IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,

Plaintiffs,

v.

DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*,

Defendants.

Case No. 1:19-cv-118

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

MOTION

Pursuant to Rule 65 of the Federal Rules of Civil Procedure, Planned Parenthood Southwest Ohio Region (PPSWO), Planned Parenthood of Greater Ohio (PPGOH), Sharon Liner, M.D., and Women's Med Group Professional Corporation (WMGPC) move for a preliminary injunction enjoining Defendants David Yost, Attorney General of Ohio; Michael O'Malley, Cuyahoga County Prosecutor; Ronald O'Brien, Franklin County Prosecutor; Joseph Deters, Hamilton County Prosecutor; and Mathias Heck, Montgomery County Prosecutor, from enforcing Ohio Rev. Code § 2919.15, which will go into effect, absent an order of this Court, on March 22, 2019. Should the Court be unable to enter the requested preliminary injunction before the Act takes effect, Plaintiffs respectfully request the Court enter a temporary restraining order.

Pursuant to Rule 65(b)(1)(B), the undersigned counsel certify that upon electronically filing this motion and the Complaint using the Court's CM/ECF system, counsel will electronically mail the filed documents to: David Yost, Ohio Attorney General; Michael O'Malley, Cuyahoga County Prosecutor; Ronald O'Brien, Franklin County Prosecutor; Joseph Deters, Hamilton County Prosecutor; and Mathias Heck, Montgomery County Prosecutor.

Plaintiffs request that the injunction be granted without bond.

MEMORANDUM IN SUPPORT

The Ohio legislature recently enacted Ohio Rev. Code § 2919.15 (the Act), which criminalizes the performance of an abortion using the dilation and evacuation (D&E) method, "the most commonly used method for performing previability" abortions after approximately 15 weeks of pregnancy, and the only method that can be performed outside a hospital after this gestational age. *Stenberg v. Carhart*, 530 U.S. 914, 945 (2000). This is the latest salvo in Ohio's unremitting assault on women's right to safe and lawful abortions, and part of a broader campaign to limit abortion access and force providers to substitute their professional medical judgment for lawmakers' ideology. The Act is unconstitutional and should be enjoined.

Plaintiffs—Ohio providers of women's health and abortion services—amply satisfy all the requirements for emergency injunctive relief. The Act is unconstitutional under binding Supreme Court and Sixth Circuit precedent holding that a ban on D&E abortions imposes an undue burden. *See, e.g.*, *Stenberg*, 530 U.S. at 945. As the Sixth Circuit has made clear, a ban on D&E is "simply barred." *Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323, 330 (6th Cir. 2007). *Every* court to have considered a similar ban has held it unconstitutional. *See, e.g.*, *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310 (11th Cir. 2018); *Whole Woman's Health v. Paxton*, 280 F. Supp. 3d 938 (W.D. Tex. 2017).

Plaintiffs and their patients will be irreparably harmed if the Act is permitted to take effect on March 22, 2019, as currently scheduled. The Act unduly burdens a woman's constitutional right to obtain an abortion by requiring that, before obtaining a D&E, she must first undergo a procedure to cause fetal demise. To cause demise, Plaintiffs would have to subject every patient to a separate, invasive procedure that increases the risk to the woman without any evidence-based medical benefit. And there is no guaranteed way to safely ensure fetal demise in every case. Nor is there any way for a physician to know whether a demise

procedure will work in any given case. Because they cannot guarantee their patients' safety while complying with the demise requirement, some physicians will be forced to consider abandoning the provision of D&Es entirely. Others are concerned that if they continue performing D&Es to provide necessary abortion services to their patients, the demise requirement would prevent them from exercising their clinical judgment regarding what is best for each patient.

The equities and the public interest strongly support maintaining the status quo while this case is litigated. Hundreds of women seek second-trimester abortion services in Ohio each year for an array of personal and medical reasons. Delaying or impeding access to the most common second-trimester abortion method violates women's constitutional rights and creates other immediate and irreversible consequences. By contrast, an injunction will merely preserve the longstanding status quo; it will impose no burden on the government to require compliance with decades of constitutional precedent protecting women's access to abortion.

Plaintiffs, therefore, respectfully request that the Court act on an expedited basis and preliminarily enjoin this unconstitutional law prior to its March 22, 2019 effective date, and if it is unable to so act, enter a temporary restraining order, to prevent the State from inflicting irreparable harm on women in need of reproductive health care.

STATEMENT OF FACTS

A. Abortion in Ohio

Legal abortion is one of the safest medical procedures in the United States and is markedly safer for women than childbirth. Declaration of Lisa Keder, M.D., M.P.H. (Keder Decl.) ¶ 13; *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016) ("Nationwide, childbirth is 14 times more likely than abortion to result in death[.]"); *id.* at 2320

(Ginsburg, J., concurring) (noting that "abortion is one of the safest medical procedures performed in the United States" (citing the American College of Obstetricians and Gynecologists (ACOG) et al.'s Amicus Br. 6-10)). Abortion is also very common; approximately one-quarter of women nationwide will have an abortion at some point in their lifetime. Keder Decl. ¶ 15.[1]

The vast majority of abortions—more than 85% in Ohio—occur during the first trimester of pregnancy, which lasts up through approximately 13.6 weeks[2] gestational age, measured from the first day of the woman's last menstrual period (LMP).[3] Keder Decl. ¶ 15. Women seek abortions for many reasons, including poverty, youth, and having completed one's family. *Id.* ¶ 16. Reasons that women seek an abortion after the first trimester include late confirmation of pregnancy, delay in obtaining funds necessary for the procedure and related expenses (travel, childcare), or difficulties locating and travelling to a provider. *Id.* In addition, the identification of most major fetal anatomic or genetic anomalies occurs in the second trimester, and women may seek an abortion for this reason. *Id.*

During the first trimester of pregnancy, there are two types of abortion: medication and surgical. Keder Decl. ¶ 18. A medication abortion, which is available only up to 10.0 weeks LMP in Ohio, involves taking two types of medication (pills), usually one day apart. *Id.*

---

[1] *See also* Declaration of Jennifer Branch (Branch Decl.) Ex. B (Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence on Abortion: United States, 2008-2014*, 107 Am. Pub. Health Ass'n 1904, 1908 (Dec. 2017)).

[2] Throughout this brief, as is common in the medical literature, gestational age is written as the number of weeks, followed, after the decimal point, by the number of days of the subsequent week. For example, "14.0 weeks" represents a gestational age of 14 weeks, 0 days, while "17.6 weeks" represents a gestational age of 17 weeks, 6 days.

[3] *See* Branch Decl. Ex. C (Ohio Dep't of Health, *Induced Abortions in Ohio* 9 (2017), https://odh.ohio.gov/wps/wcm/connect/gov/89d03903-856b-4a70-8022-b908fccce800/VS-AbortionReport2017.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-89d03903-856b-4a70-8022-b908fccce800-mrWcCSZ (finding that 85.5% of Ohio abortions occur prior to 13 weeks gestation)).

Surgical abortions in the first trimester are performed by dilating (opening) the woman's cervix and then using suction to remove the contents of the uterus, including the fetus and placenta. *Id.*

During the second trimester, which begins at approximately 14 weeks LMP, the vast majority of abortions are performed using D&E,[4] which ACOG explains is "evidence-based and medically preferred because it results in the fewest complications for women compared to alternative procedures" at that stage of pregnancy.[5] D&E involves two steps: first, dilation of the cervix and second, removal of the fetus, placenta, amniotic fluid, and uterine lining with surgical instruments. Keder Decl. ¶ 19; *see Paxton*, 280 F. Supp. 3d at 947-48. Dilation is achieved over a period of hours, up to one day ahead of the evacuation portion of the procedure. Keder Decl. ¶ 20. As the physician evacuates the uterus, because the cervical opening is narrower than the fetus, some separation of fetal tissues usually occurs as the physician uses instruments to bring the tissue through the cervix. *Id.* ¶ 21; *Paxton*, 280 F. Supp. 3d at 946, 948. The whole evacuation process generally takes approximately 10 minutes and is safely performed as an outpatient procedure. Keder Decl. ¶ 21.

