UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
(Columbia Division)

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*, Plaintiffs, v. ALAN WILSON, in his official capacity as Attorney General of South Carolina, *et al.*, Defendants.	Case No. _____

PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Plaintiffs hereby move pursuant to Federal Rule of Civil Procedure 65 for a temporary restraining order and preliminary injunction to enjoin Defendants from enforcing Senate Bill 1, the "South Carolina Fetal Heartbeat and Protection from Abortion Act" (hereinafter, "the Act" or "SB 1"). SB 1 bans nearly all abortions in South Carolina beginning at approximately six weeks of pregnancy and threatens abortion providers with felony criminal and other penalties for running afoul of it.

The South Carolina Senate and House of Representatives have passed SB 1, and it is now before Governor McMaster, who has pledged to sign it "immediately."[1] The Act will take immediate effect upon his signature, which is expected imminently.

At that point, to avoid SB 1's harsh effects, Plaintiffs, who are health care providers, will

[1] Gov. Henry McMaster, State of the State Address, Jan. 13, 2021 ("Send me the heartbeat bill and I will immediately sign it into law."); Gov. Henry McMaster (@henrymcmaster), Twitter (Jan. 26, 2021, 12:26 PM), https://twitter.com/henrymcmaster/status/1354118432900460544 ("As the Heartbeat Bill goes to the Senate floor today, I urge my colleagues in the General Assembly to send this bill to my desk for my signature!").

be forced to stop providing abortion services to the vast majority of their patients. They have more than 75 patients who are scheduled for abortion appointments in the next 72 hours, including some as soon as tomorrow, February 19, 2021. Among the patients with appointments in the next 72 hours are at least three patients whose pregnancies are likely within just days of the second trimester, at which point Plaintiffs could no longer, consistent with their state abortion clinic licenses, provide abortion services to these patients, even if SB 1 were later enjoined. Many additional South Carolinians await services next week and in the weeks that follow. Plaintiffs anticipate the vast majority of these patients will be barred from obtaining an abortion in South Carolina if SB 1 is in effect.

A temporary restraining order, followed by a preliminary injunction, is urgently needed. As is more fully explained in the accompanying memorandum of law, South Carolina may not "prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992). Yet six weeks of pregnancy is months before any fetus could be viable, as existing South Carolina Code makes clear. *See* S.C. Code Ann. § 44-41-10(l) (creating a legal presumption that "viability occurs no sooner than the twenty-fourth week of pregnancy"). Plaintiffs will, therefore, ultimately prevail on their claim that SB 1 violates the substantive due process rights of their patients under the Fourteenth Amendment to the U.S. Constitution. Preliminary relief is also warranted because SB 1 will cause immediate, irreparable harm and the balance of equities and public interest weigh in favor of enjoining this blatantly unconstitutional law.

Plaintiffs request that, given the nature of the relief sought, this Court waive any requirement for bond.

Plaintiffs further request that the Court issue a temporary restraining order forthwith to

restrain Defendants, their employees, agents, and successors from enforcing SB 1 and to allow Plaintiffs to continue offering constitutionally protected abortion services to patients this week and in the weeks that follow.

Plaintiffs include with this motion (1) a memorandum of law, (2) the Declaration of Katherine Farris, M.D., (3) the Declaration of Terry L. Buffkin, M.D., (4) a proposed order for a temporary restraining order, and (5) a proposed order for a preliminary injunction.

Respectfully submitted,

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Dated: February 18, 2021

* *Pro hac vice motions to be filed*

CERTIFICATE OF EFFORTS TO NOTIFY DEFENDANTS OF PENDING MOTION

I certify that today, February 18, 2021, co-counsel Julie A. Murray personally emailed a copy of the foregoing motion and supporting attachments to all defendants, with an electronic copy to me, at the following email addresses:

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PLANNED PARENTHOOD SOUTH ATLANTIC, on behalf of itself, its patients, and physicians and staff, *et al.*, *Plaintiffs*, v. ALAN WILSON, in his official capacity as Attorney General of South Carolina, *et al*., *Defendants*.	Case No. _____

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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* *Pro hac vice motions to be filed*

Dated: February 18, 2021

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INTRODUCTION AND NATURE OF THE CASE

The right to end a pregnancy is protected by decades of unbroken precedent, beginning with *Roe v. Wade*, 410 U.S. 113 (1973), which held that under the U.S. Constitution's Fourteenth Amendment, states may not ban abortion before fetal viability. Openly flouting this law, the South Carolina Legislature today passed Senate Bill 1 ("SB 1" or "the Act"), a law banning nearly all abortions before fetal viability. The Act will take effect immediately when Governor Henry McMaster signs it, as he has vowed to do and which is expected imminently. Without urgent injunctive relief from this Court, the Act will cause immediate, irreparable harm to Plaintiffs and their patients, at least 75 of whom are scheduled for abortion services in the next 72 hours alone, including some as early as tomorrow, February 19, 2021.

The Act bans abortion after the detection of fetal or embryonic "cardiac activity," which occurs as early as approximately six weeks of pregnancy, as dated from the first day of the patient's last menstrual period ("LMP"). Existing South Carolina law—left unchanged by the Act—creates a legal presumption that viability is not possible until "the twenty-fourth week of pregnancy," a presumption that is well-supported by fact. S.C. Code Ann. § 44-41-10(l). Indeed, many patients do not even know they are pregnant by the point at which the Act would ban abortion. If permitted to take effect, the Act will criminalize almost all abortion beginning at the earliest stages of pregnancy, forcing patients either to carry pregnancies to term or to attempt to travel out of state to obtain constitutionally protected health care banned by their own state government.

SB 1 is an affront to the dignity and health of South Carolinians. In particular, it is an attack on families with low incomes, South Carolinians of color, and rural South Carolinians, who already face inequities in accessing medical care, and who will bear the brunt of the cruelties of this law. Plaintiffs seek a temporary restraining order and preliminary injunction to prevent enforcement of SB 1 and to safeguard their patients from the Act's flagrant constitutional violations.

STATEMENT OF FACTS

A. Access to Abortion Under Prior South Carolina Law

Plaintiffs Planned Parenthood South Atlantic ("PPSAT") and Greenville Women's Clinic, P.A. ("GWC") are health care providers in South Carolina that offer a range of sexual and reproductive health services, including abortion. Decl. of Katherine Farris, M.D. ("Farris Decl.") ¶¶ 17–18; Decl. of Terry L. Buffkin, M.D. ("Buffkin Decl.") ¶¶ 2–3. PPSAT operates health centers in Columbia and Charleston, Farris Decl. ¶ 17, and GWC operates a clinic in Greenville, Buffkin Decl. ¶ 2. Working with physicians licensed to practice medicine in South Carolina, PPSAT and GWC run the only clinics in the state that provide abortion services to the public. Farris Decl. ¶ 25; Buffkin Decl. ¶ 12. They hold state licenses for each of their clinics to perform abortions through the end of the first trimester, *see* S.C. Code Ann. § 44-41-75(A), which corresponds to 14 weeks of pregnancy LMP, *id.* § 44-41-10; S.C. Code Ann. Regs. 61-12.101(S)(4); Farris Decl. ¶ 24; Buffkin Decl. ¶ 7. Plaintiff Terry Buffkin, M.D., is one of the physicians who works at GWC and a co-owner of the clinic. He is a board-certified obstetrician-gynecologist.

Because PPSAT and GWC perform abortions only in the first trimester of pregnancy, all abortions they perform are well before the point of fetal viability. Viability is generally understood as the point when a fetus has a reasonable likelihood of sustained life after birth, with or without artificial support. Farris Decl. ¶ 20; Buffkin Decl. ¶ 14. South Carolina law has long banned the performance of nearly all post-viability abortions, *see* S.C. Code Ann. § 44-41-450, and it contains

a "legal presumption" that "viability occurs no sooner than the twenty-fourth week of pregnancy," *id.* § 44-41-10(l); *see also* S.C. Code Ann. Regs. 61-12.101(T).[1]

Plaintiffs' patients seek abortion for a range of reasons. Many are already mothers, having had at least one child, and they may struggle with basic unmet needs for their families. Farris Decl. ¶ 28; *see* Buffkin Decl. ¶ 24. Other patients decide that they are not ready to become parents because they are too young or want to finish school before starting a family. Farris Decl. ¶ 28; *see* Buffkin Decl. ¶ 24. Some patients have health complications during pregnancy that lead them to conclude that abortion is the right choice for them. Farris Decl. ¶ 28. In some cases, patients are struggling with substance abuse and decide not to become parents or have additional children during that time in their lives. *Id.* Still others have an abusive partner or a partner with whom they do not wish to have children for other reasons. *Id.*; Buffkin Decl. ¶ 24.

Although patients generally obtain an abortion as soon as they are able, the majority of patients who obtain abortions in South Carolina are at least six weeks LMP by the time of the abortion. Farris Decl. ¶ 31; Buffkin Decl. ¶ 8. In 2020, for example, only four percent of PPSAT's patients obtained abortions before six weeks LMP. Farris Decl. ¶ 31.

There are many reasons why most patients do not obtain abortions before six weeks LMP, the point in pregnancy at which most abortions would be banned under the Act. For a person with regular monthly periods, fertilization typically occurs two weeks after the beginning of their last menstrual period (two weeks LMP). *Id.* ¶ 32. Thus, even a woman with a highly regular, four-week menstrual cycle would already be four weeks LMP when she misses her next period,

[1] Indeed, South Carolina has banned even previability abortions beginning at 20 weeks post-fertilization (22 weeks LMP), *see* S.C. Code Ann. § 44-41-450, a restriction that to date has not been challenged in court and which does not affect Plaintiffs' current provision of abortion.

generally the first clear indication of a possible pregnancy. *Id*.[2] At-home pregnancy tests are not generally effective until at least four weeks LMP. *Id*. As a result, even a person with regular menstrual cycles might have just two weeks before her pregnancy reaches six weeks LMP to learn she is pregnant, decide whether to keep or terminate the pregnancy, and seek and obtain an abortion at one of only three available locations in South Carolina. Farris Decl. ¶¶ 32–36; *see also* Buffkin Decl. ¶ 18. The Columbia and Charleston health centers offer abortion only two days per week due to operational limitations. Farris Decl. ¶ 36. And South Carolina law requires people seeking abortion to wait at least 24 hours after having the opportunity to review specific, State-published informational materials before they can attend their abortion appointment, delaying patients even further. S.C. Code Ann. § 44-41-330(A), (C); Farris Decl. ¶ 42; *see also* Buffkin Decl. ¶ 23.

