

**IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA**

OKLAHOMA CALL FOR REPRODUCTIVE JUSTICE, on behalf of itself and its members; TULSA WOMEN’S REPRODUCTIVE CLINIC, LLC, on behalf of itself, its physicians, its staff, and its patients; ALAN BRAID, M.D., on behalf of himself and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS, INC., on behalf of itself, its physicians, its staff, and its patients; and PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, on behalf of itself, its physicians, its staff, and its patients,

Plaintiffs,

v.

JOHN O’CONNOR, in his official capacity as Attorney General for the State of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; STEVE KUNZWEILER, in his official capacity as District Attorney for Tulsa County; LYLE KELSEY, in his official capacity as Executive Director of the Oklahoma State Board of Medical Licensure and Supervision; KATIE TEMPLETON, in her official capacity as President of the Oklahoma State Board of Osteopathic Examiners; LANCE FRYE, in his official capacity as the Commissioner of the Oklahoma State Board of Health; and JUSTIN WILSON, in his official capacity as the President of the Oklahoma State Board of Pharmacy; as well as their employees, agents, and successors,

Defendants.

CASE NO. _____

VERIFIED PETITION

Plaintiffs, by and through their undersigned attorneys, bring this Petition against the above-named Defendants, their employees, agents, and successors in office, and in support thereof allege the following:

I. PRELIMINARY STATEMENT

1. “Every woman in this country has a constitutionally protected right to choose whether to terminate her pregnancy before viability.” *Burns v. Cline*, 2016 OK 121, ¶ 8, 387 P.3d 348, 351. Trampling on this right and other constitutional guarantees, the Oklahoma Legislature passed five bills during its 2021 legislative session that outright ban abortion or restrict it so dramatically that Oklahomans will face tremendous or insurmountable barriers to accessing care.

2. Plaintiffs bring this action under the Constitution of the State of Oklahoma challenging these five bills: House Bill 1102, 2021 Okla. Sess. Law Serv. Ch. 205, House Bill 2441, 2021 Okla. Sess. Law Serv. Ch. 219, House Bill 1904, 2021 Okla. Sess. Law Serv. Ch. 211, Senate Bill 778, 2021 Okla. Sess. Law Serv. Ch. 577, Senate Bill 779, 2021 Okla. Sess. Law Serv. Ch. 578 (collectively, the “Challenged Laws”). Copies of each of the Challenged Laws are attached hereto as Exhibits A-E. The Challenged Laws are scheduled to take effect on November 1, 2021.

3. The Challenged Laws are unconstitutional and contrary to clear Oklahoma Supreme Court precedent. In some instances, the Challenged Laws purport to reenact requirements largely *identical* to ones already struck down as unconstitutional by the Oklahoma Supreme Court.

4. H.B. 1102 (the “Total Ban”) effectively bans abortion entirely by declaring that providing abortion is unprofessional conduct by physicians that carries a penalty of, at a minimum, suspension of medical licensure for one year.

5. H.B. 2441 (the “6-Week Ban”) bans abortion at approximately six weeks in pregnancy, as dated from the first day of a woman’s last menstrual period (“LMP”),¹ a point before many people even know they are pregnant and roughly *four months* before viability.

¹ LMP is a common measure of the gestational age of a pregnancy. Fertilization typically occurs around two weeks LMP. Pregnancy is generally considered to begin around three weeks LMP, when a fertilized egg typically implants in the uterus. Pregnancy typically lasts until forty weeks LMP.

6. H.B. 1904 (the “OB/GYN Requirement”) arbitrarily disqualifies highly trained abortion providers because they are not board-certified in obstetrics and gynecology (“OB/GYN”). Six out of ten of Plaintiffs’ doctors will be barred from providing care under the OB/GYN Requirement without any medical justification.

7. S.B. 778 imposes myriad medically unnecessary and burdensome requirements on the provision of medication abortion—one of the safest medication regimens prescribed in the United States, which is no riskier than Advil.² As just two examples of this law’s many provisions, most of which bear no relation to one another—one requires that patients obtain an ultrasound at least 72 hours prior to a medication abortion—a more stringent version of a requirement that the Oklahoma Supreme Court has already declared unconstitutional—and another requires providers to file individual reports for each medication abortion.³

8. S.B. 779 imposes a similarly labyrinthine certification system for manufacturers, distributors, and providers of medication abortion.⁴ The law includes a dizzying array of requirements, most of which bear no relation to one another. As just two examples—the bill includes a requirement that providers of medication abortion have admitting privileges at a nearby hospital or contract with a physician who does, even though similar requirements have been

² National Academy of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, 163-165 (2018) (“NAS Report”).

³ *Nova Health Sys. v. Pruitt*, 2012 OK 103, ¶ 1, 292 P.3d 28 (invalidating a law that required an ultrasound one hour in advance of a procedure).

⁴ S.B. 778 and S.B. 779 also mandate that physicians inform patients about so-called “medication abortion reversal,” a scientifically unsupported and potentially dangerous medical treatment. S.B. 778 §§ 6(E)(6), 6(E)(8)-(10), 6(E)(11)(b), 6(E)(11)(e), 7(A), and 7(C); S.B. 779 §§ 7(8), 7(9). A similar requirement has been enjoined since October 2019. *Tulsa Women’s Reproductive Clinic, LLC, et al v. Hunter, et al*, No. CV-2019-2176 (Dist. Ct. Okla. Cnty. Oct. 29, 2019). These components of S.B. 778 and S.B. 779 have been challenged on separate grounds in that case (challenging the provisions as unconstitutional restrictions on free speech, as unconstitutionally vague, and as violations of the prohibition on special laws).

deemed unconstitutional by the Oklahoma Supreme Court only five years ago and by the United States Supreme Court as recently as last year,⁵ and it also limits the time period during which medication abortion can be prescribed.

9. The Challenged Laws include no legislative findings, but the State’s strategy is nonetheless transparent—Oklahoma’s purpose is to deprive people in Oklahoma of their constitutionally protected right to choose whether to terminate their pregnancy before viability.

10. The Challenged Laws violate the constitutional rights of Oklahomans to reproductive autonomy, bodily integrity, and health; the Oklahoma Constitution’s prohibition against special laws; and the Oklahoma Constitution’s single-subject rule.

11. Plaintiffs include the Oklahoma Call for Reproductive Justice, an organization that represents Oklahomans seeking abortion care, as well as abortion providers and their patients. To protect Oklahomans from this phalanx of unconstitutional abortion restrictions, and to avoid irreparable harm, Plaintiffs seek declaratory and injunctive relief to block enforcement of the Challenged Laws.

II. JURISDICTION AND VENUE

12. Jurisdiction is conferred on this Court by Okla. Const. art. VII, § 7(a).

13. Plaintiffs’ claims for declaratory and injunctive relief are authorized by Okla. Stat. tit. 12, §§ 1651 and 1381 and by the general equitable powers of this Court.

14. Venue is proper under Okla. Stat. tit. 12, § 133 because Defendants O’Connor, Prater, Kelsey, Templeton, Frye, and Wilson have official residences in Oklahoma County.

⁵ *Burns v. Cline* (“*Cline III*”), 2016 OK 121, ¶ 19, 387 P.3d 348, 354; *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103, 2132 (2020) (plurality); *id.* at 2134 (Roberts, C.J., concurring); *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2313 (2016).

III. PARTIES

A. Plaintiffs

a. Oklahoma Call for Reproductive Justice (“OCRJ”)

15. OCRJ is a 501(c)(4) nonprofit founded in 2010 to advance reproductive justice and protect access to reproductive healthcare, including abortion, in Oklahoma. OCRJ is dedicated entirely to this cause. OCRJ’s mission is to promote reproductive justice in Oklahoma through education, empowerment, and advocacy.

16. OCRJ pursues its mission by providing education in the community. OCRJ publishes a zine, *How to Get an Abortion in Oklahoma*, which is updated regularly and provides information to Oklahomans who need to navigate the many overlapping laws restricting abortion in the State. OCRJ has also held educational campaigns, such as Faith & Abortion and Abortion is an Act of Love, to lessen the stigma attached to abortion, abortion providers, and patients.

17. OCRJ also pursues its mission by lobbying against bills that restrict abortion and other reproductive healthcare. It supports bills that help pregnant people, including legislation barring the shackling of pregnant incarcerated patients during labor. Prior to the COVID-19 pandemic, OCRJ hosted lobby days, during which it organized its members to lobby legislators around issues of reproductive justice. OCRJ holds events and speaks to the media in order to educate Oklahomans about legislation and the potential impact of such legislation on Oklahomans’ access to reproductive healthcare.

18. During this most recent legislative session, OCRJ marshalled its limited resources to combat the bills challenged in this case. Should any of these bills go into effect, OCRJ will continue to support people who need to access to abortion. OCRJ would likely have to shift their educational efforts and limited resources towards educating people on the new laws and/or how to navigate barriers in other states when they need to obtain abortions outside of Oklahoma. OCRJ

may also choose to redirect its resources to help people financially as they find ways to obtain care out of state, which it does not currently offer.