The only medically proven alternative to D&E is induction abortion, in which a physician uses medication to induce labor and delivery of a non-viable fetus. Keder Decl. ¶ 24; *see Paxton*, 280 F. Supp. 3d at 948. Induction abortions must be performed in a hospital or similar facility that has the capacity to monitor the patient overnight—exposing women to the ordinary risks (*e.g.*, of infection) attendant to hospitalization. Keder Decl. ¶¶ 24-25; *see Paxton*, 280 F.

---

[4] Branch Decl. Ex. D (O'Connell et al., *Second-trimester surgical abortion practices: a survey of National Abortion Federation members*, 78 Contraception 492, 497 (Dec. 2008)).

[5] Branch Decl. Ex. E (ACOG, *ACOG statement regarding abortion procedure bans*, (Oct. 9, 2015), https://www.acog.org/About-ACOG/News-Room/Statements/2015/ACOG-Statement-Regarding-Abortion-Procedure-Bans?IsMobileSet=false; *see also* Keder Decl. ¶ 18 (explaining that by around 15 weeks LMP, suction alone is no longer sufficient to perform an abortion)); *see Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 198 (6th Cir. 1997).

Supp. 3d at 948. Though still relatively safe, induction abortions are riskier than D&Es. Keder Decl. ¶ 22. Because induction abortions require inpatient treatment and can last between eight hours and three days, they are also extremely expensive. *Id.* ¶ 24; *see Paxton*, 280 F. Supp. 3d at 948. For these reasons, induction is an uncommon method of abortion both nationally and in Ohio. Keder Decl. ¶ 26; *see Paxton*, 280 F. Supp. 3d at 948.

B. Plaintiffs' Provision of Reproductive Health Services, Including Abortion

Plaintiffs and their physicians, including Plaintiff Dr. Liner, have dedicated their professional lives to providing high-quality, compassionate reproductive health care to women in Ohio, including abortion services. *See* Declaration of Sharon A. Liner, M.D. (Liner Decl.) ¶¶ 1, 3; Declaration of Katherine Rivlin, M.D. (Rivlin Decl.) ¶¶ 1-2; Declaration of W.M. Martin Haskell (Haskell Decl.) ¶¶ 3, 5.[6] Plaintiff Planned Parenthood Southwest Ohio Region (PPSWO), operates a surgical center in Cincinnati, at which Dr. Liner performs abortions and which offers medication abortions up to 10.0 weeks LMP and surgical abortions up to 21.6 weeks LMP. Liner Decl. ¶ 3. Plaintiff Planned Parenthood of Greater Ohio (PPGOH) operates two surgical centers that provide abortion services in East Columbus and Bedford Heights. These surgical centers offer medication abortions up to 10.0 weeks LMP and surgical abortions, including D&E, up to 19.6 weeks LMP and 18.6 weeks LMP respectively. Rivlin Decl. ¶ 10. Women's Med Group Professional Corporation (WMGPC) operates a surgical center in Kettering that provides abortion services, including medication abortions up to 10.0 weeks LMP and surgical abortions up to 21.6 weeks LMP. Haskell Decl. ¶¶ 8, 10-11. No outpatient

[6] It is well established that physicians have standing to assert their own as well as their patients' constitutional rights in cases challenging abortion restrictions. *See, e.g.*, *Singleton v. Wulff*, 428 U.S. 106, 117-18 (1976); *Planned Parenthood of Cent. Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Planned Parenthood Ass'n of Cincinnati, Inc. v. City of Cincinnati*, 822 F.2d 1390, 1396 (6th Cir. 1987).

providers in Ohio perform induction procedures, and abortions are only available in hospitals in extremely limited situations of fetal anomalies and maternal health issues.

C. Existing Hurdles to Obtaining Abortion Services in Ohio

Women in Ohio already face significant hurdles to accessing abortion. *See* Keder Decl. ¶ 14. Ohio requires women to make an additional "informed consent" trip to a physician at least 24 hours in advance of her procedure to receive a state-mandated ultrasound and counseling. Ohio Rev. Code §§ 2317.56, 2919.191, 2919.192; *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 363 (6th Cir. 2006). It is unlawful to perform an abortion when the "probable post-fertilization age" is twenty weeks or greater.[7] Ohio Rev. Code § 2919.201. Physicians must also determine whether there is a detectable fetal heartbeat prior to providing an abortion, and if so, must inform the pregnant woman in writing. *Id.* §§ 2919.191-.192. Clinics performing surgical abortions must be licensed as an ambulatory surgical facility and secure a written transfer agreement with certain hospitals within 30 miles of their location. *Id.* §§ 3702.30, 3702.303, 3727.60(B)(1); *Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 951 (S.D. Ohio 2015). Ohio law also bans dilation and extraction (D&X) or intact D&E abortions, Ohio Rev. Code § 2919.151, which abortion opponents call "partial-birth abortion."[8] In 2018, Ohio passed a law prohibiting abortion if one reason for a woman's decision to terminate her

---

[7] 20 weeks post-fertilization corresponds to 22.0 weeks LMP.

[8] The ban on D&X procedures was upheld because it explicitly exempted D&Es. *See Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436, 451, 453 (6th Cir. 2003). S.B. 145 specifically removes the exception for standard D&Es that was contained in the ban on D&X procedures, further evidence that the legislature's intent was to ban D&E procedures.

pregnancy is a fetal indication of Down syndrome. *Id.* § 2919.10. While that last restriction is enjoined, these restrictions have led to greatly reduced abortion access in Ohio.[9]

D. Ohio Enacts S.B. 145 Banning D&E

Ohio's D&E ban is the State's latest attempt to impose burdensome, medically unnecessary restrictions on abortion in violation of a woman's constitutional rights. The ban criminalizes the performance of what the statute calls a "dismemberment abortion." Although the statute does not use medical terms, its definition makes clear that it prohibits the dilation and evacuation, or D&E, procedure.[10] Keder Decl. ¶ 9. The ban only exempts D&Es if there is a "serious risk [to the woman] of the *substantial* and *irreversible* physical impairment of a major bodily function." Branch Decl. Ex. A (S.B. 145, creating Ohio Rev. Code § 2919.15) (emphases added). Violating the Act constitutes a fourth-degree felony and subjects physicians to civil liability and potential loss of their medical license if convicted of violating the statute. The Act is scheduled to take effect on March 22, 2019.

The Act does not apply if the physician—through a separate, invasive procedure—causes fetal demise before starting the second (*i.e.*, evacuation) phase of the D&E. As is discussed in

---

[9] *Compare* Jones & Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Persp. on Sexual & Reprod. Health 17, 23 (Mar. 2017), *and* Jones & Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46 Persp. on Sexual & Reprod. Health 3, 9 (Mar. 2014).

[10] S.B. 145 defines "dismemberment abortion" as follows:

> "[D]ismemberment abortion" means, with the purpose of causing the death of an unborn child, to dismember a living unborn child and extract the unborn child one piece at a time from the uterus through use of clamps, grasping forceps, tongs, scissors, or similar instruments that, through the convergence of two rigid levers, slice, crush, or grasp a portion of the unborn child's body to cut or rip it off. "Dismemberment abortion" does not include a procedure performed after the death of the unborn child to extract any remaining parts of the unborn child.

