STATE OF MICHIGAN

COURT OF CLAIMS

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

Plaintiffs,

v

Case No. 24-000011-MM

Hon. Sima G. Patel

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

Defendants,

and

THE PEOPLE OF THE STATE OF MICHIGAN,

Intervening Defendant.
_____/

OPINION AND ORDER

On November 8, 2022, the people of Michigan voted to approve Proposal 3 and explicitly enshrine a right to reproductive freedom in the Michigan Constitution. Const 1963, art 1, § 28.

Under this constitutional amendment, Michiganders have the fundamental right to reproductive freedom, including the right to abortion care, and the state cannot deny, burden, or infringe upon this freedom barring a compelling state interest to protect the health of the individual seeking care. Additionally, any statute or regulation that does deny, burden, or infringe upon reproductive freedom must only do so in order to protect the patient's health, achieve this goal by the least restrictive means, be consistent with accepted clinical standards of practice and evidence-based medicine, and not infringe upon an individual's autonomous decision making.

Plaintiffs Northland Family Planning Center, Northland Family Planning Center Inc., East, Northland Family Planning Center Inc., West, (collectively "Northland"), and Medical Students for Choice (MSFC) filed this suit seeking a declaration that three Michigan abortion regulations under MCL 333.17015 and 333.17015a—a 24-hour mandatory waiting period, mandatory uniform informed consent for women seeking an abortion, and a ban on advanced practice clinicians performing an abortion (collectively the "challenged laws")—are unconstitutional under Const 1963, art 1, § 28. Plaintiffs seek declaratory relief holding that the challenged laws are unconstitutional, and preliminary and permanent injunctions barring their enforcement.

The Court hereby concludes that the balancing of the pertinent factors weighs in favor of granting partial preliminary injunctive relief. For the reasons set forth in this opinion, plaintiffs' motion for preliminary injunction is GRANTED in part and DENIED in part. The Court holds that, based on the record before it, defendants are preliminarily enjoined from enforcing or implementing all parts of MCL 333.17015 (except MCL 333.17015(11)(i), as implicated by MCL 333.17015a), which includes the mandatory 24-hour waiting period, the mandatory uniform informed consent, and the ban on APCs providing abortion care. The Court DENIES the request

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

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

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

II. PLAINTIFFS' COMPLAINT AND MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs filed a complaint for declaratory and injunctive relief challenging the constitutionality of MCL 333.17015 and 333.17015a under Const 1963, art 1, § 28. Plaintiffs filed suit against Attorney General Dana Nessel, in her official capacity, Director Marlon Brown, in his official capacity as Director of Michigan Licensing and Regulatory Affairs (LARA), and Director Elizabeth Hertel, in her official capacity as Director of Michigan Department of Health and Human Services (DHHS). Plaintiffs also concurrently moved for a preliminary injunction.

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

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

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

III. THE CHALLENGED LAWS

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

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

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

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

Under MCL 333.17015(1) and (3), a "physician shall not perform an abortion . . . without the patient's informed written consent," and that consent must be obtained "not less than 24 hours before that physician performs an abortion . . . ." Plaintiffs challenge this mandatory 24-hour waiting period, asserting that it does not serve patient health. Plaintiffs assert that mandatory waiting periods do not improve decision making or protect against regret, reproductive coercion, or mental health harms. Instead, plaintiffs argue that the 24-hour, mandatory waiting period harms patients by increasing incremental risk and imposing significant logistical barriers that force patients to obtain care later in pregnancy.

The People, on the other hand, argue that the 24-hour waiting period does not "deny, burden, or infringe upon" a patient's reproductive freedom because it does not unduly burden access. Instead, the People argue that the 24-hour waiting period is designed to ensure that an individual can exercise their right in an informed, voluntary, and reflective manner, and the impact on the right to access abortion care is only incidental. The People further argue that the challenged laws are afforded a presumption of constitutionality, and plaintiffs have not overcome this burden.

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

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

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

First, "[c]onfirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus." *Id*.

Second, "[o]rally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability" three things, "the probable gestational age of the fetus the patient is carrying," "information about what to do and whom to contact should medical complications arise from the abortion," and "[i]nformation about how to obtain pregnancy prevention information through the department of health and human services." *Id*.