19. OCRJ's members are diverse in their party affiliation, economic background, and lived experience, but all believe that pregnant Oklahomans deserve the ability to make decisions about their healthcare in line with their own values and intentions. OCRJ sues on behalf of itself and its members.

b. Tulsa Women's Reproductive Clinic ("Tulsa Women's")

20. Tulsa Women's is located in Tulsa, Oklahoma and has been offering abortion services since 1974. Until 2018, Tulsa Women's was operated by a predecessor, Nova Health Systems. Tulsa Women's provides reproductive healthcare services, including medication and procedural abortions. It is licensed as an abortion facility by the Oklahoma State Department of Health (the "Health Department") and is a member of the National Abortion Federation ("NAF"). Tulsa Women's employs, among other licensed healthcare clinicians, physicians licensed by the Oklahoma State Board of Medical Licensure and Supervision (the "Medical Board") and the Oklahoma State Board of Osteopathic Examiners (the "Osteopathic Board"). Tulsa Women's brings claims on behalf of itself, its physicians, its staff, and its patients.

21. Tulsa Women's provides medication abortion up through ten weeks, 0 days LMP and procedural abortion care. People⁶ who reside throughout the state of Oklahoma, as well as people from Missouri, Kansas, Arkansas, and Texas, travel to Tulsa Women's to access high quality abortion services.

⁶ This Complaint uses the term "women," but the denial of reproductive healthcare also affects individuals who may not identify as women, including transgender and gender-nonconforming individuals.

22. Six physicians, including Dr. Alan Braid, who is also a Plaintiff in this case, provide abortion care at Tulsa Women's. Five of the physicians are medical doctors licensed by the Medical Board, and one is an osteopathic physician licensed by the Osteopathic Board. Three of these physicians are board-certified family medicine physicians. The other three are board-certified OB/GYNs. Tulsa Women's generally provides abortions five days a week. Approximately 80 percent of Tulsa Women's abortion patients choose medication abortion.

c. Dr. Alan Braid

23. Plaintiff Alan Braid, M.D. is a board-certified OB/GYN and is the principal owner of Tulsa Women's. He took ownership of the clinic in 2018 after the previous owner retired to ensure that it continued to provide Oklahomans with abortion care. Dr. Braid also provides abortion care at Tulsa Women's. Dr. Braid sues on behalf of himself and his patients.

**d. Comprehensive Health of Planned Parenthood Great Plains
("CHPPGP")**

24. CHPPGP is a not-or-profit corporation organized under the laws of Kansas and registered to do business in Oklahoma. CHPPGP operates one health center in Oklahoma, located in Oklahoma City, which is licensed as an abortion facility by the Oklahoma State Department of Health. The Oklahoma City health center keeps pharmaceutical medication in a drug room licensed by the Oklahoma State Board of Pharmacy. CHPPGP sues on behalf of itself, its physicians, its staff, and its patients.

25. CHPPGP provides a wide variety of sexual and reproductive health care at its Oklahoma City location, including contraceptives, cancer screenings, pap smears, wellness exams, breast exams, colposcopies, and abortion care. CHPPGP's Oklahoma City location provides medication abortion, up through 11 weeks, 0 days LMP, as well as procedural abortion.

26. CHPPGP employs four physicians who each provide abortion care a few days per month at CHPPGP’s Oklahoma City location. All four physicians are licensed to practice medicine in Oklahoma by the Medical Board. Three of the four physicians reside out-of-state and must travel to Oklahoma to provide care (the other physician works primarily at the Planned Parenthood facility in Tulsa described *infra* ¶ 27). Three of the four physicians are board-certified in Family Medicine, the fourth is a board-certified OB/GYN.

e. Planned Parenthood of Arkansas & Eastern Oklahoma (“PPAEO”)

27. PPAEO is a not-for-profit corporation organized under the laws of Oklahoma. It operates one health center in Oklahoma, located in Tulsa, which is licensed as an abortion facility by the Oklahoma State Department of Health. The Tulsa health center keeps pharmaceutical medication in a drug room licensed by the Oklahoma State Board of Pharmacy. PPAEO sues on behalf of itself, its staff, and its patients.

28. PPAEO provides a wide variety of sexual and reproductive health care at its Tulsa location, including contraceptives, cancer screenings, pap smears, wellness exams, breast exams, colposcopies, and abortion care. PPAEO’s Tulsa location provides medication abortion, up through 11 weeks, 0 days LMP, as well as procedural abortion.

29. PPAEO employs one full-time physician who provides abortion care at its Tulsa facility. This physician is licensed to practice medicine in Oklahoma by the Medical Board and is board-certified in Family Medicine.

B. Defendants

30. Defendant John O’Connor is the Attorney General of the State of Oklahoma. The Attorney General is the “chief law officer of the state,” 74 O.S. § 18, whose duties include “appear[ing] in any action in which the interests of the state or the people of the state are at issue. . . .” 74 O.S. § 18b(A)(3). He is sued in his official capacity.

31. Defendant David Prater is the District Attorney for Oklahoma County. Defendant Prater is responsible for prosecuting all criminal matters occurring within Oklahoma County pursuant to Okla. Stat. tit. 19, § 215.4. *See* H.B. 2441 § (1)(D); H.B. 1904 § (1)(A); S.B. 778 § 11(A)(4)(c); S.B. 779 § 11(E)(3). He is sued in his official capacity.

32. Defendant Steve Kunzweiler is the District Attorney for Tulsa County. Defendant Kunzweiler is responsible for prosecuting all criminal matters occurring within Tulsa County pursuant to 19 O.S. § 215.4. *See* H.B. 2441 § (1)(D); H.B. 1904 § (1)(A); S.B. 778 § 11(A)(4)(c); S.B. 779 § 11(E)(3). He is sued in his official capacity.

33. Defendant Lyle Kelsey is the Executive Director of the Oklahoma Medical Board. The Medical Board, among other responsibilities, issues medical licenses and has authority to take disciplinary action against its licensees. 59 O.S. §§ 495, 503, 509, 509.1; H.B. 1102 § 1(20); S.B. 779 § 12(A). He is sued in his official capacity.

34. Defendant Katie Templeton is the President of the Oklahoma Osteopathic Board. The Osteopathic Board, among other things, issues licenses to osteopathic physicians and has authority to take disciplinary action against its licensees. 59 O.S. §§ 622(A)(1), 633, 637, 637.1; H.B. 1102 § A(14); S.B. 779 § 12(A). She is sued in her official capacity.

35. Defendant Lance Frye is the Oklahoma Interim Commissioner of Health. He oversees the Oklahoma State Board of Health, which issues licenses to facilities at which abortions are performed and oversees compliance with the regulation of such facilities. 63 O.S. §§ 1-706(A), (B); O.A.C. §§ 310:600-7-3, -13-2; S.B. 778 § 4(B), (8)(A); S.B. 779 § 8(2)(c)-(d), (g). He is sued in his official capacity.

36. Defendant Justin Wilson is the President of the Oklahoma State Board of Pharmacy (“Board of Pharmacy”). The Board of Pharmacy, among other things, issues licenses and oversees

compliance with pharmacy regulations. 59 O.S. § 8-353.7(9)-(11); S.B. 779 § 12(A). He is sued in his official capacity.

IV. FACTUAL ALLEGATIONS

A. Abortion is an Extraordinarily Safe Form of Medical Care

37. Abortion is one of the safest and most common medical procedures performed in the United States.⁷

38. Nationwide, nearly one in four women will obtain an abortion by age forty-five.⁸

39. There are generally two methods of providing abortion care: medication abortion and procedural abortion. Abortion by either method is safe and effective. Complications from abortion occur less than 1% of the time, making abortion safer than carrying a pregnancy to term.⁹ Nationally, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion.¹⁰

40. The most common form of medication abortion is a regimen of two prescription drugs, mifepristone and misoprostol, which are pills taken orally. Mifepristone, also known by its commercial name Mifeprex, was first approved by the U.S. Food and Drug Administration (“FDA”) in 2000 as an effective alternative to procedural abortion in early pregnancy when used in conjunction with misoprostol. As with other prescription drugs, the combined use of mifepristone and misoprostol—collectively referred to as “medication abortion”—is regulated by

⁷ See NAS Report at 163-5.

⁸ New Release, Guttmacher Inst., *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (Oct. 19, 2017), <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>.

⁹ See NAS Report at 55, 60, 163.

¹⁰ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth In The United States*, 119 *Obstetrics & Gynecology* 215-9 (2012).

the FDA. The FDA has confirmed that the regimen of mifepristone and misoprostol is extremely safe and effective in terminating pregnancy.¹¹

41. Since 2000, over four million women in the United States have had a medication abortion.¹²

42. As provided by the 2016 FDA label, the protocol for the administration of medication abortion is as follows: on day 1, the patient takes 200 mg of mifepristone orally; 24 to 48 hours later, the patient takes 800 mcg of misoprostol buccally (meaning, held inside the cheek while the pills dissolve).¹³ The 2016 label contemplates the use of medication abortion through seventy days, or ten weeks LMP.¹⁴ Medical evidence also supports the use of this regimen through 77 days, or eleven weeks LMP.

43. Research consistently shows that medication abortion is comparable in safety to many common prescription medications, such as antibiotics, and even over-the-counter medications, such as Advil and Tylenol.

44. Given the robust evidence of the safety of medication abortion, the medical consensus is moving away from medically unnecessary restrictions on access to the regimen. In 2016, the FDA revised its original protocol to recommend lower dosages, longer availability, and removal of in-person follow-up requirements, reflecting the superior evidence-based protocols

¹¹ *Mifeprex (mifepristone) Highlights of Prescribing Information*, (Mar. 2016) (“FDA Label”).