Branch Decl. Ex. A. S.B. 145 "does not prohibit the suction curettage procedure of abortion or the suction aspiration procedure of abortion." *Id.*

more detail below, this means that women would have to endure one of three procedures prior to having an abortion: (1) an injection of a medication called digoxin through her abdomen or vagina; (2) an abdominal injection of potassium chloride (KCl) into the fetal heart; or (3) an umbilical cord transection in which the physician divides the umbilical cord prior to evacuation. Each of these procedures adds additional risks without providing any evidence-based medical benefits to patients. *See Paxton*, 280 F. Supp. 3d at 953. According to ACOG, "[n]o evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion." Keder Decl. ¶ 29 (citing ACOG, *Practice Bulletin Number 135: Second-Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1396, 1406 (2013)).[11] While burdensome for all women, the Act exposes women with gestational ages between 15.0 and 18.0 weeks LMP to particularly heightened risk; for these women, demise procedures would amount to experimental procedures, would be inconsistent with the standard of care, and would be particularly difficult due to the extremely small fetal size.

1. Digoxin injections

Some physicians, including some of Plaintiffs' providers, attempt demise via digoxin injections prior to performing a D&E after 18.0 weeks LMP; but they do so to ensure compliance with state and federal bans on D&X abortions rather than because of any benefit established by the medical literature.[12] Liner Decl. ¶¶ 15, 17; Rivlin Decl. ¶ 18; Haskell Decl. ¶ 14. Digoxin injections entail using a long hypodermic needle to administer the drug either transabdominally

[11] Courts have routinely relied on the medical expertise of the ACOG, the largest professional organization of OB/GYNs in the United States, in cases dealing with abortion restrictions. *See, e.g., Hellerstedt*, 136 S. Ct. at 2312; *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 488 n.10 (1983); *Voinovich*, 130 F.3d at 198 n.7.

[12] Under those existing laws, a physician who tries but fails to cause demise would not be prosecuted, *see* 18 U.S.C. § 1531(b)(1)(A); Ohio Rev. Code § 2919.151(5)(G), whereas the Act contains no such safe harbor.

(through the abdomen into the uterus) or transvaginally (through the vaginal wall or cervix) on the day prior to the evacuation. Liner Decl. ¶ 15. For pregnancies before 18.0 weeks LMP, the injections are a wholly unproven and untested method of demise, and the practice at all of the Plaintiffs' facilities is not to attempt it. *Id.* ¶ 17; Rivlin Decl. ¶¶ 16, 18; Haskell Decl. ¶ 21-22. Doing so would therefore subject women to experimental treatment without any medical justification. Liner Decl. ¶ 23; Rivlin Decl. ¶ 18; Keder Decl. ¶¶ 31, 35; *see Paxton*, 280 F. Supp. 3d at 950.

At all stages of pregnancy, digoxin carries risks beyond the risks associated with the D&E procedure itself. Digoxin is administered via injection and thus increases the woman's risk of infection. Keder Decl. ¶ 32; *see Paxton*, 280 F. Supp. 3d at 949. It also increases the risk of a woman delivering a non-viable fetus outside of a healthcare facility, which could be dangerous to her health and cause significant pain and emotional distress. Rivlin Decl. ¶ 17. Some patients find the injection painful. Keder Decl. ¶ 30. The long needle required may also cause anxiety, and for some women, knowing that the fetus is receiving the injection can be emotionally difficult. Liner Decl. ¶ 15; Keder Decl. ¶ 30; *see Paxton*, 280 F. Supp. 3d at 949. Digoxin injections are also difficult or impossible to perform on some women due to obesity, fibroids, or fetal positioning. Keder Decl. ¶ 36; *see Paxton*, 280 F. Supp. 3d at 949. And they can be dangerous for women with certain cardiac conditions, like arrhythmia. Keder Decl. ¶ 36.

Moreover, digoxin fails to cause demise after 24 hours in up to 10% of cases, and there is no way to know in advance whether it will fail. Keder Decl. ¶ 34. If the Act were to take effect, in order to ensure demise, the physician would have to attempt a second injection in the case of an initial failure. *Id.* ¶ 35. But such repeat injections are unstudied and are not used in Ohio abortion practice. *Id.*; Rivlin Decl. ¶ 19; Liner Decl. ¶¶ 16, 19; Haskell Decl. ¶ 16; *see*

Williamson, 900 F.3d at 1323. Performing a second injection and waiting to confirm fetal demise could also delay the procedure for another day for no medical reason. Keder Decl. ¶ 35. Such a delay poses risks to the patient, since a patient's cervix will already be dilated following the first injection, and there is no guarantee that a second injection would work. Liner Decl. ¶ 19. The better course for the patient's health in the case of failure following one digoxin injection is to complete the procedure (as Ohio physicians who use digoxin do). *Id.*; Haskell Decl. ¶¶ 17-18. But doing so would violate the Act, and the effects of delaying for a second injection, while harmful, are very unlikely to meet the Act's narrow exception for "a serious risk of the substantial and irreversible impairment of a major bodily function." Branch Decl. Ex. A; *see* Keder Decl. ¶¶ 35, 46.

2. Potassium chloride injections

Fetal demise can also be accomplished through the use of potassium chloride (KCl). But in order to reliably cause demise, KCl must be injected directly into the fetal heart, which is difficult given its extremely small size. Keder Decl. ¶ 39; *Paxton*, 280 F. Supp. 3d at 950. Inadvertent injection of KCl into the patient's bloodstream carries the serious risk of cardiac arrest and fatality for the patient. Keder Decl. ¶ 39; *see also Paxton*, 280 F. Supp. 3d at 950. Given its complexity, the procedure requires extensive training typically provided only to sub-specialists in high-risk obstetrics, known as maternal-fetal medicine (MFM) specialists. Keder Decl. ¶ 40; *see Paxton*, 280 F. Supp. 3d at 950. None of the Plaintiffs has this training, nor do any use KCl in their clinical practice. Rivlin Decl. ¶ 20; Liner Decl. ¶ 22; Haskell Decl. ¶ 19.

3. Umbilical cord transection

Finally, fetal demise can be accomplished through umbilical cord transection (UCT), which requires inserting an instrument or suction tube into the uterus, locating and securing the umbilical cord, and then transecting (dividing) it. Keder Decl. ¶ 41. Like digoxin, UCT does not

provide physicians with a feasible, reliable means of complying with the Act for at least three reasons. *See* Rivlin Decl. ¶¶ 22-23; Liner Decl. ¶¶ 21, 25; Haskell Decl. ¶¶ 20, 23.

First, UCT subjects women to health risks without any medical benefit, as the procedure may require the physician to make multiple additional passes of instruments into the woman's uterus, which increases the risk of uterine perforation, cervical injury, heavy bleeding, and infection. Keder Decl. ¶ 44; *see Williamson*, 900 F.3d at 1323. If a physician is able to transect the cord, she must wait for demise to occur, which can take approximately 10 minutes. Keder Decl. ¶ 41. UCT therefore would significantly prolong the D&E process, potentially taking as long as the D&E procedure itself, which increases risks to the patient. *Id.* ¶¶ 41, 42; *see Paxton*, 280 F. Supp. 3d at 948, 951.

Second, while attempting to reach for the cord with instruments, a physician may accidentally grasp and remove fetal tissue instead of the cord, as the cord and tissue are virtually impossible to distinguish on an ultrasound once the amniotic fluid has been drained. Keder Decl. ¶¶ 42-43. This would constitute a D&E without demise—a violation of the Act. *See* Branch Decl. Ex. A; *Williamson*, 900 F.3d at 1323. Thus, with each attempted UCT, physicians would risk unintentionally violating the Act.

Third, locating the cord is not always possible, depending on the position of the fetus and the gestational age of the pregnancy. UCTs are difficult to perform, particularly in earlier pregnancies when the cord is extremely small. Keder Decl. ¶ 43; *see Williamson*, 900 F.3d at 1323. In other cases, access to the cord may be blocked by the fetus. Keder Decl. ¶ 43; *see Paxton*, 280 F. Supp. 3d at 951. If a physician is unable to locate the cord and complete transection, she would need to move forward with the procedure because the patient's cervix is

already dilated and her amniotic fluid drained, but this situation is very unlikely to meet the D&E Ban's narrow exception. Keder Decl. ¶¶ 45-46.

