thus classified as low-income.[7] For a family of three, a household income of less than $43,920 is considered low income. For an individual, an annual income of less than $24,760 is considered low income.

16. Even 200% of the federal poverty line is not considered a living wage. The Cleveland-based Center for Community Solutions—relying on Census Bureau Data and the MIT Living Wage Calculator—estimates the minimum income needed by a family of three (single parent, two children) to be $54,852 per year in Ohio, significantly higher than the "low income" cut off threshold, *see* above.[8]

17. The minimum wage in Ohio is currently $9.30 per hour, or $19,344 per year (based on 2,080 hours/year).[9] Thus, a single mother with two children working 40 hours per week at minimum wage for 52 weeks would be classified as "poor." Even if she earned *twice* the

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[5] Nat'l Ctr. for Children in Poverty, *United States Demographics of Low-Income Children*, https://www.nccp.org/demographic/.

[6] *Id.*

[7] U.S. Census Bureau, *American Community Survey S1702: Poverty Status in the Past 12 Months of Families,* https://data.census.gov/cedsci/table?q=ohio&t=Poverty&tid=ACSST1Y2019.S1702. These data are from 2019, the most recent year for which they are available.

[8] The Center for Community Solutions, *State of Ohio*, https://www.communitysolutions.com/wp-content/uploads/2018/04/Ohio2018.pdf (2018 figures).

[9]Ohio Department of Commerce, 2021 Minimum Wage Poster, https://www.com.ohio.gov/documents/dico_2022MinimumWageposter.pdf.

minimum wage and worked 40 hours per week for 52 weeks, a single mother with two children would still be classified as "low-income" and would earn only slightly more than two-thirds of the living wage for a family of three in Ohio. In the Cincinnati region, even after obtaining higher education, such as a Bachelor's degree, 32% of employed Black women make less than $15 per hour (i.e., less than two times the minimum wage in Ohio) compared to 11% of white men.[10]

18. According to Policy Matters Ohio, in 2020, six out of Ohio's ten most common occupations "pay so little that the median worker supporting a family of three cannot cover the cost of food without [public food assistance]. Half of these jobs pay less than $24,000 at the median, and all but one pay less than $35,000. Workers in these 10 most common jobs number 1.18 million people and account for more than a fifth of all employed Ohioans."[11]

19. It is also worth noting that minimum and low-wage workers often do not get paid vacation or sick days.[12] This creates barriers to accessing necessary medical care and can further exacerbate health disparities based on income. According to the Institute for Women's Policy Research, 41% of working parents at or below 200% of the poverty line have no access to paid

[10] Women's Fund of the Greater Cincinnati Found. & Univ. of Cincinnati Econ. Ctr., *Realizing the Potential of an Equitable Economy: Centering Black Women's Upward Mobility in the Cincinnati Region* at 10 (April 2021).

[11] Policy Matters Ohio, *Working for Less 2020: Too Many Jobs Still Pay Too Little* (May 1, 2020), https://www.policymattersohio.org/research-policy/fair-economy/work-wages/working-for-less-2020.

[12] *See* U.S. Dep't of Labor Bureau of Labor Statistics, USDL-21-1690, News Release, Employee Benefits in the United States—March 2021 at 1, 17 (Sept. 23, 2021), https://www.bls.gov/news.release/pdf/ebs2.pdf.

sick leave, vacation days, personal days, or any other form of compensated leave.[13] If a minimum or low-wage worker is able to get time off from work, they likely have to forgo wages. Indeed, many low-wage workers are not even able to take unpaid time off without potentially being replaced or having to disclose the reason why they are taking time off.

20. Even a woman working full-time and earning significantly above the minimum wage, and who would not be classified as "poor" or "low-income," may struggle to pay for basic living expenses.[14] For example, as the U.S. Department of Housing and Urban Development explains, "[Families] who pay more than 30 percent of their income for housing" are considered cost-burdened and "'may have difficulty affording necessities such as food, clothing, transportation and medical care.'"[15] Families who pay more than 50%of their income on housing are considered "severe[ly] rent burdened."[16] Nearly half (47%) of Ohio renters are cost-burdened, and 25% are severely housing cost-burdened.[17]

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[13] Andrea Lindemann Gilliam, *An Introduction to Paid Time Off Banks*, Institute for Women's Policy Research (June 20, 2012), https://iwpr.org/iwpr-general/an-introduction-to-paid-time-off-banks/.

[14] The Center for Community Solutions, *State of Ohio*, https://www.communitysolutions.com/wp-content/uploads/2018/04/Ohio2018.pdf (2018 figures).

[15] U.S. Dep't of Housing & Urban Dev., *Rental Burdens: Rethinking Affordability Measures*, https://www.huduser.gov/portal/pdredge/pdr_edge_featd_article_092214.html#:~:text=HUD%20defines%20cost%2Dburdened%20families,of%20one's%20income%20on%20rent.

[16] *Id.*

[17] Ohio Hous. Fin. Agency, *Ohio Housing Needs Assessment* at 8 (2019), https://ohiohome.org/news/documents/2019-HousingNeedsAssessment.pdf.

21. Even small unexpected expenses can cause significant financial strain, regardless of whether an individual is low-income. Nearly 40% of American adults report that, when faced with a hypothetical unexpected expense of $400, they would be unable to pay it using cash or savings.[18]

III. Financial Barriers to Accessing Abortion Care

22. Women seeking abortion care in Ohio already face an unexpected, but extremely time-sensitive, expense. I understand that the cost of a first trimester procedural abortion varies, but in Ohio is several hundred dollars. I further understand that Medicaid in Ohio does not cover abortion care except in rare instances and even private insurance often does not cover abortion care. The cost of the procedure is only compounded by the need to gather funds to pay for transportation to and from the abortion clinic, which may not be in a patient's community, arrange for childcare[19], and account for lost wages that may result from missing work for appointments.[20] I understand that because Ohio law requires patients to make two separate trips to an abortion clinic before an abortion, patients will have to arrange for transportation, childcare, and account for potential lost wages twice.

23. As a result, if SB27 goes into effect, a cost increase of $100-$200 would render the cost of care tremendously burdensome for many patients, forcing some patients to delay care

[18] Bd. of Governors of the Fed. Rsrv. Sys., *Report on the Economic Well-Being of U.S. Households in 2018 - May 2019*, https://www.federalreserve.gov/publications/2019-economic-well-being-of-us-households-in-2018-dealing-with-unexpected-expenses.htm.

[19] 59% of abortion patients already have at least one child. Guttmacher Inst., Induced Abortion in the United States Fact Sheet (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states.

[20] *See supra* ¶ 19.

further and even fully preventing some patients from being able to access abortion care altogether.

24. These burdens are likely to affect the majority of women seeking abortion in Ohio. Research demonstrates that women who seek abortion care in the United States are disproportionately poor and low-income. In 2014, 49% of women having abortions in the United States had incomes below 100% of the federal poverty level, and another 26% had incomes below 200% of the federal poverty level.[21] Thus, approximately 75% of women seeking abortions in the United States were either poor or low-income. These burdens will also disproportionately harm Black women, who comprise almost 30% of abortion patients.[22]

25. As I noted above, because the cost of an abortion procedure increases as the pregnancy advances, some women may be caught in a vicious cycle: they will be forced to delay their abortions even further while they gather the needed funds for care which means that the cost of the procedure will continue to rise.

26. In raising the cost of care, SB27 would only exacerbate the difficulties patients face. Poor, low-income, and cost-burdened women seeking abortion care must employ strategies to quickly raise funds that come at great risk to their financial, and in some cases physical, wellbeing and that of their families. First, many women will be forced to make financial sacrifices by foregoing other necessities, such as by not paying for rent or utilities, drastically reducing their food budgets, or delaying or going entirely without necessary medical care. This

[21] Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes since 2008 (2016)*, https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.

[22] *Id.*

compromises their health, safety, and well-being, as well as access to secure housing for themselves and their children or families.

27. Second, some will be forced to take out high-interest payday loans or turn to loan sharks or other predatory lenders, which can end up throwing them into a deeper cycle of debt because of the high interest rate and fees.

28. Third, due to limited access to job opportunities and financial resources, some will feel like they are forced to engage in work outside of the mainstream economy in order to procure funds on an expedited basis. Thus, the steps some women will take to raise money may themselves be harmful. In my research, I have interviewed women with few options of finding work in the formal economy, who instead do what they need to do just so they can meet the basic necessities, like food. For example, one woman whose mother was dying of brain cancer told me that she started doing sex work around age fourteen to help support her family.

29. Fourth, some women will try to borrow money from friends and family members, but coming up with the funds may be difficult for those individuals, who are likely to also lack financial resources for unexpected emergencies. Seeking to borrow money from people in their community will also necessarily jeopardize the confidentiality of their decision to have an abortion, and may be subject to the friend or family member's views about abortion. I have interviewed women who could not borrow needed funds from a loved one because that individual was opposed to abortion and refused to provide financial assistance.

30. Urgently seeking the resources to obtain abortion care from others can be dangerous and jeopardize women's safety. Some women facing such challenges in accessing abortion care may find themselves staying or reuniting with an abusive partner in order to access financial assistance. In my research, I have interviewed women who initiated relationships with

violent former partners in order to obtain financial help for necessities, including to pay for an abortion. In addition, women in abusive relationships will likely be unable to conceal their pregnancies and/or their abortion decisions from their partners if they need to rely on them to pay for the abortion procedure. Women have shared with me the difficulties they face in tolerating abuse in order to alleviate an economic crisis or cover emergency expenses.

31. Furthermore, given the economic, health, and travel circumstances around the COVID-19 pandemic, paying for abortion care has become even more daunting and out of reach for low-income women. Low-income families, especially those headed by single mothers, have been disproportionately affected by pandemic-related unemployment as well as potential exposure to COVID-19, since they work in the sectors that are most affected by the pandemic—such as the service industry or personal/household services.[23]

IV. Conclusion

32. Based on my research, it is my expert opinion that the significant, urgent, and unforeseen costs associated with this law would delay and even prevent a significant number of women from seeking the abortion care they need.

[23] Matthew Dey et al., *Update on Demographics, Earnings, and Family Characteristics of Workers in Sectors Initially Affected by COVID-19 Shutdowns*, U.S. Bureau of Labor Stat., https://www.bls.gov/ers/update-on-demographics-earnings-and-family-characteristics-of-workers-in-sectors-initially-affected-by-covid-19-shutdowns.htm.

FURTHER AFFIANT SAYETH NAUGHT

Carolette Norwood Nishikawa
Signed on 2022/01/05 12:13:12 -8:00

Carolette R. Norwood, Ph.D.

01/05/2022

Signed before me this ___ day of January, 2022

Signed on 2022/01/05 12:13:12 -8:00

Notary Public

NOTARY PUBLIC STATE OF OHIO

Theresa M Sabo
Commission # 2016-RE-619622
Electronic Notary Public
State of Ohio
My Comm Exp. Nov 28, 2026

Notary Stamp 2022/01/05 13:13:12 PST EA29F45BE24A

Notarial act performed by audio-visual communication

EXHIBIT A

Carolette R. Norwood, PhD

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Education

2004, Ph.D., Sociology with concentrations in Demography and International Development, University of Nebraska-Lincoln, Lincoln, NE, December.
1999, M.A., Liberal Arts with concentration in African and African American Studies, Louisiana State University, Baton Rouge, LA 70803, August.
1997, B.A., Sociology, Louisiana State University, Baton Rouge, LA 70803, December.
1997, B.A., French, Louisiana State University, Baton Rouge, LA 70803, December.