South Carolina abortion providers generally do not initiate an abortion until the physician is able to locate the pregnancy in the uterus, which does not occur until sometime between four and five weeks LMP. Farris Decl. ¶ 22; Buffkin Decl. ¶ 7. Accordingly, even patients who discover that they are pregnant at an early date could have just a matter of days between the point when abortion becomes available to them in South Carolina and when an ultrasound would detect cardiac activity, triggering the Act's prohibition. Farris Decl. ¶ 48.

While patients who learn very early that they are pregnant are unlikely to access abortion before six weeks LMP for all the reasons described above, many patients do not even know they are pregnant until at or after six weeks LMP, such as patients who have irregular menstrual cycles or who experience bleeding during early pregnancy, a common occurrence that is frequently and

[2] Plaintiffs use "woman" or "women" as a short-hand for people who are or may become pregnant, but people of all gender identities, including transgender men and gender-diverse individuals, may also become pregnant and seek abortion services, and would thus also suffer irreparable harm under SB 1.

easily mistaken for a period. Farris Decl. ¶¶ 33–35; Buffkin Decl. ¶¶ 19–20. Other patients may not develop or recognize symptoms of early pregnancy. Farris Decl. ¶ 35; Buffkin Decl. ¶¶ 19–21.

Particularly for patients living in poverty or without insurance, financial difficulties and travel-related logistics also prevent patients from obtaining an abortion before six weeks LMP. Fifteen percent of women in South Carolina live in poverty, higher than the national average of 12% and the tenth highest of all fifty states. Farris Decl. ¶ 37. This rate rises to 23% among Black women and to 26% among Latina women in South Carolina. *Id.* Rates of insurance coverage among women in South Carolina are strikingly low: 14.2% of South Carolina women of childbearing age are uninsured, compared to the national average of 11.9%. *Id.* ¶ 38. Unsurprisingly, more than 17% of South Carolina women reported not receiving health care in the prior twelve months due to cost. *Id.* Moreover, even those patients with insurance are unlikely to be able to use that insurance to defray the cost of an abortion: with very narrow exceptions, South Carolina bars coverage of abortion through its Medicaid program and in private insurance plans offered on the State's Affordable Care Act exchange. S.C. Code Ann. §§ 1-1-1035; 38-71-238.

Patients living in poverty or without insurance must, therefore, often make difficult tradeoffs among other basic needs like food or rent to pay for their abortions. Farris Decl. ¶ 40. Many must seek financial assistance from extended family and friends or from local abortion funds to pay for care, a process that takes time. *Id*. Moreover, many patients must navigate other logistics, such as inflexible or unpredictable work schedules and childcare needs, that may delay them in obtaining an abortion. *Id*.

The COVID-19 pandemic has only exacerbated these impediments to care for patients seeking an abortion, particularly Black patients whose communities have been hardest hit by illness and the related economic downturn. *Id.* ¶ 41. Patients understandably fear the health risks

of being in a clinic and traveling across the state to obtain health care. *Id*. In addition, many South Carolinians are navigating job losses or reductions in hours, the related loss of health insurance, and a lack of child care due to COVID-19, all of which may delay the point when a patient recognizes she is pregnant and when she is actually able to obtain an abortion. *Id.*; Buffkin Decl. ¶ 12.

Patients whose pregnancies are the result of sexual assault or who are experiencing interpersonal violence may need additional time to access abortion services due to ongoing physical or emotional trauma. Farris Decl. ¶ 45. For many of these patients, too, obtaining an abortion before six weeks LMP is exceedingly difficult, if not impossible. *Id.*

Patients are also unlikely to obtain an abortion by six weeks LMP because of unnecessary legal barriers that South Carolina has imposed on patients seeking abortion services. South Carolina prohibits the use of telehealth for medication abortion, a safe and effective abortion method involving two medications taken to end an early pregnancy in a process similar to miscarriage. *Id.* ¶ 44; Buffkin Decl. ¶ 11; S.C. Code Ann. § 44-47-37(C)(6). Moreover, South Carolina typically requires patients sixteen years old or younger to obtain written parental authorization for an abortion. Without such authorization, a patient must get a court order to obtain care, *see* S.C. Code Ann. §§ 44-41-31, -32, -33, which South Carolina law expressly recognizes could take three days, *see id.* § 44-41-32(5), not including time for appeal.

South Carolina also has a mandatory-delay law: Patients must have access, at least 24 hours in advance of an abortion, to certain State-mandated information designed to discourage the patient's abortion choice. *Id.* § 44-41-330. Those materials, which are available online, include contact information for "crisis pregnancy centers" that are opposed to abortion and offer free ultrasounds; information regarding the benefits that may be available to a patient for prenatal care,

childbirth, and neonatal care; and information regarding "the probable anatomical and physiological characteristics of the embryo or fetus at two-week gestational increments." *Id.* § 44-41-340(A)(2).

For all of these reasons, the vast majority of Plaintiffs' patients seek and obtain abortions after six weeks LMP and would be unable to do so sooner.

B. The South Carolina Legislature's Adoption of SB 1

On January 28, 2021, the South Carolina Senate passed SB 1, and the House of Representatives adopted an identical version of the bill on February 18. The Act, which amends the South Carolina abortion code, is now before Governor Henry McMaster, who urged the Legislature to adopt the bill and vowed to sign the bill "immediately."[3] The Act will take effect immediately upon his approval. SB 1, § 9.

The Act leaves in place the existing legal presumption that "viability occurs no sooner than the twenty-fourth week of pregnancy," S.C. Code Ann. § 44-41-10(l), and the restriction that prohibits nearly all post-viability abortions, *id.* § 44-41-450. The Act imposes dramatic changes to South Carolina law, however, by banning abortion after roughly six weeks LMP (the "Six-Week Ban"). The Act also includes new ultrasound, mandatory disclosure, recordkeeping, reporting, and written notice requirements that are closely intertwined with the operation of the Six-Week Ban. *See, e.g.*, SB 1, § 3 (adding S.C. Code Ann. §§ 44-41-640, -650); *id.* § 4 (amending S.C. Code Ann. § 44-41-460(A)); *id.* § 5 (adding S.C. Code Ann. § 44-41-330(A)(1)(b)); *id.* § 6 (amending S.C. Code Ann. § 44-41-60).

[3] Gov. Henry McMaster, State of the State Address, Jan. 13, 2021 ("Send me the heartbeat bill and I will immediately sign it into law."); Gov. Henry McMaster (@henrymcmaster), Twitter (Jan. 26, 2021, 12:26 PM), https://twitter.com/henrymcmaster/status/1354118432900460544 ("As the Heartbeat Bill goes to the Senate floor today, I urge my colleagues in the General Assembly to send this bill to my desk for my signature!").

The Six-Week Ban provides that "no person shall perform, induce, or attempt to perform or induce an abortion" where the "fetal heartbeat has been detected." SB 1, § 3 (adding S.C. Code Ann. § 44-41-680(A)). It defines "fetal heartbeat" to include any "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac." *Id.* (adding S.C. Code Ann. § 44-41-610(3)). The term, therefore, covers not just a "heartbeat" in the lay sense, but also early cardiac activity present before development of any cardiovascular system. Farris Decl. ¶ 5. Such cardiac activity may be detected by transvaginal ultrasound as early as six weeks LMP (and sometimes sooner). *Id.* ¶¶ 6, 23. Early in pregnancy, even with an ultrasound, this activity would not be audible but would instead appear as a visual flicker. *Id*.

As defined by the Act, a "fetal heartbeat" need not occur in a fetus to trigger the Six-Week Ban's prohibition on abortion. In the medical field, the developing organism present in the gestational sac during pregnancy is most accurately termed an "embryo" until at least ten weeks LMP; the term "fetus" is used after that time. *Id.* ¶ 5. Despite this accepted distinction, the Act defines "human fetus" to include an "individual organism of the species homo sapiens from fertilization [of an egg] until live birth." SB 1, § 3 (adding S.C. Code Ann. § 44-41-610(6)).

The Six-Week Ban contains only narrow exceptions: (1) to save the life of the pregnant patient; (2) to prevent certain types of irreversible bodily impairment to the patient; (3) in cases of a fetal health condition that is "incompatible" with sustained life after birth, and (4) in some circumstances where the pregnancy is the result of rape or incest. *Id.* (adding S.C. Code Ann. § 44-41-680(B), which cross-references S.C. Code Ann. § 44-41-430(5)). Of note, the rape and incest exceptions apply only if, within 24 hours of the abortion, the physician reports the alleged rape or incest and the patient's name and contact information to the sheriff in the county where the abortion was performed, irrespective of the patient's wishes, where the alleged crime occurred,

and whether the provider has already complied with other mandatory reporting laws, where applicable. *Id.* (adding S.C. Code Ann. § 44-41-680(C)).

Both the physician who performs an abortion, and the clinic in which the abortion is performed, risk severe penalties for violating the Six-Week Ban. Those penalties include a felony offense that carries a $10,000 criminal fine and up to two years in prison. *Id.* § 3 (adding S.C. Code Ann. § 44-41-680(D)); *see also* S.C. Code Ann. § 16-1-40 (accessory liability). Moreover, violation of the Six-Week Ban could result in revocation of a doctor's medical license and a clinic's license to perform abortions. S.C. Code Ann. §§ 40-47-110(A), (B)(2); 44-41-70; 44-41-75(A). The Act also creates a new civil cause of action that authorizes a patient "on whom an abortion was performed or induced" in violation of the Six-Week Ban to sue the abortion provider for damages, and to recoup her court costs and attorney's fees as well. SB 1, § 3 (adding S.C. Code Ann. § 44-41-740).

C. The Impact of SB 1 on Plaintiffs and Their Patients

To avoid the threat of criminal penalties, license revocation, and civil liability under SB 1, Plaintiffs, their physicians, and staff will be forced to stop providing nearly all previability abortions to patients. Farris Decl. ¶¶ 47, 50; Buffkin Decl. ¶¶ 13, 26. When patients with pregnancies with detectable cardiac activity seek abortions, Plaintiffs will provide care only where they can determine that one of the extremely narrow exceptions to the Six-Week Ban applies. Farris Decl. ¶¶ 7, 57–8; Buffkin Decl. ¶ 15.