In short, there is no safe, reliable way to guarantee demise in 100% of cases, Keder Decl. ¶ 27; *see Williamson*, 900 F.3d at 1327 n.14, 1329, and therefore no way for physicians to begin any D&E procedure without fear of criminal prosecution, Rivlin Decl. ¶¶ 4, 19, 25. There are some women for whom, due to physical characteristics or underlying health conditions, no demise procedure is safe or feasible. *Id.* ¶ 25; Keder Decl. ¶ 27. In addition, demise attempts will sometimes simply fail, forcing Plaintiffs to choose between making a second attempt (which would be untested, experimental, and prolong the procedure), proceeding with the procedure (which would be in the patient's best interest but risk prosecution), or waiting for the patient's condition to deteriorate to the point where the Act's narrow health exception is triggered. Keder Decl. ¶ 35; *see Williamson*, 900 F.3d at 1329. Faced with these constraints, some Ohio physicians would consider abandoning the practice of D&E and referring patients seeking second-trimester abortions out of state. Keder Decl. ¶ 11. Others would be forced to substitute their best medical judgment and the patient's best interests with the ideology of Ohio lawmakers to continue providing D&Es, at risk to their patients' health. *See* Rivlin Decl. ¶ 25; Haskell ¶ 24.

ARGUMENT

"In evaluating a request for a preliminary injunction, a district court should consider: (1) the movant's likelihood of success on the merits; (2) whether the movant will suffer irreparable injury without a preliminary injunction; (3) whether issuance of a preliminary injunction would cause substantial harm to others; and (4) whether the public interest would be served by issuance of a preliminary injunction." *McNeilly v. Land*, 684 F.3d 611, 615 (6th Cir. 2012). "None of these factors, standing alone, is a prerequisite to relief; rather, the court should

balance them." *Connection Distrib. Co. v. Reno*, 154 F.3d 281, 288 (6th Cir. 1998) (internal quotations omitted). Each of the four factors weighs heavily in favor of Plaintiffs.

I. Plaintiffs Are Likely To Prevail On The Merits

A. The Act's Ban On D&E Abortions Is Unconstitutional

The Act violates four decades of unwavering Supreme Court precedent holding that it is unconstitutional to ban the most common method of abortion because such a ban is an undue burden. *See Gonzales v. Carhart*, 550 U.S. 124 (2007); *Stenberg v. Carhart*, 530 U.S. 914 (2000); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976). Likewise, the Sixth Circuit has repeatedly applied that precedent to strike down laws that effectively banned D&E. *Northland Family Planning v. Cox*, 487 F.3d 323 (6th Cir. 2007); *Eubanks v. Stengel*, 224 F.3d 576 (6th Cir. 2000); *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997).[13] And *every other court* to consider statutes nearly identical to the Act have applied that same precedent and found them unconstitutional.[14]

In *Danforth*, the Supreme Court first held that a statute outlawing the most prevalent method of second-trimester abortions is unconstitutional when there are no "safe alternative" options. 428 U.S. at 76-79 (considering a ban on the saline amniocentesis procedure, the method of abortion used in approximately 70% of abortions after the first trimester at that time). The State contended that alternative procedures remained available, but the Court rejected that argument: one proposed alternative had been used only on an experimental basis, *id.* at 77, and thus was not "available[] in any meaningful sense of that term," *id.* at 77 n.12, and others were

---

[13] In fact, in the single instance in which the Sixth Circuit upheld a procedure ban, it did so only and precisely because it "secure[d], by means of an explicit exception, the continued availability of traditional D&E." *Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436, 452 (6th Cir. 2003).

[14] *See, e.g., Williamson*, 900 F.3d 1310; *Paxton*, 280 F. Supp. 3d 938.

similarly unacceptable, as they would "force[] a woman and her physician to terminate her pregnancy by methods *more dangerous to her health* than the method outlawed," *id.* at 79 (emphasis added). Given the lack of safe alternatives, the ban constituted "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks" and could "not withstand constitutional challenge." *Id.*

The Supreme Court reiterated the principle that an abortion regulation prohibiting the most common second-trimester abortion method is unconstitutional when it struck down a Nebraska law purporting to target a less common abortion method, D&X, because the law was written so broadly that it banned D&E, the "most commonly used" second-trimester procedure, as well. *Stenberg*, 530 U.S. at 948. The Court reasoned that by "impos[ing] an undue burden on a woman's ability to choose a D&E abortion, [the law] thereby *unduly burden[ed] the right to choose abortion itself*." *Id.* at 930 (emphasis added). As the Sixth Circuit later explained, "*Stenberg*'s holding is relatively straightforward: if a statute prohibits pre-viability D&E procedures, it is unconstitutional." *Northland Family Planning*, 487 F.3d at 330.

In 2007, the Court again reaffirmed that a ban on D&E is unconstitutional. In *Gonzales*, 550 U.S. at 150-54, the Court upheld a federal statute restricting D&X precisely because it explicitly *exempted* standard D&E, "the usual [second-trimester] abortion method," *id.* at 135. Unlike the statutes at issue in *Danforth* and *Stenberg*, the statute in *Gonzales* permitted the ongoing use of "a commonly used and generally accepted method, *so* it does not construct a substantial obstacle to the abortion right." *Id.* at 165 (emphasis added). That is, a ban on a minority procedure was permissible only because there remained an accessible, common alternative—D&E—that had "extremely low rates of medical complications" and was "the safest method of abortion during the second trimester." *Id.* at 164 (internal quotations omitted).

Sixth Circuit precedent confirms what this line of cases makes clear: a statute that prohibits D&E "create[s] an unconstitutional undue burden on a woman's right to terminate her pregnancy." *Northland Family Planning*, 487 F.3d at 339; *see Voinovich*, 130 F.3d at 201. That principle "has in no way been undermined" by the Court's decision in *Gonzales*. 487 F.3d at 339. In *Northland Family Planning*, the Sixth Circuit found that a Michigan law banning D&E posed an unconstitutional undue burden because there were no safe and reliable alternative second-trimester abortion methods. *Id.* at 329-30.[15] Induction abortion, for example, carries with it "all the potential complications of labor and delivery at term," and thus entails more pain, expense, and risk of infection. *Id.* (internal quotations omitted). Other alternatives, such as removal of the uterus (which leaves the woman sterile), are "obviously much more invasive and dangerous" than D&E. *Id.* at 330.[16]

Given the Supreme Court's clear instruction on this point, courts outside the Sixth Circuit have *uniformly* concluded that D&E bans are unconstitutional. *See, e.g.*, *Hope Clinic v. Ryan*, 249 F.3d 603, 604-05 (7th Cir. 2001) (per curiam); *Causeway Med. Suite v. Foster*, 221 F.3d 811, 812 (5th Cir. 2000); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 145-46 (3d

---

[15] Indeed, in another case, while the Sixth Circuit upheld a law banning medication abortions at some (but not all) gestational ages, it was clear that "[t]he parties agree[d]" that the alternative procedure was "extremely safe." *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490, 494 (6th Cir. 2012). In fact, that court upheld an injunction covering those instances when the alternative would pose a threat to women's health. *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 518 (6th Cir. 2006).

[16] Before *Stenberg*, the Sixth Circuit reached the same conclusion with respect to an Ohio law purporting to ban D&X, but which the evidence showed also prohibited D&E. *See Voinovich*, 130 F.3d at 198-99. As is still true today, the evidence also showed that D&E was "the most common method of abortion in the second trimester." *Id.* at 198. Therefore, the Sixth Circuit held: "Because the definition of the banned procedure includes the D&E procedure, the most common method of abortion in the second trimester, the Act's prohibition on the D&X procedure has the effect 'of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" *Id.* at 201.

Cir. 2000). Indeed, within the past two years, courts have continued this unbroken line of cases and struck down or enjoined the enforcement of D&E bans that are virtually identical to the Act.[17] No court to consider similar legislation has reached a contrary conclusion.