Academic Appointments

2021 to Present, Department Chair and Full Professor, Department of Sociology and Criminology, Howard University.
2015-2021, Associate Professor, Department of Women's, Gender, and Sexuality Studies, University of Cincinnati.
2014-2015, Associate Professor, Department of Africana Studies, University of Cincinnati, September.
2006-2013, Assistant Professor, Department of Africana Studies, University of Cincinnati, September.
2004-2006, Assistant Professor, Department of Sociology, Saint Mary's College (Notre Dame, IN) August.
2012-2014, Visiting Summer Fellow, Center for AIDS Prevention Studies, Health Disparities in Minority Communities Collaborative Program, University of California – San Francisco.

Administrative Positions

2019 - present, Assistant Department Head, Women's, Gender, and Sexuality Studies, University of Cincinnati.
2019 - present, Director of Social Justice Certificate Program, University of Cincinnati.
2007-2012, Advisor to Minors, Africana Studies, University of Cincinnati.

Research Areas of Specialization

Race and Health Disparities, Urbanization, Jim Crow Geographies, Segregation
Gendered Violence
Africana/Black Feminism
Reproductive Justice and Sexual health
Women's Roles in Development and Microfinance/Microcredit/Informal Banking

Study Abroad

2011, University of Ghana-Legon, Accra, Ghana West Africa, Faculty-led Study Abroad Course for the Honors College at University of Cincinnati.

2002-2003, Andrew W. Mellon Fellow Doctoral Student Exchange in African Demography, Université de Montréal, Montréal, Québec H3C 3J7.

2000, University of Ghana-Legon, Accra, Ghana West Africa, Summer Exchange Program.

Language

French, earned Bachelors of Arts in French (working knowledge)

Certification and Internships

2005, Certified Red Cross HIV Education and Prevention Instructor, Chicago, IL.

2004 (July), University of California- Santa Barbara, Center for Spatially Integrated Social Science.

2001 (Summer), Bureau of United States Census, Division of Population Estimates and Projection.

Current Research Projects

Community Based Participatory Research, Sexual and Reproductive Health in Cincinnati Low Income Neighborhoods, OPEN (Ohio Policy Evaluation Network), $238K, Period: January 2018-December 2020 (Lead Researcher: Carolette Norwood).

Black Women in Cincinnati and Economic Mobility, commissioned research by the Greater Cincinnati Women's Fund, $30K, Period: 2020-2021, (Lead Researcher: Carolette Norwood).

PUBLICATIONS

Carolette Norwood *, Farrah Jacquez, Thembi Carr, Stef Murawsky, Key Beck, Amy Tuttle "Reproductive Justice, Public Black Feminism in Practice: A Reflection on Community- Based Participatory Research in Cincinnati" Societies, Manuscript ID: societies-1488476. **Revise and Resubmit**

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2000. Norwood, Carolette. "IMPERIALISM" in World of Sociology – Encyclopedia, ed. Palmisano, Joseph M., Gale Group.

2000. Norwood, Carolette. "COLONIZATION" in World of Sociology – Encyclopedia, ed. Palmisano, Joseph M., Gale Group.

2000. Norwood, Carolette. "DECOLONIZATION" in World of Sociology – Encyclopedia, ed. Palmisano, Joseph M., Gale Group.

2000. Norwood, Carolette. "POST-COLONIZATION" in World of Sociology – Encyclopedia, ed. Palmisano, Joseph M., Gale Group.

Manuscripts in Progress

The Boundaries of Confusion: Racial Disparities in State House and Congressional District Line Congruity (Barbara Harris Combs, Benjamin Plener Cover, David Niven, Carolette Norwood, Kalyn Rossiter, Michael Solimine)

Norwood, C. "Jim Crow Geography: Mapping the intersection of gender, race, and sexuality in urban space," Monograph.

Norwood, C. and Martinez, A. "Spatial & Statistical Analysis of STI and HIV/AIDS in Cincinnati Neighborhood Context," Journal Article (to be submitted Fal1 2020).

Norwood, C. "Not Our Mother's Doll: The New Black Barbie and the Commercialization of Natural Hair," Journal Article (to be submitted Fal1 2020).

Norwood, C. Angry, Incompetent Black woman, Don't speak so harsh to me!: White Tears and White Women's Fragility An Autoethnography of a Black woman Who Navigate White Space, Journal Article (to be submitted Spring 2021).

Norwood, C., Carr, T., Hill, J., and Taylor, S. "Why Reproductive Justice Matters: A Policy Evaluation of How Ohio Family Service Programs and the 6-week Abortion Ban Fail Women" (to be submitted Summer 2021).

Norwood, C., Gaynor, T. Jones, C. and Blesset, B. "Black Feminist Social Justice." Edited Volume Monograph (to be submitted Summer 2022).

INVITED LECTURE /PRESENTATION

Unapologetically Speaking: Unpacking Black Feminism, National Underground Railroad Freedom Center, March 11, 2021

7th Annual Cincinnati Project Symposium, University of Cincinnati, "Socially-Just Community Partnered Research," March 5, 2021

Sociology of Black Health Care, University of Cincinnati, "In Pursuant of Health Justice: Jim Crow Health Infrastructure in Cincinnati", February 26, 2021

The Minority Health Disparities Initiative, University of Nebraska-Lincoln, "The Politic of Spatial Confinement: Jim Crow Geographies, Sexual and Reproductive Health Disparities, and Housing Insecurity from the Progressive Era to the 21st Century," October 2020

Colloque "Feminismes Noir" (Colloquium in Black Feminisms) Campus Condorcet à Aubervilliers Paris, France, March 3-5, 2020.

Peaslee Community Center, Urban Residency Teaching Program, the American City Since 1940: Class, Race, Gender, Culture, Space, invited to lead lecture on Patrisse Khan-Cullor's *When They Call You A Terrorist*, *A Black Lives Matter Memoir*, September 26, 2019.

Harvard University, Interdisciplinary Approaches for Female Success in Academia, April 20-21, 2018.

The Cincinnati Project, University of Cincinnati, "Jim Crow Geography: Cincinnati Urban Reservation and the Ordinary Lives of Black Women." February 2016.

Urban Health Colloquium Series, University of Cincinnati, Department of Sociology, TAFT center, "Structural, Spatial and Interpersonal Violence and Black Women's Sexual Health in High HIV Prevalent Neighborhoods in Cincinnati." May 2014.

Invited Plenary Speaker on Health Disparities session title "Womb to Womb: The Persisting Influence of Health Disparities Across the Lifecourse." National Council of Family Research, November 2012.

Sociology Colloquium Series, University of Cincinnati TAFT Research Center, "Condom Use and HIV Risk Among African American Women College Students." May 2012.

University of Cincinnati School of Medicine, "Public Health and Microfinance." March 2011.

Tulane University School of Medical, "Healthcare Disparities." April 2009.

"Strategies in Research Methods." Tulane University School of Medical, September 2008.

University of Cincinnati Sociology Colloquium, "Women's status and HIV/AIDS risk prevention strategies: A mixed-method evaluation of the effects of Microcredit Participation in Yaoundé, Cameroon." October 2007.

Saint Mary's College, "Microcredit in Africa." April 2005.

INVITED PANEL PRESENTATIONS

The National Underground Railroad Freedom Center, "Unapologetically Speaking: Unpacking Black Feminism" Thursday, March 11th, 2021.

The Cincinnati Project 7th Annual Symposium, "The Art and Science of Socially Just Community Partnered Research" Friday, March 5, 2021.

"Institutional Racism in Healthcare Panel," Cincinnati Start Up Week, October 30, 2020, Virtual Meeting (Zoom).

"Addressing Sexual Health for National Public Health Week," with panelist Bob Kirkcaldy, Tavon Hall, Eric Washington and Jason Blackard, April 3, 2019, Department of Public Health, University of Cincinnati, Kowaleski Hall Room 141.

"Doing Community Health Research" for the UC Global Med *Community Health Speaker Series* (other speakers included Dr. Chris Lewis and Roseanne Hountz), Friday October 19, 2018 Annie Laws Conference Room #407.

"Sexual Assault On the Margins" with panelist Amy Schlag, Patrice Delean, Amina Darish and Dalenna Garcia-Tayeb, April 6, 2017, African American Cultural Resource Center, University of Cincinnati, Harambe Room.

"Old South" with panelist Brandy Turnbow, Christina Brown, moderated by Amy Lind. October 8, 2015, University of Cincinnati, Annie Laws Conference Room #407.

"Tavis Smiley's The Rich and the Rest of Us: A Poverty Manifesto" Taft Symposium, Taft Research Center, University of Cincinnati, April 2013.

"Women of Color Faculty Round Table." College of Arts and Science, University of Cincinnati, March 2013.

"Globalization and its Future." Taft Research Center, University of Cincinnati, February 2012.

"Women's Status, HIV Risk Reduction Strategies and Microcredit Participation" (for Women's History Month), Saint Mary's College, March 2005.

"Feminist Methodologies in Research." McGill University, May 2003.

SELECTED RESEARCH PRESENTATIONS

"Not Our Mother's Afro Movement: The 21st century Black women's Natural Hair Transition in Diasporic Representations." Washington DC, Georgetown University, American Comparative Literature Association (ACLA), March 7-10, 2019.

"Spatial & Statistical Analysis of STI and HIV/AIDS by Neighborhood Context." New Orleans, La. American Association of Geographers (AAG) annual conference, April 10-14, 2018.

"Jim Crow Cincinnati: Gender, Race, and Violence in Urban Space." Cincinnati, OH. Taft Center Fellow Presentation, with interlocutor Dr. Nikki Jones (UC Berkley, African American Studies), February 27, 2018.

Structural Violence as Urban Renewal Policy: A Look at Gentrification and the Force Relocation of Black Women Within and Across Cincinnati's Jim Crow neighborhoods." Baltimore, MD. National Women's Studies Association, November 16-19, 2017.

"Navigating Gender, Race, Sexuality and Space: Assessing the Impact of Gendered Violence on Black Women's Sexual Health in Jim Crow Cincinnati Neighborhoods." Notre Dame, Indiana, Intersectional Inquiries and Collaborative Action: Gender and Race, March 2-4, 2017

"Girlhood Interrupted: Struggle, Survival, and Cost of Strong Black Womanhood." Notre Dame, Indiana, Intersectional Inquiries and Collaborative Action: Gender and Race, March 2-4, 2017

"Boarder Violence: Black women on the Cincinnati Urban Reservation." Montreal, QC, Canada. National Women's Studies Association, November 10-13, 2016.

"Decolonizing Feminist Studies: Bridging the Feminist African Diaspora Across Settler and Occupied Territories" on Panel Decolonizing Women's Studies through African Feminist Interventions. Montreal, QC, Canada. National Women's Studies Association, November 10-13, 2016.

"Structural, Spatial and Interpersonal Violence AND Black Women's Sexual Health in High HIV Prevalent Neighborhoods in Cincinnati." Philadelphia, PA. American Black Sexologist Conference, Oct. 1-3, 2016

"Gendered Violence in Ghana and the Failed Promise of Microcredit." Feminist Transgressions, National Women's Studies Association, Paper Presentation in session 508 Invisible Injustices in Postcolonial African Contexts. San Juan, Puerto Rico. November 13-16, 2014.