Third, "[p]rovide the patient with a physical copy of the written standardized summary . . . that corresponds to the procedure the patient will undergo and is provided by the department of health and human services," and if the procedure is "allowed under Michigan law," but has not been summarized by the DHHS, "the physician shall develop and provide a written summary that describes the procedure, any known risks or complications of the procedure, and risks associated with live birth . . . ." *Id*.

Fourth, "[p]rovide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the department of health and human services . . . at the gestational age nearest the probable gestational age of the patient's fetus." *Id*.

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

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

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

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

As directed by § 17015(11)(c), the DHHS has developed a uniform written consent form in keeping with the above requirements.[2] Patients are required to download and complete an "Informed Consent Confirmation Form" available on the DHHS site at least 24 hours before an abortion procedure. MCL 333.17015(5). If the form is not downloaded and brought to the appointment, a provider may not provide care until the form has been completed and 24 hours have elapsed from the time of completion. MCL 333.17015(3). Significantly, no other medical procedure in Michigan requires a similar set of prescribed uniform "informed consent." In all other instances, informed consent is left to the discretion of medical professionals and the dictates of their ethical and professional obligations.

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

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

infringe on the right to receive abortion care without serving a legitimate compelling state interest. They assert that the uniform informed-consent counseling is at odds with the standard of care, which requires medical providers to give individualized, patient-centered advice in keeping with the applicable professional and ethical standards. Plaintiffs also argue that the laws require abortion providers to give inapplicable information (like pregnancy and parenting information) and inaccurate information (such as showing pictures of the gestational age of the fetus with comparisons to pieces of fruit, which plaintiffs argue are not always accurately depicted). Plaintiffs further assert that there is no medically necessary reason to show patients seeking an abortion a depiction of a fetus or provide parenting advice, and doing so places an emphasis on choosing against an abortion, is stigmatizing, paternalistic, and unnecessary. In support, plaintiffs have attached the affidavits of a number of expert witnesses, which will be discussed in further detail below.

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

C. MCL 333.17015(1)—PROVIDER BAN

MCL 333.17015(1) provides that "a *physician* shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort." (Emphasis added.) Thus, in Michigan, only a licensed physician can provide abortion care, precluding Advanced Practice Clinicians (APCs) from doing so. APCs include nurse practitioners, certified nurse midwives, and physician assistants.

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

on obtaining abortion care by arbitrarily restricting the number of available providers. Plaintiffs contend that APCs routinely manage miscarriages in Michigan by administering the same medical protocols involved with abortion care. In keeping with their scope of practice and professional standards, APCs provide safe abortion care in other states.[3] In Michigan, APCs are able to prescribe and oversee the use of controlled substances, and nurse midwives are permitted to attend deliveries, all of which is riskier and more complex than early abortion care. Plaintiffs argue that the APC ban does not serve a legitimate medical purpose and instead artificially limits the number of abortion care providers in the state. As a result, it creates barriers to abortion access, increases patient wait times, and increases travel distances. This impact exacerbates provider shortages and is acutely felt in rural and underserved communities.

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

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

The state cannot deny, burden, or infringe upon an individual's fundamental right to reproductive freedom unless it has a compelling state interest in "protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making." Const 1963, art 1, § 28 (4). Plaintiffs have attached affidavits from a number of expert witnesses to support

[3]See Yannow, *It's Time to Integrate Abortion Into Primary Care*, 103 Am J Public Health, 14-16 (January 2013) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3518342/> (accessed June 24, 2024).

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

DR. M. ANTONIA BIGGS

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

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

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

Dr. Biggs sums up her opinions as follows:

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

Professor Kayte Spector-Bagdady

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

Professor Bagdady reviewed the 24-hour mandatory waiting period and mandatory informed-consent counseling provisions in MCL 333.17015 and MCL 333.17015a, and, based on her years of experience, research, and expertise in the field of bioethics, she opines that the challenged laws do not improve—and in fact, undermine—informed consent to a medical procedure. She articulates that informed consent should be focused on a neutral and timely presentation of the most important risks, benefits, and alternatives such that the patient can decide in line with their own values without the coercive influence of the state, clinician, or others on that decision. Professor Bagdady further explains that the purpose of informed consent is to protect patients' bodily integrity and right to medical self-determination. The common law standard that has developed over time establishes that physicians have a duty to disclose medical risks and benefits related to a proposed procedure, and the relevant standards allow for flexibility and tailoring to a patient's circumstances. In jurisdictions like Michigan, the scope of the disclosure is tied to the professional standard of care.