Accordingly, the Act will make it virtually impossible to access abortion in South Carolina. Patients who can scrape together the resources to do so will be forced to travel out of state for medical care. Farris Decl. ¶ 51. Given the logistical hurdles of traveling out of state, these patients are likely to obtain abortions later than they would have had they accessed care from Plaintiffs. *Id.*l¶ 53. Many others who cannot travel will be forced to carry a pregnancy to term against their

will, or will seek ways to end their pregnancies without medical supervision, some of which may be unsafe or even deadly. *Id.* ¶ 54.

The Act will be particularly devastating for South Carolinians with low incomes, South Carolinians of color, and rural South Carolinians, who already face inequities in access to medical care. *See id.* ¶¶ 38, 47, 55. Forcing patients to carry their pregnancies to term will place Black patients, for example, at even greater risk of adverse health outcomes. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common in pregnancies ending in live births than among those ending through abortions. *Id.* ¶ 26; *see also id.* ¶ 39 (explaining that South Carolina ranks 43rd in the nation with respect to the rate of maternal mortality). Moreover, Black and other non-white women in South Carolina are 2.6 times more likely to die from pregnancy-related causes than white women. *Id.* ¶ 55.

The Act's harms will fall heavily on other groups of patients as well. It will injure those patients whose mental or physical wellbeing is threatened by continuing their pregnancies, but whose conditions may not satisfy the ban's health exception. *Id.* ¶ 54. It will add to the anguish of patients and their families who receive certain fetal diagnoses that may not constitute conditions that are "incompatible" with sustained life after birth. *Id.* ¶ 57. And it will bar abortion for survivors of sexual assault who, afraid of the law's reporting requirements, will forgo abortion in order to protect their privacy. *Id.* ¶ 58; *see* Buffkin Decl. ¶ 16.

Even those patients able to qualify for one of the Act's exceptions will be harmed. Farris Decl. ¶ 58. Because of the Act, the decision to have an abortion—one that a patient is constitutionally entitled to make—will instead be carefully scrutinized. *Id.* Moreover, the Act will require health care professionals to disclose to a local sheriff the names and contact information

of sexual assault survivors in order to provide care to these patients at or after approximately six weeks LMP. This requirement blatantly intrudes on a patient's right to privacy and autonomy. *Id.*

ARGUMENT

The standards for issuance of a preliminary injunction or temporary restraining order are the same. *See, e.g.*, *In re Search Warrant Issued June 13, 2019*, 942 F.3d 159, 171 (4th Cir. 2019); *Accident, Inj. & Rehab., PC v. Azar*, 336 F. Supp. 3d 599, 604 (D.S.C. 2018). In each instance, the Court considers four factors: (1) whether the plaintiff "is likely to succeed on the merits," (2) whether the plaintiff "is likely to suffer irreparable harm in the absence of preliminary relief," (3) whether "the balance of equities tips in [the Plaintiffs'] favor," and (4) whether "an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

As set forth below, each of these factors tips heavily in Plaintiffs' favor. Plaintiffs will prevail on the merits because SB 1 directly contravenes decades of binding Supreme Court and Circuit precedent; enforcement of SB 1 will inflict severe and irreparable harm on Plaintiffs and their patients; the balance of hardships weighs decisively in Plaintiffs' favor; and the public interest will be served by blocking the enforcement of this unconstitutional and harmful law. Plaintiffs are therefore entitled to a preliminary injunction barring enforcement of the Act and, in the interim, a temporary restraining order.

I. Plaintiffs Will Succeed on the Merits of Their Claims

SB 1's Six-Week Ban is blatantly unconstitutional. Nearly five decades ago, the Supreme Court struck down as unconstitutional a state criminal abortion statute proscribing all abortions except those performed to save the life of the pregnant woman. *Roe*, 410 U.S. at 166. The Court held that the Due Process Clause of the U.S. Constitution's Fourteenth Amendment protects a woman's right to decide to have an abortion, *id.* at 153–54, and, prior to viability, the State has no interest sufficient to justify a ban on abortion, *id.* at 163–65. Rather, the State may "proscribe"

abortion only after viability—and, even then, it may not ban abortion where necessary to preserve the life or health of a woman. *Id.*

The Supreme Court has repeatedly adhered to that core holding. For example, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court reaffirmed *Roe*'s "essential holding" that, "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion." 505 U.S. 833, 846 (1992). Although a plurality in *Casey* announced an "undue burden" standard, under which "a provision of law [restricting previability abortion] is invalid[] if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion," 505 U.S. at 878 (plurality opinion), it emphasized:

> Our adoption of the undue burden analysis does not disturb the central holding of *Roe v. Wade*, and we reaffirm that holding. Regardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.

Id. at 879; *see also id.* at 871 (stating that any state interest is "insufficient to justify a ban on abortions prior to viability even when it is subject to certain exceptions"). The Supreme Court reaffirmed the core holding of *Roe* and *Casey* just last year. *See June Med. Servs., LLC v. Russo*, 140 S. Ct. 2103, 2135 (2020) (Roberts, C.J., concurring) ("*Casey* reaffirmed the most central principle of *Roe v. Wade*, a woman's right to terminate her pregnancy before viability" (internal citations and quotations omitted)); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 920–21 (2000) (declining to "revisit" the legal principle that "before 'viability . . . the woman has a right to choose to terminate her pregnancy'" (quoting *Casey*, 505 U.S. at 870)); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 166 (4th Cir. 2000) (describing *Casey* as reaffirming *Roe*'s "essential holding" that "a woman has a constitutional right to 'choose to have an abortion before viability'" (quoting *Casey*, 505 U.S. at 846)).

Since *Roe*, courts considering the constitutionality of laws that ban abortions beginning at a gestational age prior to viability have "universally" invalidated those laws, including some in which the prohibition began several months later in pregnancy than SB 1's Six-Week Ban would. *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630 (M.D.N.C. 2019) (20-week ban), *appeal pending on other grounds*, No. 19-1685 (4th Cir. June 26, 2019); *see also, e.g.*, *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265, 269 (5th Cir. 2019) (15-week ban); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 776 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 981 (2016) (6-week ban); *Edwards v. Beck*, 786 F.3d 1113, 1115 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 895 (2016) (12-week ban); *McCormack v. Herzog*, 788 F.3d 1017, 1029 (9th Cir. 2015) (equivalent of 22-week LMP ban); *Isaacson v. Horne*, 716 F.3d 1213, 1217 (9th Cir. 2013), *cert. denied*, 571 U.S. 1127 (2014) (20-week ban); *Jane L. v. Bangerter*, 102 F.3d 1112 (10th Cir. 1996) (equivalent of 22-week LMP ban); *Sojourner T v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992), *cert. denied*, 507 U.S. 972 (1993) (ban at all gestational ages); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69 (9th Cir. 1992), *cert. denied*, 506 U.S. 1011 (1992) (ban at all gestational ages).

Notably included within this unbroken string of precedent are decisions addressing bans that, like SB 1, are tied to the detection of embryonic or fetal cardiac activity. *SisterSong Women of Color Reprod. Justice Collective v. Kemp*, 472 F. Supp. 3d 1297, 1312 (N.D. Ga. 2020), *appeal filed*, No. 20-13024 (11th Cir. Aug. 11, 2020); *see also Jackson Women's Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020) (affirming preliminary injunction); *EMW Women's Surgical Ctr., P.S.C. v. Beshear*, No. 3:19-CV-178-DJH, 2019 WL 1233575, at *2 (W.D. Ky. Mar. 15, 2019) (temporary restraining order); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019) (preliminary injunction); *Memphis Ctr. for Reprod. Health v. Slatery*, No. 3:20-CV-00501, 2020 WL 4274198, at *2 (M.D. Tenn. July 24, 2020) (preliminary injunction), *appeal filed*,

No. 20-5969 (6th Cir. Aug. 24, 2020).

Under this binding precedent, the Act is unquestionably unconstitutional, irrespective of any interest the State may assert to support it. *See Casey*, 505 U.S. at 846; *Roe*, 410 U.S. at 164–65. Accordingly, Plaintiffs have decisively demonstrated that they are likely to succeed on their substantive due process claim.[4]

II. SB 1 Will Cause Irreparable Harm to Plaintiffs' Patients

Plaintiffs have also demonstrated that SB 1 will cause irreparable injury to their patients. As noted above, Plaintiffs have at least 75 patients scheduled for abortion services in the next 72 hours, and the vast majority of these patients will have pregnancies at or beyond six weeks LMP. *See* Farris Decl. ¶ 60; Buffkin Decl. ¶ 23. Indeed, at least three of those patients with appointments in the next 72 hours are just days away from reaching the second trimester of pregnancy, at which point Plaintiffs could not, consistent with their state abortion clinic licenses, provide abortion services, even if SB 1 were later enjoined. Farris Decl. ¶ 60.

SB 1 will likely deny to each of these patients, and the vast majority of Plaintiffs' future patients, access to timely and constitutionally protected previability abortions. In doing so, SB 1 squarely violates the Fourteenth Amendment. And "it is well settled that any deprivation of constitutional rights 'for even minimal periods of time' constitutes irreparable injury." *Condon v. Haley*, 21 F. Supp. 3d 572, 588 (D.S.C. 2014) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976);

[4] Because banning abortion is the main purpose of SB 1, and because the Six-Week Ban is inextricably intertwined with the Act's ultrasound, mandatory disclosure, recordkeeping, reporting, and written-notice requirements, SB 1 must be enjoined in its entirety. *See In re DNA Ex Post Facto Issues*, 561 F.3d 294, 301 (4th Cir. 2009) (holding that under South Carolina law, a statute must be enjoined in its entirety where an unconstitutional provision and other portions of the statute are not "wholly independent" or where the other portions of the statute would not "remain[] complete" in the absence of the unconstitutional provision) (quoting *Joytime Distribs. & Amusement Co. v. South Carolina*, 528 S.E.2d 647, 654 (S.C. 1999)); *see also, e.g.*, *Envtl. Tech. Council v. Sierra Club*, 98 F.3d 774, 788 n.21 (4th Cir. 1996).