"Navigating Gender, Race, Sexuality and Place in a Spatial Context of HIV Prevalence Neighborhoods in Cincinnati." American Public Health Association 141st Annual Meeting & Exposition. Oral Presentation in session 4116: Role of place in sexual health and HIV, Boston, MA. November 2-6, 2013.

"Navigating Intersectionality, A Look at African American Women in a Spatial Context of Sexual Health Disparities in HIV/AIDS." National Council of Family Studies, Phoenix, AZ. October 31-November 03, 2012.

"HIV and Condom Use among African American college women students." North Central Sociological Association, Pittsburg, PA. April 12-15, 2012.

"HIV and Condom Use Among Non-marginalized African American women." National Council of Black Studies, Atlanta, GA. March 7-10, 2012.

"Assessing Racial Identity Salience on HIV AIDS Testing." National Council of Black Studies, Cincinnati, OH. March 16-19, 2011.

"The Deafening Silence of HIV and AIDS risk in the US Black Community: African American Women, HIV/AIDS Testing and Condom Use." Midwest Sociological Association and North Central Sociological Association, Chicago, IL. March 31- April 3, 2010.

"The Feminization of HIV and AIDS in Africa: How the Politics of Population Control Neglects Women's Reproductive Health." The 25th Annual Symposium on African American Culture and Philosophy. November 6-7, 2009.

"Mitigating HIV with Women's Empowerment, A look at urban women in Yaoundé, Cameroon." Midwest Sociological Association, Des Moines, IA. April 2-5, 2009.

"Pedagogical Cultures: Teaching in Different Academic Environments." North Central Sociological Association, Cincinnati, OH. March 27-29, 2008.

"Women's Status, HIV Risk Reduction Strategies and Microcredit Participation: A Mixed-Method Evaluation of the Effects of Microcredit Participation in Yaoundé, Cameroon." American Sociological Association, Montreal, QC. August 11-14, 2006.

"Desegregated Fertility: A Spatial Proximity Analysis of Black and White Biracial Fertility in the United States." Population Association of America, Los Angles, CA. March 30 -April 1, 2006.

MEDIA (INVITED) PRESENTATION/DISCUSSANT

"Unapologetically Speaking: Unpacking Black Feminism" WVXU with Tana Weingartner, Monday, March 8, 2021.

"Campus Sexual Assault and Ways to Prevent It" 101.5 SOUL WBDZ-FM, Class in Session, November 2, 2017 https://www.facebook.com/ClassinSession2/posts/184117052147491.

"Evolving Attitudes On Interracial Marriages" WVXU/WMUB, Cincinnati NPR, All Things Considered, May 19. 2016 http://wvxu.org/post/evolving-attitudes-interracial-marriages#stream/0.

FUNDING AND GRANTS

Norwood, Carolette (PI), African American Women and Economic Mobility, Commissioned Qualitative Research Study, The Women's Fund of the Greater Cincinnati Foundation, February 2020. Amount: $30K.

Toward an Open Monograph Ecosystem (TOME Provost Award) ($20,000): Funding period 2018-19. Project Title: Jim Crow Geography: Mapping the Intersections of Gender, Race, and Sexuality in Cincinnati Urban Space.

Reproductive Justice in Urban Cincinnati ($236,000) anonymous donor: Funding period 2018-2020: Project Title: Community-Based Participatory Research: Sexual and Reproductive Health in Cincinnati.

The Cincinnati Project, University of Cincinnati, ($2,500, Awarded). Funding Period: 2016-present. Project title: Navigating Gender, Race, Place and Space in Urban Neighborhoods

Third Century Faculty Research Materials Grant ($1,500, Awarded), Funding Period: April 2015. Project title: A Spatial Analysis of HIV/AIDS in the Cincinnati Metropolitan Area 1990-2010.

Center for AIDS Prevention Studies, Health Disparities in Minority Communities Collaborative Program. 6 Week Stipend $36K for 3 Summers and Research Grant for Pilot Study $25K. Funding Period 2012-2014. Project title: Navigating Gender, Race Place and Space in Urban Neighborhoods.

Taft Research Center, Direct Research Cost Grant, University of Cincinnati, ($1000.00, Awarded). Funding Period 2007. Project Title: Women's Status and HIV/AIDS Risk prevention strategies: A mixed-method evaluation of the effects of Microcredit Participation in Yaoundé, Cameroon (PI: Carolette Norwood, PhD).

Faculty Research Support Grant, University of Cincinnati ($6500.00, Awarded). Funding Period 2006. Project Title: Women's Status and HIV/AIDS Risk Prevention Strategies: A Mixed-Method Evaluation of the Effects of Microcredit Participation in Yaoundé, Cameroon (PI: Carolette Norwood, PhD).

Summer Research Grant from Vice President and Faculty of Dean's office. Saint Mary's College, ($5000.00, Awarded) Funding Period 2004-2005. (PI: Carolette Norwood, PhD).

Center for Women's Intercultural Leadership Co-Sponsorship Grant, Saint Mary's College ($900.00, Awarded). Funding Period 2005. Project title: Women, HIV and Microcredit in Africa (PI: Carolette Norwood, PhD).

Ford Foundation Funded Human Rights, Human Diversity Predoctoral Dissertation Research Award ($5000.00, Awarded) Funding Period: 2001-2002. Project Title: Microeconomic schemes in rural Ghana: A mixed-method evaluation of microcredit membership on women's empowerment, and family planning practices (PI: Carolette Norwood, PhD).

2000. Science, Technology, and Research Scholars (STARS) summer fellowship ($5000.00, Awarded).

INTERNAL AWARDS AND FELLOWSHIPS

Taft Research Center Competitive Lecture Grant, Mario Small, University of Cincinnati ($[redacted], Awarded). Funding Period 2018. Project Title: Heterogeneity and American Ghettos. (PI: Carolette Norwood, PhD).

Taft Center Fellowship, Funding Period 2017-18: University of Cincinnati (1 year, 100% research time, Awarded). Project Title: Navigating Race, Sex, and Sexuality in Spatial Context of High HIV Prevalence (PI: Carolette Norwood, PhD).

Taft Research Center Competitive Lecture Grant, Marlon M. Baily, University of Cincinnati ($[redacted], Awarded). Funding Period 2017. Project Title: Butch Queens UP In Pumps: Gender, Performance and Ballroom Culture in Detroit (PI: Carolette Norwood, PhD).

Taft Faculty Release Fellowship, Funding Period 2014-15: University of Cincinnati (100% research time, Awarded). Project Title: Navigating Race, Sex, and Sexuality in Spatial Context of High HIV Prevalence (PI: Carolette Norwood, PhD).

Office of Diversity and Inclusion, Lecture Grant, Tamara Beauboeuf-Lafontant, University of Cincinnati ($[redacted] Awarded). Funding Period 2016. Project Title: The Strong Black Woman: A Half-Told Tale of Voice, Race, and the Body (PI: Carolette Norwood, PhD).

Taft Research Center Competitive Lecture Grant, Tamara Beauboeuf-Lafontant, University of Cincinnati ($[redacted], Awarded). Funding Period 2016. Project Title: The Strong Black Woman: A Half-Told Tale of Voice, Race, and the Body (PI: Carolette Norwood, PhD).

UC International Awards Grants for Developing New International Experiences, University of Cincinnati, ($2500 Awarded, $700 departmental matched funds). Funding Period 2012-13. Project title: Introduction to Africana Studies.

Taft Research Center Competitive Lecture Grant, University of Cincinnati ($2300.00, Awarded). Funding Period 2012. Project Title: Women, Population and Development (PI: Carolette Norwood, PhD).

Center for the Enhancement of Teaching & Learning (CET&L) grant ($1000.00, Awarded). Funding Period 2007. Project Title: Women's Studies and Urban Studies Initiative: Core Curriculum Development and Service Learning.

Faculty Development Council Individual Grant, University of Cincinnati ($3650.00, Awarded). Funding Period 2007. Project Title: Learning Structural Equation Modeling. University of Michigan, Inter-university Consortium for Political and Social Research (ICPSR), Summer Program in Quantitative Research Methods "Structural Equation Models and Latent Variables: An Introduction," Summer 2009.

Intercultural Travel for Student Groups led by Faculty/Staff Coordinator, Saint Mary's College ($500.00, Awarded). Funding Period 2005. Project title: Urban Sociology Field Trip to Chicago.

2002-2003. Andrew W. Mellon Doctoral Exchange Fellowship, Université de Montréal, African Demography 2002-2003 ($15,000.00, Awarded).

2001-2002. University of Nebraska-Lincoln, Teaching Assistantship, Larson Minority Fellowship ($2500.00, Awarded) .

2000-2001. University of Nebraska-Lincoln, Teaching Assistantship, Larson Minority Fellowship ($2500.00, Awarded).

1999-2000. University of Nebraska-Lincoln, Teaching Assistantship, Larson Minority Fellowship ($2500.00 Awarded).

RECOGNITION FOR EXCELLENCE IN RESEARCH

2018 (April 13), Utafiti Award Excellence in Research, Celebration of Black Excellence from the Black Faculty Association.

TEACHING AWARDS

2011 Nomination Letter, Commencement Planning Committee, University of Cincinnati

2009 African American Cultural and Research Center, University of Cincinnati

2007 Darwin T. Turner Scholars Program, University of Cincinnati

ADVISING EXPERIENCE

Associate Professor, University of Cincinnati, Department of Women's Gender and Sexuality Studies

Course taught

- US Black Feminism
- Comparative Black Feminism (graduate seminar)
- Feminist Research Methods (I, II) (graduate seminar)
- Black Women in the US

- Reproductive Political Justice

Assistant Professor, University of Cincinnati, Department of Africana Studies
Course taught
- Sociology of the Black Community (I, II, III)
- Black Feminism
- Black Health Care
- Seminar in Gentrification
- Senior Capstone
- Introduction to Africana Studies
- Introduction to Africana Studies (Online)
- Women, Population and Development (Study Abroad to Ghana for Honors College)

Assistant Professor, Saint Mary's College (Notre Dame, IN), Department of Sociology
Course taught
- Quantitative, Qualitative and Feminist Research Methodology
- Women, Population and Development (special topics)
- Urban Sociology
- Nationality and Race Relations
- Social Problems
- Introduction to Sociology

Advising at University Cincinnati

PhD Committee (Member), University of Cincinnati

Victory Baah-Binney, Victory "Liberated 'Trokosi' Women in Ghana." Department of Counselor Education and Supervision, University of Cincinnati, 2015-2021.

McCuistian, Caravella, "Community Collaboration to Address Transactional Sex Among Substance Using Women for HIV Prevention", University Cincinnati, Department of Psychology, 2017-2019.

Thesis Committees (Chair, Co-Chair*), University of Cincinnati

Devonte Stewart, "Performing Queerness: A Content Analysis of Professional Television Wrestlers from the Midcentury (1950) to the Second millennium (2020)," Spring 2020-present.

Aparna Singh, "Women's Experiences During Natural Disaster: A Case Study of the 2015 Nepal Earthquake," 2016-2018.

Gabrielle Simmons, "Literature and the Possibilities of Alternative Black Girlhood" 2016-2018.

Haya Abusway, "Deploying the Domestic: The Utilization of Palestinian Women in Modern Warfare" Department of Women, Gender and Sexuality Studies, 2015- 2017.

Maria C. Castro, "The Intersections of Sex Work and Motherhood" Department of Women, Gender and Sexuality Studies, 2016- Present.