Professor Bagdady opines that the 24-hour waiting period forces needless delay on patients after they consent to a procedure. While recognizing that the ostensible reason for the delay is to ensure that patients are given sufficient time for consideration of their choice, Professor Bagdady relates that she is unaware of any scientific literature demonstrating that waiting 24 hours improves the patient's ability to make a medical decision for themselves. In addition, she notes that the mandatory waiting period fails to account for time a patient may have waited and deliberated on their choice before contacting a medical facility. Professor Bagdady concludes that the 24-hour waiting period does not improve a patient's capacity to make a good decision for themselves regarding a legally allowable procedure or serve an interest in informed consent. Instead, she opines that its intent is to erect a barrier between the patient and a legal medical procedure and

restrict free choice in medical decision making by adding logistical burdens. She reasons that the 24-hour waiting period only serves to constrain choice by making abortion logistically complex to access, such that some patients will be delayed in obtaining the procedure or denied access to the care they require. Instead, Professor Bagdady opines that providers should offer care as soon as is medically appropriate, and when patients who are competent give their consent when they choose.

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

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

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

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

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

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

[6] *Id*.

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

Dr. Charise Loder

Dr. Charise Loder is a board-certified obstetrician-gynecologist (OB/GYN) licensed to practice medicine in the state of Michigan. For the last 10 years, she has provided full-spectrum gynecological and obstetric care, from labor and delivery to contraception and abortion. Dr. Loder has authored and co-authored over a dozen peer-reviewed journal articles on a variety of topics related to reproductive health issues, including contraception, abortion, and access to healthcare. She is currently serving as a clinical assistant professor in obstetrics and gynecology at the University of Michigan. In 2018, she was appointed the director of Clinical Family Planning Services at the University of Michigan.

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

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[7] *Id*.

[8] *Id*.

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

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

Dr. Loder also opines that under the accepted standard of care, patients should receive abortion care as soon as possible once a patient has made their decision and delaying a patient's care by even one day is a tremendous barrier. For patients whose pregnancies are close to 11 weeks, which is typically the point at which medication abortion is no longer available in Michigan, the barriers imposed by the 24-hour waiting period can mean patients lose the option of a medication abortion or, given that some clinics in Michigan only offer medication abortion, an abortion at all. Abortion care also becomes more expensive and complex as gestational age increases and, in some cases, patients are unable to overcome the logistical and financial barriers caused by the delay in care and are not able to receive their abortion. Further, Dr. Loder notes confusion caused by the waiting period sometimes results in patients having to travel to a facility twice, thereby requiring them to take another day off from work, arrange for additional childcare, and either travel back home and return to the hospital or clinic, or find accommodations nearby for the night. Dr. Loder explains that the mandatory waiting period sometimes causes confusion when a medical emergency may require emergent abortion care. Because of the wording of the

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

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

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

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

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

Dr. Loder explains:

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

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

Renee Chelian

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

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

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

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

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

Pamela Merritt

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

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

Amy Levi, PhD, CNM, WHNP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Natasha Bagdasarian is the Chief Medical Officer of the State of Michigan. She was appointed to the post by Director Hertel under MCL 333.2202(2), which makes her responsible to the Director for the medical content of the DHHS's policies and programs. Dr. Bagdasarian, in her official capacity, opined that the challenged laws impose duties that require health care providers to violate the standard of care.

