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**[ADDITIONAL COUNSEL LISTED ON
SIGNATURE PAGE]**

ARIZONA SUPERIOR COURT
MARICOPA COUNTY

Paul A. Isaacson, M.D., on behalf of himself,
his staff, and his patients; William Richardson,
M.D., on behalf of himself, his staff, and his
patients; and the Arizona Medical Association,
on behalf of itself, its members, and its
members' patients,

Plaintiffs,

v.

State of Arizona, a body politic,

Defendant.

No. _____

**VERIFIED COMPLAINT FOR
INJUNCTIVE AND DECLARATORY
RELIEF**

1 Plaintiffs, Paul A. Isaacson, M.D., William Richardson, M.D., and the Arizona Medical
2 Association (“ArMA”) (collectively, “Plaintiffs”), by and through their attorneys, bring this
3 Complaint against the above-named Defendant, its employees, agents, and successors in office
4 and in support thereof state the following:

5 **PRELIMINARY STATEMENT**

6 1. On November 5, 2024, Arizonans voted overwhelmingly in favor of adopting
7 article II, section 8.1 of the Arizona Constitution (the “Amendment”), establishing and
8 protecting “a fundamental right to abortion” in the Arizona Constitution.¹ Ariz. Const. art. II,
9 § 8.1. A copy of the Amendment is attached hereto as Exhibit A.

10 2. By the terms of the Amendment, “the state shall not enact, adopt or enforce any
11 law, regulation, policy or practice that . . . [d]enies, restricts or interferes with” the fundamental
12 right to abortion “before fetal viability unless justified by a compelling state interest that is
13 achieved by the least restrictive means.” Ariz. Const. art. II, § 8.1(A)(1).

14 3. Despite the proven safety of abortion care, the State of Arizona has enacted
15 restrictions subjecting abortion providers and their patients to requirements that do not improve
16 or maintain the health of individuals seeking abortion care. They instead serve only to infringe
17 on pregnant Arizonans’ autonomous decision making and restrict, interfere with, and in some
18 cases deny altogether their ability to access abortion care.

19 4. Plaintiffs challenge several core components of Arizona’s burdensome statutory
20 and regulatory scheme that deny, restrict, or interfere with Arizonans’ constitutional right to
21 abortion. They include:

22
23
24

¹ *2024 Arizona General Elections Results - Proposition 139 - Right to Abortion*, USA Today, <https://www.usatoday.com/elections/results/2024-11-05/race/83101/arizona> (last updated November 25, 2024).

- 1 a. Statutes that ban the provision of certain pre-viability abortions based on the
2 patient’s reasons for seeking the abortion. A.R.S. § 13-3603.02, A.R.S. § 36-
3 2157, A.R.S. § 36-2158(A)(2)(d) and A.R.S. § 36-2161(A)(25) (collectively
4 the “**Reason Ban Scheme**”), attached hereto as Exhibit B;
- 5 b. Statutes and regulations that collectively force every patient to make at least
6 two trips to an abortion provider by requiring, at least 24 hours before the
7 abortion, an ultrasound, lab testing, and the provision—orally and in person—
8 of certain state-mandated information. A.R.S. § 36-2153(A), (F), A.R.S. § 36-
9 2158(A), A.R.S. § 36-2156(A), A.R.S. § 36-2162.01, A.R.S. § 36-
10 449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1)
11 (collectively the “**Two-Trip Scheme**”), attached hereto as Exhibit C;
- 12 c. Statutes and regulations that ban physicians from providing medication
13 abortion to Arizonans through telemedicine and prohibit sending abortion
14 medications in the mail. A.R.S. § 36-2153(A), A.R.S. § 36-2156(A), A.R.S.
15 § 36-2158(A), A.R.S. § 36-3604, A.R.S. § 36-2160(B), A.R.S. § 36-
16 449.03(D), A.A.C. R9-10-1501(8), and A.A.C. R9-10-1509(A)–(E)
17 (collectively the “**Telemedicine Ban Scheme**”), attached hereto as Exhibit D.

18 5. The Reason Ban Scheme, the Two-Trip Scheme, and the Telemedicine Ban
19 Scheme (together, the “Challenged Laws” or the “Schemes”) individually and collectively fail
20 to further any compelling state interest, as defined by the Amendment. Ariz. Const. art. II,
21 § 8.1(B)(1). Instead, they trample Arizonans’ autonomous decision making by, *inter alia*,
22 policing the reasons Arizonans have abortions and violating the fundamental tenets of informed
23 consent. The Challenged Laws also impose unnecessary and harmful delays, requiring some
24 patients to travel hundreds of miles for care, and jeopardizing their ability to access the method

1 of abortion that is best for them or to keep their abortion confidential. And far from advancing
2 or protecting the health of patients seeking abortion care, they are inconsistent with clinically
3 accepted standards of evidence-based medicine, violate the most basic principles of medical
4 ethics, and inflict significant physical and emotional harm on patients.

5 6. Additionally, by imposing harsh criminal, civil, and/or licensure penalties, the
6 Challenged Laws penalize abortion providers for assisting their patients in exercising their
7 fundamental right to abortion, in direct contradiction of the Amendment. Ariz. Const. art. II,
8 § 8.1(A)(3).

9 7. Accordingly, Plaintiffs, individual Arizona physicians who provide abortion care
10 and Arizona's largest physician-led membership organization, seek a declaratory judgment that
11 the Challenged Laws violate the Amendment and permanent injunctive relief to vindicate the
12 fundamental rights guaranteed to all Arizonans under the Arizona Constitution.

13 **JURISDICTION AND VENUE**

14 8. This Court has jurisdiction under A.R.S. § 12-123, A.R.S. § 12-1831, and the
15 Arizona Constitution.

16 9. Venue is proper under A.R.S. § 12-401.

17 **PARTIES**

18 **I. PLAINTIFFS**

19 10. Plaintiff Paul A. Isaacson, M.D., is a licensed, board-certified obstetrician-
20 gynecologist ("OB-GYN"). Dr. Isaacson has been providing safe, high-quality abortion care in
21 Arizona for nearly 30 years. Dr. Isaacson is the co-owner of Family Planning Associates Medical
22 Group ("FPA"), an independent licensed abortion clinic located in Phoenix, where he offers
23 procedural and medication abortion services. Dr. Isaacson's clinic is one of the only medical
24 practices in Arizona that regularly provides abortion care up to 23 weeks and 6 days after the

1 first day of a patient’s last menstrual period (“LMP”). Until the Reason Ban Scheme took effect
2 in July 2022, FPA was the foremost practice in Arizona providing care to patients referred by
3 other physicians and who are seeking abortion care because of medical indications, including
4 following a diagnosis of a fetal condition. Dr. Isaacson teaches in one of the abortion-training
5 programs available to Arizona’s OB-GYN resident physicians and is a member of the Arizona
6 Medical Association. Dr. Isaacson brings this suit on his own behalf and on behalf of his staff
7 and his patients.

8 11. Plaintiff William Richardson, M.D., is a licensed, board-certified OB-GYN and
9 has been providing safe, high-quality abortion care in Arizona for 25 years. Dr. Richardson is a
10 member of the Arizona Medical Association. Dr. Richardson is the owner and medical director
11 of Choices Women’s Center, an independent licensed abortion clinic located in Tucson which
12 offers medication abortion services. Dr. Richardson brings this suit on his own behalf and on
13 behalf of his staff and his patients.

14 12. Plaintiff ArMA is a professional membership organization for Arizona’s
15 physicians and physicians-in-training. ArMA’s mission is to “foster[] medicine,” “champion[]
16 care,” and “serv[e] Arizona,” which it achieves by “advocat[ing] for physicians and their
17 patients” and “lead[ing] efforts to build a healthier Arizona.”² The largest organization of
18 physicians in Arizona, ArMA has nearly 4,000 members, including nearly 1,600 medical student,
19 resident, or fellow members. ArMA’s members practice throughout the state and in all medical
20 disciplines, including a variety of disciplines that provide reproductive healthcare—i.e.,
21 Obstetrics and Gynecology, Maternal and Fetal Medicine, and Family Medicine³—and who care
22

23 ² Ariz. Med. Ass’n (ArMA), *About the Arizona Medical Association*,
24 <https://www.azmed.org/page/about> (last visited May 13, 2025).

³ *Id.*

1 in myriad ways for pregnant patients, provide genetic testing and counseling for pregnant
2 patients, and/or provide or refer for pregnancy termination. ArMA’s members regularly practice
3 telemedicine for non-abortion healthcare, including other reproductive healthcare, such as
4 prenatal and post-partum care. ArMA’s Code of Medical Ethics requires that “physician[s] shall
5 provide competent medical care, with compassion and respect for human dignity and rights,”
6 and that “[a] physician shall respect the law and recognize a responsibility to seek changes in
7 those requirements which are contrary to the best interests of the patient.”⁴ ArMA sues on behalf
8 of itself, its members, and its members’ patients.

9 **II. DEFENDANT**

10 13. Defendant State of Arizona is a body politic.

11 **THE CHALLENGED LAWS**

12 **I. THE REASON BAN SCHEME**

13 14. The Reason Ban Scheme consists of several interdependent provisions that
14 collectively prohibit providing an abortion if a provider knows that the patient’s decision to
15 obtain an abortion is to some uncertain degree motivated by an unclearly defined set of “genetic
16 abnormalities” in the fetus or embryo.

17 15. The Reason Ban Scheme defines “genetic abnormality” as the “presence or
18 presumed presence of an abnormal gene expression in an unborn child, including a chromosomal
19 disorder or morphological malformation occurring as the result of abnormal gene expression.”
20 A.R.S. § 13-3603.02(G)(2)(a).

21 16. The Reason Ban Scheme creates a class 3 felony punishable by two to 8.75 years
22 of imprisonment for any person who “knowingly . . . [s]olicits or accepts monies to finance . . .

23 ⁴ ArMA, *Arizona Medical Ass’n (ArMA) Code of Medical Ethics* (Mar. 31, 2021),
24 https://cdn.ymaws.com/www.azmed.org/resource/resmgr/governance/ArMA_Member_Code_of_Ethics.pdf.

1 an abortion *because of a genetic abnormality*” of the fetus or embryo. A.R.S. § 13-3603.02(B)(2)
2 (emphasis added); A.R.S. § 13-702(D). The Reason Ban Scheme also creates a class 6 felony
3 punishable by four months to two years of imprisonment for any person who “[p]erforms an
4 abortion knowing that the abortion is *sought solely because of a genetic abnormality*” of the fetus
5 or embryo. A.R.S. § 13-3603.02(A)(2) (emphasis added); A.R.S. § 13-702(D).

6 17. The Reason Ban Scheme also prohibits abortion care unless the provider first
7 executes an affidavit swearing they have “no knowledge” the pregnancy is being terminated
8 “*because of a genetic abnormality*” of the fetus or embryo. A.R.S. § 36-2157 (emphasis added).

9 18. The Reason Ban Scheme further prohibits abortion care unless the provider first
10 tells any patient “diagnosed with a nonlethal fetal condition” that Arizona law “prohibits
11 abortion . . . *because of a genetic abnormality.*” A.R.S. § 36-2158(A)(2)(d) (emphasis added).

12 19. The Reason Ban Scheme requires providers to report to the Arizona Department
13 of Health Services (“ADHS”) “[w]hether any genetic abnormality . . . was detected at or before
14 the time of the abortion by genetic testing, such as maternal serum tests, or by ultrasound, such
15 as nuchal translucency screening, or by other forms of testing.” A.R.S. § 36-2161(A)(25). This
16 is in addition to the requirement that providers ask every patient’s “reason for the abortion,”
17 including whether the “abortion is due to fetal health considerations,” and report any such reason
18 provided. A.R.S. § 36-2161(A)(12).

19 20. The Reason Ban Scheme does not prohibit abortions in the case of “lethal fetal
20 condition[s]” “diagnosed before birth and that will result, with reasonable certainty, in the death
21 of the unborn child within three months after birth.” A.R.S. § 13-3603.02(G)(2)(b); A.R.S. § 36-
22 2158(G)(1).

23 21. In addition to criminal penalties, those who violate any provision of the Reason
24 Ban Scheme risk suspension or revocation of their medical and/or facility license, public censure,

1 and civil penalties of at least \$1,000 and up to \$10,000 for each violation found. A.R.S. § 32-
2 1401(27); A.R.S. § 32-1403(A)(2), (A)(5); A.R.S. § 32-1403.01(A); A.R.S. § 32-1451(A), (D)–
3 (E), (I), and (K).

4 22. The Reason Ban Scheme also broadly imposes liability on any “physician,
5 physician’s assistant, nurse, counselor or other medical or mental health professional who
6 knowingly does not report known violations [of the Scheme] to appropriate law enforcement
7 authorities.” A.R.S. § 13-3603.02(E).

8 23. Finally, the Reason Ban Scheme imposes broad civil liability. A.R.S. § 13-
9 3603.02(D).