Doe v. Charleston Area Med. Ctr., Inc., 529 F.2d 638, 644 (4th Cir. 1975) (concluding that the denial of a right to abortion is "beyond argument" irreparable injury); *accord Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. Unit B 1981).

"The detriment that the State would impose" on pregnant patients by denying them the choice to have an abortion "is apparent." *Roe*, 410 U.S. at 153. If SB 1 is in place, some South Carolinians will be forced to carry unwanted pregnancies to term. Farris Decl. ¶¶ 11, 54; Buffkin Decl. ¶ 17. As the Supreme Court recognized in *Roe*, an abortion ban's impact in this respect may cause physical and psychological harm to the patient, and place additional and long-term burdens on her entire family. *Roe*, 410 U.S. at 153. The Fourth Circuit has held to the same effect, *see Doe*, 529 F.2d at 644, and has recognized more generally that the loss of "needed medical care" is an irreparable injury, *Pashby v. Delia*, 709 F.3d 307, 329 (4th Cir. 2013). As described above, SB 1 will be especially devastating for South Carolinians with low incomes, South Carolinians of color, and rural South Carolinians. Farris Decl. ¶ 47.

South Carolinians who *are* able to obtain abortions at or after six weeks LMP but who are forced to go to an out-of-state provider will also suffer irreparable injury if SB 1 takes effect. The nearest available out-of-state abortion providers are located in Charlotte and Asheville, North Carolina, and in Augusta, Georgia. *Id*. ¶ 51. Many patients will experience further delay in care if they have to travel to these locations, resulting in an increased risk to their health, additional financial burdens, and the psychological and physical toll of prolonging an undesired pregnancy. *Id*. ¶¶ 53–54. In order to make all of the necessary transportation and childcare arrangements, some may also be forced to explain the reason for their travel to employers, acquaintances, or family members, thus compromising the confidentiality of their decision to have an abortion. *Id*. ¶ 52.

Even the small share of patients who are able to have an abortion in South Carolina through

one of the Six-Week Ban's exceptions could do so only after having their abortion decision carefully scrutinized, and some of them may also be reported to local law enforcement. *Id.* ¶ 58.

None of these harms can be rectified after judgment. *See*, *e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013) (affirming finding of irreparable harm where abortion restriction would delay care, which could "result in the progression of a pregnancy to a stage at which an abortion would be less safe"); *Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (affirming finding of irreparable harm where individuals would experience complications and other adverse effects due to delayed medical treatment); *Roe v. Crawford*, 396 F. Supp. 2d 1041, 1044 (W.D. Mo. 2005) (finding irreparable injury where delay in abortion might increase "medical, financial, and psychological risks"), *stay of preliminary injunction denied*, 546 U.S. 959 (2005). *Cf. Condon*, 21 F. Supp. 3d at 588 (holding "legal, financial, social and psychic harms" caused by same-sex marriage bans were irreparable). A temporary restraining order and preliminary injunction against SB 1 are warranted to avoid these imminent, grave, and irreparable harms.

III. The Balance of Equities and the Public Interest Tip Strongly in Favor of a Temporary Restraining Order and Preliminary Injunction

Plaintiffs and their patients will unquestionably face far greater harm while SB 1 is in effect than Defendants would face if the court entered an injunction to preserve the status quo. The State is "in no way harmed by issuance of a preliminary injunction which prevents it from enforcing" a law that "is likely to be found unconstitutional." *Newsom ex rel. Newsom v. Albemarle Cnty. Sch. Bd.*, 354 F.3d 249, 261 (4th Cir. 2003). "If anything, the system is improved by such an injunction." *Giovani Carandola, Ltd. v. Bason*, 303 F.3d 507, 521 (4th Cir. 2002) (citation omitted). And because South Carolina already bans nearly all abortions after viability, *see* S.C. Code Ann. § 44-41-450, the only effect of an injunction would be to prevent South Carolina from enforcing its

plainly unconstitutional ban on *previability* abortions. The balance of equities thus weighs decisively in Plaintiffs' favor, further demonstrating that preliminary injunctive relief is necessary and appropriate.

In addition, the public interest is served by entry of an injunction necessary to "uphold[] constitutional rights." *League of Women Voters of N.C. v. North Carolina*, 769 F.3d 224, 248 (4th Cir. 2014) (quoting *Newsom*, 354 F.3d at 261); *accord Centro Tepeyac v. Montgomery Cnty.*, 722 F.3d 184, 190 (4th Cir. 2013) (en banc). The public has a particularly strong interest in a speedy injunction here to block a law whose basis runs afoul of nearly fifty years of Supreme Court precedent and where temporary relief would merely preserve the longstanding status quo on which South Carolinians seeking an abortion have come to rely.

IV. The Injunction Should Issue Without Bond

This Court has wide discretion to set the preliminary injunction bond "in an amount that the court considers proper," Fed. R. Civ. P. 65(c), including by waiving it altogether, *Pashby*, 709 F.3d at 332. It should use that discretion to waive the bond requirement here, where the relief sought will result in no monetary loss to Defendants. *See, e.g.*, *Accident, Inj. & Rehab., PC*, 336 F. Supp. 3d at 606 (citing *Hoechst Diafoil Co. v. Nan Ya Plastics Corp.*, 174 F.3d 411, 421 n.3 (4th Cir. 1999)). Moreover, the providers here are dedicated to serving low-income and underserved communities, and a bond would strain their limited resources.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for a temporary restraining order, followed by a preliminary injunction, and enjoin Defendants from enforcing SBx1.

Respectfully submitted,

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Dated: February 18, 2021

* *Pro hac vice motions to be filed*

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
(Columbia Division)

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*, Plaintiffs, v. ALAN WILSON, in his official capacity as Attorney General of South Carolina, *et al.*, Defendants.	Case No. _____

DECLARATION OF TERRY L. BUFFKIN, M.D.,
IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Terry L. Buffkin, M.D., declares and states as follows:

1. I am a board-certified obstetrician/gynecologist ("OB/GYN") licensed to practice medicine in the State of South Carolina. I received my M.D. from Medical University of South Carolina in Charleston, South Carolina, in 1974. I completed an OB/GYN residency at Greenville Hospital System (currently known as Prisma Health) in South Carolina, which included training in the performance of abortions. Over the course of my medical career, I have regularly provided first-trimester abortions.

2. I am the co-owner of Greenville Women's Clinic ("GWC" or "the Clinic"), a healthcare facility in Greenville, South Carolina. I have been providing abortion services at Greenville Women's Clinic since 1976 along with Dr. Thomas W. Campbell, the other co-owner of the Clinic.

3. The Clinic has provided reproductive health care including pregnancy testing, birth control, testing and treatment for sexually transmitted diseases, general gynecological care, and abortions to patients since 1976.

4. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction barring enforcement of South Carolina Senate Bill 1, entitled the "South Carolina Fetal Heartbeat and Protection from Abortion Act" ("SB 1" or "the Act"). I understand that the Act bans abortion, with extremely limited exceptions, as early as the detection of what the law calls a "fetal heartbeat." In order to effectuate this ban, the Act requires providers to, among other things, determine, by ultrasound, whether the fetus or embryo has a "detectable heartbeat."

5. The Act places me in an impossible position: risk criminal, civil and professional penalties for continuing to provide abortion care, or stop providing my patients the care they seek and need.

Background

6. Dr. Campbell and I are the only two physicians who work at the Clinic. We both provide pregnancy testing, birth control, testing and treatment for sexually transmitted diseases, general gynecological care, and abortion services.

7. The Clinic is licensed to provide first-trimester abortion care in South Carolina. Abortion care is available at the Clinic from approximately 5 weeks LMP through 14 weeks, 0 days LMP.[1] Before performing an abortion, we date the pregnancy and confirm it is located in the uterus, using an ultrasound when medically appropriate. This cannot occur until sometime between

[1] "LMP" refers to "last menstrual period." Pregnancy is commonly measured by the number of days or weeks that have passed since the first day of a woman's last menstrual period. LMP may also be understood as roughly two weeks prior to fertilization.

4 and 5 weeks LMP. At the Clinic, I provide medication abortion generally up to 10 weeks LMP, and abortion by procedure (surgical abortion) up to 14 weeks, 0 days LMP.

8. The Clinic is open six days per week, but abortion care is typically provided only in the mornings and early afternoons. The Clinic provides abortion care to patients who have appointments, and it also provides abortion care to patients without a scheduled appointment who bring a Certification Statement showing they reviewed the State's biased counseling material at least 24 hours prior to their visit. In 2020, the Clinic provided approximately 2,000 abortions. Of these, a large majority of abortions were provided to patients who were at or beyond 6 weeks, 0 days LMP. For 2021 so far, the Clinic has seen approximately 40 to 60 abortion patients per week.

The Existing Landscape in South Carolina

9. Prior to passage of the Act, our patients already faced extreme obstacles to accessing abortion. South Carolina has imposed numerous laws that delay or impede women from accessing abortion care. For example, South Carolina has a mandatory, twenty-four-hour waiting period before a patient can receive abortion care. Additionally, a woman in South Carolina cannot obtain abortion care at public hospitals except in cases of rape, incest, or a life-threatening situation.

10. Outpatient abortion facilities are subject to onerous regulations and licensing requirements that do not apply to other healthcare providers.

11. And although South Carolina specifically encourages the use of telemedicine for many other types of medical care, and telemedicine is used in other states to provide medication abortions, telemedicine cannot lawfully be used in South Carolina to provide abortion care.

12. The Clinic is one of just three licensed first-trimester abortion clinics in the entire state. Our patients already face multiple challenges arranging appointments around work, school,

and childcare, and obtaining transportation to the clinic. COVID-19 has made it even more difficult for patients to access abortion care. Patients with children and limited or no childcare options face additional scheduling challenges. With many people out of work, it is more difficult for patients to pay for the procedure. With very narrow exceptions, South Carolina bars coverage of abortion in its Medicaid program, and it even prohibits coverage of abortion in private insurance plans offered on the state's Affordable Care Act exchange. While we offer discounts to many patients, women must pay out of pocket or seek private financial assistance for the remainder.