Bisola Sosan, "The Fruits of Our Labor: Reading Toni Morrison's Beloved as an Oneiric Space" School of Architecture and Design of the College of Design, Architecture, Art and Planning, 2016- 2018.

*Amber Davis, "Economic Empowerment for All: An Examination of Economic Development for Low-, Middle, and High-Income Women in Maha Sarakham, Thailand" Department of Community Planning in College of Design, Architecture, Art and Planning (DAAP). 2017

Thesis Committees (Member), University of Cincinnati

Maggie Kane, "Decoding Discipline: 'Appropriate' Femininity and Disparate School Discipline Practices" Department of Women's, Gender, and Sexuality Studies. 2019-Present

Azia Carnes, "Black Women's Lives Matter: Examining the Lack in Awareness of Violence and Injustice Against African American Women Overtime." Department of Women's, Gender, and Sexuality Studies. 2019

Nehal Elmeligy, "Making a Scene: How Young Women in Cairo Challenge Patriarchy in the Public Sphere." Department of Women's, Gender, and Sexuality Studies. 2018

Christopher Colizza, "The Sociological Impact of Rotating Savings and Credit Associations: The Impact of ROSCAs on Women/Families in Ethiopia." Department of Planning, University of Cincinnati. 2010

Latoya Moore, "The Spatial Distribution of Antipoverty Nonprofits and the Shifting Geography of Need: A Look at Cincinnati, OH." Department of Planning, University of Cincinnati. 2009

Randi Moore, "Paradoxical Possibilities: Black Women, Resistance, and the Politics of Respectability." Department of Women's Studies, University of Cincinnati. 2009

Rwebiita Atucungwiire. "The Illusion of Gender Equality and Poverty Alleviation in Uganda." Department of Women's Studies, University of Cincinnati. 2007

Professional Development in Teaching

Center for Enhance Teaching and Learning (CETL), Study Abroad Institute, 1 week, May 2013

Center for Enhance Teaching and Learning (CETL), Lesson Study Research Institute, 7 Weeks, April 2012-June 2012

PROFESSIONAL SOCIETIES

Present: National Women's Studies Association (NWSA), 2015- present

Past: Alpha Kappa Delta Honor Society (AKD), American Geography Association (AAG), the National Council of Black Studies (NCBS), the American Sociological Association (ASA), Population Association of America (PAA), the Midwest Sociological Association (MSA), and the North Central Sociological Association (NCSA)

SERVICE IN THE PROFESSION

Reviewer for

Hypatia – A Journal of Feminist Philosophy

Journal of Women's Health

Souls- A Critical Journal of Black Politics

Social Identities: Journal for the Study of Race, Nation and Culture

Women, Gender & Families of Color
Journal of Marriage and Family
Journal of Black Psychology
The Howard Journal of Communication
Journal Reviewer for African Journal of Reproductive Health
Gender and Society
Sociological Focus
Social Science Quarterly
World Medical & Health
European Journal of Development Research
Journal of Family Issues

Reviewer for
National Science Foundation (invited) 2012.
Reviewer/Panelist for Boren Fellowship for International Study, Washington DC (African Division, invited) 2011, 2012, and 2013.
Chair of Undergraduate and Graduate Student Paper Competition, North Central Sociological Association (NCSA), 2009, 2010, 2011, 2012 and 2013.
Council Member (elected), North Central Sociological Association (NCSA), 2006-2009.
Committee for Women in the Profession (elected), Midwest Sociological Association (MSA) 2008-2010.

Reviewer for
Tenure and Promotion to Associate Professor, Dr. Alyssa Robillard at the Arnold School of Public Health at the University of South Carolina (Summer 2017).

SERVICE AT THE UNIVERSITY
College governance, committee work, college-wide activities, etc.

Marshalls and Rhodes Scholar Nominee Committee, Fall 2019
Yates Scholar Program Evaluator, Spring 2019
UC TAFT Research Support Committee, 2013-2014; 2019-present
The Cincinnati Project Advisory Board, 2017-2019
UC Women's Center, Black Feminist Symposium, 2016-2017; 2019
Women's Gender Sexuality Studies (WGSS) Graduate Committee, 2013-2014
UC International, African Strategy Committee, 2012, 2013
UC International, African Ambassador's Meeting and Dinner, Fall 2012
UC International Vice Provost Search Committee 2012-2013
Women's Studies Undergraduate Curricular Committee 2007-2008; 2008-2009; 2009-2010;

Department Service and Committees

Director of Social Justice Certificate, 2019 – Present
Advisory Council, Department of Women's, Gender, and Sexuality Studies, 2019-present

Chair, WGSS Lecture Series Coordinator (In conversation with Dani McClain author of *We Live for the We: The Political Power of Black Motherhood* at Charles Phelps Taft Research Center), Spring 2019
Chair, Social Justice Ad Hoc Committee, 2019-present
Chair, Reappointment and Tenure Committee (Dr. JT Roane), 2019
Chair, Scholarship and Awards Committee, 2019
Chair, Search Committee, Open Rank Faculty Position, Urban Future's Scholar 2016-2017.
Member, Reappointment and Promotion Committee (Carolyn Peterson), 2015
Events Coordinator, WGSS, 2015 –2017; spring 2019.
Undergraduate Minor's Advisor, 2007-2008; 2008-2009; 2009-2010; 2010-2011; 2012-2013.
Curriculum Committee 2010-2011; 2011-2012.
Junior Search Committee, 2007, 2010.
Minor/Major Data Base, Winter 2009 – 2010.
Public relations (webpage and department brochures), 2008-2009
Search Committee, Winter 2007.
Department Retreat 2010-2011; 2011-2013; 2012-2013.
Travel Committee 2012-2013.
Study Aboard to University Ghana, Honor's College, Fall 2011.
Exploring the Study Aboard course development to University West Indies St. Augstine, May 2013.

Student Mentoring

Yates Fellow Mentor

- Devonte Stewart, 2019- present
- Gabrielle Simmons, 2016 – 2018

Putting Retention 1st in the Zest for Excellence (PR1ZE) Faculty mentor to:

- Tyrick Allen 2009, 2010, and 2011
- Heather Cooper 2010, 2011, and 2012

Research Mentor (Independent Studies)

- Michelle Siddiqui, Fall 2019 – to present
- Erika Nyguen, Summer 2019, Fall 2019, Spring 2020
- Lonnie Jennings, Spring 2020
- Devonte Stewart, Spring 2020
- Ariel Shaw, Spring 2020
- Juliana Madzia, 2015-2018

SERVICE IN THE COMMUNITY AND PARTNERSHIPS

- Peaslee Neighborhood Community Center, Board of Directors, 2019-Present.
- OTR Community Housing, 1227 Vine St, Cincinnati, OH.
- The Community Builders, Inc 3539 Reading Road, the Avondale Town Center, Cincinnati, OH.
- Cradle Cincinnati, 3333 Burnet Ave, Cincinnati, OH.
- Cincinnati Birth Center, 841 Lincoln Ave, Cincinnati, OH.
- CO-Hear Community Engagement and Strategy, 1160 140th Ave NE suite e & f, Bellevue, Cincinnati, Ohio.
- Josephine's Clinic, 1953 Central Ave, Cincinnati, OH 45214
- Caracole Inc. (provides HIV prevention and testing services for the community and affordable housing and case management for individuals and families living with HIV/AIDS), 2016 to 2018.
- Greater Cincinnati World Affairs Council, NKU, Highland Heights, KY 41099.
- Stop AIDS, 220 Findlay Street, Cincinnati, OH, 2010 – 2011.
- International Family Resource Center, 200 McFarland Street, Cincinnati, OH, 2006-2008.

EXHIBIT 10

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A21 00870 Judge Alison Hatheway

AFFIDAVIT OF REVEREND TERRY WILLIAMS IN SUPPORT OF PLAINTIFFS' SECOND MOTION FOR PRELIMINARY INJUNCTION

I, Reverend Terry Williams, being duly sworn on oath, do depose and state as follows:

1. I am an Ordained Minister of the United Church of Christ. I am currently the Lead Pastor of the Orchard Hill United Church of Christ in Chillicothe, Ohio, a position I have held since December 2012. I am also a Faith Organizer with Faith Choice Ohio (formerly the Ohio Religious Coalition for Reproductive Choice), a multi-faith organization that elevates the moral power of faith communities to ensure that all people can access reproductive healthcare, mainly through education and counseling. In my role at Orchard Hill and with Faith Choice Ohio, I have counseled approximately six hundred individuals and their families making the decision of whether or not to continue a pregnancy.

2. I hold both a Master of Theological Studies and a Master of Divinity from the Methodist Theological School in Ohio. I hold a B.A. in Religion and Religious Studies from Ohio Wesleyan University.

3. A copy of my CV is attached hereto as Exhibit A. I am over the age of eighteen, competent to testify, and make this affidavit based on personal knowledge, my review of the statute at issue, and, where noted, information provided by Plaintiffs' counsel.

4. I submit this affidavit in support of Plaintiffs' Second Motion for Preliminary Injunction to prevent enforcement of Senate Bill 27 ("SB27"). I have reviewed SB27 and its implementing rules. I understand the law to require embryonic and fetal tissue from a procedural abortion be cremated or interred. I believe that SB27 is an inappropriate imposition of one particular set of views of when life begins on all Ohioans, namely that a fetus or embryo is a human life. Based on my experiences as a pastor and my experience counseling people about pregnancy options, I am convinced that SB27 will result in significant mental and spiritual damage, including imposing trauma, guilt, shame, and anger, especially on individuals who maintain deeply held religious and spiritual beliefs that are in conflict with the views that SB27 enshrines.

SB27 Harms Ohioans By Imposing One Set of Views of Human Life

5. Different religious traditions espouse different views about when human life begins.

6. For example, in the Jewish tradition, life begins at first breath.[1] In contrast, the official doctrine of the Roman Catholic Church holds that life begins at conception.[2] Meanwhile, other Christian denominations, like the Lutheran Church, do not have a central decision-maker that determines the uniform teachings and, thus, perspectives on when life begins within those denominations vary.[3]

[1] Joseph G. Schenker, *The Beginning of Human Life*, 25 J. Assisted Reprod. Genetics 271, 272 (2008).

[2] The Holy See, Sacred Congregation for the Doctrine of the Faith, *Declaration on Procured Abortion* (1974), https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19741118_declaration-abortion_en.html.

[3] Moira Stephens et al., *Religious Perspectives on Abortion and a Secular Response*, 49 J. Religion & Health 513, 516 (2010).

7. The United Church of Christ acknowledges the many differing and overlapping views regarding the beginning of human life.[4] Importantly, the United Church of Christ recognizes that because of these differences, "one particular view should not be forced on society through its legal system."[5] Rather than mandate one specific view, the United Church of Christ calls on individuals to make the determination of when human life begins using their own religious and moral convictions, and stresses that they must be able to do so free from intimidation or coercion.[6] In the United Church of Christ, this tenet stems from a belief that the goals of gender and economic equity cannot be advanced without reproductive freedom of choice.[7] And even within other specific faiths there is often a variety of viewpoints on the morality of abortion. For example, differing beliefs about abortion are articulated within the branches of Judaism and within protestant churches, like the United Methodist Church and the Episcopal Church in the United States. I have counseled many people, including those of the Catholic, Church of Jesus Christ of Latter-day Saints, or Jehovah's Witness faiths, who decided to have an abortion even though their faith community doctrine dictates that life begins at conception.