10 **II. THE TWO-TRIP SCHEME**

11 24. The Two-Trip Scheme consists of a collection of statutory and regulatory
12 provisions that, independently and collectively, require patients to make at least two trips to a
13 healthcare clinic—on days that a physician is present and available—before receiving an
14 abortion:

15 a. A.R.S. § 36-2156(A)(1) requires a patient to undergo a mandatory ultrasound
16 at least 24 hours before an abortion, regardless of medical necessity or the
17 patient’s individual circumstances. *See also* A.A.C. R9-10-1509(A)(4)
18 (incorporating A.R.S. § 36-2156 ultrasound requirement); A.R.S. § 36-
19 2162.01 (reporting requirement for A.R.S. § 36-2156).

20 b. A.R.S. § 36-2153(A)(1) mandates a patient complete an in-person
21 consultation at least 24 hours before an abortion, during which the physician
22 must orally recite to the patient state-mandated, stigmatizing, and irrelevant
23 information including but not limited to the probable anatomical and
24 physiological characteristics of the fetus at the time the abortion is to be

1 performed, regardless of the patient’s wishes or individual circumstances. *See*
2 *also* A.A.C. R9-10-1509(E)(1) (incorporating requirements of A.R.S. § 36-
3 2153); A.R.S. § 36-2162.01 (reporting requirement for A.R.S. § 36-2153).

4 c. A.R.S. § 36-2153(A)(2) also mandates that “the physician who is to perform
5 the abortion, the referring physician or a qualified physician, physician
6 assistant, nurse, psychologist or licensed behavioral health professional to
7 whom the responsibility has been delegated by either physician” recite
8 additional information to the patient, orally and in person, at least 24 hours
9 before an abortion, again regardless of the patient’s individual circumstances.

10 This information includes but is not limited to:

- 11 • “Medical assistance benefits may be available for prenatal care, childbirth
12 and neonatal care.”
- 13 • “The father of the unborn child is liable to assist in the support of the
14 child, even if he has offered to pay for the abortion. In the case of rape or
15 incest, this information may be omitted.”
- 16 • “Public and private agencies and services are available to assist the
17 woman during her pregnancy and after the birth of her child if she chooses
18 not to have an abortion, whether she chooses to keep the child or place
19 the child for adoption.”

- 1 d. A.R.S. § 36-2153(A)(2)(f)–(g) requires a physician to refer patients to a state-
2 created website⁵ and pamphlet⁶ containing inaccurate, biased, and/or
3 misleading information about abortion at least 24 hours before an abortion.
- 4 e. A.R.S. § 36-2158(A) further mandates that a medical provider must provide
5 certain additional information to a patient, orally and in person, at least 24
6 hours before an abortion if the patient is seeking abortion care after the fetus
7 has been diagnosed with a lethal or nonlethal condition. *See also* A.A.C. R9-
8 10-1509(E)(1) (incorporating requirements of A.R.S. § 36-2158).
- 9 f. A.R.S. § 36-449.03(D)(3) requires the promulgation of rules regarding
10 laboratory tests for Rh typing, which in turn require that, prior to an abortion,
11 all patients receive a test for Rh typing “unless the patient provides written
12 documentation of blood type acceptable to the physician.” A.A.C. R9-10-
13 1509(A)(3)(b); *see also* A.A.C. R9-10-1509(B) (requiring providers to offer
14 treatment based on Rh typing results within 72 hours after abortion and
15 document patient refusal); A.R.S. § 36-449.03(G)(5) (same).

16 25. A physician who knowingly violates A.R.S. § 36-2153, A.R.S. § 36-2156, or
17 A.R.S. § 36-2158(A) is subject to license suspension or revocation, *see* A.R.S. § 36-2153(J), (L);
18 A.R.S. § 36-2156(B), (D); A.R.S. § 36-2158(C), as well as other civil penalties, *see* A.R.S. § 36-
19 2153(K); A.R.S. § 36-2153(L). An abortion clinic that is not in “substantial compliance” with
20 the Rh typing requirement may be subject to a range of civil penalties, including, among others,
21

22 _____
23 ⁵ Ariz. Dep’t of Health Servs. (ADHS), *Woman’s Right to Know Act – Home*,
24 [https://www.azdhs.gov/prevention/womens-childrens-health/informed-
consent/index.php#right-to-know-home](https://www.azdhs.gov/prevention/womens-childrens-health/informed-consent/index.php#right-to-know-home) (last visited May 13, 2025).

⁶ *Id.*

1 a fine of to \$1,000 per violation, per patient impacted by the violation, reduction or termination
2 of services, and suspension or revocation of the clinic’s license. A.R.S. § 36-449.03(J)(1).

3 **III. THE TELEMEDICINE BAN SCHEME**

4 26. The Telemedicine Ban Scheme consists of a collection of statutory and regulatory
5 provisions that independently and collectively prohibit medical providers from providing
6 abortion through telemedicine.

7 27. Arizona law expressly bans the use of telemedicine for abortion care, providing in
8 A.R.S. § 36-3604(A) that “[a] health care provider shall not use telehealth to provide an
9 abortion.”

10 28. For medication abortions, A.R.S. § 36-449.03(D) and the statute’s implementing
11 regulation, A.A.C. R9-10-1509, require patients to travel to a clinic and undergo an in-person
12 physical examination performed by a physician, which must include a bimanual examination, an
13 ultrasound, and various laboratory tests. A.R.S. § 36-449.03(D); A.A.C. R9-10-1509(A)–(D);
14 *see also* A.A.C. R9-10-1501(8).

15 29. A.R.S. § 36-2156(A), which requires an ultrasound at least 24 hours before an
16 abortion, regardless of medical necessity, and A.R.S. §§ 36-2153(A) and 36-2158(A), which
17 require patients to obtain state-mandated counseling in person, effectively preclude telemedicine
18 for abortion because they compel patients to schedule at least two in-person visits to an abortion
19 provider as a condition of obtaining care.

20 30. Lastly, A.R.S. § 36-2160(B) imposes a mailing ban that prohibits “a manufacturer,
21 supplier or physician or any other person . . . from providing an abortion-inducing drug via
22 courier, delivery or mail service.” An “abortion-inducing drug” is defined as “a medicine or drug
23 or any other substance used for a medication abortion.” A.R.S. § 36-2160(D).

24

1 31. Due to this mailing ban, even if a patient seeking medication abortion could meet
2 virtually with their provider for a telehealth consultation, they would still have to make an
3 unnecessary trip to pick up their abortion medication in person. Only three other states enforce
4 such a mailing ban.⁷

5 32. A physician who knowingly violates the express ban on the use of telemedicine
6 for abortion “commits an act of unprofessional conduct and is subject to license suspension or
7 revocation[.]” A.R.S. § 36-3604(B).

8 33. A clinic provider who violates the mailing ban may be fined up to \$1,000 per
9 violation, per day and per patient affected. A.R.S. § 36-431.01.

10 34. A licensed abortion clinic that is not “in substantial compliance with” the
11 requirements to conduct an in-person physical exam, ultrasound, or laboratory tests may be fined
12 up to \$1,000 per violation per day by ADHS. A.R.S. § 36-449.03(J)(1); A.R.S. § 36-431.01.
13 ADHS may also “[i]mpose an intermediate sanction,” such as “immediate restriction of
14 admissions or readmissions, selected transfer of patients out of the facility, reduction of capacity
15 and termination of specific services, procedures, practices or facilities.” A.R.S. § 36-
16 449.03(J)(1); A.R.S. § 36-427. In addition, ADHS may suspend, revoke, or deny a facility
17 license or bring an action to enjoin the future operation or maintenance of the clinic. *See* A.R.S.
18 § 36-430.

22 ⁷ The others are Florida, Texas, and Oklahoma, where strict abortion bans are currently
23 in effect. Fla. Stat. § 390.0111; Okla. Stat. tit. 63, § 1-756.3; Tex. Health & Safety Code Ann.
24 § 171.063; *see also* Guttmacher Inst., *State Laws and Policies: Medication Abortion*,
<https://www.guttmacher.org/state-policy/explore/medication-abortion> (last updated Apr. 23,
2025).

1 **FACTUAL ALLEGATIONS**

2 **I. THE ABORTION AMENDMENT**

3 35. The Amendment establishes and protects “a fundamental right to abortion” in
4 Arizona. Ariz. Const. art. II, § 8.1.

5 36. By the terms of the Amendment, “the state shall not enact, adopt or enforce any
6 law, regulation, policy or practice that . . . denies, restricts or interferes with” the fundamental
7 right to abortion “before fetal viability unless justified by a compelling state interest that is
8 achieved by the least restrictive means.” Ariz. Const. art. II, § 8.1(A)(1).

9 37. By the terms of the Amendment, a “[c]ompelling state interest’ means a law,
10 regulation, policy or practice that meets *both* of the following:”

11 a. First, it “is enacted or adopted for the limited purpose of improving or
12 maintaining the health of an individual seeking abortion care, consistent with
13 accepted clinical standards of practice and evidence-based medicine.”

14 b. Second, it “[d]oes not infringe on that individual’s autonomous decision
15 making.”

16 Ariz. Const. art. II, § 8.1(B)(1)(a)–(b) (emphasis added).

17 38. Thus, the Amendment permits only those regulations of pre-viability abortion that
18 *both* protect patient autonomous decision making *and* make the abortion safer (according to
19 clinically accepted standards) for the person seeking an abortion, using the least restrictive
20 means.

21 39. The Amendment further prohibits the State from “enact[ing], adopt[ing] or
22 enforce[ing] any law, regulation, policy or practice that . . . penalizes any individual or entity for
23 *aiding or assisting* a pregnant individual in exercising the individual’s right to abortion.” Ariz.
24 Const. art. II, § 8.1(A)(3) (emphasis added).

1 **II. ABORTION AND PRE-NATAL CARE IN ARIZONA**

2 **A. The Abortion Decision**

3 40. Approximately one in four women in this country will have had an abortion by age
4 forty-five.⁸

5 41. The decision to have an abortion is one of the most personal and intimate decisions
6 a person can make about their body, their health, and their life. That decision is informed by a
7 combination of diverse, complex, and interrelated factors that are intimately tied to an
8 individual’s values, beliefs, culture, religion, health status, reproductive history, familial
9 situation, resources, economic stability, and life plans.

10 42. There is no typical abortion patient. Some people have abortions because they
11 decide it is not the right time to have a child or to add to their existing families. Others have
12 abortions because they do not wish to have a child at all.

13 43. Like most abortion patients in the United States, the majority of Arizona abortion
14 patients in 2023 had at least one child, and nearly 30% had two or more children.⁹ These pregnant
15 people and their families must consider how another child will impact their ability to care for the
16 children they already have. For some, an additional child can place economic and emotional
17 strain on a family that they are simply unable to bear.

18 44. For some people, continuing a pregnancy and having a child will make it too
19 difficult for them to pursue educational or career goals and support themselves and their families

20
21 ⁸ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008 - 2014*, 107 Am. J. Pub. Health 1904, 1907 (2017).

22 ⁹ ADHS, *Abortions in Arizona: 2023 Abortion Report* 11 (Dec. 18, 2024),
23 <https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2023-arizona-abortion-report.pdf> [hereinafter “2023 ADHS Abortion Report”]; see also Katherine Kortsmit et al., *Abortion Surveillance - United States, 2019*, 70(9) CDC Morbidity & Mortality
24 Weekly Report 1 (2021), <https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm> (almost 60% of women who obtained an abortion in 2019 already had at least one child).

1 going forward. Indeed, nationwide, new mothers’ earnings drop after they give birth and often
2 do not fully return to their pre-pregnancy earnings paths.¹⁰

3 45. Some people seek abortion care because of a fetal condition.

4 46. Others seek abortion care because continuing their pregnancies would threaten
5 their health or life, or because they conclude that pregnancy, childbirth, and an additional child
6 may exacerbate an already difficult and dangerous situation with an abusive partner.

7 **B. Abortion Safety & Methods**

8 47. A typical full-term pregnancy is approximately 40 weeks.

9 48. In a typical pregnancy, viability does not occur until, at the earliest, approximately
10 23 or 24 weeks LMP.

11 49. In Arizona, abortion is legal until viability. A.R.S. § 36-2301.01. After viability,
12 abortion is legal when “necessary to preserve the life or health of” the pregnant person, A.R.S.
13 § 36-2301.01(A)(1), but there are no providers of post-viability abortions in Arizona.

14 50. Abortion is one of the safest medical interventions in the United States.

15 51. Serious complications from abortion care are extremely rare, occurring in fewer
16 than 1% of abortions.¹¹

17 52. The risk of death associated with abortion is also exceedingly low. For example,
18 it is far lower than the risks associated with other routine medical procedures, such as
19 colonoscopies and tonsillectomies.¹²

20 ¹⁰ See Danielle H. Sandler & Nicole Szembrot, *New Mothers Experience Temporary Drop*
21 *in Earnings*, U.S. Census Bureau (Jun. 16, 2020),
22 [https://www.census.gov/library/stories/2020/06/cost-of-motherhood-on-womens-employment-
and-earnings.html](https://www.census.gov/library/stories/2020/06/cost-of-motherhood-on-womens-employment-and-earnings.html).

23 ¹¹ See Nat’l Acads. of Sci., Eng’g, & Med., *The Safety and Quality of Abortion Care in*
the United States, 77 (2018), [https://nap.nationalacademies.org/catalog/24950/the-safety-and-
quality-of-abortion-care-in-the-united-states](https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states) [hereinafter “National Academies Safety Report”].