¹² Dance Laboratories, LLC, *Mifeprex Effectiveness and Advantages*, <https://www.earlyoptionpill.com/is-mifeprex-right-for-me/effectiveness-advantages/>.

¹³ *See* FDA Label.

¹⁴ *Id.*

employed by physicians.¹⁵ At present, the FDA is reevaluating the remaining restrictions on medication abortion.¹⁶

45. According to data collected by the Health Department, the proportion of abortions by medication abortion in Oklahoma has been steadily increasing. “In 2002, non-surgical abortions made up only 4.5 percent of all abortions performed in Oklahoma, while in 2020 non-surgical abortions made up 64.0 percent of all abortions.”¹⁷

46. Patients seeking an abortion can choose between a medication abortion and a procedural abortion up through 10 or 11 weeks LMP, depending on the provider’s practice; thereafter, only procedural abortion is available.

47. Many patients prefer medication abortion because they can complete the process (that is, take the second pill) in the privacy of their homes, with the company of loved ones, and at a time of their choosing. Other patients, including rape survivors, prefer medication abortion to a procedural abortion because it can feel less invasive or more natural.

48. Medication abortion can also be medically preferred for some patients. For example, some patients have common medical conditions that make medication abortion a medically preferable option.

49. Except in narrow circumstances, abortion is illegal in Oklahoma after 22 weeks LMP. O.S. 63 § 1-745.5.

¹⁵ *Id.*

¹⁶ *Chelius v. Becerra*, Joint Mot. to Stay, No. 1:17-cv-00493-JAO-RT (D. Hi. May 7, 2021).

¹⁷ Oklahoma State Department of Health, *Abortion Surveillance in Oklahoma, 2002-2020*, Oklahoma State Department of Health (May 2020), <https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/data-and-statistics/center-for-health-statistics/2020%20AbortionReport.pdf> (“OK Abortion Report 2020”).

50. Procedural abortion involves gently dilating (opening) the cervix and then removing the contents of the uterus. Procedural abortion is a straightforward procedure. It is almost always performed in an outpatient setting and involves local anesthesia and sometimes conscious sedation to make the patient more comfortable.¹⁸ Though it is sometimes referred to as “surgical” abortion, it is not what is commonly understood to be surgery. There is no incision and no need for general anesthesia or a sterile field.

51. Procedural abortion is safe and effective, with a rate of complications comparable to or lower than many other outpatient procedures such as colonoscopies and wisdom tooth extractions.

B. Oklahoma’s Existing Regulatory Requirements Governing Abortion

52. For decades, Oklahoma has engaged in a persistent campaign to make abortion difficult, if not impossible, to access. Since 2008, the Oklahoma Legislature has enacted over 20 bills addressing abortion, imposing a maze of requirements. Many of these bills have been enjoined:

- *Okla. Coal. for Reprod. Just. v. Cline (“Cline IV”)*, 2019 OK 33, ¶ 43, 441 P.3d 1145, 1161 (permanently enjoining a law mandating an outdated protocol for providing medication abortion);
- *Cline III*, 2016 OK 121, ¶ 19, 387 P.3d 348, 354 (permanently enjoining bill including an admitting-privileges requirement);
- *Burns v. Cline (“Cline II”)*, 2016 OK 99, ¶ 10, 382 P.3d 1048, 1051 (permanently enjoining bill including amendments to minor consent for abortion);
- *Cline v. Okla. Coal. for Reprod. Just. v. Cline (“Cline I”)*, 2012 OK 102, ¶ 2, 292 P.3d 27, 28 (permanently enjoining law restricting access to medication abortion);
- *Nova Health Sys. v. Pruitt*, 2012 OK 103, 292 P.3d 28 (permanently enjoining mandatory ultrasound law);

¹⁸ See NAS Report at 77-78, 162-66.

- *Davis v. Edmondson*, No. CJ-2009-9154, 2010 WL 1734636 (Okla. Dist. Mar. 2, 2010) (permanently enjoining a 2009 statute imposing multiple abortion restrictions);
- *Nova Health Sys. v. Edmondson*, 2010 OK 21, 233 P.3d 380 (permanently enjoining a 2008 statute imposing multiple abortion restrictions);
- *S. Wind Women’s Ctr. LLC v. Stitt*, 455 F. Supp. 3d 1219, 1232 (W.D. Okla. 2020), *appeal dismissed as moot*, 823 F. App’x 677 (10th Cir. 2020) (enjoining most of executive order banning abortions purportedly due to COVID-19);
- *Tulsa Women’s Reproductive Clinic, LLC, et al v. Hunter, et al*, No. CV-2019-2176 (Dist. Ct. Okla. Cnty. Oct. 29, 2019) (preliminarily enjoining law requiring disclosure of information about “medication abortion reversal”).

53. Oklahoma’s administrative code outlines extensive regulations for abortion facilities governing administration, staffing, clinical services, recordkeeping, and physical plants. O.A.C. §§ 310:600-1-1; 310:600-13-3. No public facilities or hospitals may be used for abortions, and with limited exceptions, no public employees may provide abortions. 63 O.S. § 1-741.1(A). All patients seeking abortions are required to wait 72 hours after receiving state-mandated information. 63 O.S. § 1-738.2. People who rely on Medicaid can obtain coverage for abortion only if the pregnancy is life-threatening or the result of rape or incest. 63 O.S. § 1-741.1(B); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 128 Stat. 409, §§ 506-07.

C. Access to Abortion is Central to the Health and Wellbeing of Oklahomans

54. Access to abortion benefits the health and wellbeing of pregnant people and their families, including people who already have children. Over the past fifty years, access to abortion has been essential to facilitating women’s equal participation in society, including in the economic and social life of the nation.

55. There is no typical abortion patient. People seek abortions for a variety of deeply personal and often complex reasons, including familial, medical, and financial concerns.¹⁹ Some people have abortions because they conclude that it is not the right time in their lives to have a child or to add to their families. Some decide to end a pregnancy because they want to pursue their education. Some choose abortion because they feel they lack the necessary economic resources, level of partner support, or stability. Three-fourths of abortion patients cite responsibility to other individuals (such as children or elderly parents) as a reason; many also say they cannot afford to become a parent or to add to their families, and that having a baby would interfere with work, school, or the ability to care for dependents.²⁰ Some decide to have an abortion because they do not want children at all. Some decide to have an abortion because of an indication or diagnosis of a fetal medical condition. Some patients experience intimate partner violence and may face additional threats to their safety if their partner becomes aware of their pregnancy or desire for an abortion; many such patients fear that being forced to carry the pregnancy to term would further tether them to their abusers.

56. Data from the Department of Health likewise shows that, when asked their reason for seeking abortion care, patients most frequently report that having a baby would “dramatically change” their life, that it would interfere with their education or career, or that they cannot afford to have a child.²¹

¹⁹ Stanley K. Henshaw & Kathryn Kost, *Abortion Patients in 1994-1995: Characteristics and Contraceptive Use*, 28(4) *Family Planning Perspectives* 140-47, 158 (1996), <https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/2814096.pdf>.

²⁰ Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37(3) *Perspectives on Sexual and Reproductive Health* 110-18, 117 (Sept. 2005), https://www.guttmacher.org/sites/default/files/article_files/3711005.pdf.

²¹ See OK Abortion Report 2020 at 24.

57. When people are denied the ability to choose an abortion, their lives are irrevocably altered—the State intrudes on their bodily autonomy and their ability to direct their own lives. Denial of care also imposes substantial medical risk, as in all instances carrying a pregnancy to term is far riskier than any method of abortion. Further, people denied access to abortion experience worse psychological, physical, and financial health outcomes than people who were able to access such care. These women are more likely to experience poverty, health difficulties, and physical violence, as are their families.

D. Abortion Patients in Oklahoma Have a Diversity of Experience and Some Communities are Particularly Harmed by Restrictions on Abortion

58. Abortion patients in Oklahoma are diverse, but the rates of abortion are highest for people of color. According to data collected by the Health Department, the overall rate of abortions is declining—but the proportion of patients of color and those with fewer resources receiving abortions has increased.²² “Black women, women with less education and those who were unmarried had higher rates of abortions compared to other women of child-bearing age.”²³ Increasingly, restrictions on abortion thus impact Black women more significantly than other populations. Indigenous patients also experience outsized harms from abortion restrictions. In particular, Indigenous patients are most likely to obtain a medication abortion,²⁴ and they will thus be hardest hit by restrictions on that method.

59. At the same time, these communities have a much higher rate of maternal death. In 2020, the Oklahoma Maternal Mortality Review Committee issued its inaugural report. It found

²² *See id.* at 7.

²³ *Id.*

²⁴ *Id.*

that Oklahoma is the fourth-worst state in the nation for maternal mortality.²⁵ And, specifically, Black women in Oklahoma were two and a half times more likely to die of complications related to birth or pregnancy than white women.²⁶ The report characterized this as an “alarming disparity.”²⁷ Indigenous women were up to one and a half times more likely to die compared to white women.²⁸ “For every woman who dies, about 70 have life-threatening complications related to birth or pregnancy, according to data obtained from the health department.”²⁹

60. Black and Indigenous communities in Oklahoma face heightened challenges across the spectrum of reproductive choices. These same communities have experienced oppression for generations, dating back to horrific race- and gender-based violence—from the Tulsa Race Massacre to the forced removal of Indigenous children from their families. And, today, these same communities disproportionately experience poverty and lack of access to healthcare, education, and other services.