8. In most religious traditions, interment and cremation are rituals associated with the death of human beings.[8] People ascribe deep personal meaning to the human life being interred or

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[4] United Church of Christ, *General Synod Statements and Resolutions Regarding Freedom of Choice* (1971–89), https://www.uccfiles.com/pdf/GS-Resolutions-Freedom-of-Choice.pdf. General Synod is considered the highest body of ecclesiastical record in the United Church of Christ and the only body empowered to speak on behalf of the Church in general matters.

[5] *Id.* at Eighth General Synod, 1971.

[6] *Id.* at Eleventh General Synod, 1977.

[7] *Id.*

[8] *See, e.g.*, Ashley Collette, *Concern or Calculation: An Examination of State Law Mandating the Burial or Cremation of a Fetus*, 9 Wake Forest L. Rev. Online 1, n.17 (Jan. 31, 2021) (burial and cremation "implicat[e] religious traditions and deeply held personal beliefs"), http://www.wakeforestlawreview.com/2019/01/concern-or-calculation-an-examination-of-state-law-mandating-the-burial-or-cremation-of-a-fetus/; Francoise Dastur, *Mourning as the Origin of Humanity*, 48 Mosaic: a J. Interdisc. Study Literature 1, 6–7 (2015).

cremated through these rituals. For example, in the United Church of Christ, the primary understanding of burial is rooted in the Biblical principle that we came from earth and must return to earth; our mortality and the very essence of humanity stems from being connected to the physical earth.

9. By mandating burial or cremation, SB27 enshrines into Ohio law a narrow set of beliefs regarding the personhood of an embryo or fetus. SB27 presupposes that embryos and fetuses are human lives.

10. By requiring that embryonic and fetal tissue be disposed of either through interment or cremation, regardless of the patient's views and without exception, the State imposes its view that embryos and fetuses are human beings on private individuals. Many people do not share that belief—indeed, it may run directly counter to their deeply held religious and spiritual beliefs—and SB27 will force them to undergo a ritual that violates their beliefs. So, SB27 forces individuals to participate in rituals which, for many, hold religious and spiritual meaning and which they do not believe is appropriate for tissue from a pregnancy.

11. The State treating this tissue as human remains by mandating cremation or burial signals to individuals with different beliefs that the State views their religious or spiritual beliefs as inferior. The State is endorsing one religious perspective over others.

12. In many faiths, the religious rituals associated with burial and cremation are practices to process and communicate grief and loss. But in my counseling experience I have learned that abortion, for many patients, is not a loss at all, but a relief. People who do not feel a loss after the end of a pregnancy will likely not experience grief for the pregnancy. For others, losing a wanted pregnancy is a loss—not so much a loss of the embryo or fetus, but rather a loss of the baby that was to be born at the end of a full pregnancy. This grief is thus not related to fetal

tissue but rather the hoped-for birth of a fully developed baby at the end of a full-term pregnancy. Still other people do grieve a miscarriage or ectopic pregnancy as a loss of a potential child. Each of these perspectives is informed by a person's values, which are individual to their circumstances, religion, and sense of morality.

13. Mandating the rituals of cremation or interment also presupposes a spiritual or close relationship between the pregnancy and the pregnant person when often this is not the case. Scholars have explained that cremation and interment rituals allow the creation of "a new mode of human relationship with the one who has passed away [because they] continue[] to exist in some indeterminate kind of the 'beyond.'"[9] But such a relationship between the pregnant person and the tissue from a procedural abortion may not exist. While some families regard a pregnancy as a child in its own right and celebrate it (and sometimes mourn its loss), many do not. Mandating cremation or interment can be very harmful for individuals who do not believe such a relationship with their pregnancy exists because it signals to them that the State believes that they *should* feel a closeness or spiritual connection. In other words, the State is telling these individuals that how they feel and their own spiritual understanding of human life is wrong.

14. For individuals who believe that these rituals—cremation and interment—are reserved for human beings, the act of interring or cremating tissue that they do not regard as a human being is profane. The knowledge that something they do not regard as human has been honored with rituals reserved for human beings can be deeply distressing. For abortion patients that I counsel, the ability to choose what happens to one's own body is central to the decision to

[9] Dastur, *supra* note 8, at 6–7; *see also* Katharina Rebay-Salisbury, "Inhumation and Cremation: How Burial Practices Are Linked to Beliefs," in *Embodied Knowledge: Historical Perspectives on Belief and Technology* 15, 15 (Marie Louis Stig Sorensen & Katharina Rebay-Silisbury eds., 1st. ed. 2012) (discussing cremation and burial as different practices by which the living may continue spiritual connections with the deceased).

seek an abortion in the first place. Forcing a person to give over tissue from their abortion procedure to another person for burial or cremation, both against their will and against their religious convictions, will no doubt cause grave moral injury and psychological harm, including imposing stigma and shame, for many if not most patients. This may be especially distressing to patients who have experienced intimate partner violence or sexual assault, who often experience shame after experiencing such trauma and will be further harmed by additional stigma and shame imposed by SB27.

15. All of this is true even when the pregnant person is not physically present during interment or cremation. SB27 does not allow a pregnant person to choose to not memorialize the pregnancy through cremation or interment. Even if a pregnant person does not take the opportunity to select the method of disposition, they will still be informed of how the tissue will be disposed and will thereby be harmed by the State's imposition of its ideology on the pregnancy.

16. As I have learned through my extensive counseling experience, no two people or families are exactly alike—their theologies, personal convictions, circumstances, and spiritual needs are always unique and their pastoral care needs are similarly varied. Some people may choose to perform funeral rituals following pregnancy loss, and it is my understanding that such a choice is already permitted under current Ohio law. But for the many who would not otherwise choose a funeral ritual, mandating one would be a profound violation of their faith and their beliefs about when life begins.

17. For example, a small number of my congregants have preserved tissue from a first trimester miscarriage and have requested that I lead a service to honor the lost pregnancy, which, to those congregants, was the loss of a life. Several of these congregants went to local abortion providers for miscarriage management and received assistance in obtaining the tissue for the

service they desired. Conversely, most people I have counseled did not wish to have any service, let alone arrange for cremation or interment of the fetal tissue, following an abortion or miscarriage. In my role as a pastor and counselor, I do not endorse any one view as superior: I help navigate individuals' spiritual perspectives with their desired or needed medical care. For example, through my work in Faith Choice Ohio, I counseled an individual of Jewish faith who decided to have an abortion and was forced to participate in cremation of the fetal tissue because of the laws in a neighboring state where she received her abortion care. A central tenet of Judaism is that life begins at first breath; a requirement that embryonic or fetal tissue must be cremated or interred necessarily violates this tenet by ascribing qualities of human life to the embryonic or fetal tissue. During our counseling conversation, this individual expressed the feelings of violation and frustration she experienced by being forced to cremate embryonic tissue and thus being forced to participate in a religious tradition that is deeply against Jewish law.

18. In my counseling, I hear people discuss the frustrations caused by Ohio abortion restrictions that are already in effect. For example, the patients I counsel share that they understand Ohio's mandatory 24-hour delay prior to abortion care, especially when paired with the biased counseling requirements in Ohio law, as state-sanctioned impediments to the patient's care and an intervention of the State in the choices of patients meant to deter abortion even if the patient's own moral and religious beliefs support abortion. Patients have told me that they view these laws as rooted in the establishment of a religious viewpoint in state law that disfavors the religious beliefs of the patient. Countless people have expressed hurt and anger at knowing that their own beliefs and spiritual convictions about what is happening inside their body are being ignored and denigrated by the State.

19. SB27 furthers the harm imposed by the State on abortion patients by inappropriately imposing the ritual of cremation or interment. Such an imposition violates the faith of many people, including their religious and spiritual beliefs about when life begins, and will cause severe and irreversible harm.

FURTHER AFFIANT SAYETH NAUGHT.

Reverend Terry Williams

Signed before me this 5 day of January, 2022.

Notary Public

RITA S. FUCHSMAN, Attorney At Law
NOTARY PUBLIC, STATE OF OHIO
My commission has no expiration date.
Section 147.03 R. C.

EXHIBIT A

Rev. Terry Williams

47 ½ E. Main Street
Chillicothe, Ohio 45601
Terry.Williams.2006@OWU.edu
614.477.9317

CURRICULUM VITAE

FORMAL EDUCATION

Clinical Pastoral Education — **Graduated March 20, 2017**

Trinity Community Beavercreek | Beavercreek, Ohio
Completed one unit of Clinical Pastoral Education at an ACPE-accredited United Church of Christ care community
Engaged pastoral care, preaching, and teaching skills across an ecumenical and interfaith context

Master of Theological Studies — **Graduated May 19, 2012**

Methodist Theological School in Ohio | Delaware, Ohio
Certified Concentration in Christian Theology and Ethics
Electives including *The Church and Race*, *The Problem of Evil*, and *Gender, Sin, & Addiction*

Master of Divinity — **Graduated May 19, 2012**

Methodist Theological School in Ohio | Delaware, Ohio
Certified Specialization in Biblical Languages and Texts
Electives including *Advanced Greek*, *Dead Sea Scrolls*, and *Identity & Second Temple Judaism*

Bachelor of Arts — **Graduated May 14, 2006**

Ohio Wesleyan University | Delaware, Ohio
Religion with significant Chemistry Studies
Named a Ralph E. Hall Honors Fellow in Chemistry

Diploma — **Graduated May 26, 2002**

Waverly High School | Waverly, Ohio
Graduation with High Honors

AWARDS

2016 City of Chillicothe Martin Luther King Jr. Service Award — **January 18, 2016**
For Dedicated Advocacy in Civil Rights & Inclusion in the City of Chillicothe, Ohio

Fellowship Seminarian Award — **May 17, 2012**
For Outstanding Leadership in Music & Worship Arts at the Methodist Theological School in Ohio

Past International President's Award — **February 6, 2006**
For Committed Service Leadership in support of Ohio District Kiwanis

Ralph E. Hall Fellowship in Chemistry — **May 12, 2005**
For Excellence in Scholarship in the study of Chemistry at Ohio Wesleyan University

VOCATIONAL EXPERIENCE (COMPENSATED WORK)

Lead Pastor — **December 1, 2012 – Present**

Orchard Hill United Church of Christ | Chillicothe, Ohio
Preaching, Teaching, Counseling, Leading, & Empowering people within a theologically and politically diverse Appalachian congregation that is committed to a public witness that is anti-racist, anti-sexist, anti-homophobic, pro-People, and which openly recognizes all people as Children of God.

Faith Communities Organizer **March 18, 2019 – Present**

Faith Choice Ohio | Columbus, Ohio

Equipping, Organizing, & Counseling diverse interfaith voices who share a common commitment to the agency of people to make their own reproductive choices in accordance with their conscience and religion to advocate for their own rights in government, public forums, and within their faith communities. (*Note: Faith Choice Ohio was known as the Ohio Religious Coalition for Reproductive Choice prior to 2022*)

Regional Clergy Coordinator for Southeast Ohio **July 1, 2019 – Present**

Faith in Public Life | Columbus, Ohio

Organizing & Empowering clergy and faith leaders in Southeast Ohio to engage public policy frameworks in non-partisan, prophetic ways for the benefit of directly-affected populations including prison inmates, persons convicted of death penalty crimes, persons who use drugs, and others.

Southeast Ohio Organizer for Prison Reform **August 10, 2018 – November 30, 2018**

Faith in Public Life | Columbus, Ohio

Organized & Empowered directly impacted persons to advocate for anti-racist changes in mandatory minimum sentencing, cash bail systems, and non-violent felony drug convictions in the state of Ohio.