24 ¹² See *id.* at 75.

1 53. Abortion is also far safer than its only alternative—trying to continue a pregnancy
2 to term and childbirth.

3 54. The starkest risk of carrying a pregnancy to term is death, and pregnancy is
4 growing more dangerous. In Arizona, women died from pregnancy-related causes at a ratio of
5 26.3 per 100,000 live births in 2018–2019, the most recent years for which ADHS has published
6 data.¹³ During that period, 43 women died of pregnancy-related causes in Arizona; 0 died from
7 abortion.¹⁴

8 55. Pregnancy is significantly more dangerous for American Indian/Alaska Native¹⁵
9 and Black or African American women in Arizona. In Arizona, American Indian/Alaska Native
10 women account for 5.8% of live births in the state, but 15.1% of pregnancy-associated deaths.
11 Black or African American women account for 5.9% of live births in the state, but 14.3% of
12 pregnancy-related deaths.¹⁶

13 56. Nationally, the risk of death associated with childbirth is approximately 14 times
14 higher than that associated with abortion, and every pregnancy-related complication is more
15 common among patients giving birth than among those having abortions.¹⁷

16 57. Serious long-term medical and physical consequences short of death may arise
17 from carrying a pregnancy to term and giving birth, even for those who are healthy and have
18

19 ¹³ See ADHS, *Maternal Mortality in Arizona, 2018-2019*, 19 (Jan. 2024),
20 <https://www.azdhs.gov/documents/prevention/womens-childrens-health/reports-fact-sheets/mm-2018-2019.pdf>; see also *id.* at 11 (women died from pregnancy-related causes in Arizona at a ratio of 18.3 per 100,000 live births in 2016-2017).

21 ¹⁴ *Id.* at 20.

22 ¹⁵ Plaintiffs use the term “American Indian/Alaska Native” here because that is the term used in ADHS statistics.

23 ¹⁶ ADHS, *Maternal Mortality in Arizona, 2018-2019*, *supra* note 13, at 28.

24 ¹⁷ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) *Obstetrics & Gynecology* 215 (2012).

1 uncomplicated pregnancies. Pregnancy stresses most major organs and involves profound and
2 long-lasting physiological changes, including on a pregnant person’s health and ability to have
3 children in the future. For someone with a medical condition caused or exacerbated by
4 pregnancy, the risks of complications are increased.

5 58. Two types of abortion are commonly available in Arizona: medication abortion
6 and procedural abortion.

7 59. Medication abortion is generally available in the first 11 weeks LMP. It typically
8 entails two prescription medications, mifepristone and misoprostol. Mifepristone, also known as
9 “RU-486” or by its commercial name Mifeprex, blocks the actions of progesterone, which is
10 necessary to sustain a pregnancy, and increases the efficacy of the second medication in the
11 regimen, misoprostol. Misoprostol is generally taken within 48 hours after the mifepristone, and
12 causes the uterus to contract and expel its contents, which occurs while the patient is at home or
13 another location of their choosing, in a process no different than a spontaneous miscarriage. Staff
14 schedule a follow-up visit within two weeks of when mifepristone is provided, though these
15 appointments are often cancelled by the patient or done by phone.

16 60. Approximately 59% of clinician-provided abortions provided in Arizona in 2023
17 were medication abortions.¹⁸ This is in line with national trends: as of 2023, medication abortion
18 accounted for 63% of all clinician-provided abortions in the United States.¹⁹

21 ¹⁸ Rachel K. Jones and Amy Friedrich-Karnik, *Policy Analysis: Medication Abortion*
22 *Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020*,
Guttmacher Inst. (Mar. 2024), <https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020>; Guttmacher Inst., *Arizona: Monthly*
23 *Abortion Provision Study*, <https://www.guttmacher.org/monthly-abortion-provision-study> (last
24 visited May 13, 2025).

¹⁹ *Id.*

1 61. The rate of clinically significant complications for medication abortion is
2 exceedingly low, regardless of whether it is provided in person or by telemedicine. Indeed, the
3 reported low risks of medication abortion are similar in magnitude to the adverse effects of
4 common prescriptions and over-the-counter medications.²⁰ For example, mifepristone has a
5 safety profile comparable to that of an NSAID, like ibuprofen.²¹

6 62. Procedural abortion²² involves the use of aspiration (gentle suction) and/or
7 instruments to evacuate the uterus. Depending on the stage of pregnancy, procedural abortion
8 takes approximately five to ten minutes to complete.

9 **C. Fundamental Principles of Informed Consent, Decisional Autonomy, and**
10 **Bodily Integrity**

11 63. Obtaining informed consent prior to providing medical treatment is the standard
12 of care and an ethical imperative of medical practice generally, as well as a legal requirement
13 for all physicians practicing medicine in Arizona. *Duncan v. Scottsdale Med. Imaging, Ltd.*, 70
14 P.3d 435, 439 (Ariz. 2003) (recognizing negligence claims for lack of informed consent).

16 ²⁰ National Academies Safety Report, *supra* note 11, at 58.

17 ²¹ *See id.*; see also Jack Resneck Jr., *Reducing Access to Mifepristone Would Harm*
18 *Patients*, Am. Med. Ass’n (Mar. 25, 2024), [https://www.ama-](https://www.ama-assn.org/about/leadership/reducing-access-mifepristone-would-harm-patients)

19 ²² Though sometimes called “surgical abortion,” this is a misnomer. See Am. Coll. of
20 Obstetricians & Gynecologists (ACOG), *ACOG Position Statement: Definition of “Procedures”*
21 *Related to Obstetrics and Gynecology* (Mar. 2023), [https://www.acog.org/clinical-](https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology)
22 [information/policy-and-position-statements/position-statements/2018/definition-of-procedures-](https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology)
23 [related-to-obstetrics-and-gynecology](https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2018/definition-of-procedures-related-to-obstetrics-and-gynecology) (“A procedure is a short interventional technique that
24 includes . . . non-incisional diagnostic or therapeutic intervention through a natural body cavity
or orifice”); ACOG, *ACOG Guide to Language and Abortion 1* (Oct. 2024)
<https://www.acog.org/contact/media-center/abortion-language-guide> (“The abortion procedure
is not a surgery. Referring to it as a procedure is clinically accurate.”); Am. Med. Ass’n (AMA),
AMA Code of Medical Ethics 4.2.7 Abortion, [https://code-medical-ethics.ama-](https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2023-08/4.2.7.pdf)
[assn.org/sites/amacoedb/files/2023-08/4.2.7.pdf](https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2023-08/4.2.7.pdf) (last visited May 13, 2025) (describing abortion
as “a safe and common medical procedure”).

1 64. Central tenets of medical ethics provide that the physician may not act upon the
2 patient without the patient’s informed consent; that the physician must respect the patient’s
3 autonomy; that the physician must act in the patient’s best interests; and that the physician must
4 avoid causing unnecessary harm to patients.

5 65. The American College of Obstetricians and Gynecologists (“ACOG”), the nation’s
6 leading professional association of obstetricians and gynecologists, instructs in its Code of Ethics
7 that “respect for the right of individual patients to make their own choices about their health care
8 (*autonomy*) is fundamental,” and “the welfare of the patient must form the basis of all medical
9 judgments.”²³

10 66. Informed consent is the process by which a healthcare provider educates a patient
11 about the nature and purpose, risks and benefits of, and alternatives to, a medical procedure or
12 intervention to ensure that the patient can make a fully informed and voluntary decision about
13 whether to undergo the procedure or intervention.

14 67. Informed consent serves the important medical ethics principle of patient
15 autonomy by ensuring that the patient’s dignity and right to self-determination is respected.
16 Informed consent is also a process designed and intended to build trust between the patient and
17 their medical provider.

18 68. The standard of medical care before starting any abortion is for healthcare
19 providers to counsel their patients to be certain in their decision to terminate the pregnancy,
20 consistent with their general ethical duty of obtaining informed consent for medical procedures.

23 ²³ ACOG, *ACOG Code of Professional Ethics* 1–2 (Dec. 2018), <https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf?rev=efb878bf939d46b1a05f8775eff49c0b>.

1 69. To ensure informed consent, fundamental principles of medical ethics require that
2 healthcare providers exercise their clinical judgment to provide medically relevant and accurate
3 information about the nature and purpose of the proposed course of treatment; its risks and
4 benefits, as well as its alternatives; and to answer any questions the patient may have.

5 70. The extent and nature of this information should be tailored to the patient’s
6 particular needs, values, preferences, and concerns. The American Medical Association’s
7 (“AMA”) Code of Medical Ethics, which is widely recognized as a comprehensive ethics guide
8 for physicians, dictates that the informed consent process should take account of a patient’s
9 individual circumstances and physicians should tailor the information they provide to the
10 patient’s needs and expectations.²⁴

11 71. For example, patients vary widely in their preferences concerning the level of
12 detail they wish to receive related to a medical condition or intervention and the manner in which
13 the information is communicated to them. Medical images and descriptions are a prime example
14 of this; some patients believe they will benefit from seeing medical images and others do not.
15 Similarly, ACOG states that “[t]he highest ethical standard for adequacy of clinical information
16 requires that the amount and complexity of information be tailored to the desires of the individual
17 patient and to the patient’s ability to understand this information.”²⁵

18 72. To make informed consent possible, patients must be given medically accurate,
19 necessary information about the treatment or procedure so that they can make the right decisions
20 for themselves. Patients rely upon their medical providers to give them accurate, relevant
21

22 ²⁴ AMA, *Code of Ethics, Opinion 2.1.1, Informed Consent*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent> (last visited May 13, 2025).

23 ²⁵ ACOG, *ACOG Committee Opinion No. 819* (Feb. 2021),
24 <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology>.

1 information, and when providers present information to patients about the treatment options that
2 are available and their expected outcomes, patients expect the information to be grounded in
3 evidence and the medical provider's best medical judgment.

4 73. It is antithetical to the purpose of informed consent, and a violation of medical
5 ethics, for a medical provider to give misleading or inaccurate information to a patient during
6 the informed consent process. Doing so would undermine the patient's ability to make an
7 informed decision about whether to undergo a particular medical treatment, thereby
8 misinforming the patient at the very moment she requires a clear, accurate presentation of
9 pertinent information so that she can decide on a course of treatment. For the same reasons, the
10 information provided should be unbiased and non-stigmatizing.²⁶

11 **D. Availability of Abortion in Arizona**

12 74. There are only seven licensed abortion clinics in the state and many of those
13 facilities provide abortion only during the early weeks of pregnancy. These clinics are located in
14 Phoenix, Tucson, and Flagstaff, leaving large swaths of the state without any known providers.

15 75. In 2023 alone, there were nearly 13,000 total abortions in the state of Arizona, the
16 vast majority of which were provided by these seven facilities.²⁷

17 76. The only known providers of abortion care beyond 16 weeks LMP are in Phoenix.

18 77. A small number of abortions are also provided in hospitals, though this care is
19 typically limited to health- and life-saving abortions, and complex cases.

20 78. Additionally, although physicians can provide medication abortion and procedural
21 abortion in their private practices, Arizona law limits this care to five abortions per month. *See*
22 A.R.S. §§ 36-449.01–.02 (requiring facilities providing more than five first trimester abortions

23 ²⁶ AMA, *Code of Ethics, Opinion 2.1.1, supra* note 24.

24 ²⁷ *See* 2023 ADHS Abortion Report, *supra* note 9, at 4.

1 or any second or third trimester abortions each month to be licensed as abortion clinics). As a
2 result, the availability of abortion care outside a licensed clinic is generally limited to physicians'
3 existing patients.

4 79. Due to structural barriers to accessing reproductive healthcare, the vast majority
5 of abortion patients are poor or low-income.²⁸

6 80. Furthermore, approximately two-thirds of abortion patients in Arizona are
7 American Indian/Alaska Native and/or people of color, though these populations account for
8 approximately half of Arizona's total population.²⁹

9 81. Medically unnecessary laws that make abortion more difficult, if not impossible,
10 to obtain therefore disproportionately impact American Indian/Alaska Native people, people of
11 color, people with low incomes, young people, and people living in rural areas—that is, those
12 who already face barriers to accessing healthcare.³⁰

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14
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17 ²⁸ Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes*
18 *Since 2008*, Guttmacher Institute, 7 (May 2016), [https://www.guttmacher.org/sites/default/files](https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf)
[/report_pdf/characteristics-us-abortion-patients-2014.pdf](https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf).

19 ²⁹ ADHS, *Abortions in Arizona: 2022 Abortion Report*, 8 (Dec. 5, 2023),
20 [https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2022-](https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2022-arizona-abortion-report.pdf)
[arizona-abortion-report.pdf](https://www.azdhs.gov/documents/preparedness/public-health-statistics/abortions/2022-arizona-abortion-report.pdf); U.S. Census Bureau, *QuickFacts: Arizona*,
<https://www.census.gov/quickfacts/AZ> (last visited May 22, 2025).