61. As Hannibal Johnson, historian and author who studied the Tulsa Race Massacre, has stated, there are “two main casualties of the massacre” that contribute to racial disparities and “affect everyday life—a breach in trust between Black and white communities and the inability to

²⁵ Oklahoma Maternal Mortality Review Committee, *Maternal Mortality in Oklahoma 2004-2018* (2020), <https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/family-health/maternal-and-child-health/maternal-mortality/annual-mmrc-report.pdf>.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ Kassie McClung, *Most of Oklahoma’s maternal deaths preventable, state review finds*, *The Frontier*, Aug. 10, 2020, <https://www.readfrontier.org/stories/mostof-oklahomas-maternal-deaths-preventable-state-review-finds/>.

transfer accumulated wealth.”³⁰ The wealth disparities that exist today in Oklahoma ultimately stem from the “inability of Black people to accumulate wealth and transfer it intergenerationally.”³¹ According to the Oklahoma Policy Institute: “[n]ow we see more clearly why households of color in Oklahoma have less wealth on average than [w]hite households: some had ancestors whose wealth was destroyed during the Tulsa Race Riot in the 1920s, grandparents who were denied a college education or homeownership in the 1940s and 50s, and parents who faced employment discrimination throughout the 1970s and 80s.”³²

62. Government-inflicted traumas, including removal of land and resources, have also hindered the Indigenous communities in Oklahoma.³³ Tribes from all over the United States were relocated to reservations in what became the State of Oklahoma through the trail of tears and other removals. Devastatingly, Indigenous families repeatedly suffered the horrific crime of having their children forcibly removed from their care. Unsurprisingly, Indigenous people have the highest rate of poverty of any minority group—25.4%.³⁴

63. In short, although promised as a place of freedom, the State of Oklahoma has repeatedly devastated the ability of Black and Indigenous people to form families, grow their

³⁰ Randi Richardson, *Tulsa Race Massacre, 100 years later: Why it happened and why it's still relevant today*, NBC News, May 28, 2021, <https://www.nbcnews.com/news/nbcblk/tulsa-race-massacre-100-years-later-why-it-happened-why-n1268877>.

³¹ *Id.*

³² Kate Richey, [*Closing The Gap, Part 5*] *Past is future: Intergenerational wealth*, Oklahoma Policy Institute (Aug. 28, 2013), <https://okpolicy.org/closing-the-gap-part-5-past-is-future-intergenerational-wealth/>.

³³ Dedrick Asante Muhammad, Rogelio Tec, and Kathy Ramirez, *Racial Wealth Snapshot: American Indians/ Native Americans*, National Community Reinvestment Coalition (Nov. 18, 2019), <https://ncrc.org/racial-wealth-snapshot-american-indians-native-americans/>.

³⁴ Poverty USA, *The Population of Poverty USA (2021)*, <https://www.povertyusa.org/facts>.

communities, and succeed. While failing to address these persistent disparities, the State continues to pursue policies that disproportionately harm Black and Indigenous people and make it ever more challenging to direct their own lives.

64. Most people who need to access abortion are living in poverty. Nationally, approximately three-fourths of abortion patients are low income—49% living at less than the federal poverty level, and 26% living at 100-199% of the poverty level.³⁵

65. There is no state funding for abortion care in Oklahoma. Thus, the people with the least means pay out of pocket for an abortion.

66. Additionally, low-income patients in Oklahoma face logistical barriers to care. Oklahoma is a rural state, with higher poverty rates in rural and small-town Oklahoma than in the major metropolitan areas.³⁶ Traveling in Oklahoma is challenging, especially for those without a car, since there is no meaningful public transportation in the State.

67. In Oklahoma, about two-thirds of abortion patients already have at least one child.³⁷ One in three Oklahomans living in poverty are in single-mother households.³⁸ Thus, many patients struggle to find safe and affordable childcare when they go to a clinic.

³⁵ Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* at 7, 11 (“Jerman & Jones”), Guttmacher Inst. (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

³⁶ *See Richey, supra.*

³⁷ *See OK Abortion Report 2020* at 21.

³⁸ *See Richey, supra.*

68. Further, according to statistics cited by the Department of Health, in Oklahoma, 49% of women have experienced intimate partner violence at some time in their lives.³⁹ These patients also face additional challenges accessing care, including threats to their safety and the safety of their families.

69. Women working low-wage jobs also often have no access to paid time off or sick days. According to the Institute for Women’s Policy Research, 41% of working parents at or below 200% of the poverty line have no access to paid sick leave, vacation days, personal days, or any other form of compensated leave.⁴⁰ “In Oklahoma, even *unpaid* leave under the federal Family and Medical Leave Act is inaccessible for 64 percent of working people.”⁴¹

70. Research consistently shows that access to abortion care is very sensitive to increases in these logistical burdens—even small increases in travel distance or congestion at abortion facilities due to reduced access can stop people from getting care and force them to carry an unwanted pregnancy to term.⁴²

³⁹ Oklahoma State Department of Health, *Intimate Partner Violence*, <https://oklahoma.gov/health/prevention-and-preparedness/injury-prevention-service/intimate-partner-violence.html>.

⁴⁰ Andrea Lindemann Gilliam, *An Introduction to Paid Time Off Banks*, Institute for Women’s Policy Research, (June 20, 2012), <http://www.iwpr.org/blog/2012/06/20/an-introduction-to-paid-time-off-banks>.

⁴¹ National Partnership for Women & Families, *Paid Leave Means a Stronger Oklahoma* (Jan. 2021), <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-leave-means-a-stronger-oklahoma.pdf>.

⁴² Daniel Grossman, *The Use of Public Health Evidence in Whole Woman’s Health v Hellerstedt*, 177(2) *JAMA Intern Med.* 155-56 (2017); Jason M. Lindo & Caitlin Knowles Myers & Andrea Schlosser & Scott Cunningham, *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions*, 55(4) *Journal of Human Resources* 1137-60 (2020); Troy Quast et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 *Inquiry* 1 (2017); Stefanie Fischer et al., *The impacts of reduced access to abortion and family planning services on abortions, births, and contraceptive purchases*, *Journal of Public Economics* 167 (Nov 2018); Joanna Venator and Jason Fletcher, *Undue Burden Beyond Texas: An Analysis of Abortion Clinic Closures, Births, and Abortions in Wisconsin*, NBER Working Paper 26362 (2019).

71. Being pregnant in Oklahoma thus comes with a host of challenges regardless of one's intentions for the pregnancy, and this is especially true for Black and Indigenous people and people living in poverty.

72. The Provider Plaintiffs see their patients attempt to navigate these challenges every day.

73. OCRJ and its members strive to shed light on and expose how restrictions on abortion negatively impact all Oklahomans but have particularly devastating impacts on people of color and low-income people.

V. THE CHALLENGED LAWS ARE UNCONSTITUTIONAL AND WILL IMMEASURABLY HARM THE PROVIDER PLAINTIFFS AND THEIR PATIENTS, AS WELL AS OCRJ AND ITS MEMBERS

A. The Total Ban

74. The Total Ban defines the provision of abortion care as “unprofessional conduct” by physicians. It effectively prohibits *all* abortion care except in exceedingly narrow circumstances. If permitted to take effect, the Total Ban will prevent the Provider Plaintiffs from providing abortion care, thus eliminating access to abortion in Oklahoma. Such a law is clearly unconstitutional and would impose the same harms as the ban invalidated in *Roe v. Wade*.

75. The Total Ban amends an existing statute setting forth various forms of unprofessional conduct by physicians licensed by the Medical Board—adding the “[p]erformance of an abortion” as a category of “unprofessional conduct.” H.B. 1102 § 1(20) (amending 59 O.S. § 509).

76. The penalty for violation of the Total Ban includes, but is not limited to, suspension of a physician's medical license “for a period of not less than one (1) year.” *Id.* The Medical Board also has available the full range of enforcement mechanisms provided for unprofessional conduct,

including permanent revocation of medical license and fines of up to \$5,000 per violation. 59 O.S. § 509.1.

77. The Total Ban has an extremely narrow medical emergency exception where “in reasonable medical judgment, [the patient] has a condition that so complicates her medical condition that it necessitates” an abortion “to avert her death or to avert serious risk of substantial and irreversible physical impairment of a major bodily function.” H.B. 2441 § 1(A). This exception does not apply to “psychological or emotional conditions,” however—even where there is a claim or diagnosis that the patient “will engage in conduct which she intends to result in her death.” *Id.*

78. The Total Ban imposes similar, corresponding penalties for osteopathic doctors licensed by the Osteopathic Board who provide abortion services. H.B. 1102 § A(14) (amending 59 O.S. § 637(14)) (categorizing performance of an abortion as cause for licensure sanctions except in extremely limited circumstances); 59 O.S. § 637.1 (authorizing revocation of license and administrative fines of up to \$1,000 for each count or separate violation).

79. A total ban on pre-viability abortion will irreparably harm the Provider Plaintiffs’ patients as well as members of OCRJ, as described above in Parts IV(C) and IV(D).

B. The 6-Week Ban

80. In clear violation of Oklahoma Supreme Court precedent, the 6-Week Ban prohibits abortion roughly four months prior to viability, which medical consensus concludes typically occurs around 23-24 weeks LMP. A full-term pregnancy is approximately 40 weeks LMP. No fetus is viable at approximately 6 weeks LMP.