In sum, a law that bans the most common second-trimester abortion procedure, in the absence of safe and reliable alternatives, cannot stand. The Supreme Court and the Sixth Circuit have each upheld just one method ban, and in each case did so only after confirming that the ban did not reach what the parties agreed was the most common—and safe—alternative method of abortion—that is, D&E. Because the Act bans D&E (and there are no acceptable alternatives), it "impose[s] an unconstitutional undue burden," *Northland Family Planning*, 487 F.3d at 337, and must be enjoined.

B. Fetal Demise Cannot Save the Act

The State will likely contend, as have other states in similar litigation, that the Act does not run afoul of this precedent because it does not outright ban D&E, given that it does not apply when physicians cause fetal demise prior to the D&E via a separate procedure. Courts have consistently rejected this argument. *See Williamson*, 900 F.3d at 1327 ("[E]very court to consider the issue has ruled that laws banning dismemberment abortions are invalid and that *fetal demise methods are not a suitable workaround*." (emphasis added)); *see also Whole Women's Health v. Paxton*, 280 F. Supp. 3d 938, 949-52 (W.D. Tex. 2017), *appeal filed*, No. 17-51060 (5th Cir. Nov. 22, 2017); *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1064 (E.D. Ark. 2017), *appeal filed*, No. 17-2879 (8th Cir. Aug. 28, 2017). That uniform rejection makes good sense, particularly in light of the Supreme Court's decision in *Stenberg*. There, the Court struck down a statute that, like the Act, banned the performance of D&Es on "living" fetuses (*i.e.*, where the

[17] *See* n.14, *supra*.

physician had not first caused fetal demise) even though the Court was aware that some physicians performed demise beginning at 20 weeks LMP. *See* 530 U.S. at 925, 945-46. If the theoretical availability of demise methods did not save the statute in *Stenberg*, it cannot do so here. Indeed, requiring women to endure a separate procedure that is medically unnecessary, inconsistently effective, and sometimes infeasible does not alleviate the Act's undue burden; rather, the requirement itself imposes an undue burden. *See Danforth*, 428 U.S. at 78 (an act imposing gratuitous medical risk on women seeking abortions imposes an undue burden).

The Supreme Court has made clear that a state regulation imposes an undue burden if the burdens it imposes outweighs any benefits it advances. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (explaining that courts must consider a law's burdens "together with" its benefits (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 887-98 (1992))). Here, the Act greatly burdens women seeking abortions after 15 weeks LMP because it forces them to undergo an additional, invasive medical procedure that provides no attendant benefit in order to access abortion. Keder Decl. ¶ 47. For patients under 18 weeks LMP, these procedures not only add risks but would be experimental procedures that do not comply with medical standards of care. *Id.* ¶ 31. Regardless of the State's asserted interest, no court has ever held that government-mandated imposition of a medically unnecessary, untested, and invasive procedure, or a more complicated and risky medical procedure with no proven medical benefits, is a permissible means of regulating pre-viability abortion. *See Gonzales*, 550 U.S. at 161 (stating that a ban on an abortion method would be unconstitutional if it subjected women to significant health risks).

Indeed, every court to consider a D&E ban like the Act has invalidated it on the basis that demise *cannot* be safely and consistently achieved in every case before a physician performs a

standard D&E. *See, e.g., Williamson*, 900 F.3d at 1327-28 & n.16 (proposed methods of fetal demise "were not safe, effective, and available"); *Paxton*, 280 F. Supp. 3d at 953 (same); *Hopkins*, 267 F. Supp. 3d at 1064; *accord Farmer*, 220 F.3d at 145 ("The increased risk of injury or death to the woman by attempting to ensure fetal demise in utero … clearly constitutes an undue burden."). And because demise procedures sometimes fail, physicians will be faced with the choice of either trying again (which is untested, adds further risk, and prolongs the procedure), continuing the procedure and violating the Act, or waiting for the patient's condition to deteriorate to the point where she faces such grave health risks that the Act's narrow health exception is triggered, in violation of medical ethics. *See* Rivlin Decl. ¶¶ 19, 25; *Stenberg*, 530 U.S. at 945 (law that subjects "[a]ll those who perform abortion procedures using [D&E to the] *fear [of] prosecution, conviction, and imprisonment*" unduly burdens the "right to choose abortion itself (emphasis added)). There can be no doubt that a law that bans D&E imposes an undue burden on women's access to abortion.

II. The Remaining Preliminary Injunction Factors Weigh In Favor Of Plaintiffs

Unless the State is enjoined from enforcing the Act prior to its March 22, 2019 effective date, women seeking second-trimester abortions in Ohio, including Plaintiffs' patients, will face irreparable, immediate injuries to their constitutional rights and to their health and safety. The deprivation of constitutional rights is itself irreparable harm. *See Elrod v. Burns*, 427 U.S. 347, 373 (1976) ("The loss of [constitutional] freedoms … unquestionably constitutes irreparable injury."); *Overstreet v. Lexington-Fayette Urban Cty. Gov't*, 305 F.3d 566, 578 (6th Cir. 2002) ("[A] plaintiff can demonstrate that a denial of an injunction will cause irreparable harm if the claim is based upon a violation of the plaintiff's constitutional rights."). Further, Plaintiffs' patients face irreparable harm to their health. The Act requires that every woman seeking a D&E

must first endure a separate, medically unnecessary procedure that introduces additional risk. *See* Rivlin Decl. ¶¶ 3, 25; Keder Decl. ¶ 29. As explained above, these procedures add risk at all stages of pregnancy, but prior to 18.0 weeks LMP, these procedures are additionally experimental and not the standard of care. Further, demise methods are not always successful. Digoxin fails in up to 10% of cases and performing a UCT may not be feasible (particularly early in the second trimester). Keder Decl. ¶¶ 34, 43. But by the time that is apparent, the D&E procedure will already be underway, and the physician must proceed to the evacuation portion of the D&E (even without causing demise) to protect her health. *Id.* ¶ 45; *see supra* pp. 10, 12. Further, because physicians cannot guarantee that they can safely and reliably cause demise, some may be unwilling to risk prosecution by even beginning the procedure, possibly denying their patients access to second-trimester abortion altogether. *See* Keder Decl. ¶¶ 11, 28.

On the other side of the equation, Defendants will not be harmed by the issuance of an injunction that preserves the status quo, allowing Plaintiffs to continue to safely provide second-trimester abortions to their patients, as they have for decades, while the constitutionality of the Act is adjudicated. *See Martin-Marietta Corp. v. Bendix Corp*., 690 F.2d 558, 568 (6th Cir. 1982) (courts must balance irreparable injury against harm that would be imposed on defendants by granting an injunction). A preliminary injunction that merely preserves the status quo does no harm to Defendants. *See Preterm-Cleveland v. Himes*, 294 F. Supp. 3d 746, 758 (S.D. Ohio 2018) (granting a preliminary injunction against another Ohio abortion restriction found likely unconstitutional). Indeed, Defendants have no "interest in enforcing a law that is likely constitutionally infirm." *Chamber of Commerce of the United States v. Edmondson*, 594 F.3d 742, 771 (10th Cir. 2010). Courts engaged in this balancing exercise when confronted with nearly identical laws have repeatedly determined that the irreparable harm caused by a D&E ban

outweighs any harms to defendants. *See, e.g., Paxton*, 264 F. Supp. 3d at 824; *Hopkins*, 267 F. Supp. 3d at 1068; *W. Ala. Women's Ctr. v. Miller*, 217 F. Supp. 3d 1313, 1335 (M.D. Ala. 2016).

Finally, "[t]he public interest in preserving the status quo and in ensuring access to the constitutionally protected health care services while this case proceeds is strong." *Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 961 (S.D. Ohio 2015). "The public interest is promoted by the robust enforcement of constitutional rights," *Am. Freedom Def. Initiative v. Suburban Mobility Auth. for Reg'l Transp.*, 698 F.3d 885, 896 (6th Cir. 2012), and "[i]t is in the public's interest to uphold [those] right[s] when [they are] being arbitrarily denied … absent medical or other legitimate concerns," *Doe v. Barron*, 92 F. Supp. 2d 694, 697 (S.D. Ohio 1999). Granting a preliminary injunction will thus serve the public interest by ensuring that women continue to have access to constitutionally-protected abortions.