21 ³⁰ Racial disparities in abortion rates are attributable in part to the fact that “Black,
22 Hispanic, American Indian and Alaska Native (AIAN), and Native Hawaiian or Pacific Islander
(NHPI) women have more limited access to healthcare, which affects their access to
23 contraception and other sexual health services that are important for pregnancy planning.”
24 Latoya Hill et al., *What are the Implications of the Dobbs Ruling for Racial Disparities?*, Kaiser
Fam. Found. (Apr. 24, 2024), [https://www.kff.org/womens-health-policy/issue-brief/what-are-](https://www.kff.org/womens-health-policy/issue-brief/what-are-the-implications-of-the-dobbs-ruling-for-racial-disparities/)
[the-implications-of-the-dobbs-ruling-for-racial-disparities/](https://www.kff.org/womens-health-policy/issue-brief/what-are-the-implications-of-the-dobbs-ruling-for-racial-disparities/).

1 **E. Telemedicine Safety and Benefits**

2 82. Medication abortion is safely and effectively provided via telemedicine in the
3 majority of states where abortion is legal.³¹ Over the past decade, medication abortion via
4 telemedicine has been provided in numerous states, including, for example, California,
5 Colorado, Connecticut, Delaware, Hawai'i, Illinois, Iowa, Kansas, Maine, Maryland, Michigan,
6 Minnesota, Montana, New Hampshire, New Mexico, New York, New Jersey, Nevada, Ohio,
7 Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, Wyoming, and the
8 District of Columbia.³²

9 83. Telemedicine is a safe, cost-effective, and common way to deliver medical care. It
10 refers to the use of secure audio and/or video to deliver a medical service when patients and
11 healthcare providers are not in the same physical location.

12 84. In many cases, telemedicine is an equally effective method of healthcare
13 administration. It also saves clinicians and patients unnecessary, time-consuming, and expensive
14 travel.

15 85. Moreover, telemedicine patients have comparable clinical outcomes to those who
16 receive face-to-face care, with equivalent success rates and a low prevalence of adverse events.

17 86. Arizona has long used telemedicine to expand access to healthcare. More than
18 three decades ago, the Arizona legislature established one of the nation's first networks of
19 facilities with telemedicine capabilities—the Arizona Telemedicine Program (“ATP”). Today,
20

21
22 ³¹ See Reprod. Health Initiative for Telehealth Equity & Solutions, *State of Telehealth*
23 *Medication Abortion (TMAB)* (Apr. 27, 2025), <https://www.rhites.org/maps#state-info-section>
(reporting that Arizona is one of just six states that permits abortion but bans telemedicine for
24 abortion).

³² Kaiser Family Found., *Abortion in the United States Dashboard, Telehealth*
Availability, <https://tinyurl.com/yefchdaf> (last updated May 7, 2025).

1 ATP is an award-winning leader in the field and allows physicians to diagnose, consult, and treat
2 patients from remote locations.

3 87. The use of telemedicine in Arizona has expanded patients’ access to care. As of
4 2014, ATP was providing care in over 60 specialties and had facilitated over 1.3 million services
5 through its network. And as of 2015, ATP had expanded to 160 sites throughout the state.
6 Additionally, a study from July 2021 through July 2022 revealed that more than one in five
7 Phoenix-area households are using telehealth services, and “usage is even higher among the
8 aging population, women, lower-income brackets, Black communities, and those who are more
9 likely to report depression and difficulties with physical mobility.”³³

10 88. ATP has focused on rural access and cost savings from its inception. Arizona is
11 the sixth-largest state in the country by land area, but it consists of only 15 counties, 13 of which
12 are considered rural. The Arizona Legislature founded ATP, in part, to provide accessible, top-
13 quality healthcare to Arizonans in geographically isolated or underserved communities,
14 including Indigenous populations. Telemedicine, and ATP in particular, are generally praised
15 for improving access to expert healthcare (especially in rural or other sparsely populated areas),
16 facilitating consistent management of chronic diseases, and reducing costs due to improved
17 efficiency, shared staffing, and diminished travel and time away from work or school.

18 89. In 2021, Arizona passed H.B. 2454—the most expansive and comprehensive
19 telemedicine legislation in the country—making telemedicine a permanent feature of Arizona’s
20 healthcare system. Among other things, the Arizona Legislature enacted a telemedicine parity
21 law, which requires private health plans to cover healthcare services when delivered via
22 telemedicine to the same extent the service is covered when provided in person unless the weight

23
24 ³³ Amanda Hagerman, *Who is Using Telehealth?*, Goldwater Inst. (Jan. 31, 2024),
<https://www.goldwaterinstitute.org/policy-report/who-is-using-telehealth/>.

1 of evidence (based on practice guidelines, peer-reviewed clinical publications, research, or
2 recommendations from the Telehealth Advisory Committee on Telehealth Best Practices)
3 demonstrates that the service cannot appropriately be provided via telehealth. A.R.S. § 20-
4 1057.13(A). Many of the telemedicine services that must be covered to the same extent as in
5 person services—such as trauma, burns, cardiology, pulmonology, infectious diseases, and
6 neurologic diseases (including strokes)³⁴—have higher risks of complications than abortion care.

7 90. In all medical contexts except abortion, Arizona law permits physicians to use
8 telemedicine to provide consultations and treatment.

9 91. A telemedicine abortion is very similar to an in-person medication abortion. With
10 in-person medication abortion, the patient typically takes mifepristone at the clinic, then goes
11 home or to a location of their choosing and takes the misoprostol later. Clinic staff then schedule
12 a follow-up visit within two weeks.

13 92. In a telemedicine setting, the physician would communicate with the patient via
14 two-way, secure audio and/or video and, after reviewing and establishing the patient’s eligibility
15 for care, prescribe the necessary medications. The patient would then use the prescription to
16 order the medications for delivery via a mail-order pharmacy to their home or other location of
17 their choosing.³⁵

18 93. The patient would take the mifepristone at a time and location of their choosing
19 and, as with an in-person medication abortion, take the misoprostol within 48 hours. The

20
21 ³⁴ See Ariz. Health Care Cost Containment Sys., Telehealth Advisory Comm., *Audio-
22 Only Recommendations: House Bill 2454 Report* (2021),
https://www.azahcccs.gov/AHCCCS/Downloads/TelehealthAdvisoryCommittee/Agendas/TAC_AudioOnlyRecommendations-HOUSEBILL2454Report2021Final.pdf.

23 ³⁵ Although both mifepristone and misoprostol can legally be obtained from brick-and-
24 mortar pharmacies, pharmacies usually do not stock mifepristone. Additionally, patients,
especially those in small communities, often prefer to receive their medications by mail for
privacy reasons.

1 provider would also give the patient a toll-free number to call if the patient has questions during
2 or after the medication abortion process and to schedule a follow-up telehealth appointment.

3 94. According to ACOG’s clinical standards for medication abortion, clinicians can
4 safely and effectively provide medication abortion to eligible patients without an ultrasound
5 examination or in-person testing.³⁶

6 95. Guidelines and practices for performing medication abortion in this manner via
7 telemedicine have been successfully developed and deployed in the United States since at least
8 2008.

9 96. The latest data, collected from more than 6,000 patients in 20 states, shows that
10 “[t]elehealth medication abortion is effective, safe, and comparable to published rates of in-
11 person medication abortion care.”³⁷

12 97. Complications from medication abortion are rare, and because the second set of
13 pills used in medication abortion, misoprostol, is taken outside a provider’s office, such
14 complications would most commonly occur after the patient has left the office. In other words,
15 such events would occur outside of the providers’ office whether medication abortion is provided
16 in person or by telemedicine.

17 98. If not for the Telemedicine Ban Scheme, Plaintiff Dr. Richardson would, using
18 telemedicine, follow the same procedures as if the patient were physically present in a clinic.
19 These procedures include having a qualified healthcare provider (1) confirm the patient’s
20 pregnancy; (2) collect all necessary information to ensure that a medication abortion is an
21 appropriate course of treatment (such as ensuring that the pregnancy is not ectopic); (3) provide

22
23 ³⁶ ACOG, *Practice Bulletin No. 225: Medication Abortion Up to 70 Days of Gestation*
(Oct. 2020, reaff’d 2023) [hereinafter “ACOG Medication Abortion Practice Bulletin”].

24 ³⁷ Ushma D. Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion*
in the United States, 30(4) *Nature Med.* 1191 (2024).

1 the patient with necessary information regarding the abortion; and (4) prescribe the necessary
2 medication.

3 **F. Impact of Delayed Abortion Care**

4 99. Although abortion is one of the safest medical interventions in the United States,
5 and always safer than continuing the pregnancy to term, there is an incremental but continuous
6 increase in the risk level and complexity of abortion care as pregnancy progresses.

7 100. In addition, the cost of an abortion typically increases as pregnancy progresses and
8 the procedure becomes more complex. As a result, unnecessary delays may lead to higher total
9 costs that in turn may lead to further delays as patients struggle to save additional money to cover
10 their care.

11 101. When patients are forced to travel long distances to reach an abortion provider,
12 they often must delay until they are able to secure time off from work and enough money to pay
13 for not only the abortion itself, but also transportation, lodging, childcare, and/or the cost of
14 missing work. When they are forced to make multiple trips—with each trip potentially taking
15 multiple days—these costs can increase, along with delay.

16 102. Delays can also push patients past the gestational point at which medication
17 abortion is available, resulting in patients being denied access to medication abortion and
18 requiring them to instead undergo a more invasive procedure.

19 103. There are many reasons a person may have a strong preference for a medication
20 abortion over a procedural abortion. For some patients with certain medical conditions,
21 medication abortion is medically preferable. Other people strongly prefer medication abortion
22 because it can offer privacy and control. As described *supra*, a medication abortion in effect
23 induces a process indistinguishable from a spontaneous miscarriage, making it far easier to keep
24 the abortion private, including from an abusive partner.

1 104. Medication abortion via telemedicine provides even further privacy protections by
2 eliminating the need for patients to take multiple out-of-town trips and ensuring medications can
3 be ordered and received in a safe, private location.

4 105. People who are survivors of sexual abuse or other forms of intimate-partner
5 violence may also strongly prefer medication abortion because it does not require the insertion
6 of instruments into the vagina.

7 106. Remaining pregnant longer than necessary also poses risks to an individual’s
8 physical and mental health, as well as to the stability and well-being of their family, including
9 their existing children.

10 107. Remaining pregnant longer than necessary can increase health risks for patients
11 with underlying health problems. Pregnancy can exacerbate the symptoms of diabetes,
12 hypertension, autoimmune disorders, cardiac disease, and mental health conditions. It can also
13 trigger the onset of new conditions, including, *inter alia*, hyperemesis gravidarum (severe nausea
14 and vomiting), severe depression, and gestational diabetes.

15 108. In sum, when a patient has made the decision to have an abortion, delaying their
16 ability to do so can limit their healthcare options and/or cause a substantial toll on their physical,
17 emotional, and psychological health.

18 **G. Screening for, and Diagnosis of, Fetal Conditions During Prenatal Care**

19 109. Offering genetic screening and testing to pregnant patients is standard medical
20 practice. Likewise, ultrasound screening for structural (or “morphological”) indications of fetal
21 conditions is standard pregnancy care.

22 110. Joint practice bulletins from ACOG and the Society of Maternal-Fetal Medicine
23 (“SMFM”)—the leading professional organization for physicians and scientists focused on high
24 risk maternal and/or fetal issues—that provide guidelines to aid physicians in meeting

1 professional standards and providing quality care emphasize that “each pregnant patient should
2 be counseled in each pregnancy about options for testing for fetal chromosomal” conditions.³⁸

3 111. Chromosomal screening and/or diagnostic testing occurs only after complete pre-
4 test counseling and upon “patient choice based on provision of adequate and accurate
5 information, the patient’s clinical context, accessible healthcare resources, values, interests, and
6 goals. All patients should be offered both screening and diagnostic tests, and all patients have
7 the right to accept or decline testing after counseling.”³⁹

8 112. Testing capabilities continue to evolve and today there are a variety of testing
9 options to attempt to detect a wide range of clinically significant fetal genetic conditions.
10 Screening tests provide preliminary information about likelihood or risk, and do not identify
11 with certainty any condition. Diagnostic tests, which can determine whether a given condition is
12 present in the fetus, take time (including for the cultivation of cells) and may only be available
13 later in pregnancy.

14 113. The standard ultrasound testing that pregnant patients in prenatal care receive at
15 18–22 weeks LMP is used to assess fetal development and can identify unusual structural
16 development. These structural issues may or may not be related to a genetic cause or a particular
17 genetic condition.

18 114. All of this prenatal screening and testing aims to provide additional information to
19 physicians and their patients to guide pregnancy management: testing can identify the presence
20

21 ³⁸ ACOG & SMFM, *Practice Bulletin No. 226: Screening for Fetal Chromosomal*
22 *Abnormalities* (May 2016) [hereinafter “Screening Bulletin”], [https://www.natera.com/wp-](https://www.natera.com/wp-content/uploads/2021/04/ACOG-PB-226.pdf)
23 [content/uploads/2021/04/ACOG-PB-226.pdf](https://www.natera.com/wp-content/uploads/2021/04/ACOG-PB-226.pdf); *see also* ACOG & SMFM, *Practice Bulletin No.*
24 *162: Prenatal Diagnostic Testing for Genetic Disorders* (Mar. 2016) [hereinafter “Diagnostic
Bulletin”], [https://s3.amazonaws.com/cdn.smfm.org/publications/223/download-f5260f3bc66](https://s3.amazonaws.com/cdn.smfm.org/publications/223/download-f5260f3bc6686c15e4780f8100c74448.pdf)
[86c15e4780f8100c74448.pdf](https://s3.amazonaws.com/cdn.smfm.org/publications/223/download-f5260f3bc6686c15e4780f8100c74448.pdf).