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

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

Dr. Bagdasarian further notes that the 24-hour waiting period potentially is affirmatively harmful, insofar as it delays the patient's exercise of their decision-making authority until later in their pregnancy. Obtaining an abortion later in the patient's pregnancy is positively correlated with the procedure's invasiveness and adverse health outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

V. ANALYSIS

A. PRELIMINARY INJUNCTION LEGAL STANDARD

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

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

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

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

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

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

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

Plaintiffs have presented a facial challenge to the constitutionality of MCL 333.17015 and MCL 333.17015a. "[A] statute comes clothed in a presumption of constitutionality" because we presume that "the Legislature does not intentionally pass an unconstitutional act." *Cruz v Chevrolet Grey Iron Div of Gen Motors Corp*, 398 Mich 117, 127; 247 NW2d 764 (1976). "The party challenging the facial constitutionality of an act must establish that no set of circumstances exists under which the act would be valid. The fact that the act might operate unconstitutionally under some conceivable set of circumstances is insufficient." *League of Women Voters of Michigan v Secretary of State*, 508 Mich 520, 534–35; 975 NW2d 840 (2022) (cleaned up). "Our task, then, is to determine whether [the statute] is unconstitutional in the abstract, rather than to analyze the statute 'as applied' to the particular case." *Id.*

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

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

> (1) Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care.
>
> An individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means.
>
> Notwithstanding the above, the state may regulate the provision of abortion care after fetal viability, provided that in no circumstance shall the state prohibit an abortion that, in the professional judgment of an attending health care professional, is medically indicated to protect the life or physical or mental health of the pregnant individual.
>
> (2) The state shall not discriminate in the protection or enforcement of this fundamental right.

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

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

Plaintiffs argue that the challenged laws are unconstitutional under § 28 because they deny, burden, and infringe upon a patient's fundamental right to reproductive freedom in accessing abortion care, and the laws do not achieve the compelling interest of protecting the patient's health by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine. The intervening defendant, on the other hand, argues that the laws do not deny, burden, or infringe upon the right to access abortion care because they do not unduly burden a patient's access to abortion care and, even if they do, they pass the compelling-interest standard, which intervening defendant characterizes as strict-scrutiny review See *Planned Parenthood of Southeastern Pennsylvania v Casey*, 505 US 833, 878; 112 S Ct 2791; 120 L Ed 2d (1992).

As an initial matter, it is necessary to identify the appropriate legal standard applicable to the challenged laws. The Court agrees with plaintiffs that a strict-scrutiny standard applies, as stated in the text of § 28. That is, the challenged laws can only pass constitutional muster if they: (1) do not deny, burden, or infringe upon an individual's fundamental right to make and effectuate decisions about abortion care, and (2) if the laws do deny, burden, or infringe upon that right, they do so only to achieve the purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and the laws do not infringe on that individual's autonomous decision-making.

The Court disagrees with intervening defendant that, by adopting § 28, the voters of Michigan merely reverted the state of the law back to what it was before the United States Supreme Court reversed *Roe v Wade*, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147 (1973), and its progeny in *Dobbs v Jackson Women's Health Org*, 597 US 215; 142 S Ct 2228; 213 L Ed 2d 545 (2022). The Court rejects intervening defendant's argument that the undue burden standard articulated by the majority opinion in *Casey* is now the governing standard in Michigan.

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

necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id*.

In *Casey v Planned Parenthood*, the Supreme Court softened the strict-scrutiny standard adopted in *Roe*. *Casey*, like the challenged laws here, also involved constitutional challenges to statutes requiring that a woman seeking an abortion give her informed consent prior to the abortion procedure, and that she be provided with certain information at least 24 hours before the abortion is performed. Each of these provisions were facially challenged, with plaintiffs seeking preliminary and permanent injunctions. *Casey* distilled from *Roe* three essential holdings:

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

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

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

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself. [*Id.* at 872.]

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

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

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

Thus, the *Casey* Court concluded that state regulation that burdened access to abortion was permissible, so long as it did not pose an "undue burden," because of the State's competing interest in the potential for life: "The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. Not all burdens on the right to decide whether to terminate a pregnancy will be undue. In our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty." *Id*. at 876.

The undue burden test in *Casey* was inextricably connected to the Court's determination that states have a compelling interest in potential for life. Thus, the Court concluded that state regulation on abortion care was permissible so long as it did not place an *undue burden* on an individual's access to abortion. "An undue burden exists, and therefore a provision of law is

invalid, if its purpose or effect is to place a *substantial obstacle* in the path of a woman seeking an abortion before the fetus attains viability." *Id*. at 878.