81. According to Department of Health data, from 2002-2018, approximately 60% of abortions took place after 6 weeks LMP.⁴³ Thus, the 6-Week Ban will prohibit a large percentage of abortions performed in Oklahoma.

82. The 6-Week Ban turns on the detection of a “heartbeat,” and prohibits performing or inducing an abortion “without first detecting whether or not [the] unborn child has a heartbeat.” H.B. 2441 § 1(A)-(B). No abortion may be performed where a heartbeat is detectable. *Id.*

83. A person who violates the ban is “guilty of homicide.” *Id.* § 1(D).

84. The only exception mirrors the callously limited language used in the Total Ban described *supra* ¶ 77.

85. In a typically developing embryo, cells that eventually form the basis for development of the heart later in pregnancy produce cardiac activity that is generally detectable via ultrasound beginning at approximately 6 weeks LMP.

86. The cells that produce this early cardiac activity have not yet formed a “heart.” The term “heartbeat” as used in the statute is *not* a “heartbeat” in a lay sense, but more accurately, electrical impulses present before the development of the cardiovascular system.

87. Patients generally seek abortion care as soon as they are able, but the majority of abortion patients are simply not able to confirm a pregnancy and schedule and obtain an abortion before 6 weeks LMP.

88. Some individuals have fairly regular menstrual cycles (periods), with a 4-week cycle being typical; others have regular cycles of different lengths; and still others have irregular cycles or rarely have a period at all

⁴³ Okla. State Dept. of Health, *Detailed Induced Termination of Pregnancy Statistics*, https://www.health.state.ok.us/stats/Vital_Statistics/ITOP/Final/Statistics.shtml. The most recent Abortion Surveillance Report only reports abortions performed after 8 weeks LMP.

89. In a person with regular monthly periods, fertilization typically occurs 2 weeks LMP—that is, 2 weeks after the first day of the last menstrual period. This means an individual with a highly regular, 4-week cycle would be 4 weeks LMP at the time of the first missed period. Thus, the 6-Week Ban limits them to a mere 2 weeks after they will have missed their period to make a decision and then schedule and obtain an abortion.

90. Prior to and even after 6 weeks LMP, many individuals do not know they are pregnant—particularly people who have irregular cycles, who have certain medical conditions, who have been using contraceptives, who are breastfeeding, and who may not be getting a period at all.

91. By prohibiting a majority of abortions performed in Oklahoma, the 6-Week Ban will irreparably harm the Provider Plaintiffs’ patients as well as members of OCRJ—prohibiting them from exercising their constitutional right to choose abortion and direct the course of their lives, as described above in Parts IV(C) and IV(D).

C. The OB/GYN Requirement

92. The OB/GYN Requirement arbitrarily prohibits qualified physicians from providing abortions unless they are board-certified in obstetrics and gynecology. *See* H.B. 1904 § 1 (amending O.S. § 63-1-731(A)). Providing an abortion in violation of the OB/GYN Requirement is a felony, punishable by one to three years in prison. *Id.* It may also result in the revocation, suspension, or nonrenewal of the professional license of the physician or abortion facility. O.S. §§ 59-509(9); 59-637(5).

93. If the OB/GYN Requirement is permitted to take effect, half of the physicians at Tulsa Women’s, the only physician at CHPPGP, and three quarters of PPAEO’s physicians will

be barred from providing abortion care, which they have done safely and effectively in Oklahoma and/or other states for years.⁴⁴ This requirement has no medical justification.

94. The OB/GYN Requirement is similar in effect to, and even more onerous than, the admitting privileges requirement deemed unconstitutional by the Oklahoma Supreme Court in *Cline III*. Like the law invalidated in *Cline III*, the OB/GYN Requirement will dramatically reduce the number of providers without medical justification.

95. Barring a significant percentage of the Provider Plaintiffs' physicians from providing abortion care would have the same kind of dramatic effect on access to abortion in this state demonstrated in Texas and Louisiana, respectively, in *Whole Woman's Health* and *June Medical*, where the United States Supreme Court invalidated state laws that curtailed access.⁴⁵

96. The legislative history of the OB/GYN Requirement makes clear that the bill was intended to restrict abortion access in Oklahoma, not to make abortion care safer. Representative Cynthia Roe, the bill's primary sponsor, stated unequivocally that "[t]his Bill is about reducing the number of abortions done in this state." H.R., 58th Leg., 1st Reg. Sess., Day 18 (Okla. Mar. 2, 2021), Statement of Rep. Cynthia Roe. Representative Roe conceded that "complications are rare." *Id.*; *see also id.* (noting that "[b]etween 2012 and 2019 there were over 96,000 abortions performed in this state and that's 96,000+ too many"). In the Oklahoma Senate, Senator Shane Jett, also a co-sponsor, made clear that the bill would restrict abortion access, remarking that "House Bill 1904 will reduce the number of babies who are killed in the womb." Senate Chamber Session, 58th Leg. (Okla. Apr. 20, 2021), Statement of Sen. Shane Jett.

⁴⁴ Currently, Oklahoma law only permits physicians to provide abortion care. O.S. § 63-1-731.

⁴⁵ *June Med. Servs.*, 140 S. Ct. at 2132 (plurality); *id.* at 2134 (Roberts, C.J., concurring); *Whole Woman's Health*, 136 S. Ct. at 2313.

97. There is no medical basis for the OB/GYN Requirement. Training and experience, not specialty, determines competency to provide abortion care, which is why a wide variety of clinicians can safely provide abortion services.

98. For example, abortion is well within the broad scope of practice of family medicine physicians, which includes a large array of outpatient procedures in which individual physicians may achieve competency through training and experience. Some family medicine physicians perform procedures more complex than abortion, such as colonoscopies. Some family medicine doctors provide obstetrical care including prenatal care and delivery, which is far riskier than abortion.

99. A host of clinicians, including family medicine doctors, can provide prescription medications that are comparable to or riskier than medication abortion, such as antibiotics or pain medications, such as fentanyl.

100. Clinicians manage miscarriages with largely the same medications and procedures used in abortion care, but this care is not subject to any similar restriction.

101. OB/GYNs are not inherently more qualified to provide—or learn how to provide—abortion care than physicians with other specialties, such as family medicine. OB/GYNs are not required to train in abortion care. One survey of residency program directors found that “only 51% of obstetrics and gynecology residency programs offered routine abortion training.”⁴⁶

102. Thus, the fact that a physician does or does not have board certification in OB/GYN is irrelevant to the question of their training and competence to provide abortion care.

⁴⁶ American College of Obstetricians and Gynecologists, Comm. on Health Care for Underserved Women, *Committee Opinion 612, Abortion Training and Education* 124(5) Obstetrics & Gynecology 1055-59 (Nov. 2014, reaff'd 2017), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2014/11/abortion-training-and-education.pdf> (“ACOG Comm. Op. 612”).

103. For all of these reasons, leading professional medical organizations oppose laws like the OB/GYN Requirement. For example, the American College of Obstetricians & Gynecologists (“ACOG”) recognizes that clinicians in many medical specialties—including advanced practice clinicians such as a nurse practitioners—can provide safe abortion care, and that requiring board-certification in obstetrics and gynecology is “medically unnecessary” and “designed to reduce access to abortion.”⁴⁷ The President of the Academy of Family Physicians has likewise said that “[t]here is no evidence that these requirements improve patient safety; they just serve to reduce patient access to care.”⁴⁸ Organizations such as the National Academy of Sciences, Engineering, and Medicine have also specifically endorsed the provision of abortion care by clinicians other than board-certified OB/GYNs.⁴⁹

104. It would be infeasible for abortion providers with other specialties to obtain OB/GYN board-certification. To become board-certified in family medicine, for example, one must apply to, be accepted to, and complete a three-year family medicine residency program, which includes rotations in various specialties. A physician must then prepare for and pass a board exam. To obtain board-certification in a new specialty such as OB/GYN, a physician would have

⁴⁷ ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 815, Increasing Access to Abortion* 136(6) *Obstetrics & Gynecology* e107-15 (Dec. 2020) (replaces Committee Opinion No. 613, Nov. 2014) (“ACOG Comm. Op. 815”), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf>.

⁴⁸ Brief of Amicus Curiae American College of Obstetricians and Gynecologists et al. in Support of Petitioners, *June Medical Services L.L.C., et al. v. Gee* (No. 18-1323).

⁴⁹ Am. Academy of Family Physicians, *Recommended Curriculum Guidelines for Family Medicine Residents: Women’s Health And Gynecologic Care* 9 (Aug. 2018); see ACOG Comm. Op. 612; National Academies at 163-65.

to repeat this entire process—including applying to, being accepted to, and completing another multi-year residency program and then preparing for and passing another board exam.

105. It would be very difficult to recruit board-certified OB/GYNs to replace all of the physicians who will be disqualified by the OB/GYN Requirement. Abortion providers in Oklahoma already face myriad obstacles, including medically unjustified restrictions that single them out for heavy penalties, along with harassment and stigma, which make it more difficult for clinics to recruit and retain physicians.