³⁹ Screening Bulletin at e1.

1 of disorders for which prenatal treatment may provide benefit; help optimize maternal and
2 neonatal outcomes by ensuring the appropriate location and staff for delivery; and inform
3 patients’ consideration of future steps, including termination (if that is something the patient is
4 considering) or how best to manage the birth and continued care of a child with needs that may
5 be especially significant.

6 115. As ACOG and SMFM Clinical Management Guidelines emphasize, both
7 “[p]retest and posttest counseling [are] essential.”⁴⁰

8 116. This counseling about fetal testing is provided by, for example, patients’
9 OB/GYNs, MFMs, and/or genetic counselors and includes detailed information about the
10 conditions at issue, is responsive to patient questions and concerns, and does not direct or attempt
11 to determine patient decision making.⁴¹ The nondirective approach to counseling is central to
12 and used in many aspects of OB/GYN care and is one in which practitioners in OB/GYN care
13 are well versed.

14 117. Pregnant patients may have misconceptions about fetal conditions or little
15 information about them before testing. Pre- and post-test counseling enables patients to base any
16 decisions on available medical facts and case histories. Without that counseling, they may
17 exaggerate the significance or likely consequences of a given condition or confuse it with other
18 genetic and/or structural manifestations. This counseling ensures that “patients realize there is a
19 broad range of clinical presentations, or phenotypes, for many genetic disorders and that the
20 results of genetic testing cannot predict all outcomes.”⁴²

21
22 ⁴⁰ Screening Bulletin at e2.

23 ⁴¹ *See* Screening Bulletin at e9 (“Counseling should be performed in a clear, objective,
and nondirective fashion, allowing patients sufficient time to understand and make informed
24 decisions regarding testing” and their pregnancy.); *see also* Diagnostic Bulletin.

⁴² Diagnostic Bulletin at 1.

1 118. Depending on the condition, patients may also participate in counseling regarding
2 risk to future pregnancies or testing of potentially affected family members. Counseling also
3 includes information about potential care resources in the community for the patient, for other
4 family members, and for the child.

5 119. If the patient wishes to discuss and/or proceed with an abortion, post-test
6 counseling includes information about that option. This post-test counseling would also include
7 information about where to find abortion care and, often, communication between the two
8 physicians concerning the transfer of care.

9 120. The prognosis for fetal conditions that are or might be present is extremely varied,
10 both among different conditions and within any given one. Medical advances are making some
11 fetal structural issues treatable in the fetal and neonatal periods, but there is a wide range of
12 outcomes even where attempted treatment is possible. Some are invariably incompatible with
13 sustained life, but even for those, there may be considerable uncertainty as to how long a child
14 born with the anomaly may live.

15 121. Patients who were experiencing a wanted pregnancy but then decide after fetal
16 testing to terminate the pregnancy are often devastated and quite emotional about that turn of
17 events, and often rely on their physicians and other healthcare providers, including mental
18 healthcare providers, for support. They commonly volunteer information about the testing and
19 decision making they have been through to physicians and others involved in subsequent care.

20 **III. THE CHALLENGED LAWS VIOLATE THE AMENDMENT**

21 122. The Reason Ban, Two-Trip, and Telemedicine Ban Schemes each independently
22 infringe the right to abortion, as guaranteed by article II, section 8.1 of the Arizona Constitution.

23

24

1 123. In addition, all three Schemes have similar and/or overlapping requirements such
2 that enjoining only isolated provisions of any of the Schemes would be insufficient to address
3 the constitutional harms the Schemes inflict.

4 **A. The Reason Ban Scheme Denies, Restricts, and Interferes with Access to**
5 **Abortion**

6 124. The Reason Ban Scheme explicitly prohibits and criminalizes providing certain
7 pre-viability abortions. As such, it cannot survive constitutional scrutiny.

8 125. To avoid the severe criminal, professional, and civil penalties under the Reason
9 Ban Scheme, Plaintiff Physicians have no choice but to turn away any patient who reveals that
10 they are or may be seeking abortion care wholly or in part for a prohibited reason.

11 126. By explicitly targeting pregnant people who decide to have a pre-viability abortion
12 after fetal genetic screening or diagnostic testing and denying, restricting, or interfering with that
13 decision, the Reason Ban Scheme, by definition, fails to advance a compelling state interest
14 because it infringes on an individual’s autonomous decision making. *See* Ariz. Const. art. II,
15 § 8.1.

16 127. The Reason Ban Scheme also fails to advance a compelling state interest because
17 it does not “improv[e] or maintain[] the health of an individual seeking abortion care” and is not
18 “consistent with accepted clinical standards of practice and evidence-based medicine.” Ariz.
19 Const. art. II, § 8.1(B)(1)(a)–(b).

20 128. For example, according to ACOG, “[r]estricting abortions on the basis of a
21 woman’s reason for needing one is not medically appropriate and endangers the health of
22 women.”⁴³

23 ⁴³ Mark DeFrancesco, *ACOG Statement on Abortion Reason Bans*, ACOG (Mar. 10,
24 2016), <https://www.acog.org/news/news-releases/2016/03/acog-statement-on-abortion-reason->

1 129. Moreover, the Reason Ban Scheme chills patients from sharing certain information
2 with their abortion providers, including communications from other healthcare providers
3 involved in their care, out of fear that such information could prevent them from getting care due
4 to the Reason Ban Scheme.

5 130. Cutting off open and honest communication between patients and their providers
6 about fetal testing and fetal conditions is contrary to accepted clinical standards governing
7 prenatal care, as well as fundamental principles of medical ethics, informed consent, and the
8 integrity of the patient-physician relationship. And gagging abortion patients from speaking with
9 their medical providers puts their health and well-being in jeopardy and strips them of their
10 ability to fully participate in the informed consent process.

11 131. The patient-provider relationship is irreparably harmed when patients cannot speak
12 openly with their provider about their pregnancy intentions, genetic testing, or a possible fetal
13 diagnosis—lest they otherwise lose access to a previability abortion. Those patients’ loss of their
14 right to speak openly with their physicians or other medical care providers restricts and interferes
15 with their right to abortion.

16 132. For all these patients, the Reason Ban Scheme operates as an outright ban on, or
17 otherwise restricts and interferes with, their fundamental right to abortion.

18 **B. The Two-Trip Scheme Denies, Restricts, and Interferes with Arizonans’**
19 **Right to Abortion**

20 133. The Two-Trip Scheme denies, restricts, and interferes with the fundamental right
21 to abortion by requiring multiple unnecessary visits to a health center, which can extend over
22

23 _____
24 bans#:~:text="Access%20to%20reproductive%20services%2C%20including,endangers%20th
e%20health%20of%20women.

1 several days if not weeks. These forced delays cause physical, emotional, and financial harm,
2 and sometimes preclude patients from exercising their right to abortion altogether.

3 134. The Two-Trip Scheme also infringes on the right to abortion by forcing patients to
4 receive biased, stigmatizing, often outdated and/or medically incorrect information that is not
5 relevant to their medical care or their circumstances. This causes emotional harm to patients,
6 serves no purpose other than to impose shame and stigma, and interferes with patients'
7 autonomous decision making.

8 135. Further, by requiring that all patients without acceptable documentation of blood
9 type receive Rh testing, even where such testing is medically unnecessary based on a patient's
10 pregnancy gestation and medical history, the Two-Trip Scheme, in practice, forces many patients
11 to wait at least a day for their testing to be completed, thereby making it all but impossible to
12 schedule their abortion until at least 24 hours after the patient's first required visit. *See* A.A.C.
13 R9-10-1509(A)(3)(b) (requiring abortion clinics to test for Rh type "before the patient's abortion
14 is performed" "unless the patient provides written documentation of blood type acceptable to the
15 physician"); A.R.S. § 36-449.03(D)(3) (same).

16 **1. Forced Delays**

17 136. The Two-Trip Scheme requires, among other things, that patients seeking abortion
18 care complete an in-person consultation with a licensed physician, undergo Rh testing (absent
19 acceptable documentation of blood type), and receive an ultrasound at least 24 hours before
20 receiving an abortion. A.R.S. § 36-449.03(D)(3); A.R.S. § 36-2153; A.R.S. § 36-2158(A);
21 A.R.S. § 36-2156(A)(1); A.A.C. R9-10-1509(A)(3)(b), (A)(4), (E).

22 137. In effect, these requirements force patients seeking abortion care to make multiple
23 trips to their healthcare provider to obtain an abortion, regardless of that patient's distance from
24

1 the provider, reasons for seeking an abortion, medical circumstances, how certain they are, or
2 how advanced their pregnancy is.

3 138. There is no medical justification for singling out abortion and overriding a
4 patient’s ability to determine, in conjunction with their provider, what information is necessary
5 to receive *in person* (as opposed to over the phone or videoconference) prior to the abortion,
6 when that information should be provided, and whether or when any pre-abortion tests should
7 be performed.

8 139. Forcing patients to make multiple, unnecessary visits to an abortion provider
9 doubles the amount of time a person needs to take off work or school to obtain abortion care
10 (and doubles the loss of income or risk of losing their job if they have no access to paid sick
11 leave⁴⁴); doubles the time and expense necessary to arrange transportation to and from their
12 healthcare provider, as well as lodging if the patient is traveling a long distance; and doubles the
13 time and expense necessary to arrange childcare. *See supra* §§ II.A, II.F (most abortion patients
14 already face structural barriers to accessing healthcare, have low incomes, and are already
15 parents).

16 140. Having to arrange, pay for, and make multiple visits also makes it more difficult
17 for an individual to keep their abortion decision confidential from others in their lives, which
18 jeopardizes the safety of those who risk retaliation or violence if their decision is discovered. *See*
19 *supra* ¶¶ 5, 103.

23 ⁴⁴ Arizona employees can accrue up to 24 or 40 hours of paid sick time per year,
24 depending on the size of their employers. A.R.S. § 23-372. Workers without “employee” status
have no protected sick time available to them.

1 141. Moreover, while even a 24-hour mandatory delay for all abortion patients is not
2 legally or medically justifiable, in practice, the Two-Trip Scheme rarely results in only the 24-
3 hour delay required by law.

4 142. For most patients, it can be difficult to schedule an appointment with a physician
5 on two consecutive days, as appointments are dependent on clinic schedules and physician
6 availability. Additionally, if a patient cannot return on the next available appointment date, for
7 example because they cannot get time off from their job on that day, they will in practice be
8 forced to wait even longer.

9 143. The Two-Trip Scheme's Rh testing requirement also, in practice, can function as
10 a forced delay that can last more than one day. Major medical organizations agree that Rh testing
11 is not medically necessary prior to 12 weeks LMP.⁴⁵ Nonetheless, Arizona mandates Rh testing
12 for all patients without acceptable documentation of blood type, which requires an unnecessary
13 blood draw and lab tests. A.R.S. § 36-449.03(D)(3)(c), (G)(5); A.A.C. R9-10-1509(A)(3)(b),
14 (B). It also mandates that patients undergo Rh testing *before* an abortion, notwithstanding that
15 any treatment a patient may need based on their testing results is effective if given within 72
16 hours of an abortion—a fact Arizona law itself acknowledges. *See* A.R.S. § 36-449.03(G)(5)
17 (requiring that physicians ensure Rhogam will be available to patients for whom it is indicated
18 within 72 hours after abortion procedure); A.A.C. R9-10-1509(B)(2) (requiring that clinics
19

20 ⁴⁵ Nat'l Abortion Fed'n, *2024 Clinical Policy Guidelines* 12-13 (2024),
21 <https://prochoice.org/wp-content/uploads/2024-CPGs-FINAL-1.pdf>; ACOG, *ACOG Clinical*
22 *Practice Update: Rh D Immune Globulin Administration After Abortion or Pregnancy Loss at*
Less Than 12 Weeks of Gestation, 144 *Obstetrics & Gynecology* e140-e143 (Dec. 1, 2024); Sarah
23 Horvath et al., *Society of Family Planning Committee Consensus on Rh Testing in Early*
Pregnancy, 114 *Contraception* P1-5 (Oct. 2022),
24 [https://www.contraceptionjournal.org/article/S0010-7824\(22\)00197-4/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(22)00197-4/fulltext); World Health
Organization, *Abortion Care Guideline* 44-45 (2022),
<https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf>.

1 ensure patients for whom it is indicated are offered Rhogam within 72 hours after abortion
2 procedure).

3 144. According to ADHS, which conducts laboratory inspections for federal
4 compliance, an Arizona abortion provider cannot comply with Arizona law by providing Rh
5 testing to patients in-house unless the provider becomes certified as a high-complexity lab under
6 onerous federal requirements. Therefore, to test Rh type, a provider must *either* draw the
7 patient’s blood at the clinic and send it to an external lab for testing *or* send patients to an external
8 lab to determine the patient’s Rh type before their abortion and then have the patient return.
9 External labs take at least one full day but sometimes longer to process patients’ lab results.