The Michigan Court of Appeals adopted the *Casey* standard, holding that MCL 333.17015 was constitutional under the due process clause of the Michigan Constitution because the statute bears a reasonable relationship to a permissible legislative purpose. *Mahaffey v Attorney Gen*, 222 Mich App 325, 344; 564 NW2d 104 (1997). The Court noted that "[t]he stated purposes behind the informed-consent law are to ensure that a woman's decision to obtain an abortion is informed, voluntary, and reflective, and to protect, within the limits of federal constitutional law, the life of the fetus." *Id.* at 344. Citing *Casey*, the Court concluded that "[t]hese are legitimate legislative objectives," and the statute was constitutional under the Michigan Constitution, as it existed in 1997. *Id*.

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

an individual's freedom to make and effectuate decisions about abortion care. "Undue" is not a part of the constitutional text.

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

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

24-Hour Mandatory Waiting Period

The 24-hour mandatory waiting period forces patients to delay constitutionally protected abortion care by at least 24 hours after receiving information mandated by the state. MCL 333.17015(1) and (3). The record currently before the Court is sufficient to convince the Court that plaintiffs have demonstrated a substantial likelihood of success on the merits as to the question of whether the 24-hour waiting period is unconstitutional. That is, at this time, the Court is convinced that the mandatory delay exacerbates the burdens that patients experience seeking abortion care, including by increasing costs, prolonging wait times, increasing the risk that a

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

patient will have to disclose their decision to others, and potentially preventing a patient from having the type of abortion that they prefer. The 24-hour waiting period forces needless delay on patients after they are able to consent to a procedure, thus burdening and infringing upon a patient's access to abortion care. This burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care.

Mandatory Uniform Informed Consent

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

The statute is titled "Performance of abortion; informed consent; duties of physician; requirements," and in keeping with this title, starts in subsection (1) by mandating that "a physician shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort." Subsection (2) sets out definitions that govern the statute, and the remainder sets forth the substance of the standardized informed consent and how it is to be administered:

- Subsection 3 requires that the provider, at least 24 hours before a procedure:
    - confirm that the patient is pregnant, MCL 333.17015(3)(a);

- orally describe the probable gestational age of the fetus, give information about what to do and whom to contact in case of complications with the abortion, and pregnancy prevention information through the DHHS, MCL 333.17015(3)(b);

- provide the patient with a standardized summary developed by the DHHS regarding the procedure involved, or, if a DHHS summary is not available, develop a **summary that includes the known risks of the procedure and live birth meeting other statutory requirements**, MCL 333.17015(3)(c);

- **provide the patient with a depiction, illustration, or photograph and description of the fetus supplied by the DHHS**, MCL 333.17015(3)(d);

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

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

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

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

- Subsection 6 mirrors subsection 3, only this time providing instructions to the provider regarding obtaining the patient's consent 24 hours before the procedure. MCL 333.17015(6).

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

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

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

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

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

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

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

    - **state that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if these symptoms occur and are intense or persistent, professional help is recommended,** MCL 333.17015(11)(b)(iii);

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

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

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

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

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

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

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

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

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

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

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

  - Develop notices to be posted at facilities that contain statements that it is illegal under Michigan law to coerce an individual to have an abortion, that help is available if an individual is being threatened or intimidated, and telephone number of at least 1 domestic violence hotline and 1 sexual assault hotline.

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

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

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

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

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

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

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

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

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

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

- Subsection 19 states that a patient's identity is to remain confidential and can only be disclosed if informed consent is litigated. MCL 333.17015(19).
- Subsection 20 instructs the local health department regarding confidentiality and duty to destroy identifying patient information within 30 days after assisting a patient. MCL 333.17015(20).

MCL 333.17015a instructs that a provider must orally screen a patient for coercion to abort using the screening tools in subsection (11), and that the screening may occur after the informed-consent requirements in subsection (3) have been met. The statute further provides that, if a patient discloses domestic violence, even without coercion to abort, the provider shall follow protocols developed by DHHS set forth in subsection (11).