106. Abortion providers in Oklahoma are regularly picketed by protestors, who harass physicians, staff, and patients. Across the United States, abortion providers are regularly subjected to harassment, threats, and acts of violence. Abortion providers have been murdered, including in a neighboring state. Anti-abortion groups have historically sought to obtain and post on the internet the home addresses of abortion providers, the names of their family members, and their personal phone numbers. This information is used to identify abortion providers and pressure them into no longer providing abortion care. The Provider Plaintiffs have personally experienced harassment as a result of anti-abortion protestors and activists.

107. Physicians who reside locally often will not provide abortions, even on a part-time basis, because it would be difficult for them to maintain an outside practice due to the stigma attached to providing abortion. For this reason, the Provider Plaintiffs have had to recruit many physicians who travel from out of state to provide care.

108. If the OB/GYN Requirement takes effect and the number of clinicians providing in the state is significantly reduced, and the pool of clinicians who are even eligible to provide is

shrunk to include only board-certified OB/GYNs,⁵⁰ people seeking abortions in Oklahoma will face tremendous barriers to care. CHPPGP and PPAEO (collectively “Planned Parenthood”)—which collectively provide approximately one quarter of all abortions provided in Oklahoma—will be reduced to a single part time provider who offers care only a few days per month. PPAEO will be unable to offer abortion care at all. Tulsa Women’s, which provides approximately another half of abortions in the state, would lose half of its capacity. The remaining providers will struggle to meet the need.

109. As a result, patients will be subjected to long wait times for appointments. The resulting logistical and financial obstacles will greatly harm the majority low-income patients who seek abortion care and disproportionately impact Black and Indigenous women, as described above in Parts IV(C) and IV(D).

110. Delays in accessing abortion subject patients to more complex and expensive procedures and increased medical risk. Although remaining low, the risk associated with abortion increases with gestational age. Patients who are close to the cutoff for medication abortion may be forced to have a procedural abortion instead, even if a medication abortion would be a more appropriate option. Patients may be pushed from a first-trimester procedure to a second-trimester procedure, which carries additional health risks for women and costs more. Some patients may be pushed beyond the time period within which they can access abortion in Oklahoma entirely.

⁵⁰ Oklahoma has a shortage of OB/GYNs. See Michelle Linn & Ryan Love, *Oklahoma OB-GYN shortage; state ranks among worst to have a baby*, Fox 23 News (Oct. 8, 2019), fox23.com/news/oklahoma-ob-gyn-shortage-state-ranks-among-worst-to-have-a-baby/995047451/.

D. S.B. 778 and S.B. 779

111. S.B. 778 and S.B. 779 (the “Medication Abortion Restrictions”) impose a massive array of requirements for providers, manufacturers, and distributors of abortion-inducing drugs, including the medications that make up the medication abortion regimen.

112. Oklahoma has a long history of attempting to restrict medication abortion in medically unjustified ways. In 2011, the Legislature enacted H.B. 1970, which essentially codified an outdated FDA protocol that had long been replaced by safer and more effective evidence-based protocols. In 2012, the Oklahoma Supreme Court struck down H.B. 1970 as unconstitutional. *Oklahoma Coal. for Reprod. Just. v. Cline*, 2012 OK ¶ 2, 292 P.3d at 27.

113. In response to the Oklahoma Supreme Court’s decision invalidating H.B. 1970, in 2014, the Oklahoma Legislature then enacted House Bill 2684, an even more extreme version of H.B. 1970. The State continued to litigate the case even after the FDA revised its protocol in 2016 to account for the widely used evidence-based practices. In 2019, the Oklahoma Supreme Court determined that H.B. 2684 too was unconstitutional. *Oklahoma Coal. for Reprod. Just. v. Cline*, 2019 OK ¶ 9, 441 P.3d at 1150.

114. In S.B. 778 and S.B. 779, Oklahoma has *again* attempted to legislate the medical practice of providing medication abortion in ways that limit the availability of care and are out of line with evidence-based medicine, irrelevant to the provision of safe care, and lacking in any medical or other justification.

115. As described *supra* at § IV(A), medication abortion is an extraordinarily safe regimen. Like H.B. 1970 and H.B. 2684, S.B. 778 and S.B. 779 are “so completely at odds with the standard that governs the practice of medicine” that they “serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do.” *Cline v. Okla. Coal. for Reprod. Just.*, 2013 OK 93, ¶ 27, 313 P.3d 253, 262 (internal citations

omitted); *Cline IV*, 2019 OK ¶ 1, 441 P.3d at 1161 (Combs, J., Gurich, C.J., Kauger, and Reif, J.J., specially concurring) (“I write to reemphasize my writing in *Oklahoma Coalition For Reproductive Justice v. Cline*, wherein I noted this Court’s prior disapproval of a law’s drastic interference in the role of physicians which restricted the use of abortion-inducing drugs . . .”).

116. There is no medical justification for subjecting medication abortion to enhanced regulation, much less the arbitrary and extensive schemes set out in S.B. 778 and S.B. 779. During the debate on S.B. 778 and S.B. 779, Representative Mark Lepak, a co-author of the bills admitted that he could not speak to the origins of S.B. 778 and did not know if any physicians were consulted on it. H.R., 58th Leg., 1st Reg. Sess., Day 65, Statement of Rep. Mark Lepak. However, he acknowledged that the restrictions “requested by Oklahomans for Life,” *id.*, and supported by other anti-abortion organizations, H.R., 58th Leg., 1st Reg. Sess., Day 45, Statement of Rep. Mark Lepak.

117. S.B. 778 and S.B. 779 apply to medication abortion, but not to the use of the same medications when used for miscarriage management.

118. Still further, components of these schemes have already been declared unconstitutional by the Oklahoma Supreme Court or the United States Supreme Court.⁵¹

a. S.B. 778—the Medication Abortion Protocol Act

119. S.B. 778 spans 17 pages and includes 14 new sections of Oklahoma Law with over 100 subsections, many of which bear no relationship to one another. S.B. 778 encompasses a vast array of unrelated requirements that serve no purpose other than reducing access to abortion care.

⁵¹ *Cline IV*, 2019 OK 33, 441 P.3d 1145; *Cline III*, 2016 OK 121, 387 P.3d 348; *Cline I*, 2012 OK 102, 292 P.3d 27; *Nova Health Sys. v. Pruitt*, 2012 OK 103, 292 P.3d 28; *June Med. Servs.*, 140 S. Ct. 2132; *Whole Woman’s Health*, 136 S. Ct. 2292.

This scheme as a whole will impose irreparable harm. Many of its provisions impose tremendous obstacles on their own.

120. Given the documented safety and commonality of medication abortion, *see supra* § IV(A), S.B. 778 has no medical justification.

121. Compliance with the scheme will drastically alter the Provider Plaintiffs' provision of medication abortion, impose significant delays and other logistical burdens on patients, and reduce access to abortion in Oklahoma.

122. S.B. 778 requires an additional, medically unnecessary visit to a provider by requiring an ultrasound at least 72 hours before an abortion. S.B. 778 § 6(B),(C), (E)(1). In *Pruitt*, the Oklahoma Supreme Court invalidated an ultrasound requirement that mandated an ultrasound a mere *one hour* in advance of the procedure, much less than the 72 hours in advance required by S.B. 778.⁵² This two-trip requirement is imposed only for patients seeking a medication abortion. Although patients currently must receive state-mandated information at least 72 hours prior to their procedure, they are not required to make two visits because the existing state-mandating information can be provided to patients by phone. 63 O.S. § 1-738.2.

123. The logistical and financial obstacles imposed by S.B. 778's two visit requirement will greatly harm the majority low-income patients who seek abortion care and disproportionately impact Black and Indigenous women, as described above in Part IV(C) and IV(D). Scheduling standalone ultrasound appointments 72 hours in advance for all medication abortion patients would create significant backlogs and thus delay care. Combined with the logistical difficulties patients will face in having to schedule and travel to two appointments, this will create substantial delays

⁵² *Pruitt*, 2012 OK ¶ 1, 292 P.3d at 29.

for patients in receiving care. As described *supra* ¶ 110, delays in accessing abortion also subject some patients to greater medical risk and more complex and expensive procedures.

124. The Provider Plaintiffs offer ultrasounds at very reasonable cost, so it is likely that most patients will travel to a clinic twice, rather than obtain an ultrasound elsewhere. It is also likely that patients might receive unreliable ultrasounds, which the Provider Plaintiffs cannot accept—it is not uncommon for crisis pregnancy centers to misdate patients.

125. Separate and unrelated to this two visit requirement, S.B. 778 also sets forth extensive reporting obligations, which far exceed existing requirements, and require the Department of Health to publish additional data for medication abortions in a manner that compromises the confidentiality of patients and security of abortion providers and those who refer patients to them. S.B. 778 § 8.

126. S.B. 778 requires that each medication abortion be reported and that such reports include the name of the providing physician, as well as the name of any referring agency or physician. S.B. 778 § 8. This will have a substantial chilling effect on physicians and agencies who may become afraid to refer patients for abortions, even where medically indicated, for fear of being identified for harassment. Indeed, the bill seems designed to create this fear of harassment, as it deems these reports on medication abortions to be “public records.” *Id.*

127. These reports will also include information about each medication abortion, including the patient’s age and race; number of previous pregnancies, live births, and abortions; probable gestational age; abortion drugs used, date provided, reason for abortion; preexisting medical conditions which would complicate pregnancy; whether the patient returned for follow-up in person; whether the patient suffered from any complications; and amount billed for complications. This is in stark contrast to the State’s existing practice, which publishes aggregated

reports and has never made individual patient records “public records.”⁵³ Although S.B. 778 includes a vague disclaimer that “information or identifiers that would make it possible to identify, in any manner or under any circumstances, a woman who has obtained or seeks to obtain a chemical abortion” must not be publicized, S.B. 778 § 8(C), it raises serious risks for the confidentiality of patient information. The information contained in these reports would expose a host of information about patients. S.B. 778 § 8. This is particularly dangerous in the context of abortion, where abusive partners of pregnant women may seek to access patient information.