10 145. For those traveling from outside the area where the provider is located—in
11 practice, most patients not based in Phoenix or Tucson—paying for round-trip transportation,
12 lodging, childcare, and getting extended time off work can be difficult to do multiple times in a
13 short time period.

14 146. Patients are frequently forced to delay abortion care in order to amass the financial
15 resources needed to cover transportation, childcare, and/or accommodation costs associated with
16 attending a second appointment. *See supra* ¶ 101.

17 147. The cost of an abortion typically increases as pregnancy progresses and the
18 procedure becomes more complex. As a result, unnecessary delays may lead to higher total costs,
19 which in turn could lead to further delays as patients struggle to save additional money to cover
20 their care. *See supra*.

21 148. Even patients local to the clinic may not be able to get time off and arrange
22 childcare and/or transportation twice within 48 hours, or even within the same week.

23 149. For people seeking a medication abortion, this delay may push them past the point
24 in pregnancy where medication abortion is available; the forced delay will preclude those

1 patients from obtaining their preferred method of abortion altogether. Because there are even
2 fewer Arizona physicians providing procedural as opposed to medication abortions, it becomes
3 even harder for these patients to locate and obtain an abortion provider. Moreover, when those
4 patients are forced to have a procedural abortion instead due to the Two-Trip Scheme, this can
5 increase wait times and make it more difficult to obtain a procedural abortion.

6 150. Being prevented from obtaining a wanted abortion and forced to remain pregnant
7 longer can have serious and long-term impacts on a person’s health, causing them to face new,
8 pregnancy-related complications or the exacerbation of underlying health conditions.⁴⁶

9 151. But for each of these laws, Plaintiffs and Plaintiffs’ members could provide
10 abortion care for eligible patients without requiring multiple in-person visits and therefore
11 without any medically unnecessary, and harmful, delay.

12 152. Delays, additional travel distances, and additional trips also hinder a patient’s
13 ability to keep their abortion confidential, which is particularly important for survivors of
14 intimate-partner violence and people who have become pregnant as a result of rape or incest. *See*
15 *supra* ¶¶ 5, 103.

16 153. Moreover, for patients who are pregnant as a result of rape or incest, being forced
17 to remain pregnant for longer—against their will—because of forced, state-mandated delays
18 only compounds their trauma and threatens their health and well-being.

19 154. For some patients, the state-imposed barriers to obtaining care will be
20 insurmountable, and those unable to obtain the necessary resources will be prevented from
21 accessing abortion care altogether.

22
23 ⁴⁶ Lisa H. Harris, *Navigating Loss of Abortion Services – A Large Academic Medical*
24 *Center Prepares for the Overturn of Roe v. Wade*, 386 *New Eng. J. Med.* 2061, 2063 (2022),
<https://www.nejm.org/doi/full/10.1056/NEJMp2206246>; Raymond & Grimes, *supra* note 17, at
215–19.

1 155. In no other area of medicine does Arizona law impose medically baseless delays
2 on patients seeking medical care—in practice, forcing patients to wait days if not weeks to obtain
3 medical care—regardless of their medical circumstances and decisional certainty.

4 **2. Biased Counseling**

5 156. As noted above, Arizona already requires clinicians to obtain informed consent
6 before providing medical treatment, according to their medical judgment. *See supra* ¶ 63.

7 157. Plaintiff Physicians Drs. Isaacson and Richardson require all clinicians providing
8 in their clinics to obtain informed consent from their patients, consistent with their legal and
9 ethical obligations.

10 158. However, the Two-Trip Scheme requires that, except in medical emergencies,
11 specific state-mandated information be provided “orally and in person” to every abortion patient
12 at least 24 hours prior to the procedure, regardless of the patient’s individual circumstances.
13 A.R.S. § 36-2153(A).⁴⁷

14 159. In addition to the forced delays, the Two-Trip Scheme’s biased counseling
15 requirement, A.R.S. § 36-2153, interferes with and restricts the right to abortion in multiple
16 ways.

17 160. First, A.R.S. § 36-2153 overrides both physician judgment and patient autonomy
18 by forcing every abortion patient to make a separate visit to their abortion provider to receive
19

20 ⁴⁷ A.R.S. § 36-2153(A)(1) requires that a physician or referring physician provide certain
21 information to a patient “orally and in person.” There is no medical reason this counseling must
22 be provided by a physician. The state-mandated counseling could be performed—and prior to
23 2011, was regularly performed—by other qualified clinicians, such as advanced practice
24 clinicians like nurse practitioners and physician assistants. By mandating that the information in
section (A)(1) be delivered by a physician, in practice the information in (A)(2) is also delivered
by the physician. These mandatory consultations consume significant amounts of physician time
that could otherwise be used to provide abortion care, or other health-care services to patients,
and to provide that care more promptly.

1 certain information in person, as if they are not capable of determining when, if ever, an in-
2 person visit is necessary to receive the information. In no other area of medicine does Arizona
3 law impose a blanket in-person informed consent requirement.

4 161. Second, A.R.S. § 36-2153 requires a physician to provide every abortion patient
5 with certain information even when it is not relevant to the patient’s decision-making process,
6 and even when it may be misleading, stigmatizing, or harmful. This one-size-fits-all approach
7 contradicts the ethical principle that informed consent be tailored to the needs and circumstances
8 of each patient.

9 162. For example, A.R.S. § 36-2153 requires a physician to describe the “probable
10 anatomical and physiological characteristics of the unborn child at the time the abortion is to be
11 performed.” A description of embryonic or fetal development adds nothing to the process of
12 informing patients about the risks and benefits of abortion. Further, the requirement’s language
13 (“unborn child”) is value-laden, not medical. And only pregnant people obtaining an abortion—
14 not those continuing their pregnancy or seeking prenatal care—must be given information about
15 embryonic or fetal development, demonstrating that this requirement is aimed to convey the
16 State’s disapproval of patients’ decision to have an abortion.

17 163. A.R.S. § 36-2153 also requires physicians to refer patients to a state website⁴⁸ that
18 contains biased and inaccurate information about abortion, including inaccurate information
19 about medication abortion. *See supra* ¶ 24(d).

20 164. A.R.S. § 36-2153 further requires a physician to refer all patients to a state-created
21 pamphlet containing inaccurate and biased information about abortion. For example, the website
22 and pamphlet both state that patients obtaining a medication abortion will receive mifepristone
23

24 ⁴⁸ ADHS, *A Woman’s Right to Know Act – Home*, *supra* note 5.

1 and methotrexate to initiate the abortion, with misoprostol given only in certain cases and at a
2 follow up appointment up to several weeks later.⁴⁹ This is not the standard of care for medication
3 abortion and has not been since 2000.⁵⁰ It also does not reflect the physician Plaintiffs’ practices.

4 165. Additionally, the pamphlet states that for some women, “the feelings she may
5 experience after the procedure . . . may be more difficult to handle” without support from a
6 professional counselor.⁵¹ This claim is not supported by clinical evidence and has been widely
7 debunked.⁵²

8 166. The pamphlet then refers patients to a “resource directory” of “pregnancy-resource
9 centers” that features crisis pregnancy centers (“CPCs”).⁵³ These CPCs have a clear mission: to
10 discourage pregnant people from exercising their protected right to abortion. Their websites are
11 replete with inaccurate, stigmatizing, and inflammatory statements, including:

- 12 a. “We’ve all seen the ultrasound images of tiny fingers and fingerprints, and
13 videos of a preborn baby’s heartbeat, eyelashes, hiccups, and squirms in the
14 womb. We all know the truth. Pro-abortionists like to call it a fetus because it
15
16

17 ⁴⁹ ADHS, *A Women’s Right to Know*, <https://www.azdhs.gov/documents/prevention/womens-childrens-health/informed-consent/a-womans-right-to-know.pdf> (last visited May 14,
18 2025). ADHS, *A Women’s Right to Know*, <https://www.azdhs.gov/documents/prevention/womens-childrens-health/informed-consent/a-womans-right-to-know.pdf> (last visited May 14,
19 2025).

20 ⁵⁰ ACOG Medication Abortion Practice Bulletin, *supra* note 36 (“The medication
21 abortion regimen supported by major medical organizations nationally and internationally
includes two medications, mifepristone and misoprostol.”).

22 ⁵¹ ADHS, *A Women’s Right to Know*, *supra* note 49.

23 ⁵² M. Antonia Biggs et al., *Women’s Mental Health and Well-Being 5 Years After
Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74(2) JAMA
Psychiatry 169–78 (2017).

24 ⁵³ ADHS, *A Women’s Right to Know*, *supra* note 49.

1 sounds like a neutralized bit of matter, but a fetus is just the Latin word for a
2 baby.”⁵⁴

3 b. “Young people today are singing about killing babies, trampling their graves,
4 and even eating them. If this behavior bothers you at all, then your feelings
5 likely point to a deeper knowledge of the truth: abortion ends an innocent
6 life.”⁵⁵

7 c. “Abortion is a sin unless it is medically necessary in order to save the life of
8 the mother. But even when a medical abortion appears needed to preserve a
9 mother’s life, the Christian will always proceed with the intent to preserve all
10 human life whenever possible.”⁵⁶

11 d. “Some research suggests links between abortion and the following conditions:”
12 “Breast cancer”; “Pre-term birth in subsequent pregnancies”; “Increased rates
13 of mental health issues like PTSD and depression.”⁵⁷

14 e. Multiple CPC websites advertise so-called “abortion reversal”,⁵⁸ an

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16 ⁵⁴ Choices Pregnancy Ctrs., *The Disturbing Truth Behind “Shout Your Abortion”*,
<https://choicesaz.com/the-disturbing-truth-behind-shout-your-abortion/> (last visited May 14,
17 2025); *but see* Merriam-Webster Dictionary, *Fetus*, [https://www.merriam-](https://www.merriam-webster.com/dictionary/fetus)
18 [webster.com/dictionary/fetus](https://www.merriam-webster.com/dictionary/fetus) (last visited May 14, 2025) (defining a “fetus” as “an unborn or
unhatched vertebrate especially after attaining the basic structural plan of its kind”).

19 ⁵⁵ *The Disturbing Truth*, *supra* note 54.

20 ⁵⁶ Alpha Pregnancy Resource Ctr., *What We Believe: Our position on abortion*,
<https://www.alphacenterphx.org/what-we-believe> (last visited May 14, 2025).

21 ⁵⁷ Choices Pregnancy Ctrs., *What are the After Effects of Abortion?*,
<https://choicesaz.com/what-are-the-after-effects-of-abortion/> (last visited May 14, 2025); *contra*
22 Biggs et al., *supra* note 52, at 169.

23 ⁵⁸ *See, e.g.,* Aid to Women Ctr., *Abortion Reversal*,
<https://aidtowomencenter.org/abortion-reversal> (last visited May 14, 2025); Phoenix Women's
24 Clinics, *Abortion Pill Reversal*, [https://phoenixwomensclinic.com/phoenix/abortion/abortion-](https://phoenixwomensclinic.com/phoenix/abortion/abortion-pill-reversal/)
[pill-reversal/](https://phoenixwomensclinic.com/phoenix/abortion/abortion-pill-reversal/) (last visited May 14, 2025); Choices Pregnancy Ctrs., *Abortion Pill Reversal*,
<https://choicesaz.com/get-care/abortion-pill-reversal/> (last visited May 14, 2025).

1 experimental, and potentially dangerous medical treatment that has been
2 widely disproven.⁵⁹

3 167. By forcing a physician to refer patients to state-sponsored websites and materials
4 containing inaccurate and misleading information, and promoting anti-abortion views,
5 regardless of whether the patient has expressed interest in such materials, the State overrides
6 physicians' clinical judgment, using the physician as a conduit for the State's clear message of
7 disapproval to a patient under the guise of informed consent.

8 168. Distorting the informed consent process in this manner adversely affects Plaintiffs'
9 patients. A key purpose of informed consent is to provide a patient considering a course of
10 medical treatment with clear, medically accurate information so that she can make a considered
11 decision whether to proceed with the treatment. Patients rely on their medical providers to
12 present them with truthful, relevant facts in a clear manner to facilitate thoughtful decision
13 making. Forcing physicians to make irrelevant and biased statements during the informed
14 consent process risks confusing patients and damaging the physician-patient relationship.

15 169. Requiring physicians to provide and direct patients to biased information intended
16 to discourage abortion forces physicians to shame their patients for their healthcare decisions.
17 This can place physicians in the position of having to violate the fundamental medical ethics
18 principles of benevolence and respecting patient autonomy, and can harm patients by causing
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21 ⁵⁹ ACOG has determined that “no evidence” supports the efficacy of so-called medication
22 abortion “reversal,” and that interrupting the two-drug medication abortion regimen may be
23 associated with medical risk. ACOG Medication Abortion Practice Bulletin, *supra* note 36. The
24 AMA not only opposes mandated disclosures about this practice, but also has sued North Dakota
over a medication abortion “reversal” speech mandate on the basis that the disclosure was
misleading and untruthful. *See Am. Med. Ass'n v. Stenhjem*, 412 F. Supp. 3d 1134, (D.N.D.
2019), *dismissed pursuant to stipulation*, *Am. Med. Ass'n v. Wrigley*, No. 1:19-CV-125, 2023
WL 8866596, at *1 (D.N.D. Oct. 18, 2023).!