SB 1's Impact on the Clinic, Its Practices, and Patients

13. SB 1 would prevent the Clinic from providing abortion care to most of its patients.

14. SB 1 would prohibit abortion upon detection of any embryonic or fetal cardiac activity, which in my experience occurs very early in pregnancy, potentially as early as 6 weeks LMP, and many months before a fetus could be viable. Viability is a medical determination that occurs much later in pregnancy and is generally thought to occur when, in the judgment of the clinician taking care of a particular patient based on that patient's specific facts and circumstances, there is a reasonable likelihood of the fetus's sustained survival outside the womb, with or without artificial support.

15. There are extremely limited exceptions to the prohibition on performing abortions after detection of a "fetal heartbeat." They are: (1) to "prevent the [patient's] death," (2) to "prevent the serious risk of a substantial and irreversible impairment of a major bodily function" of the patient, (3) in a case of rape or incest for which the pregnancy is fewer than 20 weeks post-fertilization (or 22 weeks LMP) and a police report is filed by the physician within 24 hours of the abortion, and (4) in the case of a fatal "fetal anomaly." SB 1, § 3 (adding S.C. Code Ann. §§ 44-41-680, -690). The Act does not include any exception to protect a woman's health before it

deteriorates to the point of serious risk of death or "substantial and irreversible impairment of a major bodily function." *Id*. Further, it explicitly excludes any exception for emotional and psychological conditions as well as the risk of suicide or self-harm. *Id.* (adding S.C. Code Ann. § 44-41-610(8)).

16. If a patient's pregnancy was the result of rape or incest, the physician may perform an abortion only if they report the allegation to the police (including the patient's name and contact information) within 24 hours, notify the patient before performing the abortion that the allegation will be reported to the police, and declare in writing that the abortion was performed pursuant to this exception and that these criteria have been satisfied. *Id*. (adding S.C. Code Ann. § 44-41-680(B), (C)). This requirement is particularly disturbing, as patients who are victims of rape and incest present extremely sensitive situations, and the Act's reporting requirement applies regardless of the patient's age and even over her objection. Some people are not comfortable filing a police report for safety or other reasons, and a physician's approach to care for these patients should be guided by patients' best interests within the bounds of existing reporting laws.

17. The large majority of the Clinic's patients obtain abortion care at or after 6 weeks, 0 days LMP. If the ban takes effect, most women seeking abortion at the Clinic will not be able to obtain abortions and will be forced to either carry their pregnancy to term against their will or go out of the state to obtain an abortion. In addition, I fear that some patients may resort to unsafe means to terminate their pregnancies.

18. Many women, including many of my patients, have no reason to suspect they may be pregnant as early as 6 weeks LMP. For a woman with an average menstrual cycle of a period every 28 days, 6 weeks LMP is just two weeks past a missed period.

19. Many women also do not have any of the physical indicators of pregnancy, including a missed period, during early pregnancy. Many women do not menstruate at regular intervals and/or sometimes go beyond six weeks without experiencing a menstrual period, and therefore may not realize they are pregnant when they miss a period for that reason. In addition, many women experience bleeding in early pregnancy, called implantation bleeding, that is easily and frequently mistaken for a period.

20. Further, women who have certain medical conditions, who are breastfeeding, or who are using hormonal contraceptives may not notice a missed menstrual period at 6 weeks LMP. Breastfeeding may suppress menstruation for weeks or months, and even when a woman's period returns, it may continue to be irregular. It is not uncommon for women who are breastfeeding to have no period for weeks or months, have irregular periods, skip periods, or have their period return and then go months before the next one. Women who are obese may have irregular periods or non-menstrual bleeding. Anxiety may cause irregular periods. And women using hormonal contraceptives can get pregnant but may not have regular periods or experience a period at all.

21. In addition, although some women experience nausea and vomiting during early pregnancy, many do not, or do not develop these symptoms until after 6 weeks LMP.

22. For all these reasons, many women may be at least 6 weeks pregnant but not realize they are pregnant.

23. The Clinic currently has 14 patients scheduled for Friday February 19, 2021 and 6 patients scheduled for Saturday February 20, 2021. Based on my several decades of experience with the Clinic, most of these patients will be past 6 weeks LMP and therefore would not be able to obtain abortion care at the Clinic, or in the State at all, if the ban goes into effect.

24. In my experience, women decide to have abortions for a variety of reasons, including to protect or preserve their physical or mental health, to provide care to existing children and family members, to avoid forgoing educational or economic opportunities due to unplanned childbirth, and to avoid raising children with absent, unwilling, or abusive partners, just to name a few. Access to safe and legal abortion benefits the health and wellbeing of my patients and their families.

25. Women who are pregnant should have the ability to make their own decisions about their pregnancies, taking into account their unique values, goals, and circumstances. The ban takes that decision out of the hands of the woman and gives it to the State instead.

26. If the Act goes into effect, the Clinic will have to stop providing most abortion care. Neither I nor the other clinician at the Clinic can risk the potential criminal, civil, and professional liability that the Act imposes.

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

Dated: February 17, 2021 /s/ Terry L. Buffkin*

Terry L. Buffkin, M.D.

*A copy of this declaration with my original signature is on file with Plaintiffs' attorneys.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
(Columbia Division)

PLANNED PARENTHOOD SOUTH ATLANTIC, *et al.*, Plaintiffs, v. ALAN WILSON, in his official capacity as Attorney General of South Carolina, *et al.*, Defendants.	Case No. _____

DECLARATION OF KATHERINE FARRIS, M.D.,
IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

I, Katherine Farris, declare as follows:

1. I serve as the Chief Medical Officer for Plaintiff Planned Parenthood South Atlantic ("PPSAT"). In this position, I provide oversight, supervision, and leadership on all medical services we provide, including abortion. As part of my role, I collaborate with other members of PPSAT senior management to develop policies and procedures to ensure that the medical services we provide follow evidence-based guidelines and comply with all relevant laws.

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 PPSAT business records, information obtained through the course of my duties at PPSAT, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

3. A copy of my *curriculum vitae* is attached as Exhibit A.

4. I submit this declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction to prevent enforcement of Senate Bill 1, entitled the "South Carolina Fetal Heartbeat and Protection from Abortion Act" (hereinafter, "the Act" or "SB 1"), to be codified at S.C. Code §§ 44-41-610 *et seq*.

5. I understand that the Act would ban the provision of abortion in South Carolina as soon as a "fetal heartbeat" is detected, as that term is defined by the Act, subject to certain narrow exceptions.[1] As I understand the Act, "fetal heartbeat" includes any "cardiac activity . . . within the gestational sac."[2] The term, therefore, covers not just a "heartbeat" in the medical sense, but also early cardiac activity present before development of any cardiovascular system. Moreover, as I understand the Act, a "fetal heartbeat" is not actually limited to a fetus. In the field of medicine, the developing organism present in the gestational sac during pregnancy is most accurately termed an "embryo" before approximately 10 weeks of pregnancy, as measured from the first day of a patient's last menstrual period ("LMP").[3] The term "fetus" is used during pregnancy after this time. Contrary to this medical distinction, my understanding is that the Act defines "human fetus" to include any "individual organism of the species homo sapiens from fertilization [of an egg] until live birth."[4]

6. Accordingly, as I understand the Act, it prohibits abortion any time after identification of embryonic or fetal cardiac activity. Based on my medical experience and expertise, that activity may be detected by vaginal ultrasound as early as six weeks of pregnancy

[1] S.B. 1, § 3 (adding S.C. Code Ann. §§ 44-41-680, -690).

[2] *Id*. (adding S.C. Code Ann. § 44-41-610(3)).

[3] The LMP method of pregnancy dating can be accomplished by patient self-reporting and, when appropriate, confirmed via ultrasound.

[4] *Id.* (adding S.C. Code Ann. § 44-41-610(6)).

LMP (and sometimes sooner). By that point in pregnancy, a vaginal ultrasound may reveal a ring, which represents the round sac within the uterus, and an electrical impulse that appears as a visual flicker on the edge of the sac. This activity cannot be made audible at that stage of pregnancy. As described further below, most patients do not realize they are pregnant until after six weeks LMP.

7. My understanding is that the Act's exceptions are very narrow. A physician could provide an abortion after embryonic or fetal cardiac activity is detectable only if the abortion is necessary to save the patient's life, to prevent limited types of harm to the pregnant patient, and in other narrow circumstances involving rape, incest, and fetal anomalies.[5]

8. The sexual assault exceptions will be functionally inaccessible to many affected patients, however. That is because the Act requires the abortion provider, when counseling a patient, to notify the patient in advance of the abortion that if she has the abortion a report to law enforcement will be required. If she goes through with the procedure, the physician will then have to report the sexual assault allegation to the county sheriff within twenty-four hours of the abortion, including the patient's name and contact information.[6]

9. I understand that the Act's ban on abortion after the detection of cardiac activity comes with heavy penalties. A physician's violation of the Act is a felony, carrying up to a two-year prison sentence and a fine of $10,000.[7] A physician may also be subject to an array of medical board licensing penalties, from reprimand or suspension through permanent license revocation.

10. I understand that, to comply with this ban on abortion after detectable cardiac activity, the Act requires the abortion provider or a trained colleague to perform an ultrasound

[5] *Id*. (adding S.C. Code Ann. §§ 44-41-680, -690).

[6] *Id*. (adding S.C. Code Ann. § 44-41-680(C)).

[7] *Id*. (adding S.C. Code Ann. § 44-41-690(D)).

before every abortion to determine whether embryonic or fetal cardiac activity can be detected, and that it is a felony to perform the abortion without taking this step, except in a medical emergency.[8]

11. By banning abortion at a point in pregnancy before most patients even realize they are pregnant, the Act will make it virtually impossible to access abortion in South Carolina. I anticipate that patients who can scrape together the resources will be forced to travel out of state for medical care, and many others who cannot do so will be forced to carry a pregnancy to term against their will or seek ways to end their pregnancies without medical supervision, some of which may be unsafe. I am gravely concerned about the effect that the Act will have on South Carolinians' emotional, physical, and financial wellbeing and the wellbeing of their families.

My Background

12. I am licensed to practice medicine in South Carolina, North Carolina, Virginia, and West Virginia. I am board-certified in Family Medicine. I am a member of the American College of Obstetricians and Gynecologists ("ACOG"), the National Abortion Federation, Physicians for Reproductive Health, and the American Academy of Family Physicians.