III. Bond Is Unnecessary In This Case

Finally, the Court should waive the bond requirement of Rule 65(c) of the Federal Rules of Civil Procedure, as the Court may do where, as here, there is no risk of financial harm to the party to be enjoined. *See, e.g., Moltan Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (district court has discretion to issue preliminary injunction with no bond); *Roth v. Bank of the Commonwealth*, 583 F.2d 527, 539 (6th Cir. 1978) (same).

CONCLUSION

For these reasons, this Court should grant Plaintiffs' motion for a preliminary injunction and/or a temporary restraining order.

February 14, 2019

Respectfully submitted,

By /s/ Jennifer L. Branch

JENNIFER L. BRANCH (OHIO BAR. NO. 0038893)
Trial Attorney for Plaintiffs
GERHARDSTEIN & BRANCH CO. LPA
441 Vine Street, Suite 3400
Cincinnati, OH 42502
(513) 621-9100
(513) 345-5543 (fax)

Counsel for Plaintiffs Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Sharon Liner, M.D., Women's Med Group Professional Corporation

MELISSA COHEN (*pro hac vice pending*)
PLANNED PARENTHOOD FEDERATION OF AMERICA
123 William Street, Floor 9
New York, NY 10038
(212) 541-7800
(212) 247-6811 (fax)

RICHARD MUNIZ (*pro hac vice pending*)
PLANNED PARENTHOOD FEDERATION OF AMERICA
1110 Vermont Ave NW, Suite 300
Washington, DC 20005
(202) 973-4800
(202) 296-3480 (fax)

Counsel for Plaintiffs Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Sharon Liner, M.D.

ALAN E. SCHOENFELD (*pro hac vice pending*)
MARGARET ARTZ
LAURA BAKST
WILMER CUTLER PICKERING HALE AND DORR LLP
7 World Trade Center
250 Greenwich Street
New York, New York 10007
(212) 230-8800

JENNY PELAEZ
WILMER CUTLER PICKERING HALE AND DORR LLP
350 South Grand Avenue, Suite 1200
Los Angeles, CA 90071
(213) 443-5300

ALLYSON SLATER
WILMER CUTLER PICKERING HALE AND DORR LLP
60 State Street
Boston, MA 02109
(617) 526-6000

SARA SCHAUMBURG
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Avenue NW
Washington, DC 20006
(202) 663-6000

Counsel for Plaintiffs Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Sharon Liner, M.D.

Certificate of Compliance with SDOH Local Rule 65.1

Trial Attorney for Plaintiffs has served Counsel for Defendants with a copy of the Complaint, Motion for Preliminary Injunction and/or Temporary Restraining Order, along with the attached Declarations via email immediately prior to the filing of this Motion and that service has been accomplished.

Certificate of Service

I hereby certify that on February 14, 2019, a copy of the foregoing pleading was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties may access this filing through the Court's system. I further certify that a copy of the foregoing pleading and the Notice of Electronic Filing has been served by ordinary U.S. mail and email upon all parties for whom counsel has not yet entered an appearance electronically, including:

Bridget E. Coontz
Assistant Attorney General
Constitutional Offices Section
30 East Broad Street, 16th Floor
Columbus, Ohio 43215
bridget.coontz@ohioattorneygeneral.gov

Putative Attorney for Defendant Yost

Pam Sears
Assistant Prosecuting Attorney
Hamilton County Prosecutor's Office
230 E. Ninth Street, Suite 4000
Cincinnati, OH 45202
Pam.Sears@hcpros.org

Putative Attorney for Defendant Deters

Arthur J. Marziale, Jr.
Assistant Prosecuting Attorney
Franklin County Prosecutor's Office
373 South High Street, 13th Floor
Columbus, Ohio 43215-6318
amarziale@franklincountyohio.gov

Putative Attorney for Defendant O'Brien

Dave Lambert
Assistant Prosecuting Attorney
Cuyahoga County Prosecutor's Office
1200 Ontario Street, 9th Floor
Cleveland, OH 44113
channan@prosectuor.cuyahogacounty.us

Putative Attorney for Defendant O'Malley

Mary Montgomery
Montgomery County Prosecutor's Office
301 W. Third St.
Dayton, OH 45402
montgomerm@mcohio.org

Putative Attorney for Defendant Heck

/s/ Jennifer L. Branch
Jennifer L. Branch
Attorney for Plaintiffs

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,

Plaintiffs,

v.

DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*,

Defendants.

Case No. 1:19-cv-118

DECLARATION OF LISA KEDER, M.D., M.P.H., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION AND/OR A TEMPORARY INJUNCTION

I, Lisa Keder, M.D., M.P.H., declare as follows:

1. I am an Obstetrician and Gynecologist (OB/GYN) licensed to practice in the State of Ohio. I have been Board Certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology since 1996. I hold a B.A. in Biology from Oberlin College and a Master of Public Health from the University of Pittsburgh School of Public Health.

2. I completed medical school at Ohio State University College of Medicine in 1989, as well as my OB/GYN residency and fellowship in Family Planning at the University of Pittsburgh Magee-Women's Hospital in 1993 and 1995, respectively. At present, I am Professor and Vice Chair of the Ohio State University Wexner Medical Center's Department of Obstetrics and Gynecology and Division Director for General OB/GYN. In addition to my academic roles, as Division Director of General OB/GYN I oversee gynecologic services and general obstetrics services provided by a group of 22 physicians and 12 advanced practice clinicians at 6 outpatient sites. As Division chief I am responsible for physician staffing and quality of care for the

inpatient gynecology service at the Ohio State University Wexner Medical Center. Throughout my thirty-year career and continuing today, I personally provide obstetric and gynecological care to patients, including treating patients throughout pregnancy. In my teaching role, I supervise resident physicians in the outpatient clinic, labor and delivery and the operating room. Additionally, I participate actively in didactic and clinical instruction for students at the Ohio State University College of Medicine. I am also the Director of the Clinical Trials and Research Program for the General Division of Obstetrics and Gynecology. I serve on various committees within the Wexner Medical Center, including as Chair of Credentials Committee.

3. I am a Fellow of the American College of Obstetrics and Gynecology (ACOG) and a member of the Ohio State Medical Association, the American Medical Association, the Association of Reproductive Health Professionals, and the Society of Family Planning. I am the Treasurer of the Society of Academic Specialists in Obstetrics and Gynecology and an Oral Board Examiner of the American Board of Obstetrics and Gynecology.

4. I have also been the principal or co-investigator in numerous research studies related to obstetrics and gynecology.

5. I have authored or coauthored research papers involving obstetrics and gynecology, including on abortion. I am an editor of the textbook *Gynecologic Care*, published by the Cambridge University Press.

6. During medical school, as well as during my residency and fellowship, I was trained to provide the full range of obstetric and gynecological care, including abortion procedures in the first and second trimesters of pregnancy. I have provided abortion care throughout my career, including working at freestanding clinics like Planned Parenthood of

Greater Ohio, where I have provided abortion care since 1998 and where I was medical director from 1999 to 2010. My practice includes D&E procedures.

7. My curriculum vitae, which sets forth my experience and credentials more fully, is attached.

8. The opinions in this declaration are my expert opinions, which are based on my education, training, and practical experience as an OB/GYN and an abortion provider; my attendance at professional conferences; review of relevant medical literature; and conversations with other medical professionals. I submit this declaration in my personal capacity. My declaration represents my opinions alone. I do not speak for or serve as an authorized representative of the Ohio State University or OSU Wexner Medical Center. All of my opinions in this declaration are expressed to a reasonable degree of medical certainty.