1 shame, psychological harm, and erosion of the trust necessary for facilitating a healthy doctor-
2 patient relationship.

3 170. Accordingly, by requiring Plaintiffs to force medically inaccurate and biased and
4 potentially harmful messages on their patients, as well as direct their patients to websites and
5 pamphlets containing the same, as a condition of receiving care, the Two-Trip Scheme violates
6 fundamental principles of informed consent and medical ethics, restricting and interfering with
7 patient autonomy to make the best medical decisions for themselves, in consultation with their
8 provider.

9 **C. The Telemedicine Ban Scheme Denies, Restricts, and Interferes with**
10 **Arizonans' Right to Abortion**

11 171. The Telemedicine Ban Scheme imposes medically unnecessary limits on, and
12 restricts access to, medication abortion. Its components work alone and in conjunction to require
13 extra, unnecessary travel and to deny pregnant individuals access to a healthcare delivery tool
14 that is not only available to other Arizonans but also affirmatively promoted by the State.

15 172. By carving out a single, medically unsupported exception to telemedicine for
16 abortion, the State denies people seeking abortion care access to a service that is available and
17 widely recognized to benefit other Arizonans.

18 173. Further, by precluding pregnant Arizonans from accessing time-sensitive abortion
19 care through telemedicine, the State forces patients to make at least one trip to a health center,
20 which could entail traveling hundreds of miles, to pick up medications for use at home.

21 174. Mandating that patients travel to obtain in-person counseling and/or abortion
22 medication delays access to care. This delay, in turn, exposes patients to unnecessary medical
23 risks because it forces them to remain pregnant longer and because, although abortion is very
24

1 safe, its risks increase as pregnancy progresses. It also compels patients to take more time off
2 from work or school and to incur costs associated with transportation, lodging, and childcare.

3 175. For example, a March 2025 study concluded that, compared to patients who had
4 to attend an in-person appointment with an ultrasound, patients who were able to access
5 medication abortion via telemedicine and the receipt of medications in the mail faced fewer
6 structural challenges (such as travel and cost) accessing abortion, felt less forced to wait after
7 making their decision, and reported increased autonomy in the abortion decision.⁶⁰

8 176. For some patients, including those for whom a medication abortion is medically
9 indicated or highly preferred, the delay and travel imposed by the Telemedicine Ban Scheme
10 denies them the abortion method of their choice or precludes them from accessing abortion
11 altogether.

12 177. Denying Arizonans the right to telemedicine abortion care, which has been proven
13 safe and effective and which providers are willing and able to provide, deprives Arizonans of
14 the opportunity to consider and avail themselves of that medical care.

15 **D. The Two-Trip, Reason Ban, and Telemedicine Ban Schemes Do Not Serve a**
16 **Compelling State Interest**

17 178. Under article II, section 8.1 of the Arizona Constitution, “the state shall not enact,
18 adopt or enforce any law, regulation, policy or practice that . . . denies, restricts or interferes
19 with” the fundamental right to abortion “before fetal viability unless justified by a compelling
20 state interest that is achieved by the least restrictive means.”

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22
23 ⁶⁰ M. Antonia Biggs et al., *Psychosocial Burden When Accessing Medication Abortion*
24 *When Using No-Test Telehealth Care Compared to In-Person Care with Ultrasound,*
Contraception (Mar. 27, 2025), [https://www.contraceptionjournal.org/article/S0010-7824\(25\)00085-X/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(25)00085-X/fulltext).

1 179. As described *supra*, the Schemes deny, restrict, and interfere with the fundamental
2 right to abortion and are therefore presumptively unconstitutional.

3 180. To be justified by a compelling state interest under the Amendment, the Schemes
4 must meet two requirements: (1) they must be “enacted or adopted for the limited purpose of
5 improving or maintaining the health of an individual seeking abortion care, consistent with
6 accepted clinical standards of practice and evidence-based medicine,” *and* (2) they must “not
7 infringe on that individual’s autonomous decision making.” Ariz. Const. art. II, § 8.1(B)(1)(a)–
8 (b). A law cannot survive constitutional scrutiny under the Amendment if it fails *either* part of
9 this test.

10 181. The Two-Trip, Reason Ban, and Telemedicine Ban Schemes each fail both parts
11 of this test.

12 **1. The Schemes Infringe on Arizonans’ Autonomous Decision Making.**

13 182. The Reason Ban, Two-Trip, and Telemedicine Ban Schemes each violate
14 fundamental clinical principles of informed consent, decisional autonomy, and bodily integrity,
15 *see supra* ¶¶ 129–31, 149–55, 160–70, 176–77, and thus they “infringe on [] individual[s]’
16 autonomous decision making.” Ariz. Const. art. II, § 8.1(B)(1)(b).

17 183. *Reason Ban Scheme.* The Reason Ban Scheme prohibits physicians from providing
18 certain abortions where the State disapproves of a patient’s reason. Banning or restricting pre-
19 viability abortion based on a patient’s reason for seeking abortion care by definition infringes on
20 an individual’s autonomous decision making and is per se unconstitutional. The Reason Ban
21 Scheme also interferes with the physician-plaintiff relationship.

22 184. *Two-Trip Scheme.* The Two-Trip Scheme infringes on autonomous decision
23 making by demeaning patients’ decision making capability and embracing unwarranted
24 stereotypes that women and pregnant people cannot make decisions and must be protected from

1 their own actions, as well as creating unnecessary obstacles to Arizonans’ ability to effectuate
2 their constitutionally protected decision to have an abortion.

3 185. The Two-Trip Scheme’s mandatory 24-hour delay, which, as noted *supra*, is much
4 longer in practice, singles out and subjects abortion patients to a forced “time out” on the
5 assumption that they are not capable of making autonomous decisions without it.

6 186. To the contrary, clinical studies have shown that pregnant patients are capable of
7 understanding the consequences of obtaining an abortion and making the decision to do so
8 without any additional waiting period, and that state-mandated delays hinder rather than enhance
9 decisional autonomy.⁶¹ For some patients, the delays and unnecessary additional expenses and
10 logistical hurdles caused by the forced delay robs them of their decisional autonomy completely
11 by entirely blocking them from accessing abortion care in Arizona.

12 187. The Two-Trip Scheme’s one-size-fits-all requirement that providers dispense the
13 State’s version of information to patients also thwarts the true goals of informed consent, which
14 is inherently individualized, and undermines autonomous decision making. Forcing providers to
15 tell patients information that is unnecessary, irrelevant, inaccurate, and/or stigmatizing—all for
16 the purpose of dissuading people from choosing to have an abortion—damages patient-provider
17 trust and takes time and attention from information targeted at the individual patient’s needs.

18 188. The Two-Trip Scheme’s state-mandated counseling requirements are also at odds
19 with accepted clinical standards of practice, which require an unbiased, individualized informed

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21 ⁶¹ See, e.g., Iris Jovel et al., *Abortion Waiting Periods and Decision Certainty Among*
22 *People Searching Online for Abortion Care*, 137(4) *Obstetrics & Gynecology* 597 (2021)
23 (finding no increase in decisional certainty in patients seeking care in states with mandatory
24 waiting periods as compared to their counterparts in states without such barriers); see also
Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95(3)
Contraception 269 (2017); Diana Greene Foster, *Attitudes and Decision Making Among Women*
Seeking Abortions at One US Clinic, 44(2) *Perspectives on Sexual and Reproductive Health* 117
(2012).

1 consent process. The non-medical, inaccurate, irrelevant, and biased information that the Two-
2 Trip Scheme requires providers to convey to patients, at least 24 hours before receiving abortion
3 care, thwarts these principles. Using the physician-patient relationship to convey the State’s
4 disapproval of a patient’s healthcare choices is also the antithesis of informed consent, as is
5 forcing patients to consume uniform information not tailored to their individual circumstances.

6 189. Further, the Two-Trip Scheme forces providers to refer patients to state-created
7 materials that contain extensive fetal imagery and are weighted toward encouraging continuing
8 a pregnancy. These materials contain numerous inaccuracies about abortion procedures, the
9 safety of abortion care, and fetal development. They are designed to induce shame and persuade
10 people to change their mind about having an abortion regardless of their personal
11 circumstances—the opposite of encouraging autonomous decision making.

12 190. The Two-Trip Scheme’s biased counseling provisions also interfere with patients’
13 decisional autonomy by compelling people who are pregnant as a result of rape or incest to listen
14 to a description of fetal development, as well as by requiring patients experiencing the
15 devastating loss of a wanted pregnancy to receive information about alternatives that are not
16 available to them.

17 191. *Telemedicine Ban Scheme.* By prohibiting physicians from expanding access to
18 abortion care via telemedicine, particularly for patients in Arizona’s many rural counties, the
19 Telemedicine Ban Scheme similarly imposes unnecessary obstacles in the path of Arizonans
20 trying to effectuate their autonomous decision to have an abortion.

21 192. The Telemedicine Ban Scheme interferes with patients’ autonomous decision
22 making by denying them their chosen method of receiving abortion care—by telehealth.

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1 193. Patients are instead forced to travel potentially long distances, take time off work,
2 arrange for childcare, and experience delays, medical tests, and physical examinations in order
3 to follow through with their decision.

4 194. As a result, some patients for whom medication abortion is either medically
5 indicated or preferred due to its unique benefits, such as privacy and control, are precluded from
6 obtaining it. This is a blatant violation of their autonomous decision to obtain a medication
7 abortion.

8 195. Denying patients access to medication abortion via telemedicine can also thwart
9 patients' autonomous decision making by exacerbating dangerous circumstances, such as risking
10 the privacy of a patient experiencing intimate-partner violence, to the extent that the patient
11 cannot safely carry out their decision to have an abortion.

12 **2. The Challenged Schemes Do Not Improve or Maintain the Health of**
13 **the Person Seeking Abortion Care**

14 196. Even if the Reason Ban, Two-Trip, or Telemedicine Ban Schemes *could* satisfy
15 the decisional autonomy prong—which they cannot—they would nevertheless be
16 unconstitutional because they do not “improv[e] or maintain[] the health of an individual seeking
17 abortion care consistent with accepted clinical standards of practice and evidence-based
18 medicine.” Ariz. Const. art. II, § 8.1(B)(1)(a).

19 197. *Reason Ban Scheme.* The Reason Ban Scheme does not maintain or advance
20 patient health. Rather, by interfering with autonomous decision making and banning pre-
21 viability abortion care for certain patients, it undermines patient health.

22 198. Preventing a patient from accessing an abortion due to that patient's reason for
23 seeking care does not improve the patient's health or safety. To the contrary, it undermines that
24

1 patient’s health by forcing them to remain pregnant against their will and exposing them to the
2 physical risks of pregnancy and the mental health risks associated with denied abortion care.⁶²

3 199. Further, forcing patients to conceal their medical history and reasons for seeking
4 abortion care from their medical providers for fear of denial of care is antithetical to accepted
5 clinical standards and accordingly cannot improve or maintain the patients’ health.

6 200. Delays caused by forcing patients to travel out of state to obtain care that clinicians
7 in Arizona are willing and able to provide but for the Reason Ban Scheme is affirmatively
8 harmful. The specter of this interferes with the physician-patient relationship, even for patients
9 who are still able to obtain care in Arizona. *See supra* at ¶¶ 129–31.

10 201. *Two-Trip Scheme*. The Two-Trip Scheme violates fundamental clinical principles
11 of informed consent, decisional autonomy, and bodily integrity. *See supra* ¶¶ 149–55, 160–70.
12 Far from improving or maintaining the health of individuals seeking abortion care, this
13 *undermines* their health and thus is not “consistent with accepted clinical standards of practice
14 and evidence-based medicine.” Ariz. Const. art. II, § 8.1(B)(1)(a); *see also supra* ¶¶ 63–73.

15 202. For example, there is no medical justification for requiring *all* patients, regardless
16 of their circumstances or medical histories, to have an ultrasound 24 hours prior to receiving an
17 abortion; receive information and counseling in person, at least 24 hours before the procedure;
18 or undergo Rh testing that can delay care up to 24 hours. To the contrary, these blanket
19 requirements introduce delays that, as discussed *supra*, undermine patients’ health.

20 203. Moreover, forcing abortion patients to make multiple trips to their healthcare
21 provider to obtain abortion care, sometimes requiring lengthy travel and/or overnight stays,

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23 ⁶² *See* Diana Greene Foster, *The Turnaway Study: Ten Years, A Thousand Women, and*
24 *the Consequences of Having—or Being Denied—an Abortion*, Scribner chs. 4, 5 (2020)
(comparing the physical and mental health effects of abortion with continued pregnancy and
childbirth).

1 jeopardizes patients’ ability to keep their healthcare decisions confidential. This exposes patients
2 who are experiencing intimate partner violence or are otherwise at risk of abuse to increased risk
3 of harm if their decision is discovered. It can also take a substantial toll on patients’ emotional
4 and psychological health or even prevent them from obtaining abortion care altogether.