128. Among other separate and unrelated components, S.B. 778 also includes a bar on mailing abortion-inducing drugs, *id.* § 3; and a prohibition on the provision of medication abortion on any school facility (including a university) or state grounds, *id.* § 5.

129. S.B. 778 imposes steep criminal, civil, and licensure penalties for even minor violations. S.B. 778 § 10. The law also creates private rights of action that can be brought by patients, spouses, parents or guardians, and current or former healthcare providers of patients, for injunctive relief preventing providers from continuing to provide medication abortion in violation of the requirements of the act. S.B. 778 § 11. The Legislature has reserved a right to intervene as a matter of right in any case challenging the law, S.B. 778 § 13, and, in an implicit acknowledgment of the bill’s many particularly unconstitutional provisions, has included a robust severability clause, S.B. 778 § 14.

⁵³ Current law even specifies that “[n]o Individual Abortion Forms or Complications of Induced Abortion Reports that have been completed and submitted to the Department by any physician” shall be made available. 63 § 1-738j(D). Indeed, the Department of Health currently suppresses “any computed statistics” in its abortion surveillance reports “when the number used in the calculation [is] less than 5” so as “[t]o address concerns regarding confidentiality of women obtaining abortions.” *See* OK Abortion Report 2020.

130. Given that there is no medical or health-related justification for S.B. 778's requirements, it seems intended only to burden patients and to threaten the confidentiality and security of patients, physicians, and referring physicians/agencies.

b. S.B. 779—The Medication Abortion Certification Program

131. S.B. 779 spans 25 pages and is comprised of over 16 new sections of law with nearly 200 subsections, many of which are unrelated to each other. The bill also amends three different existing statutes, and delegates authority to four separate state agencies. Like S.B. 778, it includes a wide array of unrelated requirements—from provider qualifications to storage of medications to how medications are shipped to reporting requirements and so much more. This scheme as a whole will impose irreparable harm. Many of its provisions impose tremendous obstacles on their own.

132. S.B. 779 creates an unprecedented scheme entitled “Oklahoma Abortion-Inducing Drug Certification Program” that ensnares physicians who provide medication abortion, as well pharmaceutical manufacturers and distributors of medication abortion. Physicians are prohibited from providing medication abortion to patients for the purpose of providing abortion care in Oklahoma unless they become certified under the S.B. 779 program. S.B. 779 §§ 3, 5(C), 5(D)(1). Manufacturers and distributors are prohibited from providing abortion-inducing drugs to physicians for the purpose of providing abortion care in Oklahoma unless they become certified under the S.B. 779 program. S.B. 779 §§ 3, 5(B)(1). To be eligible for certification under the S.B. 779 program, manufacturers and distributors must, among other things, obtain a license from the Pharmacy Board and only distribute abortion-inducing drugs to physicians certified under the act. S.B. 779 § 6(1)-(2).

133. Given the documented safety and commonality of medication abortion, *see supra* § IV(A), S.B. 779 has no medical justification. Indeed, like S.B. 778, this act includes elements that have already been deemed unconstitutional for that very reason.

134. Under S.B. 779, physicians must either maintain hospital admitting privileges at a hospital in the county or contiguous county where the medication abortion is provided and inform their patients of this, or enter into a written agreement with another physician (an “associated physician”) who has admitting privileges. S.B. 779 § 8, § 7(11). If a physician opts for a written agreement with an associated physician, their agreement must meet a host of other conditions, including submission to the physician’s Licensing Board and the Health Department of a copy of the agreement, which will contain the associated physician’s name. S.B. 779 § 8(2). The Health Department, in turn, must annually submit a copy of the agreement to *every* hospital in the county or contiguous county, including hospitals that have no association with either the medication abortion provider or the associated physician. S.B. 779 § 8(2)(d)(2). Such disclosure requirements are clearly intended to harass physicians and discourage them from being willing to act as an associated physician.

135. There is no benefit to requiring admitting privileges as a condition for providing medication abortion. As discussed *supra* in § IV(A), complications from medication abortion are exceedingly rare and, when they do arise, they generally occur after the patient has returned to her home, since the second medication is taken after the patient leaves the health center. Moreover, studies have shown that requiring admitting privileges for abortion providers does not affect the care that patients receive, including in the rare instances when complications occur.⁵⁴

⁵⁴ Ushma D. Upadhyay, et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54(2) Health Serv. Rsch. 425-36 (2018/2019), <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.13080>.

136. Hospitals grant admitting privileges to doctors who are likely to admit patients—but abortion care is so safe that abortion patients are rarely admitted to the hospital (and even if they are, in the case of medication abortion, they would not be traveling to the hospital from the health center with their physician). Admitting privileges do not reflect any special competency in care. As in other practice areas, abortion providers are able to recognize complications and make the determination of when to treat a patient in the clinic and when to refer the patient.

137. For all of these reasons, admitting privileges requirements for abortion providers have been held unconstitutional in Oklahoma as recently as 2016, *Cline III*, 2016 OK ¶ 19, 387 P.3d at 354, and by the U.S. Supreme Court as recently as last year, *June Med. Servs.*, 140 S. Ct. at 2132 (plurality); *id.* at 2134 (Roberts, C.J., concurring); *Whole Woman's Health*, 136 S. Ct. at 2313.

138. Indeed, this admitting privileges requirement is even more irrational than those invalidated in *Cline, III*, as well as *Whole Woman's Health* and *June Medical*, because it only applies to medication abortion (which primarily takes place outside the health center) and not procedural abortion (which takes place entirely at the clinic).

139. S.B. 779 will prevent doctors from providing care because they cannot obtain privileges in the county or contiguous counties where their health centers are located. Because S.B. 779 requires that any associated physician with privileges must have their information broadcast to all local hospitals annually, it is unlikely that these Plaintiffs will be able to obtain an agreement with another physician who has such privileges in order to meet S.B. 779's requirements.

140. S.B. 779 also includes a 10-week LMP limit on the provision of abortion-inducing drugs. S.B. 779 § 7(10)(b). This is effectively a prohibition on the evidence-based provision of medication abortion beyond the gestational limit on the current FDA label. This timing limitation

will prevent patients from receiving a medication abortion between 10 and 11 weeks. As set forth *supra* at ¶ 48, medication abortion can be preferred by patients or medically indicated. Similar requirements limiting the provision of medication abortion to the FDA label rather than evidence-based practice, have been previously struck down by the Oklahoma Supreme Court.⁵⁵

141. Like S.B. 778, S.B. 779 includes onerous reporting requirements, including reporting the names of any health center staff who “attend[] patients including licensing numbers” and evidence of other qualifications. S.B. 779 § 9(A). If this information is also to become public, health center staff, including physician assistants, nurses, and medical technicians may have their identifying information exposed, making them targets for anti-abortion threats and harassment.

142. S.B. 779 also directs the physician licensing boards to develop a “complaint portal” for patients, pharmacy, nursing and medical professions, and the public to submit information about potential violations. S.B. 779 § 13(B). Like the reporting requirements in S.B. 779 and 778 respectively, the complaint portal will make public the names of abortion providers—in this case, listing the names of the physicians certified under the S.B. 779 program—further making them targets for anti-abortion threats and harassment. S.B. 779 § 13(D).

143. Physicians, manufacturers, and distributors must comply with every element of this scheme or else their ability to provide medication abortion will be suspended immediately until they can prove compliance “to the satisfaction of their licensing board,” among other steep penalties. S.B. 779 § 12(A)(2). A physician who provides medication abortion in violation of the act can be fined a minimum of \$100,000 per offense; manufacturers and distributors can be fined a minimum of \$1 million per offense. S.B. 779 § 12(A)(5). S.B. 779 imposes criminal and civil penalties for violations. S.B. 779 § 10. The law also creates private rights of action for patients,

⁵⁵ *Cline IV*, 2019 OK ¶ 43, 441 P.3d at 1161; *Cline I*, 2012 OK ¶ 2, 292 P.3d at 28.

spouses, parents or guardians, and current or former healthcare providers of patients who may sue for injunctive relief preventing providers from continuing to provide medication abortion in violation of the act for patients. S.B. 779 § 11. The Legislature has reserved a right to intervene as a matter of right in any case challenging the law, S.B. 779 § 15, and, in an implicit acknowledgment of the bill's many particularly unconstitutional provisions, has included a robust severability clause. S.B. 779 § 16.

144. Oklahomans have safely received medication abortions for two decades and there is no medical or health-related justification for any S.B. 779's requirements. Rather, like S.B. 778, the requirements seem intended only to burden patients and to threaten the security of health center staff by making their identities publicly available. Further, these requirements present a stark contrast to what the FDA requires even though the FDA is charged by federal law with regulating the manufacture, distribution, and provision of prescription of drugs in the U.S. Like S.B. 778, compliance with the scheme will drastically alter the Provider Plaintiffs' provision of medication abortion and impose significant delays and other logistical burdens on patients. *See supra* at § V(D)(a).