13. I obtained a bachelor's degree in molecular and cellular biology from Northwestern University in 1995 and a medical degree from Northwestern University Medical School in 2000. I completed an internship and residency in Family Medicine at Valley Medical Center in Renton, Washington. I served as Chief Resident from 2002 to 2003.

14. I have worked for PPSAT and a predecessor organization since 2009. Throughout that time, I have provided comprehensive family planning services, including medication abortion and abortion by procedure. I have also served in a range of leadership positions, including as

[8] *Id*. (adding S.C. Code Ann. §§ 44-41-630, -650).

Laboratory Director, Acting Vice President of Patient Services, and as an Interim Abortion Facility Administrator.

15. Before joining PPSAT, I provided full-spectrum family medicine in private practice and in a hospital setting in Massachusetts. That practice included comprehensive family planning and reproductive health care, as did my work in an earlier position with Planned Parenthood League of Massachusetts. I have provided medication abortion and abortion by procedure since 2003.

PPSAT and Its Services

16. PPSAT is a not-for-profit corporation that is headquartered in North Carolina.

17. PPSAT and its predecessor organizations have provided health care in South Carolina for more than four decades. We have two health centers in South Carolina, one in Columbia and the other in Charleston.

18. We offer our patients a range of family planning and reproductive health services and other preventive care at these centers. This care includes well-person exams; contraception (including long-acting reversible contraception or "LARC") and contraceptive counseling; gender-affirming hormone therapy, as well as menopausal hormone replacement therapy; screening for breast cancer; screening for cervical cancer; screening and treatment for sexually transmitted infections ("STIs"); pregnancy testing and counseling; physical exams; and medication abortion and abortion by procedure.

19. Medication abortion involves the use of mifepristone and misoprostol, two medications taken to safely and effectively end an early pregnancy in a process similar to a miscarriage. Abortion by procedure involves the use of gentle suction and/or the insertion of instruments through the vagina to empty the contents of a patient's uterus. Although sometimes

known as "surgical abortion," abortion by procedure does not involve surgery in the traditional sense. It does not require an incision into the patient's skin or a sterile field.

20. At both the Columbia and Charleston health centers, PPSAT provides medication abortion up to 11 weeks of pregnancy, and abortion by procedure up to 14 weeks LMP. As a point of reference, a full-term pregnancy typically lasts approximately 40 weeks LMP. The point of viability is a medical determination that occurs much later in pregnancy. Although variable by pregnancy, viability is generally understood as the point when a fetus has a reasonable likelihood of sustained survival after birth, with or without artificial support.

21. Based on my education, training, and experience, it is my medical opinion that viability is medically impossible at 6 weeks LMP, when SB 1 would generally prohibit abortion, and at any time in the first trimester of pregnancy. At its South Carolina health centers, PPSAT does not provide abortions beyond the first trimester of pregnancy, the end of which is still months before any fetus could be viable.

22. On the day of a patient's abortion appointment, PPSAT staff perform an ultrasound as medically indicated. Because of the ultrasound technology, however, it is generally not possible to locate a pregnancy in the uterus using ultrasound until sometime between four and five weeks LMP; before that time, the gestational sac is simply too small for the ultrasound to detect. At the Columbia and Charleston health centers, PPSAT generally does not provide abortion before four or five weeks LMP, when the patient's pregnancy can first be located using a transvaginal ultrasound. Later in gestation, PPSAT staff are able to rely on transabdominal ultrasounds.

23. At four weeks LMP, a transvaginal ultrasound might show the gestational sac as a ring within the uterus, but the yolk sac and embryo likely would not yet be visible. At five weeks LMP, the ultrasound might show the yolk sac as well as the gestational sac. By six weeks LMP,

the ultrasound image would include the gestational sac, the yolk sac, and the embryo, and the electrical impulse that constitutes embryonic cardiac activity at this stage would usually be visible as a flicker within the embryo. Sometimes this flicker is visible as early as partway through the fifth week LMP.

24. PPSAT's health centers are licensed as "abortion clinic[s]" under South Carolina law, a license that is required for any facility other than a hospital that performs five or more first-trimester abortions in a month or any second-trimester abortions.[9] PPSAT's physicians at the Columbia and Charleston health centers are licensed to practice medicine in South Carolina.

25. According to South Carolina's Department of Health and Environmental Control, other than PPSAT, there is only one other abortion clinic in South Carolina.[10] That provider, Greenville Women's Clinic, is also a plaintiff in this case.

Current Access to Abortion in South Carolina

26. Legal abortion is one of the safest procedures in contemporary medical practice and is far safer than childbirth.[11] Less than 1% of women obtaining abortions experience a serious complication.[12] The risk of a patient experiencing a complication that requires hospitalization is even lower, approximately 0.3%.[13] A woman's risk of death associated with childbirth nationwide

[9] S.C. Code Ann. § 44-41-75(A).

[10] S.C. Dep't of Health & Env't Control, *Abortion Clinics*, (Oct. 2, 2020), https://scdhec.gov/sites/default/files/docs/Health/docs/LicensedFacilities/hrabc.pdf.

[11] *See, e.g.*, Comm. on Reprod. Health Servs., Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, 10, 59, 79 (2018).

[12] Ushma Upadhyay, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 175 (2015).

[13] *Id.*

is approximately fourteen times higher than that associated with abortion,[14] and every pregnancy-related complication is more common among women having live births than among those having abortions.

27. Abortion is also very common: Approximately one in four women in this country will have an abortion by age forty-five.[15]

28. From nearly two decades of experience providing abortion, I know how important abortion access is to our patients. Patients' lives are complicated, and their decisions to have an abortion often involve multiple considerations.[16] The majority of PPSAT's South Carolina patients—roughly 60%—who have an abortion are mothers. Our patients with children understand the obligations of parenting and decide to have an abortion based on what is best for them and their existing families, which may already struggle to make ends meet. Other patients decide that they are not ready to become parents because they are too young or want to finish school before starting a family. Some patients have health complications during pregnancy that lead them to conclude that abortion is the right choice for them. In some cases, patients are struggling with substance abuse and decide not to become parents or have additional children during that time in their lives. Still others have an abusive partner or a partner with whom they do not wish to have children for other reasons. In all of these cases, our patients believe that abortion is the best option for themselves and their families.

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[14] *See* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215 (2012).

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

[16] *See, e.g.*, M. Antonia Biggs, Heather Gould, & Diana G. Foster, *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 1 (2013).

29. Regardless of the reasons that bring a patient to us, PPSAT is committed to providing high-quality, compassionate abortion services that honor each patient's dignity and autonomy. PPSAT trusts its patients to make the best decisions for themselves and their families, taking into account the full complexity of their lives.

30. Most patients obtain an abortion as soon as they are able, and the vast majority of abortions in the United States and in South Carolina take place in the first trimester of pregnancy. According to data from the South Carolina Department of Health and Environmental Control from 2019, more than 99 percent of all abortions performed in the state occurred before approximately 15 weeks LMP.[17]

31. However, most patients are at least six weeks LMP into their pregnancy by the time they contact us seeking an abortion. In 2020, approximately 96% of all abortions that PPSAT performed in South Carolina were done at 6 weeks LMP or later.

32. That most patients seeking abortion reach us at or after 6 weeks LMP is likely because they do not learn they are pregnant before that time. Some people have fairly regular menstrual cycles; a four-week cycle is common. In a person with a regular four-week cycle, fertilization typically occurs at 2 weeks LMP. Thus, a person with a highly regular, four-week cycle would already be 4 weeks LMP when she misses her period, and before that time, most over-the-counter pregnancy tests would not be sufficiently sensitive to detect her pregnancy.

33. People can also have regular cycles of different lengths. Some individuals can go six to eight weeks, or even more, without experiencing a menstrual period.

[17] S.C. Dep't of Health and Env't Control, *A Public Report Providing Statistics Compiled from All Abortions Reported to DHEC* (2019), https://scdhec.gov/sites/default/files/media/document/2019-SC-Abortion-Report-20200629.pdf (providing data for abortions performed before 13 weeks "postfertilization," i.e., 15 weeks LMP).

34. For those who menstruate, it is also extremely common to have irregular cycles for a variety of reasons, including certain common medical conditions, contraceptive use, obesity, and age. In addition, breastfeeding can suppress menstruation for weeks or months, after which a woman's menstrual cycle may return but be irregular for a period of time.

35. Also, pregnancy itself is not always easy to detect. Some pregnant patients experience light bleeding that occurs when a fertilized egg is implanted in the uterus. This implantation bleeding is often mistaken for a menstrual period. Further, although some pregnant people experience nausea and vomiting early in pregnancy, many do not. Many experience no symptoms at all during early pregnancy.

36. Moreover, even after a patient learns that she is pregnant, arranging an appointment for an abortion may take some time. There are only three abortion clinics in South Carolina, each in a separate city. Due to provider availability and other operational demands, each of PPSAT's health centers generally provides abortion only two days per week. As a result, even assuming that we have sufficient appointments to meet patient demand each week, patients generally cannot obtain an appointment immediately (even assuming they have met the requirements of South Carolina's twenty-four-hour mandatory delay law, as discussed below).

37. For patients living in poverty or without insurance, travel-related and financial barriers also help explain why the vast majority of our patients do not—and realistically could not—obtain abortions before detection of embryonic or fetal cardiac activity. South Carolina has the tenth highest rate of poverty among women: more than 15% of women in South Carolina live in poverty, exceeding the national average of 12%,[18] and that rate rises to more than 23% among

[18] Nat'l Women's L. Ctr., *South Carolina*, https://nwlc.org/state/south-carolina (last visited Feb. 9, 2021).

Black women and 26% among Latina women in South Carolina.[19] More than 40% of female-headed households in South Carolina live in poverty,[20] and South Carolina has the eighth highest rate of children living in poverty, at nearly 23%.[21]

38. The lack of comprehensive insurance coverage also poses a barrier to South Carolina women confirming they are pregnant and obtaining abortion coverage when they need it. Notably, South Carolina is one of just twelve states that have not expanded Medicaid,[22] and uninsured rates among South Carolina women of reproductive age (14.2%) are worse than the national average of 11.9%.[23] Unsurprisingly, more than 17% of women in South Carolina reported not receiving health care in the prior 12 months due to cost.[24] Even those patients who *do* have health insurance rarely have access to abortion coverage. With very narrow exceptions, South Carolina bars coverage of abortion in its Medicaid program, and it prohibits coverage of abortion in private insurance plans offered on the state's Affordable Care Act exchange,[25] an important source of health insurance for individuals who do not have access to employer-sponsored health coverage.