Barista **May 10, 2012 – November 20, 2012**

Starbucks Coffee Company | Worthington, Ohio

Brewed great coffee for people and learned retail economics, customer conflict management, and team performance all while representing a brand built on reliability, trust, and human connection.

Sales Associate for Churchwares and Books **August 10, 2008 – November 20, 2012**

Cokesbury Christian Bookstore | Columbus, Ohio

Consulted on sales of Christian curriculum, theological titles, brasswares, church supplies, clergy vestments, and choir apparel while building connections across a wide variety of denominations in greater central Ohio.

Student Pastor **August 1, 2011 – May 30, 2012**

North Congregational United Church of Christ | Columbus, Ohio

Served as lead adult education facilitator and student preacher in a diverse congregation actively committed to anti-racism, environmental justice, poverty alleviation, and just peacemaking.

Supply Preaching on Rotation **October 2009 – August 2011**

Zion United Church of Christ | Delaware, Ohio

Cooperated with a rotating slate of four seminary students to provide preaching and pastoral care in an interim period while the congregation searched for a settled, long-term pastor.

Adjunct Professor of Chemistry **January 20, 2008 – August 18, 2008**

Ohio Wesleyan University | Delaware, Ohio

Due to an unforeseen shortage of faculty, I was invited by my former undergraduate institution to provide instruction for one full unit of Chemistry 111 Laboratory.

Special Editorial Assistant, Religion Department **January 5, 2006 – May 18, 2007**

Ohio Wesleyan University | Delaware, Ohio

Provided editorial and revision support for works of Religion Department Faculty including research for the Rev. Dr. Emmanuel's 2010 work *Religion, Politics and Cults in East Africa: God's Warriors and Mary's Saints (Bible and Theology in Africa).*

Chemistry Laboratory Assistant **August 22, 2003 – December 20, 2005**

Ohio Wesleyan University | Delaware, Ohio

Assisted various professors in the Chemistry Department providing instruction and student tutoring for introductory and organic chemistry coursework.

Annual Fund Donor Relations Specialist **August 19, 2002 – May 21, 2003**

Ohio Wesleyan University | Delaware, Ohio

Maintained relationships with donors and issue-specific funds in order to support the university through sustained giving and generous financial stewardship.

Museum Director **August 1, 2000 – June 30, 2002**

Pike Heritage Foundation and Museum | Waverly, Ohio

Interpreted the history and mission of a local region-specific museum by improving programming, developing strategic partnerships, and revitalizing donor relations.

SERVICE EXPERIENCE (VOLUNTEER BASIS)

Department of Church and Authorized Ministry

Central Southeast Ohio Association of the United Church of Christ

Department Member **October 2020 – Present**

Providing support and accountability processes to the more than 30 churches and more than 140 authorized ministers of the Central Southeast Ohio Association of the United Church of Christ.

Hunger Network in Ohio

Board of Directors President **August 2020 – Present**

Board of Directors Vice President **August 2019 – August 2020**

Board of Directors Member **January 2019 – Present**

Working to end hunger in Ohio by equipping faith communities to advocate for anti-hunger public policies and local charitable initiatives that alleviate the immediate symptoms of hunger in communities.

Ross County Ministerial Association

Ecumenical Group Member **January 2013 – Present**

Collaborating with clergy and faith leaders in my local community on matters of charitable endeavors, spirituality, community renewal, and ecumenical worship.

Adena Health System

Corporate Member Representative **December 2012 – Present**

Serving as one of eight pastors who represent the Corporate Member Churches that have final executive oversight of the mission of Adena Health System, a regional health system founded in 1895 with a 13-county service area.

Adena Health System

Volunteer Chaplain **December 2012 – Present**

Providing on-call services of pastoral care, counseling, and theological reflection for patients and families of patients encountered through Adena Health System, a regional health system founded in 1895 with a 13-county service area.

Heartland Conference of the United Church of Christ

Board of Directors Member **October 2017 – October 2021**

Served two full 2-year terms on the governing board of the 319 United Church of Christ congregations across Ohio, West Virginia, and Northern Kentucky including service as Conference Annual Gathering Parliamentarian. (*Note: the Heartland Conference of the United Church of Christ was known as the Ohio Conference of the United Church of Christ prior to 2021)*

Trinity Community Association for Clinical Pastoral Education Center
Professional Advisory Group Member **October 2017 – January 2022**

Served as an alumni member of the ACPE Center at Trinity Community in Beavercreek, Ohio, supervising the administration of clinical pastoral education across both extended and intensive education units.

General Synod of the United Church of Christ
Conference Delegate to The General Synod **January 2017 – December 2020**

Served for a full 4-year term which included representing the Heartland Conference of the United Church of Christ (*formerly known as the Ohio Conference of the United Church of Christ prior to 2021*) at both the 2017 session in Baltimore, Maryland, and the 2019 session in Milwaukee, Wisconsin.

Central Southeast Ohio Association of the United Church of Christ
Association Council Member **October 2014 – October 2021**

Served multiple terms first representing the Department of Congregational Vitality and later the Conference Board of Directors on the governing board of the 39 United Church of Christ congregations across central and southeast Ohio.

Department of Congregational Vitality
Central Southeast Ohio Association of the United Church of Christ
Chairperson **October 2014 – October 2017**
Department Member **March 2014 – October 2017**

Provided support and congregational renewal consultation for the more than 30 churches of the Central Southeast Ohio Association of the United Church of Christ including workshop leadership on social media technologies and ethical boundaries.

Heartland Conference of the United Church of Christ
Outdoor Ministries Summer Camp Director **June 2011 – June 2019**
Outdoor Ministries Camp Vision & Planning Task Force **October 2013 – October 2016**
Conference Vision Team Member **October 2014 – October 2019**

Provided leadership in various roles to support the camping and summer camp ministries of the Heartland Conference of the United Church of Christ (*formerly known as the Ohio Conference of the United Church of Christ prior to 2021*) including volunteer direction of nine years of Grandparent-Grandchild Camp sessions.

SELECT CONTINUING EDUCATION OPPORTUNITIES

Denomination-Required Antiracism Training (Must be retaken at least every 5 years)
Westerville Community UCC; Westerville, Ohio. (4 hours) **April 28, 2014**
Camp Christian, Ohio Region of the Christian Church Disciples of Christ (5 hours) **October 28, 2015**
Camp Christian, Ohio Region of the Christian Church Disciples of Christ (5 hours) **March 29, 2017**
Adena Carlisle Building; Chillicothe, Ohio. (4 hours) **November 10, 2018**

Denomination-Required Ethical Boundaries Training (Must be retaken at least every 5 years)
St. John's UCC; Newark, Ohio. (4 hours) **April 29, 2013**
Camp Christian, Ohio Region of the Christian Church Disciples of Christ (5 hours) **October 14, 2015**
Camp Christian, Ohio Region of the Christian Church Disciples of Christ (5 hours) **March 30, 2017**
Adena Carlisle Building; Chillicothe, Ohio. (4 hours) **November 10, 2018**
Pastoral Practice Group; Rev. Eric Williams, Convener. (10 hours) **December 10, 2021**

Catholics for Choice Values Clarification Training **November 4, 2021**

In-depth ethical values training based in a group-evaluative model of dialogic reflection. Session was facilitated by Marlee Breakstone and Tinsley Murphy from Catholics for Choice. (6 hours)

Abolition Reads Book Club **July 27 – November 30, 2021**

Monthly book discussions facilitated by Kelley Fox from Faith Choice Ohio about abolitionist frameworks rooted in the following titles: “We Do This Til We Free Us: Abolitionist Organizing & Transforming Justice” by Mariame Kaba; “We Still Here: Pandemic, Policing, Protesting, & Possibility” by Marc Lamont Hill; “From #BlackLivesMatter to Black Liberation” by Keeanga-Yamahtta Taylor; “Border & Rule: Global Migration, Capitalism, and the Rise of Racist Nationalism” by Harsha Walia; “Freedom is a Constant Struggle: Ferguson, Palestine, and the Foundations of a Movement” by Angela Y. Davis. (5 hours)

Restorative & Transformative Justice Book Club **February 23 – May 25, 2021**

Monthly book discussions facilitated by Kelley Fox from Faith Choice Ohio about restorative and transformative justice through the following titles: "Emergent Strategy" by adrienne maree brown; "We Will Not Cancel Us" by adrienne maree brown; "Beyond Survival: Strategies and Stories from the Transformative Justice Movement" by Ejeris Dixon & Leah Lakshmi Piepzna-Samarasinha; "Conflict Is Not Abuse: Overstating Harm, Community Responsibility, and the Duty of Repair" by Sarah Schulman; "The Revolution Starts at Home: Confronting Intimate Violence Within Activist Communities" by Ching-In Chen, Jai Dulani, & Leah Lakshmi Piepzna-Samarasinha; (4 hours)

White Nationalism and the Religious Right **October 13, 2020**

A day-long seminar confronting the religious roots of white nationalism and anti-abortion extremism from indigenous and native perspectives within a reproductive justice context coordinated by the New Mexico Religious Coalition for Reproductive Choice and convened by Joan Lamunyon-Sanford, Executive Director. (9 hours)

AAR/SBL Joint Annual Meeting **November 23-26, 2019**

Attended multiple sessions on religion, theology, theological ethics, reproductive rights, womanist theology, and biblical studies while also providing networking support and informal counseling at the exhibit hall presence of the Religious Coalition for Reproductive Choice. (38 hours)

Holy Callings: Advancing Reproductive Health & LGBTQ Justice **September 10-11, 2019**

A multi-day interfaith gathering of reproductive health, rights, and justice advocates that included multiple workshops on the intersection between LGBTQ+ rights and abortion justice, including a keynote from one of the founding mothers of the reproductive justice liberation framework, Toni Bond, and a religious blessing of the Planned Parenthood East Columbus Health Center abortion clinic in Columbus, Ohio. (14 hours)

Ruth Frost Parker Center for Abundant Aging Third Annual Symposium **October 12, 2018**

Keynote speaker Dr. Ira Byock presented “Abundant Aging through the End of Life,” and led a day-long symposium addressing dignity in aging, bodily autonomy, and elder safety. (7 hours)

Ruth Frost Parker Center for Abundant Aging Second Annual Symposium **October 20, 2017**

Keynote speaker Dr. Laura Carstensen led a full day of panel discussions and breakout sessions relating to aging and end of life planning with specific emphasis on the ethics of terminating life. (7 hours)

Ruth Frost Parker Center for Abundant Aging First Annual Symposium **November 11, 2016**

Keynote speaker Joan Lunden led a full day of intensive education sponsored by United Church Homes for local ministers focused on how best to counsel those in crisis and in need of making difficult life decisions. (7 hours)

EXHIBIT 11

ENTERED
APR 20 2021

IN THE COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, *Plaintiffs*, v. OHIO DEPARTMENT OF HEALTH, *et al.*, *Defendants.*	Case No. A 2101148 Judge Alison Hatheway

ENTRY GRANTING PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

This matter comes before the Court on Plaintiffs Planned Parenthood Southwest Ohio Region, et al.'s Motion for a Preliminary Injunction. This case involves a challenge to Senate Bill 260 (adding R.C. 2919.124(A)(1), (B)) ("SB 260" or "the Act"), which will bar a physician from providing an "abortion-inducing drug" to a "pregnant woman," unless the doctor is "physically present at the location where the initial dose of the drug or regimen of drugs is consumed" when the patient consumes that dose. In effect, SB 260 bars the provision of medication abortion via telemedicine ("TMAB").