9. I understand that Ohio Senate Bill 145 (S.B. 145 or the Act) imposes criminal and civil penalties on physicians who perform what it calls a "dismemberment abortion." Although the Act does not use medical terminology, that term encompasses an abortion procedure known as dilation and evacuation (D&E). D&E is also the *only* abortion method available in an outpatient setting starting early in the second trimester (generally around 15 weeks from the first day of the woman's last menstrual period (LMP)). The Act thus prohibits D&E, which for decades has been—and remains—the safest and most common abortion method starting early in the second trimester.

10. As I understand it, physicians can avoid liability under the Act only by successfully causing fetal demise before beginning a D&E procedure. In my expert opinion, and as explained further below, this demise requirement introduces medically unnecessary health risks to the woman and is not possible in every case. Because physicians cannot know whether

they will be able to safely cause demise when beginning a D&E, physicians would face the possibility of criminal and civil penalties with every D&E procedure undertaken.

11. In my expert opinion, the Act will be highly detrimental to women's health and safety, and to women's access to legal, high-quality abortion care. And as a provider of abortion services in Ohio, including second-trimester abortion, I would have to consider abandoning the practice of D&E and referring patients seeking second-trimester abortions to out-of-state providers if the Act were to go into effect.

THE D&E METHOD IS A COMMON AND SAFE PROCEDURE

12. Legal abortion is common in the United States; approximately one in four women will obtain an abortion at some point during their lifetime.[1]

13. Legal abortion is also one of the safest medical procedures in the country. When considering the risks of abortion, it is useful to consider the context of pregnancy and childbirth. Women who seek abortions are pregnant, which itself carries risks. For women, undergoing abortion is dramatically safer than carrying a pregnancy to term. The risk of death (maternal mortality) among women is estimated to be 8.8 per 100,000 live births, whereas less than 1 woman dies for every 100,000 abortion procedures (roughly comparable to the risk associated with miscarriage). Thus, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion.[2] Abortion-related mortality is significantly lower than that for other common outpatient medical procedures, such as colonoscopies (2.9 deaths per

[1] Guttmacher Institute, *Induced Abortion in the United States* (January 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf.

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

100,000 procedures).[3] Indeed, the National Academies of Sciences, Engineering, and Medicine recently conducted a systematic review of the safety and quality of care of abortion in the United States, including D&E, and found that D&Es are safe and effective.[4] While the risks related to second-trimester abortions remain extremely low overall, these risks do increase as pregnancy advances. Thus, delays in women accessing abortion care increase the risks of the procedure.

14. In 2014, more than half the women living in Ohio lived in a county that had no clinics providing abortions.[5] Hospitals in Ohio provide abortion care only in rare circumstances.

15. Abortion in Ohio and throughout the country is a common and safe procedure: Nearly one in four women will have an abortion during her lifetime.[6] The vast majority of abortions are performed in the first trimester of pregnancy, which goes to approximately 13 weeks LMP. In 2017, 85.5% of abortions performed in Ohio occurred before 13 weeks, and 12.3% were performed between 13-18 weeks.[7]

16. Women seek to terminate their pregnancies for a variety of reasons, including poverty, youth, their own health concerns, fetal abnormalities, and having completed their families. Although the vast majority of abortions occur early in pregnancy, some women need to

---

[3] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, Washington, DC, March 2018, https://doi.org/10.17226/24950.

[4] *Id.* at 63–65.

[5] *State Facts About Abortion: Ohio*, The Guttmacher Institute, May 2018, https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-ohio.

[6] *Abortion is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates*, The Guttmacher Institute, October 19, 2017, https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.

[7] *Induced Abortions in Ohio*, Ohio Health Department (2017), https://odh.ohio.gov/wps/wcm/connect/gov/89d03903-856b-4a70-8022-b908fccce800/VS-AbortionReport2017.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-89d03903-856b-4a70-8022-b908fccce800-mrWcCSZ.

seek abortion care after the first trimester for any number of reasons: delays in suspecting and testing for pregnancy; delay in obtaining funds necessary for the procedure and related expenses (travel, childcare, lost wages); a medical condition requiring hospital referral, and delay in obtaining a referral; as well as difficulties locating and travelling to a provider. In addition, the identification of most major anatomic or genetic anomalies in the fetus occurs in the second trimester.[8]

17. As twelve major professional organizations dedicated to women and reproductive health, including ACOG and the Society for Maternal-Fetal Medicine, have recently stated: "regulatory restrictions [on abortion] interfere with the reproductive decisions of women and girls, and obstruct evidence-based medical practice."[9]

18. In the first trimester of pregnancy, abortions are performed using medications or surgical procedures.[10] Medication abortions, which are provided up to approximately 10 weeks, as measured from LMP, involve the ingestion of two types of medications (pills) at least one day apart. Surgical abortions in the first trimester are performed by dilating (opening) the cervix and then using suction to remove the contents of the uterus, including the fetus and placenta. This procedure is sometimes called suction curettage or aspiration.

19. Starting early in the second trimester, around 15 weeks LMP, suction alone is no longer sufficient to perform the procedure. At that point, physicians switch to the D&E method. D&E is the safest and most common abortion method starting in the early second trimester,

---

[8] Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin Number 135: Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394 (2013).

[9] Eve Espey, M.D., MPH, *et al.*, *The importance of access to comprehensive reproductive health care, including abortion: a statement from women's health professional organizations*, Am. J. of Obstetrics & Gynecology (January 2019) at 67.

[10] Although it is common to refer to "surgical abortions," they are not surgical in the usual sense: they do not involve any incision into the woman's skin.

accounting for 95% of second-trimester abortions nationally.[11] A D&E has two steps: first, dilation of the cervix and second, removal of the fetus, placenta and uterine lining (decidual tissue) with surgical instruments and suction.

20. In the first step of a D&E, a physician can dilate the woman's cervix using various methods either alone or in combination. These methods include medications (similar to those used for labor induction at term); the use of graduated, tapered dilators, which are gently passed through the cervix and removed; and/or the insertion of small osmotic dilators, which are placed in the cervix and absorb moisture from the body to gently and gradually open the cervix over an interval of several hours. Based on the method of cervical dilation, the physician may start the process for a D&E abortion one day before the evacuation procedure itself, or may complete the cervical dilation and the evacuation on the same day.

21. Once cervical dilation occurs, the physician begins the second step of a D&E. The physician must continue to the evacuation phase of the D&E after the cervix has been dilated, especially if the patient's amniotic sac has already ruptured during the dilation process, because failing to complete the procedure at that point puts the woman at risk of infection, hemorrhage, and extramural delivery (delivery outside of a healthcare facility). To perform the second step, the physician administers analgesia (pain medication) and sedation (usually no more than moderate sedation in the outpatient setting), and then uses suction to remove the amniotic fluid if the amniotic sac has not already ruptured. Forceps or other surgical instruments are then used (sometimes in conjunction with suction) to remove the fetus and placenta. Usually, because the cervical opening is narrower than the fetal parts, some disarticulation or separation of fetal

[11] Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin Number 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1394, 1406 (2013).

tissues occurs as the physician withdraws the instrument through the cervix. As a final step, suction may be used to ensure that the uterus is completely evacuated. The entire D&E process takes approximately 10 minutes.

22. D&E is extremely safe. Major complications occur in less than 1% of second-trimester abortions performed by D&E.[12] The extremely low complication rate for second-trimester abortions overall is largely attributable to the development of the D&E method itself. Before the advent of the D&E method, second-trimester abortions could only be performed via hysterotomy—a surgical procedure, comparable to a cesarean section delivery, entailing an incision through the woman's abdomen and uterus, and carrying all the risks of significant abdominal surgery. Another method used was the administration or "instillation" of certain medical agents to induce labor, which was a prolonged delivery process with a poor safety record and significant side effects. While modern induction abortions, as described below, are far safer than induction abortions of the past, they remain riskier than D&E procedures.