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[19] Nat'l Women's L. Ctr., *Poverty Rates State by State*, *2018* (2019), https://nwlc.org/wp-content/uploads/2019/10/Poverty-Rates-State-by-State-2018.pdf.

[20] Nat'l Women's L. Ctr., *supra* note 18.

[21] Am.'s Health Rankings United Health Found., *Health of Women and Children Data 2020 Update* 42, https://assets.americashealthrankings.org/app/uploads/hwc20_state_summaries.pdf.

[22] Kaiser Fam. Found., *Status of State Medicaid Expansion Decisions: Interactive Map* (Feb. 4, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/#:~:text=To%20date%2C%2039%20states%20(including,available%20in%20a%20table%20format.

[23] Nat'l Women's L. Ctr., *supra* note 18.

[24] *Id*.

[25] Kaiser Fam. Found., *supra* note 22; Guttmacher Inst., *Regulating Insurance Coverage of Abortion* (Feb. 1, 2021), https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion.

39. South Carolina's lack of investment in health care is reflected in health outcomes. Since 1990, South Carolina has been among the ten worst states in overall health outcomes; it currently ranks 42nd out of 50.[26] Meanwhile, South Carolina has the tenth highest rate of mortality for women ages 20 to 44,[27] and ranks 43rd in the nation with respect to the rate of maternal mortality.[28] South Carolina also ranks 47th in infant mortality, with a rate of 7.2 infant deaths per 1000 live births among all women.[29] And even this unacceptably high rate of death conceals a stark racial disparity: while South Carolina's infant mortality rate is 5.4 infant deaths per 1000 live births among white women, that rate rises to 9.7 infant deaths per 1000 live births among Black women.[30]

40. Patients living in poverty and without insurance must often make difficult tradeoffs of other basic needs to pay for their abortions, even with assistance from PPSAT to those patients in need. Many patients must seek financial assistance from extended family and friends to pay for care, as well, a process that takes time. Many patients must navigate other logistics, such as inflexible or unpredictable job hours and child care needs, that may delay the time when they are able to obtain an abortion.

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[26] America's Health Rankings – United Health Foundation, *South Carolina*, https://www.americashealthrankings.org/explore/annual/measure/Overall/state/SC (last visited Feb. 8, 2021).

[27] Am.'s Health Rankings United Health Found., *supra* note 21 at 42.

[28] Am.'s Health Rankings United Health Found., *South Carolina Health of Women and Children* (2019), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/overall_mch/state/SC?edition-year=2019 (last visited Feb. 8, 2021). South Carolina's maternal mortality data are not available for 2020.

[29] Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Stats., *Infant Mortality Rates by State, 2018*, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Feb. 9, 2021).

[30] Am.'s Health Rankings United Health Found., *South Carolina Health of Women and Children - Infant Mortality* (2020), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/state/SC?edition-year=2020 (last visited Feb. 8, 2021).

41. The COVID-19 pandemic has only exacerbated these impediments to care for patients seeking an abortion, particularly Black patients whose communities have been hardest hit by illness and the related economic downturn. Patients understandably fear the health risks of being in a clinic and traveling across the state to obtain health care. In addition, many South Carolinians are navigating job losses or reductions in hours, related loss of health insurance, and a lack of child care due to COVID, all of which may delay the point when a patient recognizes she is pregnant and when she is actually able to obtain an abortion.

42. In addition to the medical and practical impediments I have just described to patients' obtaining an abortion before six weeks of pregnancy, South Carolina has also enacted numerous medically unnecessary statutory and regulatory requirements that must be met before a patient may obtain an abortion. South Carolina requires PPSAT to ensure that patients had available, at least 24 hours in advance of an abortion, certain state-mandated information designed to discourage them from having an abortion.[31] Practically speaking, the effect of this 24-hour delay law lasts far longer than one day, which may push even patients who have discovered they are pregnant, decided to have an abortion, and scheduled an appointment prior to 6 weeks LMP past that point by the time they actually arrive at the health center for their abortion appointment.

43. The impossibility of obtaining an abortion within the time permitted by the Act is all the more clear for our minor patients who are under seventeen. As an initial matter, minor patients without a history of pregnancy may be less likely to recognize early symptoms of pregnancy than older patients who have been pregnant before. In addition, some of these patients cannot obtain written parental authorization for an abortion as required by state law and must

[31] S.C. Code Ann. § 44-41-330(C).

obtain a court order permitting them to receive care.[32] A court may take up to seventy-two hours to rule on a patient's petition to bypass the state's parental-consent law for abortions,[33] not including any time that may be necessary for a minor patient to appeal an unfavorable decision. That process cannot realistically happen before a patient's pregnancy reaches six weeks LMP.

44. South Carolina law also prohibits the use of telemedicine for the provision of medication abortion, closing off a safe and effective option for many patients to obtain an abortion, particularly during the COVID-19 pandemic.

45. Patients whose pregnancies are the result of sexual assault or who are experiencing interpersonal violence may need additional time to access abortion services due to ongoing physical or emotional trauma. For these patients, too, obtaining an abortion before six weeks LMP is exceedingly difficult, if not impossible.

46. For all of these reasons, the vast majority of PPSAT's abortion patients in South Carolina do not obtain an abortion until after six weeks LMP.

The Act's Effects

47. If allowed to take effect, the Act would force PPSAT to stop providing nearly all, if not all, previability abortion in South Carolina, to the detriment of our patients' health, wellbeing, and financial security. The Act's impact will be harshest for our patients with low incomes, patients of color, and patients who live in rural areas. Roughly half of our abortion patients in South Carolina health centers are Black, and in 2020, those health centers provided abortion services to patients residing in all but three South Carolina counties.

[32] *See id.* §§ 44-41-31, -32, -33.

[33] *See id.* § 44-41-32(5).

48. As described above, the earliest a person could reasonably expect to learn that she is pregnant is at four weeks LMP. Accordingly, a South Carolinian would have roughly two weeks to learn she is pregnant, decide whether to have an abortion, secure the money to pay for the abortion and associated care, and seek and obtain an abortion at one of the three available locations in South Carolina. Based on my experience, the vast majority of patients, even those who suspect that they are pregnant at a very early stage, could not realistically take all of these steps before embryonic cardiac activity could be detected around 6 weeks LMP.

49. Indeed, PPSAT generally does not initiate an abortion until sometime between four and five weeks of pregnancy LMP, when a pregnancy can first be located in the uterus using transvaginal ultrasound. Accordingly, even patients who discover that they are pregnant at an early date could have just a matter of days between the point when a pregnancy can be located in the uterus and when an ultrasound would detect cardiac activity, foreclosing that patient from accessing abortion in South Carolina.

50. As described above, many other patients do not learn that they are pregnant until after six weeks LMP. Under the Act, these patients could *never* access abortion in South Carolina.

51. Given how few patients could possibly access abortions that are not banned by the Act, most patients will be forced to travel across state lines to try to access abortion if the Act takes effect. I anticipate that the number of South Carolina women forced to seek abortions in other states (if they are able to undertake the necessary travel at all) will increase significantly, as will their costs. From PPSAT's Columbia and Charleston health centers, the nearest other abortion providers outside of South Carolina are in Charlotte, North Carolina (96 miles away from the Columbia health center and 209 miles from the Charleston health center), and Augusta, Georgia (77 miles away from the Columbia health center and 154 miles away from the Charleston health

center). The nearest abortion provider outside South Carolina to Greenville Women's Clinic is about 67 miles away in Asheville, North Carolina. Additionally, there is a provider of medication abortion only in Savannah, Georgia, that is 186 miles away from the Columbia health center and 111 miles away from the Charleston health center. Patients too far along in their pregnancies to rely on medication abortion could not use this facility for care.

52. The necessary travel caused by the Act will, of course, carry with it associated costs, such as lodging, gas, food, time off work, and childcare for the patient's other children. The logistics required for out-of-state travel may also force some patients to explain the reason for their travel, thus compromising the confidentiality of their decision to have an abortion in order to obtain transportation or childcare.

53. Given the logistical hurdles of traveling out of state, I expect that women able to obtain an abortion through another provider in a different state will do so later in pregnancy than they would have had they had access to care in South Carolina. The likelihood of delay is particularly high given the fact that North Carolina and Georgia impose their own waiting periods on patients seeking abortion.[34] Although abortion is very safe, the physical risks associated with abortion—as is true with pregnancy generally—do increase with gestational age.[35] Accordingly, even for patients able to travel to another state, the delays created by the Act will still increase those patients' risk of experiencing pregnancy- and abortion-related complications and prolong the period during which they must carry a pregnancy that they have decided to end. Because the cost

[34] Ga. Code Ann. § 31-9A-3; N.C. Gen. Stat. Ann. § 90-21.82.

[35] Nat'l Acads., *supra* note 4 at 77–78.

of abortion services also increases with gestational age,[36] delays in access to care caused by the Act may impose additional financial costs on patients related to the abortion service itself.

54. If the Act goes into effect, I also expect many patients will be unable to travel out of state to obtain an abortion in light of the costs and coordination required. These patients will be forced to carry pregnancies to term against their will or seek ways to end their pregnancies without medical supervision, some of which may be unsafe. Patients who are denied a wanted abortion face a host of negative outcomes for themselves and their families. As noted above, pregnancy-related mortality rates are nearly fourteen times as high as those associated with having an abortion. In addition, studies have shown that patients who are denied a wanted abortion, when compared to those who are able to obtain abortions, face a greater likelihood of living in poverty with their families (including previous children) and staying in abusive relationships.[37] Moreover, those who are denied access to wanted abortions face large and persistent negative consequences for their financial well-being compared to those who receive wanted abortions.[38]

55. The burdens of traveling across state lines to access abortion or being forced to carry a pregnancy to term after being denied an abortion will disproportionately harm patients with low incomes, patients of color, and patients living in rural South Carolina, who are least able to

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[36] Rachel K. Jones, Meghan Ingerick & Jenna Jerman, *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 Women's Health Issues 212 (2018).