VI. IRREPARABLE HARM AND INJUNCTIVE RELIEF

145. Each of the five Challenged Laws restrict the ability of Oklahomans, including patients of the Provider Plaintiffs and members of OCRJ, to access constitutionally protected abortion care.

146. The Total Ban and the 6-Week Ban will prevent many, if not all, of Plaintiffs' patients and members from accessing abortion care in Oklahoma. The Total Ban will effectively end the provision of abortion in Oklahoma. The 6-Week Ban will force the Provider Plaintiffs to turn away many patients seeking pre-viability abortions or risk substantial criminal penalties, civil liability, and/or professional sanctions.

147. The OB/GYN Requirement will bar a large percentage of the abortion providers, including six out of ten of Provider Plaintiffs' physicians, from providing abortion care in Oklahoma or else risk professional sanctions and administrative fines. Many physicians will immediately be forced to stop providing abortion care if this law goes into effect. This would decimate access to abortion care in Oklahoma. Planned Parenthood's two clinics, which currently provide around one quarter of Oklahoma's abortions, would be reduced to a single physician providing care at one health center a few days per month, and PPAEO's Tulsa health center would have no physicians who can provide abortion care. Tulsa Women's, which provides approximately half of Oklahoma's abortions, would find lose half of its physicians.

148. S.B. 778 and S.B. 779 erect enormous if not insurmountable barriers to access to a common and effective form of abortion without providing any health or safety benefit. As just one example, S.B. 778's two visit requirement will force patients to travel to a provider for an ultrasound 72 hours ahead of their abortion and create clinic backlogs that will delay care. Similarly, S.B. 779's admitting privileges requirement will bar many abortion providers in Oklahoma from providing medication abortion. These and other requirements of S.B. 778 and 779 will create delays in access to care and obstacles to obtaining care which will irreparably harm Plaintiffs' patients and members, preventing some from being able to access the method of abortion that is best for them.

149. If the Provider Plaintiffs cannot comply with each and every component of the numerous requirements contained within the Medication Abortion Restrictions, they will have to stop providing medication abortion care altogether due to the bills' exceedingly steep civil and criminal penalties.

150. The Challenged Laws will make it extremely difficult, if not impossible, to access abortion care in Oklahoma. Patients who can do so will be forced to attempt to seek care out of state, and many others will be forced to carry a pregnancy to term against their will or seek ways to end their pregnancies without medical supervision, some of which may be unsafe.

151. If the Challenged Laws go into effect, OCRJ will have to divert time and resources to help Oklahomans access abortion care out of state or navigate the myriad restrictions imposed by the Challenged Laws. OCRJ is already spending resources on educating its members and the public about the Challenged Laws.

152. Each of these consequences constitutes irreparable harm to Plaintiffs' patients and members and a violation of their constitutional rights. Indeed, the courts have already determined irreparable harm to exist with respect to several of the Challenged Laws (or parts of them) that are similar to previously enjoined restrictions.

153. The Challenged Laws' narrow exceptions do not cure these constitutional violations.

154. Plaintiffs have no adequate remedy at law.

VII. CLAIMS FOR RELIEF

First Claim for Relief (Substantive Due Process - the Effect of the Challenged Laws)

155. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

156. The Challenged Laws each violate women's fundamental rights to choose to terminate a pregnancy and to bodily integrity in violation of Okla. Const. art. II, § 7.

Second Claim for Relief

(Substantive Due Process - The Improper Purpose Behind the Challenged Laws)

157. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

158. The Challenged Laws were enacted with the improper purpose of burdening women's fundamental rights to choose to terminate a pregnancy and to bodily integrity in violation of Okla. Const. art. II, § 7.

Third Claim for Relief

(Substantive Due Process - Violation of the Right to Health)

159. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

160. The Challenged Laws violate the right to health in violation of Okla. Const. art. II, § 7.

Fourth Claim for Relief

(Single Subject)

161. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

162. S.B. 778 and S.B. 779 each violate the Oklahoma Constitution's rule that "[e]very act of the Legislature shall embrace but one subject, which shall be clearly expressed in its title." Okla. Const. art. V, § 57.

Fifth Claim for Relief

(Special Law)

163. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

164. The Challenged Laws each create a special law where general laws could be made applicable in violation of Okla. Const. art. V, § 59 by, among other things, singling out for special treatment physicians who provide medical treatment to patients seeking abortion care, and singling out women and a medical service women require.

Sixth Claim for Relief
(Declaratory Judgment - Unconstitutional and Void)

165. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

166. Because the Challenged Laws violate the Oklahoma Constitution, and declaratory judgment would terminate the controversy giving rise to this proceeding, Plaintiffs request a declaration from this Court stating that the Challenged Laws are unconstitutional and void. 12 O.S. § 1651.

Seventh Claim for Relief
(Temporary Injunction - Unconstitutional and Void)

167. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

168. Temporary injunctive relief is warranted because Plaintiffs, and those whose interests Plaintiffs represent, will suffer irreparable injury if the Challenged Laws are allowed to take effect.

Eighth Claim for Relief
(Permanent Injunction - Unconstitutional and Void)

169. Plaintiffs reallege and incorporate by reference the allegations contained in paragraphs 1-154.

170. Because the Challenged Laws violate the Oklahoma Constitution, warranting a declaratory judgment stating that the Challenged Laws are unconstitutional and void, Defendants should be permanently enjoined from enforcing them.

VIII. PRAYERS FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that this Court:

1. Issue a declaratory judgment that the Challenged Laws violate the Oklahoma Constitution and are void and of no effect;
2. Issue permanent injunctive relief, without bond, restraining Defendants, their employees, agents, and successors in office from enforcing the Challenged Laws; and
3. Grant such other and further relief as the Court may deem just and proper, including reasonable attorney's fees and costs.

Dated: September 2, 2021

Respectfully Submitted,

J. Blake Patton, Oklahoma Bar No. 30673

WALDING & PATTON PLLC
518 Colcord Drive, Suite 100
Oklahoma City, OK 73102
Phone: (405) 605-4440
Fax: N/A
bpatton@waldingpatton.com

Rabia Muqaddam*
Caroline Sacerdote*
Jennifer Beard*
CENTER FOR REPRODUCTIVE RIGHTS
199 Water Street
22nd Floor
New York, NY 10038
Phone: (917) 637-3645
Fax: (917) 637-3666
rmuqaddam@reprorights.org
csacerdote@reprorights.org
jbeard@reprorights.org

Jerome Hoffman*
Dechert LLP
Cira Centre
2929 Arch Street
Philadelphia, PA 19104-2808
Phone: (215) 994-2496
Fax: (215) 665-2496
jerome.hoffman@dechert.com

Linda C. Goldstein*
Jenna C. Newmark*
Meghan Agostinelli*
Dechert LLP
Three Bryant Park
1095 Avenue of the Americas
New York, NY 10036
Phone: (212) 649-8723
Fax: (212) 314-0064
linda.goldstein@dechert.com

jenna.newmark@dechert.com
meghan.agostinelli@dechert.com

Jonathan Tam*
Dechert LLP
One Bush Street, Suite 1600
San Francisco, CA 94104-4446
T: (415) 262-4518
F: (415) 262-4555
jonathan.tam@dechert.com

Attorneys for Plaintiffs Oklahoma Call for Reproductive Justice, Tulsa Women's Reproductive Clinic, L.L.C., and Alan Braid, M.D.

Christine Clarke*
PLANNED PARENTHOOD FEDERATION OF AMERICA
123 Williams St., 9th Floor
New York, NY 10038
Phone: (212) 261-4749
Fax: (212) 247-6811

Diana Salgado*
PLANNED PARENTHOOD FEDERATION OF AMERICA
1110 Vermont Ave., NW, Suite 300
Washington, DC 20005
Phone: (212) 261-4399
Fax: (202) 296-3480

Attorneys for Plaintiffs Comprehensive Health of Planned Parenthood Great Plains, Inc. and Planned Parenthood of Arkansas & Eastern Oklahoma

*Out-Of-State Attorney Applications Filed/Pending

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 2nd day of September, 2021, a true and correct copy of the foregoing was served via hand delivery to the following:

John O'Connor
Oklahoma Attorney General

David Prater
Oklahoma County District Attorney

Office of the Oklahoma Attorney General
313 NE 21st Street
Oklahoma City, OK 73105

Oklahoma County Courthouse
320 Robert S. Kerr Avenue, #505
Oklahoma City, OK 73102

Steve Kunzweiler
Tulsa County District Attorney

Lyle Kelsey
Executive Director

Tulsa County Court House
500 South Denver Avenue, Suite 900
Tulsa, OK 74103

Oklahoma Board of Medical Licensure &
Supervision
101 NE 51st Street
Oklahoma City, OK 73105

Katie Templeton
President

Lance Frye
Commissioner

Oklahoma State Board of Osteopathic
Examiners
4848 N. Lincoln Boulevard, Suite 100
Oklahoma City, OK 73105

Oklahoma State Department of Health
1000 NE 10th Street
Oklahoma City, OK 73117

Justin Wilson
President

Oklahoma State Board of Pharmacy
2920 N Lincoln Blvd, Ste A
Oklahoma City, OK 73105

J. Blake Patton, Esq.