5 204. The sole effect of the mandatory delay is to force patients to remain pregnant
6 longer than necessary, against their will.

7 205. Mainstream medical consensus dictates that the best evidence-based medical
8 practice is to provide patients with timely abortion care without any unnecessary delays, and that
9 abortion restrictions like the Two-Trip Scheme do not improve patient health. For example,
10 ACOG and the Society of Family Planning (“SFP”) firmly oppose these laws. In a Committee
11 Statement, also endorsed by SFP, ACOG has “called for the cease of and repeal of all legislation,
12 policy, and executive actions that ban abortion, create barriers to abortion access, or interfere
13 with the patient–health care professional relationship and the practice of medicine, including,”
14 *inter alia*, “[m]andatory . . . ultrasonography and waiting periods before obtaining abortion care”
15 and “[m]andatory counseling on abortion risks that are not based on current understandings of
16 published evidence.”⁶³

17 206. *Telemedicine Ban Scheme*. Prohibiting the provision of abortion care through
18 telemedicine and the mailing of abortion medications likewise does not advance patient health
19 in accordance with widely accepted and evidence-based standards of care.

21 ⁶³ ACOG, *Committee Statement No. 16: Increasing Access to Abortion* (Feb. 2025),
22 [https://www.acog.org/clinical/clinical-guidance/committee-](https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion)
23 [statement/articles/2025/02/increasing-access-to-abortion](https://www.acog.org/clinical/clinical-guidance/committee-statement/articles/2025/02/increasing-access-to-abortion); *see also* National Academies Safety
24 Report, *supra* note 11, at 163 (finding that “abortion-specific regulations on the site and nature
of care, provider type, provider training, and public funding diminish . . . quality care” by
“delay[ing] care unnecessarily from a clinical standpoint,” “prohibit[ing] qualified clinicians . . .
from performing abortion,” and “mandat[ing] clinically unnecessary services” such as
“preabortion ultrasound[s]” and “in-person counseling visit[s].”).

1 207. Telemedicine has been used to safely provide medication abortion for more than a
2 decade and has been deemed to be as safe as the provision of medication abortion in person at a
3 clinic. According to the National Academies of Sciences, Engineering, and Medicine, “[t]here
4 is no evidence that the dispensing or taking of mifepristone tablets requires the physical presence
5 of a clinician . . . to ensure safety or quality. The effects of mifepristone occur after women leave
6 the clinic, and extensive research shows that serious complications are rare.”⁶⁴

7 208. Similarly, ACOG has concluded that “[m]edication abortion can be provided
8 safely and effectively by telemedicine with a high level of patient satisfaction” and that such
9 telemedicine “improves access to early abortion care, particularly in areas that lack a health care
10 practitioner.”⁶⁵

11 209. SMFM too has affirmed that “[t]elemedicine access for medication abortion
12 provides successful, safe outcomes when compared with in-person visits.”⁶⁶

13 210. Because telemedicine bans for abortion delay access to care, ACOG, SFP, the
14 AMA, and other major medical organizations have taken a strong position against them. As
15 ACOG and the AMA stated in an amicus brief filed in the Supreme Court just last year, they
16 “are aware of no medical basis to exclude those in need of reproductive care from accessing it
17 through telemedicine,” as their “patients would [not] be better served by returning to an era that
18 mandated repeated, wholly unnecessary office visits for the prescription and use of an
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22 ⁶⁴ National Academies Safety Report, *supra* note 11, at 79.

23 ⁶⁵ ACOG Medication Abortion Practice Bulletin, *supra* note 36.

24 ⁶⁶ SMFM, *Special Statement: Telemedicine in Obstetrics—Quality and Safety Considerations* at B9, Table 1 (Mar. 2023), <https://www.ajog.org/action/showPdf?pii=S0002-9378%2822%2902261-X>.

1 exceedingly safe medication.”⁶⁷ Indeed, “[f]or prescription of mifepristone for use in medication
2 abortion . . . telehealth protocols offer the same protections as in-person dispensing and provide
3 an equivalent level of care.”⁶⁸

4 211. In addition, Arizona’s ban on mailing abortion medications runs counter to the
5 Food and Drug Administration’s regulations that expressly permit the mailing of mifepristone.
6 As the AMA, ACOG, and other leading medical associations have stated, “[m]ifepristone has
7 been available by mail since” 2021, during which time their “members have observed *no change*
8 *whatsoever* in the incidence of adverse events from mifepristone.”⁶⁹

9 **E. The Challenged Laws Violate the Prohibition on Penalizing Providers for**
10 **Assisting People in Accessing Abortion**

11 212. In addition to infringing Arizonans’ right to abortion, the Reason Ban, Two-Trip,
12 and Telemedicine Ban Schemes are unconstitutional for the independent reason that they
13 penalize abortion providers for assisting people in exercising that fundamental right. *See* Ariz.
14 Const. art. II, § 8.1(A)(3).

15 213. For example, by imposing a maze of overlapping, inconsistent, and seemingly
16 contradictory requirements, the Reason Ban Scheme exposes physicians and other healthcare
17 providers to felony penalties punishable by prison time, professional penalties that include
18 suspension or loss of licensure, and extensive civil penalties. *See supra* ¶¶ 14–23.

19
20 ⁶⁷ Br. of American Coll. of Obstetricians & Gynecologists et al., as Amici Curiae
Supporting Petitioners at 24, *FDA v. All. for Hippocratic Med.*, 602 U.S. 367 (2024) (Nos. 23-
21 235 & 23-236).

22 ⁶⁸ *Id.* at 23.

23 ⁶⁹ *Id.* at 25; *see also* FDA Ctr. For Drug Eval. & Rsch., *Medical Review, Application No.*
24 *020687Orig1s020*, 47 (Mar. 29, 2016),
https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf (rates
of clinically significant adverse events arising from medication abortion are exceedingly rare,
generally far below 0.1%).

1 separate violation may be assessed “for each resident or patient who the department determines
2 was impacted by the violation.” *Id.*

3 219. The Director of ADHS is also independently authorized to suspend or revoke the
4 license of any abortion clinic that fails to “adher[e] to” “any [] law or rule concerning abortion.”
5 *See* A.R.S. § 36-449.02.

6 220. County attorneys are authorized to “conduct all prosecutions for public offenses,”
7 A.R.S. § 11-532(A)(1), subject to the Attorney General’s supervisory authority to enforce the
8 laws of Arizona. *See* A.R.S. § 41-193(A)(4) (the attorney general “shall . . . [e]xercise
9 supervisory powers over county attorneys of the several counties”); *Crosby-Garbotz v. Fell in*
10 *and for Cnty. of Pima*, 246 Ariz. 54, 60 ¶ 24 (2019) (holding the same).

11 221. Thus, the Challenged Laws penalize individuals and entities for aiding or assisting
12 a pregnant individual in exercising their right to abortion, and they are unconstitutional.

13 CLAIMS FOR RELIEF

14 COUNT I

15 (Declaratory Judgment – Fundamental Right to Abortion)

16 222. Plaintiffs incorporate paragraphs 1 through 221 as if set forth herein.

17 223. Under article II, section 8.1 of the Arizona Constitution, “the state shall not enact,
18 adopt or enforce any law, regulation, policy or practice that . . . denies, restricts or interferes
19 with” the fundamental right to abortion “before fetal viability unless justified by a compelling
20 state interest that is achieved by the least restrictive means.” Ariz. Const. art. II, § 8.1(A)(1).

21 224. As set forth *supra* in Sections III.A through III.C, the Challenged Laws deny,
22 restrict, and/or interfere with the fundamental right to abortion.

23 225. To be justified by a compelling state interest under the Amendment, the
24 Challenged Laws must meet two requirements: (1) they must be “enacted or adopted for the

1 limited purpose of improving or maintaining the health of an individual seeking abortion care,
2 consistent with accepted clinical standards of practice and evidence-based medicine,” and
3 (2) they must “not infringe on that individual’s autonomous decision making.” Ariz. Const.
4 art. II, § 8.1(B)(1)(a)–(b).

5 226. As set forth *supra* in Sections III.D, the Challenged Laws cannot satisfy both
6 prongs, and thus they are not justified by a compelling state interest.

7 227. The Challenged Laws deprive Plaintiffs’ patients of their fundamental right to
8 abortion under the Arizona Constitution, causing them to suffer significant constitutional,
9 physical, psychological, and other harms.

10 228. There is no adequate remedy at law to address these harms.

11 229. For all these reasons, Plaintiffs’ patients’ rights, status, and other legal relations
12 are directly affected by the Challenged Laws, and Plaintiffs’ patients are thus entitled to a
13 “declaration of rights, status or other legal relations thereunder.” *See* A.R.S. § 12-1832.

14 **COUNT II**

15 **(Declaratory Judgment—Prohibition on Penalizing an Individual for Assisting a** 16 **Pregnant Individual in Exercising Their Right to Abortion)**

17 230. Plaintiffs incorporate paragraphs 1 through 229 as if set forth herein.

18 231. Article II, section 8.1 of the Arizona Constitution provides: “[T]he state shall not
19 enact, adopt or enforce any law, regulation, policy or practice that . . . penalizes any individual
20 or entity for aiding or assisting a pregnant individual in exercising the individual’s right to
21 abortion.” Ariz. Const. art. II, § 8.1(A)(3).

22 232. By prohibiting Plaintiffs from providing certain abortions; requiring them to
23 violate their ethical obligations to force patients to undergo medically unnecessary mandatory
24 delays, physical examinations, and biased counseling; and otherwise compromising their ability

1 to provide abortion care in accordance with their ethical obligations under threat of severe
2 criminal, civil, and licensing penalties, the Challenged Laws penalize individuals and entities for
3 aiding or assisting a pregnant individual in exercising the individual’s right to abortion in direct
4 defiance of the Amendment, causing Plaintiffs’ patients to suffer significant constitutional,
5 psychological, and other harms.

6 233. Plaintiffs have no adequate remedy at law to address these harms.

7 234. For all these reasons, Plaintiffs’ rights, status, and other legal relations are directly
8 affected by the Challenged Laws, and Plaintiffs are thus entitled to a “declaration of rights, status
9 or other legal relations thereunder.” A.R.S. § 12-1832.

10 **PRAYER FOR RELIEF**

11 WHEREFORE, Plaintiffs ask this Court:

12 A. That the Court issue a declaratory judgment declaring that the Reason Ban
13 Scheme, A.R.S. § 13-3603.02, A.R.S. § 36-2157, A.R.S. § 36-2158(A)(2)(d), and A.R.S. § 36-
14 2161(A)(25); the Two-Trip Scheme, A.R.S. § 36-2153(A), (F), A.R.S. § 36-2158(A), A.R.S.
15 § 36-2156(A), A.R.S. § 36-2162.01, A.R.S. § 36-449.03(D)(3)(c), (G)(5), and A.A.C. R9-10-
16 1509(A)(3)(b), (A)(4), (B), (E)(1), and the Telemedicine Ban Scheme, A.R.S. § 36-2153(A),
17 A.R.S. § 36-2156(A), A.R.S. § 36-2158(A), A.R.S. § 36-3604, A.R.S. § 36-2160(B), A.R.S.
18 § 36-449.03(D), A.A.C. R9-10-1501(8), and A.A.C. R9-10-1509(A)-(E), are unconstitutional in
19 violation of article II, section 8.1 of the Arizona Constitution;

20 B. For a preliminary injunction enjoining Defendant from enforcing the Reason Ban
21 Scheme, Two-Trip Scheme, and Telemedicine Ban Scheme;

22 C. For a permanent injunction enjoining Defendant from enforcing the Reason Ban
23 Scheme, Two-Trip Scheme, and Telemedicine Ban Scheme;

24

1 D. For an order awarding Plaintiffs their attorneys' fees under the private attorney
2 general doctrine or any applicable statute or common law doctrine;

3 E. For an order awarding Plaintiffs their taxable costs under A.R.S. §§ 12-341 and
4 12-1840; and

5 F. For any other relief as may be appropriate.

6 Dated: May 22, 2025

PERKINS COIE LLP

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22 *William Richardson, M.D.*
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**Application for admission pro hac vice
forthcoming*


1 **Verification**

2 I, Paul A. Isaacson, M.D., state as follows:

3 I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and
4 I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in
5 the foregoing Complaint are true and accurate.

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

7
8 Executed this 21ST day of May, 2025.

9
10 
11 _____
Paul A. Isaacson, M.D.

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1 **Verification**

2 I, William Richardson, M.D., state as follows:

3 I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and
4 I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in
5 the foregoing Complaint are true and accurate.

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

7
8 Executed this 21st day of May, 2025.

9
10 
11 _____
12 William Richardson, M.D.

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1 **Verification**

2 I, Nadeem Kazi, state as follows:

3 I have read the foregoing Verified Complaint for Injunctive and Declaratory Relief, and
4 I am acquainted with the facts stated therein. To the best of my knowledge, the facts set forth in
5 the foregoing Complaint are true and accurate.

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

7
8 Executed this $\frac{25}{21}$ day of MAY, 2025.

9
10
11 
12 Nadeem Kazi, M.D.
13 President, Arizona Medical Association
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