[37] M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169 (2017).

[38] Sarah Miller, Laura R. Wherry, & Diana G. Foster, Nat'l Bureau of Econ. Res. (NBER), NBER Working Paper No. 26662, *The Economic Consequences of Being Denied an Abortion* (Jan. 2020), available at https://www.nber.org/papers/w26662.pdf (finding that the impact of being denied an abortion on unpaid bills being reported to collection agencies is as large as the effect of being evicted, and "the impact on unpaid bills is several times larger than the effect of losing health insurance").

resist the Act's effects. Forcing patients to carry their pregnancies to term will place Black patients, for example, at even greater risk of adverse health and other outcomes. Pregnancy is roughly 2.6 times as deadly for Black and other non-white women in South Carolina as it is for white women.[39] South Carolinians also face a critical shortage of reproductive health care providers, including obstetrician-gynecologists, particularly in rural areas.[40]

56. Although patients who obtain abortions demonstrate a strong level of certainty with respect to the decision, some patients take longer to make a decision than others. And patients in South Carolina are already required to have the opportunity to review state-mandated information at least twenty-four hours before obtaining an abortion.[41] Even if there were some way in theory for patients to have an abortion in compliance with the Act and in light of all the other legal and logistical barriers, the Act would force patients to race to a health center for an abortion, even if they did not yet feel confident in their decision.

57. The Act will also add to the anguish of patients and their families who receive fetal diagnoses later in pregnancy, nearly all of which would not meet the Act's narrow exceptions. There is no prenatal testing for fetal anomalies available at six weeks LMP or earlier. Indeed, some anomalies cannot be identified until 18 to 20 weeks LMP. Often these pregnancies are very much wanted throughout the first trimester of pregnancy and into the second. The Act would deny

[39] South Carolina Maternal Morbidity and Mortality Rev. Comm., *Legislative Brief* (Mar. 2020), https://www.scstatehouse.gov/reports/DHEC/mmmr-2020-Final.pdf.

[40] Division of Policy and Research on Medicaid and Medicare, Institute for Families in Society, University of South Carolina, *South Carolina OB/GYN Practices by County* (2013), available at https://msp.scdhhs.gov/proviso/sites/default/files/OBGYN_July2013_Count.pdf; *see* William F. Rayburn, The Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications, 2017 (Am. Coll. of Obstetrics & Gynecology, 2017) (reporting only 4.66 ACOG Fellows or Junior Fellow per 10,000 South Carolina women of reproductive age).

[41] S.C. Code Ann. § 44-41-330(C).

patients in these circumstances the ability to access an abortion in South Carolina based on the most accurate medical information available to them.

58. Even those patients able to qualify for one of the Act's narrow exceptions to the six-week ban would be harmed. Instead of being able to make their own personal decision whether to have an abortion, based on their own needs, values, and goals, these patients will find that decision closely scrutinized. And based on my experience treating survivors of sexual violence, I know that many fear the involvement of law enforcement so much that they would choose to forgo the abortion rather than trigger a mandatory report to law enforcement, especially if the report will reveal their name and address and the fact that they terminated a pregnancy. These patients, too, will be forced to carry to term the pregnancy resulting from their sexual abuse or to try and access care in another state.

* * *

59. For all of these reasons, I believe that the Act will deprive PPSAT's patients of access to critical health care and will threaten their health, safety, and lives.

60. This Court's intervention to bar enforcement of the Act and prevent these grave harms is urgently needed: PPSAT already has abortions scheduled for 56 patients on Saturday, February 20, 2021. Most of these patients' pregnancies are likely to be at or beyond 6 weeks LMP, such that these patients will likely be prohibited from obtaining abortions if SB 1 remains in effect. And for some patients, leaving SB 1 in place for even a matter of days would effectively preclude them from obtaining an abortion in South Carolina. We are aware of at least three patients scheduled for this Saturday, February 20, whose pregnancies are estimated to be at or beyond 13 weeks' gestation. Another three patients scheduled for Tuesday, February 23, are also estimated to be at or beyond 13 weeks pregnant. These patients are just days away from reaching the second

trimester of pregnancy, at which point—consistent with PPSAT's abortion clinic license—we could not provide abortion services to them in the State of South Carolina, and neither could GWC. Even if SB 1 is later enjoined, these patients would need to leave the state to obtain an abortion, assuming they could do so. Leaving SB in place, even for a matter of days, would also impose additional and substantial logistical, emotional, and financial burdens on patients. As discussed above, many of our patients must make advance preparations to have an abortion, including by finding childcare, asking for time off work and missing out on earnings for that time, and potentially traveling long distances to reach our health centers. It is critically important that PPSAT be able to assure patients relying on their upcoming appointments that abortion services in South Carolina will remain available as planned. PPSAT is already receiving calls from patients who are panicked about their options for abortion should SB 1 take effect.

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

Dated: February 17, 2021

Katherine Farris, M.D.

EXHIBIT A

Katherine A. Farris, M.D.

100 S Boylan Avenue
Raleigh, NC 27603
phone: (919) 833-7526

Employment

Planned Parenthood South Atlantic Winston-Salem/Raleigh, NC

Chief Medical Officer: April, 2020 – present

Duties of Affiliate Medical Director with increased focus on strategic planning, oversight of new service lines including Primary Care, and increased advocacy work in support of PPSAT mission.

Affiliate Medical Director: December, 2014 – April, 2020

Clinical, policy, and administrative oversight for 14 health centers located throughout NC, SC, VA and WV.

Laboratory Director: December, 2014 – present

Oversight of non-waived laboratories WS, NC; AVL, NC; WILM, NC; CLT, NC; waived laboratory VIE, WV

Interim Abortion Facility Administrator: December, 2019 – March 2020

Acting Vice President of Patient Services: March – June, 2016; May – August, 2017

Interim Affiliate Medical Director: July, 2013 – December, 2014

Reproductive Health Care: September, 2009-present

Provision of comprehensive family planning services to women of all ages as well as STI counseling, testing and treatment to men and women.

(Prior to merger and name change January 2015, organization was named Planned Parenthood Health Systems, Inc.)

Heywood Medical Group/Henry Heywood Hospital Westminster/Gardner, MA

Family Practice/Obstetrics: August, 2003 – May, 2007

Meetinghouse Family Practice; 16 Wyman Rd.; Westminster, MA 01473

Provision of full-spectrum family medicine including comprehensive family planning and reproductive health care.

Planned Parenthood League of Massachusetts Boston/Worcester, MA

Reproductive Health Care: August, 2003 – May, 2007

Provision of comprehensive family planning services to women of all ages.

Education

Valley Medical Center Family Practice Residency Renton, WA

Chief Resident: 2002-2003

Residency: 2001-2003

Internship: 2000-2001

Northwestern University Medical School Chicago, IL

Degree: MD, 1995-2000

Northwestern University College of Arts and Sciences Evanston, IL

Degree: BA, 1991-1995

Major: Molecular and Cellular Biology Minor: Religion Studies

Certifications/Special Training

Physician for Reproductive Health, Leadership Training Academy Fellow 2018-2019

Basic Life Support/AED, Provider: renewed 11/2019

Family Planning Program Training, Provider: 2015

CLIA Laboratory Director Training, Training for non-waived laboratory director: 2013

Single-rod Hormonal Implant Insertion Training, Provider: 2011

Research/Publications

Kryszczuk K*(maiden name)*, Kelsberg G, Rich J, DePietropaolo D. Should we screen adults for asymptomatic microhematuria? J Fam Pract. 2004;53(2):150-3.

Research/Publications (continued)

Diabetes Prevention Program Chicago, IL

Research assistant: Performed initial patient screenings, assisted with laboratory evaluation of participants: 1997-1998

Department of Cellular and Molecular Biology Evanston, IL

Research assistant under T. T. Wu, PhD: Performed literature searches for antibody variable region sequences and input information into Genbank database: 1992-1995

Invited Presentations

Reproductive Health Q&A. Wake Forest Medical Schools Medical Students for Choice. 18 September 2019.
Medication Abortion Workshop. Reproductive Health Access Project virtual training on implementation in practice, Asheville, Chapel Hill, and Wilmington, NC. 3 June 2019.
Abortion Care Overview. Wake Forest Medical Schools Medical Students for Choice, 17 April 2019
Physicians as Advocates for Reproductive Health. Forsyth Hospital OB/GYN Grand Rounds, Winston-Salem, NC. 13 February 2019.
Abortion Care Overview. Wake Forest Medical Schools Medical Students for Choice, 29 November 2018.
Abortion Care Overview. Wake Forest Medical Schools Medical Students for Choice, 28 November 2017.
Challenges in Abortion Care – North Carolina. Forsyth Hospital OB/GYN Grand Rounds, Winston-Salem, NC. 8 November 2017.
Challenges in Abortion Care – North Carolina. Mission Hospital OB/GYN Grand Rounds, Asheville, NC. 19 February 2016.

Professional Organizations / Positions

American Academy of Family Physicians (AAFP): 1995-present
North Carolina Academy of Family Physicians: 2007-present
National Abortion Federation (NAF): 2003-2005, 2018-present
Physicians for Reproductive Health: 2018-present
American College of Obstetricians and Gynecologists: 2020-present
Massachusetts Academy of Family Physicians: 2003-2007
Washington Academy of Family Physicians (WAFP): 2000-2003
American Medical Women's Association (AMWA): 1995-2000
Northwestern University Chapter President: 1997-1998
Vice-President: 1996-1997

Licenses

NC Physician License, active
WV Physician License, active
VA Physician License, active
SC Physician License, active
American Board of Family Physicians, Board Diplomate

Honors/Awards

Press Ganey Patient Experience Top Performing Provider 2020

Ranked in the top 10% of providers across the country for providing the highest level of patient experience.

2002 Roy Virak Memorial Family Practice Resident Scholarship Recipient

Awarded by the Washington Academy of Family Practice on the basis of academic achievement, excellence in patient care, and strong service to the community.

National Merit Scholar
Daughters of the American Revolution Scholarship Recipient

Languages

American Sign Language – conversational
Spanish – intermediate