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

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

This information guides a patient away from the choice of having an abortion by juxtaposing content that is clearly more relevant and suitable to those seeking to complete a pregnancy. Such information certainly impacts the patient's choice to seek abortion care and encroaches on the patient's decision-making process. The provisions therefore burden and infringe upon a patient's right to make and effectuate decisions about abortion care.

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

informed-consent requirements on patients and providers, squarely inserts the DHHS in between the patient and provider relationship. The mandatory nature of the information that the DHHS is required to develop and disseminate, and the very fact that the DHHS is placed in between the patient and provider, has an impact on how a patient makes and effectuates decisions regarding abortion care. This impact, contrary to the argument made by the intervening defendant, is not merely incidental or tangential. The informed-consent provisions, read as whole, are designed to force a patient to consider the alternative of *not* having an abortion. The manner in which the information is presented is not neutral; it is designed to eschew abortion in favor of completing a pregnancy. This forced deliberation, through the mandatory informed-consent process, burdens and infringes upon a patient's right to make and effectuate decisions about abortion care. The State is metaphorically putting its finger on the scale, thereby infringing upon a patient's deliberative process.

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

APC Provider Ban

Likewise, the APC provider ban, which arbitrarily limits abortion providers to physicians only, appears to the Court at this time to burden and infringe upon a patient's freedom to make and effectuate decisions about abortion care. Having access to a provider is necessarily linked to being able to make and effectuate decisions about whether to seek abortion care. The artificial limitation on the available pool of abortion providers imposes logistical barriers to abortion access, increasing patient wait time and travel distances. This exacerbates existing provider shortages, leading to large swathes of Michigan that currently lack physicians to provide abortion care. By allowing APCs to perform some abortion services, the number of healthcare professionals available to individuals seeking care would increase dramatically. The increased number of healthcare professionals would, in turn, increase access to abortion care for individual patients. Thus, the Court is satisfied at this stage with plaintiffs' ability to show the requisite likelihood of success with respect to the question of whether the limitation of abortion providers to physicians burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care.

3. The Challenged Laws Do Not Appear to Pass Strict-Scrutiny Review: They do not Achieve the Goal of Protecting Patient Health, by The Least Restrictive Means, Consistent with Accepted Clinical Standards of Practice and Evidence-Based Medicine

Having determined that the challenged laws appear highly likely to burden and infringe upon a patient's right to make and effectuate decisions about abortion care, the next step in the constitutional analysis under Const 1963, art 1, § 28, is to determine whether the state has put forth a compelling interest, and then whether the challenged laws achieve that interest by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine, without infringing upon an individual's autonomous decision-making.

Under § 28, the only compelling state interest can be the health of the patient seeking care. The Court agrees with intervening defendant that the ostensible goal of the challenged laws is to protect patient health. The inquiry, however, does not stop there. In order to survive the constitutional challenge, the challenged laws must *achieve* the purpose of protecting patient health, by the least restrictive means, and be consistent with accepted clinical standards of practice and evidence-based medicine. This is where intervening-defendant's argument unravels.

Against the mountain of expert opinions and citation of accepted clinical standards and medical literature submitted by plaintiffs establishing that the challenged laws *do not* protect patient health and *are contrary* to accepted clinical standards of practice and evidence-based medicine (set forth in extensive detail in preceding sections), intervening defendant has produced *nothing*. Intervening defendant has not attacked the qualifications or credibility of the experts presented by the plaintiffs. Nor has intervening defendant presented any countervailing experts providing a contrary point of view to rebut the opinions. On the record submitted to the Court on this motion for preliminary injunction, the only expert medical opinions presented have resoundingly agreed that the challenged laws do not achieve the goal of protecting patient health and are inconsistent with accepted clinical standard of practice.