This Court previously entered a temporary restraining order preventing Defendants from enforcing SB 260, which was slated to take effect on April 12, 2021. Defendants Ohio Department of Health ("ODH"), Ohio State Medical Board, and ODH Director Stephanie McCloud filed an opposition to the motion for a preliminary injunction. The local prosecutors named as Defendants did not file an opposition but were provided notice of the pending motion and an opportunity to be heard at the preliminary-injunction hearing. Upon review of the parties' additional filings, exhibits, and applicable law, and consideration of the parties' arguments during the hearing before this

Court on April 19, 2021, the Court now enjoins all Defendants in this case from enforcing SB 260 until such time as the Court enters final judgment.

As discussed in more detail below, the Court finds that Plaintiffs have met their burden of showing that SB 260 is substantially likely to violate the equal-protection and substantive-due-process rights of Plaintiffs and their patients and will cause irreparable harm. The Court further finds that the preliminary injunction will not harm third parties, and that preventing enforcement of a statute likely to be held unconstitutional is in the public interest.

I. BACKGROUND

Plaintiffs Planned Parenthood Southwest Ohio Region ("PPSWO"), Planned Parenthood of Greater Ohio ("PPGOH"), and Dr. Sharon Liner are health care providers in the state of Ohio who provide reproductive health care, including TMAB. Plaintiffs challenge SB 260, raising equal-protection and substantive-due-process claims under the Ohio Constitution. Defendants are the ODH, ODH Director Stephanie McCloud, the State Medical Board of Ohio, and county prosecutors charged with enforcing the criminal penalties set forth in the law. SB 260 was originally set to take effect April 12, 2021. The Court issued a temporary restraining order on April 7, 2021, and heard argument on the preliminary injunction motion on April 19, 2021.

A. Abortion in Ohio and Plaintiffs' TMAB Services

Plaintiffs have presented evidence to support the following facts regarding abortion provision in Ohio and their TMAB services, which Defendants do not dispute. Plaintiffs state there are two main methods of abortion, medication abortion and procedural abortion, and that both are effective in terminating a pregnancy. Medication abortion is available in Ohio up to 10 weeks of pregnancy, and involves patients taking two different medications one to two days apart. Because of state law requirements, patients must make two visits to a health center to obtain an abortion, at least 24 hours apart: the first for state-mandated informed consent and an ultrasound, and the

second for the abortion itself, or in the case of medication abortion, to receive and take the initial medication in the regimen. State law requires that the first visit be in person with a physician, so for their initial visit all of Plaintiffs' patients visit one of Plaintiffs' surgical facilities, in either Cincinnati, East Columbus, or Bedford Heights, which have a physician present at all times. Patients obtaining a medication abortion have the option for their second visit to return to a surgical facility or to visit one of Plaintiffs' TMAB locations in Dayton or Hamilton (for PPSWO patients), or in Mansfield or Youngstown (for PPGOH patients), where they can have their second appointment via video conference with a physician located at one of the surgical facilities. At that second visit, Plaintiffs confirm patients are certain in their decision to have an abortion, and the physician dispenses the first of the two medications (mifepristone). Patients take the second medication in the regimen (misoprostol) one to two days after the second visit at a location of their choosing, usually at home.

B. SB 260

SB 260 bars a physician from providing an "abortion-inducing drug" to a "pregnant woman," unless the doctor is "physically present at the location where the initial dose of the drug or regimen of drugs is consumed" when the patient consumes that dose. SB 260, § 1 (adding R.C. 2919.124(B)). The law effectively bans the TMAB services described above. A violation of SB 260 is a fourth-degree felony, which in Ohio carries a potential prison term of between six and eighteen months. *Id.* (adding R.C. 2919.124(E)); *see* R.C. 2929.14(A)(4). SB 260 likewise provides that licensed physicians are "subject to sanctioning" by the state medical board for violations of the Act. SB 260, § 1 (adding R.C. 2919.124(E), which cross-references R.C. 4731.22); *see also* R.C. 2925.01(W)(17).

SB 260 does not affect the provision by telemedicine of medication used to manage miscarriage, *see* SB 260, § 1 (adding R.C. 2919.124(B) (applying only where medication is given

to a "pregnant woman")); *id.* (adding R.C. 2919.124(C) (applying only where medication is given for the purpose of inducing abortion)), even though Plaintiffs treat miscarriage using the exact same medication regimen they use to provide medication abortion, and the health risks of these two treatments are comparable, if not higher among miscarriage patients. Nor does SB 260 restrict the use of telemedicine for other healthcare services. Instead, in recent years, Ohio has taken steps to reduce legal and regulatory barriers to telemedicine, including by requiring insurance coverage for telemedicine services and adopting flexible licensing and prescribing rules to facilitate telemedicine services. Ohio allows medications with far more serious risk profiles than those used in medication abortion to be prescribed via telemedicine, including controlled substances and opioids. To date, neither party has identified any other provision of state law that restricts the use of telemedicine only for a particular type of care, or that requires a physician to be physically present when a patient takes a medication prescribed by the physician.

Plaintiffs have presented party and expert affidavits demonstrating that SB 260's enforcement would completely eliminate access to the second-day medication abortion visits in Butler, Mahoning, and Richland counties, and would force patients in those areas to travel significantly farther to obtain an abortion, possibly well over 100 miles. Plaintiffs have also submitted evidence, based on high-quality research, that increases in travel distance to an abortion provider, even increases significantly less than those at issue here, reduce abortion attainment and carry other financial, physical and emotional costs for patients. These costs will delay patients' access to abortion, some to such an extent that they are no longer eligible for medication abortion, if they remain eligible for abortion in Ohio at all.

II. ANALYSIS AND DISCUSSION

As final relief, Plaintiffs seek an Order from this Court declaring the Act unconstitutional, and a permanent injunction barring its enforcement. The purpose of a preliminary injunction is to preserve the status quo prior to entry of the final order. *Procter & Gamble Co. v. Stoneham*, 140 Ohio App.3d 260, 267, 747 N.E.2d 268 (1st Dist. 2000). A party seeking preliminary relief must demonstrate that the moving party has a substantial likelihood of success in the underlying suit; that the moving party will suffer irreparable harm if the order does not issue; that no third parties will be harmed if the order is issued; and that the public interest is served by issuing the order. *Id.* at 267–68.

A. Plaintiffs Are Substantially Likely to Succeed on Their Claims.

1. Plaintiffs are likely to prevail against Defendants' threshold challenges to their standing and the availability of relief they seek.

At the outset, the Court addresses two threshold arguments made by Defendants as to the availability of relief for Plaintiffs' claims. First, Defendants contend that, to the extent Plaintiffs bring claims on behalf of their patients, those claims are barred because Plaintiffs lack third-party standing. As Plaintiffs explain, and Defendants appear to agree, this argument applies only to a subset of claims brought by Plaintiffs. Plaintiffs also bring equal-protection and due-process claims on their own behalf, and Defendants do not challenge the standing of Plaintiffs with respect to those claims.

As to Plaintiffs' equal-protection and due-process claims on behalf of their patients, the Court concludes that the Plaintiffs have third-party standing. SB 260 imposes criminal and civil penalties on abortion providers, and, if enforced, will result in a deprivation of patients' rights under the Ohio Constitution. Third-party standing is available in Ohio courts in circumstances like these, as confirmed by Ohio case law and federal court precedent, which Defendants agree this

Court may look to by analogy to interpret the third-party standing doctrine as it applies in Ohio state courts. *See June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2118–19, 207 L.Ed.2d 566 (2020) (plurality opinion), citing *Kowalski v. Tesmer*, 543 U.S. 125, 130, 125 S. Ct. 564, 160 L.Ed.2d 519 (2004); *see also id.* at 2139 fn. 4 (Roberts, C.J., concurring); *State v. Madison*, 160 Ohio St.3d 232, 2020-Ohio-3735, 155 N.E.3d 867, ¶ 95, *reconsideration denied*, 160 Ohio St.3d 1410, 2020-Ohio-4574, 153 N.E.3d 116 (Table), ¶ 20, *petition for cert. docketed, sub nom. Madison v. Ohio*, U.S. No. 20-1171 (Feb. 25, 2021).

Second, Defendants contend that the constitutional rights asserted by Plaintiffs cannot be remedied in this lawsuit because the provisions on which Plaintiffs rely are not self-executing. The Court rejects this argument on two grounds. First, Defendants ignore the availability of relief under Ohio's Declaratory Judgment Act, which provides that "any person whose rights, status, or other legal relations are affected by" a constitutional provision or statute "may have determined any question of construction or validity arising under the" constitutional provision or statute "and obtain a declaration of rights, status, or other legal relations under it." R.C. 2721.03; *Pack v. City of Cleveland*, 1 Ohio St.3d 129, 438 N.E.2d 434 (1982), at paragraph one of the syllabus. This statute provides a "legislative enactment" on which Plaintiffs may rely to seek declaratory and injunctive relief for due-process and equal-protection violations in this case. *See State v. Williams*, 88 Ohio St.3d 513, 521, 728 N.E.2d 342 (2000); *Moore v. City of Middletown*, 133 Ohio St.3d 55, 2012-Ohio-3897, 975 N.E.2d 977, ¶ 45; *Karches v. City of Cincinnati*, 38 Ohio St.3d 12, 526 N.E.2d 1350 (1988), at paragraph one of the syllabus; *Riverside v. State*, 2d. Dist. Montgomery No. 26024, 2014-Ohio-1974, ¶ 30–38; *see also* R.C. 2721.09 ("[W]henever necessary or proper, a court of record may grant further relief based on a declaratory judgment or decree previously

granted under this chapter."). Plaintiffs therefore need not show that the constitutional provisions on which they rely are self-executing.

Second, even if the Declaratory Judgment Act did not supply a cause of action for the Plaintiffs to seek declaratory and injunctive relief, however, the Ohio Constitution's guarantees of equal protection and substantive due process under Article I, Sections 1, 2, 16, 20, and 21 are self-executing because they are "sufficiently precise . . . to provide clear guidance to courts with respect to their application." *Williams* at 521; *see, e.g., In re Adoption of H.N.R.*, 145 Ohio St.3d 144, 2015-Ohio-5476, 47 N.E.3d 803, ¶ 24–25; *Arbino v. Johnson & Johnson*, 116 Ohio St.3d 469, 2007-Ohio-6948, 880 N.E.2d 420, ¶ 99–104; *Stolz v. J & B Steel Erectors, Inc.*, 155 Ohio St.3d 567, 2018-Ohio-5088, 122 N.E.3d 1228, ¶ 13, citing *Arbino* at ¶ 48–49; *In the Matter of Adoption of Y.E.F.*, Slip Opinion No. 2020-Ohio-6785, ¶ 15; *State ex rel. Brown v. Summit Cty. Bd. of Elections*, 46 Ohio St.3d 166, 169, 545 N.E.2d 1256 (1989).

2. Plaintiffs are substantially likely to succeed on their claim that SB 260 will violate their and their patients' constitutional right to equal protection.

The Ohio Constitution's guarantee of equal protection, found in Article I, Section 2, "requires that the government treat all similarly situated persons alike." *Sherman v. Ohio Pub. Emps. Retirement Sys.*, Slip Opinion No. 2020-Ohio-4960, ¶ 14, citing *McCrone v. Bank One Corp.*, 107 Ohio St.3d 272, 2005-Ohio-6505, 839 N.E.2d 1, ¶ 6.