Intervening defendant makes the confusing argument that the Court should not consider the affidavit evidence, and instead rely on its legal arguments to conclude that the challenged laws achieve the goal to protect patient health. The Court disagrees. The plain language of § 28 unambiguously requires that the challenged laws *achieve* the goal of protecting patient health and be consistent with established clinical standards and evidence-based medicine. The only way for the Court to inquire into this element is to rely on the expert evidence submitted by the parties. Indeed, courts routinely rely on the parties' evidentiary submissions when weighing requests for

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

The experts have opined that the 24-hour waiting period does not protect the health of a patient seeking care and, in fact, hinders patient care by delaying care by an arbitrary 24-hours. Clinical research has shown that there is no correlation between having a patient wait 24 hours and the patient achieving better physical and psychological outcomes. On the current record, the Court is convinced that plaintiffs have demonstrated a substantial likelihood of success on their argument that this provision does not survive strict-scrutiny constitutional review.

The mandatory standard informed-consent provisions likewise appear, at this stage, to fail strict-scrutiny review because all the experts, as well as ACOG and other nationally-recognized organizations, conclude that the uniform standard of care provisions are inconsistent with the highly individualized and patient-specific informed-consent process. There is no reason to deviate from individualized informed consent, and no basis to argue that qualified licensed medical providers will deviate from their ethical and professional obligations without state interference. The evidence submitted by plaintiffs establishes that the overwhelming medical consensus is that mandatory informed-consent schemes, enacted to persuade people to continue pregnancies despite their personal circumstances and wishes, do not serve patient health and decision-making and are contrary to the standard of care. Given that intervening defendant has not provided any contrary medical evidence, the Court agrees with plaintiffs' argument and concludes that the mandatory informed-consent provisions—with the one exception noted above—do not appear at all likely to survive strict-scrutiny constitutional review.

The APC provider ban likewise does not appear to be capable of withstanding strict-scrutiny constitutional review. The APC ban excludes qualified clinicians from providing abortion care without any medical justification. APCs are fully capable of providing early abortion care. APCs in Michigan currently provide the very same care to patients experiencing miscarriage as they could for patients seeking early abortions. Numerous other states allow APCs to provide early abortions. And leading medical authorities have concluded that laws prohibiting qualified APCs from providing these services are without medical foundation and erect barriers to care.

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

C. REMAINING PRELIMINARY INJUNCTION FACTORS

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

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

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

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

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

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

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

D. SEVERABILITY

Defendants AG Nessel and Director Hertel urge the Court to only issue a preliminary injunction as to those provisions of MCL 333.17015 and MCL 333.17015a that, under the record presented, the Court deems likely violate Const 1963, art 1, § 28. MCL 333.17015(17) is a severability clause and states:

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

Under this subsection, any portions of MCL 333.17015 that remain valid should remain operable. Mindful of this legislative directive, the Court nonetheless finds that all parts of MCL 333.17015 (except those that implement MCL 333.17015a) are subject to the preliminary injunction.

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

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

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

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

> (1) At the time a patient first presents at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed for the purpose of obtaining an abortion, whether before or after the expiration of the 24-hour period described in section 17015(3), the physician or qualified person assisting the physician shall orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11). The oral screening required under this subsection may occur before the requirements of section 17015(3) have been met with regard to that patient.
>
> (2) If a patient discloses that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).
>
> (3) If a patient discloses coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).
>
> (4) If a patient who is under the age of 18 discloses domestic violence or coercion to abort by an individual responsible for the health or welfare of the minor patient, the physician or qualified person assisting the physician shall report that fact to a local child protective services office.
>
> (5) A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i). A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall make available in an area of its facility that is accessible to patients, employees, and visitors publications that contain information about violence against women.
>
> (6) This section does not create a right to abortion. Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

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

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

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

VI. CONCLUSION

For the reasons set forth above, plaintiffs' motion for preliminary injunction is GRANTED in part and DENIED in part. The Court holds that, based on the record before it, defendants are preliminarily enjoined from enforcing or implementing all parts of MCL 333.17015 (except MCL 333.17015(11)(i), as implicated by MCL 333.17015a), which includes the mandatory 24-hour waiting period, the mandatory uniform informed consent, and the ban on APCs providing abortion care. The Court DENIES the request to preliminarily enjoin enforcement and implementation of MCL 333.17015a and MCL 333.17015a.

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

Date: June 25, 2024

Sima G. Patel
Judge, Court of Claims