SB 260 does not do so. Instead, it imposes felony criminal penalties and professional sanctions on abortion providers for providing medication abortion using telemedicine, while leaving other physicians, including physicians who treat miscarriage using the exact same medications, unrestricted in their telemedicine delivery. SB 260 also denies "pregnant wom[e]n" access to safe, effective health care via telemedicine, and all the benefits such care brings, without any countervailing benefit. SB 260, § 1 (adding R.C. 2919.124(B)).

Although Defendants contend that abortion providers are not similarly situated to other medical providers, including doctors treating miscarriage or offering comparable or higher-risk services by telemedicine, the Court disagrees. A disfavored class need not identify its mirror image to demonstrate that a similarly situated class of people is treated more favorably than the litigant. Rather, the question is whether the two classes are similarly situated with respect to the purpose of the challenged law. *See, e.g.*, *Conley v. Shearer,* 64 Ohio St.3d 284, 288–89, 595 N.E.2d 862 (1992) (emphasizing that laws "shall have an equality of operation on persons according to their relation," quoting *City of Dayton v. Keys*, 21 Ohio Misc. 105, 114, 252 N.E.2d 655 (C.P.1969)); *see also, e.g.*, *LSCP, LLLP v. Kay-Decker*, 861 N.W.2d 846, 860 (Iowa 2015) (cautioning that if courts make "intricate distinctions between purported classes of similarly situated individuals," "almost every equal protection claim could be resolved against the plaintiffs on the 'similarly situated' requirement"). The distinctions on which Defendants rely between miscarriage and abortion have nothing to do with the purpose of protecting women, for which SB 260 is advanced.

The parties disagree as to the appropriate level of review to apply to Plaintiffs' equal-protection challenge to SB 260. The Court agrees with Plaintiffs that SB 260 warrants strict scrutiny. By effectively banning a method of abortion, SB 260 burdens a fundamental right to substantive due process in matters involving privacy, procreation, bodily autonomy, and freedom of choice in health care decision making, *see, e.g.*, *Stone v. City of Stow*, 64 Ohio St.3d 156, 160–63, 593 N.E.2d 294 (1992).

SB 260 cannot survive strict scrutiny, which requires a compelling government interest and narrow tailoring of a statute to further that interest, because Defendants have not shown any medical benefit from SB 260, and the record evidence instead shows that SB 260 will harm patients' health by reducing access to abortion. Defendants have the burden of demonstrating SB

260's permissibility under strict scrutiny, *State ex rel. Brown v. Summit Cty. Bd. of Elections*, 46 Ohio St.3d 166, 168, 545 N.E.2d 1256 (1989); *Conley* at 289, but they do not dispute that any complications from medication abortion would occur long after a patient leaves a health center and takes mifepristone, such that the physical (instead of virtual) presence of a doctor during a TMAB patient's second-day appointment would have no impact on how such complications would be treated. Defendants' only evidence at this stage of litigation are U.S. Food and Drug Administration ("FDA") documents. Those documents support, rather than refute, Plaintiffs' contention that SB 260 is unnecessary to protect patient health. They confirm that, despite the FDA's regulation of mifepristone, the agency does not prohibit dispensing of this medication via telemedicine. Defendants' Response in Opposition to Plaintiffs' Motion, Exhibit 2. Indeed, as support for the FDA's most recent approval of mifepristone, the agency reviewed studies on the drug's safety, including a study that assessed outcomes of TMAB specifically, and found those studies supported the conclusion that mifepristone is safe and effective for its intended use.

Even if this Court were to hold that strict scrutiny did not apply here, it would nevertheless enjoin SB 260 because the law could not satisfy even rational-basis review, much less intermediate scrutiny. For the same reasons as with strict scrutiny, the State would fail to meet its burden under intermediate scrutiny of demonstrating an "exceedingly persuasive" justification for SB 260's sex-based classification and that the classification is "substantially related" to the State's interests in the law. *See United States v. Virginia*, 518 U.S. 515, 533, 116 S. Ct. 2264, 135 L.Ed.2d 735 (1996).

Under rational basis review, despite purportedly advancing an interest in patient safety, in application, SB 260 imposes differential treatment on individuals engaged in like conduct, including through the application of severe criminal penalties and professional sanctions. In particular, that SB 260 bans telemedicine for dispensing mifepristone to a patient seeking an

abortion, but permits telemedicine for dispensing mifepristone to a patient experiencing a miscarriage, reveals that it is in no way responsive to the purported risks of mifepristone. Even with the benefit of Defendants' defense of SB 260, the Court cannot discern any rational basis for SB 260. *Conley*, 64 Ohio St.3d at 289, 595 N.E.2d 862; *see also State v. Noling*, 149 Ohio St.3d 327, 2016-Ohio-8252, 75 N.E.3d 141, ¶ 22; *State ex rel. Dayton Fraternal Order of Police Lodge No. 44 v. State Emp. Relations Bd.*, 22 Ohio St.3d 1, 488 N.E.2d 181 (1986), paragraph 2 of the syllabus.

SB 260, therefore, must be enjoined, as it is substantially likely to violate Plaintiffs' and their patients' right to equal protection under the Ohio Constitution.

3. Plaintiffs are substantially likely to succeed on their claim that SB 260 will violate their and their patients' constitutional right to substantive due process.

The Ohio Supreme Court has on numerous occasions recognized a fundamental substantive-due-process right under the Ohio Constitution that extends to matters involving privacy, procreation, and bodily integrity and autonomy. *See, e.g., Stone*, 64 Ohio St.3d at 160–63, 593 N.E.2d 294. The Ohio Constitution's protection for substantive-due-process rights is distinct from that accorded under the U.S. Constitution because the Ohio Constitution provides a "remedy by due course of law" to "every person, for an injury done to him in his land, goods, *person*, or reputation." Ohio Constitution, Article I, Section 16 (emphasis added). Deprivation of reproductive autonomy falls squarely within the meaning of an injury done to one's person under the Ohio Constitution. Moreover, Article I, Section 21 of the Ohio Constitution confirms that freedom of choice in health care is a fundamental right. Given the breadth of the Ohio Constitution's guarantee of bodily autonomy, privacy, and freedom of choice in health care, strict scrutiny must apply to a law that infringes on this protection for patients and their medical providers. As explained above, SB 260 does not meet the demands of strict scrutiny.

Even under the federal undue-burden standard, SB 260 could not survive. That standard requires courts to "consider the burdens a law imposes on abortion access together with the benefits those laws confer" and "weigh[] the asserted benefits against the burdens." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309, 2195 L.Ed.2d 665 (2016). Under this standard, Plaintiffs are likely to succeed on their substantive due process claim. As previously explained, there is no medical benefit from SB 260, that would outweigh the burden placed on patients seeking medication abortion, such as increasing their travel distance to obtain an abortion and by imposing numerous other attendant harms, which will delay patients in obtaining an abortion and prevent some from obtaining a medication abortion altogether.

Defendants urge this Court to instead jettison balancing of benefits and burdens under the federal undue-burden standard, citing a recent concurrence by Chief Justice Roberts in *June Medical Services*. After the Court's own review of the precedent in this area, it does not agree that the Chief Justice Roberts's concurrence changed the undue-burden test. *See, e.g., Planned Parenthood of Indiana & Kentucky, Inc. v. Box*, 991 F.3d 740 (7th. Cir.2021), *petition for cert. docketed*, U.S. No. 20-1375 (Apr. 1, 2021). Even if it did, however, SB 260 would still fail that test because (as the Court concluded above) it is not reasonably related to a legitimate state interest and it imposes a substantial obstacle to pre-viability abortion. *June Med. Servs.*, 140 S. Ct. at 2138, 207 L.Ed.2d 566 (Roberts, C.J., concurring in the judgment), quoting *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 877, 112 S. Ct. 2791, 120 L.Ed.2d (1992) (plurality opinion).

B. Plaintiffs and Their Patients Will Suffer Irreparable Harm Absent Relief.

In light of the Court's findings above that Plaintiffs and their patients will be deprived of their constitutional rights to due process and equal protection unless SB 260 is enjoined, a finding of irreparable harm follows. "[I]mpair[ment]" of a constitutional right "mandates a finding of

irreparable injury." *Magda v. Ohio Elections Comm.*, 2016-Ohio-5043, 58 N.E.3d 1188, ¶ 38 (10th Dist.), citing *Bonnell v. Lorenzo*, 241 F.3d 800, 809 (6th Cir.2001). Moreover, the record demonstrates that without relief, Plaintiffs will be forced to cease providing TMAB. *See, e.g.*, Plaintiffs' Memorandum in Support of Motion for Temporary Restraining Order Followed by Preliminary Injunction Exhibit 1, Affidavit of Sharon Liner, M.D., ¶ 52; *id.* Exhibit 2, Affidavit of Adarsh Krishen, M.D., M.M.M., ¶ 24; Plaintiffs' Reply in Support of Preliminary Injunction Exhibit 4, Reply Affidavit of Adarsh Krishen, M.D., M.M.M., ¶ 5–9. Many patients will have to travel significantly farther to obtain an abortion, in some cases up to 100 miles or more, thus encountering barriers to care that will delay and that may ultimately preclude patients from accessing constitutionally protected care. The record also demonstrates that increased travel will carry other financial, physical, and emotional costs for patients for which they cannot be made whole after judgment.

Although Defendants refer to these harms as speculative, the Court sees nothing speculative about them. Plaintiffs have submitted sworn affidavits from health care providers based on their experience working with abortion patients and providing abortion care, along with expert affidavits from national experts, including individuals who are experts in telemedicine and medication abortion. The Court also takes notice of the State's own data, which shows that thousands of patients who obtain abortions in Ohio each year reside in the counties where the Plaintiffs currently offer TMAB. *See id.* Exhibit 3, ODH, *Induced Abortions in Ohio, 2019*, at 14–15 table 4 (Sept. 2020). Plaintiffs' evidence of irreparable harm is more than sufficient at this stage of litigation.

D. No Third Parties Will Be Harmed and the Public Interest Will Be Served by an Injunction.

No third parties would be harmed if Defendants are enjoined. Plaintiffs have been providing TMAB safely for more than a year, so Defendants cannot claim any threat to public health or safety. Moreover, "the state cannot be harmed when an unconstitutional law does not go into effect." *Newburgh Heights v. State*, 8th Dist. Cuyahoga Nos. 109106 and 109114, 2021-Ohio-61, ¶ 76.

In addition, the public has a particularly strong interest in a speedy injunction here where temporary relief would merely preserve the status quo on which Ohioans seeking TMAB have come to rely. In fact, the public interest will be served by allowing Plaintiffs to continue providing, and their patients to continue accessing, essential and constitutionally protected health care, particularly in the midst of the COVID-19 pandemic.

III. CONCLUSION

For the foregoing reasons, Plaintiffs' Motion for a Preliminary Injunction is hereby **GRANTED.** All Defendants and their officers, successors, agents, servants, employees, attorneys and those persons in active concert or participation with them are **PRELIMINARILY ENJOINED** from enforcing SB 260 until final judgment is entered in this case.

Because Defendants face no risk of financial loss from the injunction, and in light of the Plaintiffs' role as nonprofit health care providers, the Court hereby sets Plaintiffs' Civ.R. 65(C) bond requirement at $0.00.

IT IS SO ORDERED.

Dated: 4-19-2021

Judge Alison Hatheway
Court of Common Pleas
Hamilton County, Ohio