23. D&E was also a major innovation in abortion care because it is well-suited to outpatient, ambulatory settings. Starting early in the second trimester, D&E is the *only* abortion method available in an outpatient setting in Ohio.

24. Today, the only second-trimester alternative to D&E is an induction abortion procedure, an inpatient procedure in which physicians use medication to induce labor and delivery of a non-viable fetus. Induced labor abortions require the woman to go through labor and delivery, with all the pain and potential for complications that entails. Going through labor can be psychologically challenging for some women, especially those who are obtaining an

[12] C. Hammond & S. Chasen, *Dilation and Evacuation*, Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care 158 (Maureen Paul *et al*. eds., 2009).

abortion after learning of a devastating fetal diagnosis. Induction abortions must also be performed at a facility that can admit patients for an extended stay, such as a hospital or hospital-like facility, and the length of the procedure can vary from 8 hours up to several days. As such, induction abortions are usually far more expensive than clinic-based D&E abortions.

25. Further, following an induction, between 10-33% of women have a retained placenta and must undergo an additional surgical procedure (a dilation and curettage, which is performed in a manner akin to a D&E) to have it removed.[13] In some cases, the induction may fail, and a D&E must be performed urgently if infection or heavy bleeding occurs. Induction abortion can cause uterine rupture, which is rare but can be life-threatening. This is especially a concern for women who have had previous cesarean deliveries, a common obstetrical history.

26. Given the additional pain, time, expense, and potential for complications of an induction abortion, the overwhelming majority of women nationally and in Ohio seeking to obtain a second-trimester abortion elect D&E.

THE ACT'S FETAL DEMISE REQUIREMENT IS NOT A FEASIBLE WORKAROUND

27. It is my understanding that the Act imposes criminal and civil sanctions on physicians who perform D&Es unless the physician successfully causes fetal demise in every patient before beginning the evacuation phase of the procedure.[14] However, it is my expert medical opinion that there is no safe, reliable way to guarantee demise in 100% of cases. Further, when beginning a D&E, physicians cannot know whether they will be able to safely cause demise in that case. Thus, physicians would face the possibility of criminal and civil

[13] A.M. Autry *et al*., *A Comparison of Medical Induction and Dilation and Evacuation for Second Trimester Abortion*, 187 Am. J. Obstetrics & Gynecology 393 (2002).

[14] I understand there is a very narrow exception to preserve the life and health of the mother. I discuss that further below at ¶ 46.

penalties with every D&E procedure undertaken. The demise requirement also increases the risk, complexity, pain, and length of the abortion procedure without medical justification.

28. To my knowledge, there is no other context besides abortion where, in order to provide care, doctors must perform a separate unnecessary, painful, and invasive medical procedure, with increased risks, a contravention of their best medical judgment, the best interests of the patient, and the wishes of the patient. For physicians who hold the reasonable belief, based on medical literature and authorities, that attempting demise is medically unnecessary and subjects women to additional risk, the law leaves them no options but to discontinue performing second-trimester abortions to avoid the risk of prosecution.

29. ACOG has stated that there is no medical reason to perform a separate, invasive procedure to cause demise before performing a D&E: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion."[15] Similarly, the Society of Family Planning (SFP) has determined that, based on current medical evidence, the harms associated with fetal demise procedures outweigh their benefits.[16] ACOG's and SFP's statements are fully consistent with the medical literature, and are respected authorities within our field. In my expert opinion, a requirement to undergo—prior to *every* D&E—a separate, medically unnecessary procedure that will predictably fail in some cases, should not be imposed on every patient.[17] For these reasons, I do not perform a demise procedure before providing a D&E procedure.

---

15 Am. Coll. of Obstetricians & Gynecologists, *supra* note 5.

16 J. Diedrich & E. Drey, *Induction of Fetal Demise Before Abortion: SFP Guideline 20101*, 81 Contraception 462 (2010).

17 *Id*.

Digoxin Injections Are Not a Workaround to the D&E Ban

30. Starting in the later part of the second trimester, some physicians attempt to induce fetal demise by injecting a drug called digoxin using a long spinal needle passed through the woman's abdomen, vaginal wall, or cervix into the uterus using ultrasound guidance. After confirming correct needle placement, providers inject the digoxin either into the fetus (intrafetal) or into the amniotic fluid (intraamniotic). Physicians who attempt to cause demise with digoxin generally do so the day before the scheduled D&E procedure because when digoxin works to cause fetal demise it can take up to 24 hours to be effective. These procedures, particularly intrafetal injections, can be technically challenging for the physician. Indeed, although OB/GYNs were historically trained to do amniocentesis through a transabdominal injection, most OB/GYNs do not routinely receive that training now as the number of amniocenteses has fallen with the advent of other, less invasive forms of genetic testing—and they are not trained to provide intraamniotic transvaginal injections during residency. Based on my professional experience with colleagues who have used digoxin, I know that transabdominal injections into the uterus can be painful, create a risk of infection, and are upsetting to the patient. Further, digoxin injections carry risks over and above the risks associated with the D&E procedure itself, as I explain in detail below.

31. In my expert opinion, digoxin injections are not a viable workaround to the Act. *First*, there is virtually no data addressing the use of digoxin in women with pregnancies before 18 weeks LMP—when most D&Es occur. Because of this, attempting demise using digoxin prior to 18 weeks LMP would subject women to a procedure with risks that cannot be quantified and that has an unknown likelihood of success. Such procedures are contrary to the standard of care and would be experimental. Moreover, because the fetus is so small prior to 18 weeks, and

intrafetal injection is therefore more difficult, the administration of digoxin would likely be intraamniotic, which has a higher rate of failing to cause demise.

32. *Second*, as noted above, the Act would require all physicians to subject women to a procedure that provides no medical benefit, but entails added risk over and above the risks associated with the D&E procedure itself. The scientific research has not shown medical benefits of digoxin before abortion; to the contrary, digoxin has been shown to increase medical risks, including infection; extramural delivery, which can cause not only hemorrhage but also emotional distress; and the rate of hospital admissions, which in one study was six times higher for women who had digoxin than for other women.[18] There is also the potential for digoxin toxicity (hyperkalemia) and potential cardiovascular effects. This is rare but life-threatening. It also causes increased vomiting and nausea. On balance, research indicates that there is no medical support for routine use of digoxin injections, which carry risks.

33. While some, but not all, Ohio providers attempt demise using digoxin in certain cases—*i.e.*, procedures *over* 18 weeks LMP— physicians who use demise later in the second trimester do so primarily to comply with federal and state laws banning so-called "partial-birth abortions" (PBA ban), not for any medical reason.[19] That is, the practice is driven by the legal constraints under which physicians must operate to provide abortion services at all.

34. *Third*, digoxin is not 100% effective in causing fetal demise; it fails in up to 10% of cases, and a physician may not know whether it will be possible to successfully inject digoxin in a given patient in advance of an attempt, much less whether it will work (*i.e.*, cause demise). Intraamniotic injections are easier to perform but take longer to cause demise and are associated

---

[18] Dean *et al.*, *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation*, 85 Contraception 144 (2012); J. Diedrich & E. Drey, *supra* note 16.

[19] *Id*.

with higher rates of infection and extramural delivery than intrafetal injection.[20] Intrafetal injections are more technically difficult, and sometimes impossible to perform even for the most skilled physicians due to fetal position, uterine anatomy and other factors, especially when the fetus is smaller in size, (*i.e.*, earlier in pregnancy). Thus, it is impossible to know prior to attempting demise whether an intrafetal injection will be possible, and it is impossible to know whether a given patient will be a patient in whom digoxin simply fails to cause fetal demise.

35. Should the digoxin injection fail, a second injection would be necessary to avoid criminal liability under the Act.[21] But attempting a second injection is untested and experimental: To my knowledge, there is no published information to demonstrate the safety of multiple, sequential doses of digoxin to induce fetal demise in pregnant women after the first injection fails. Further, it would entail waiting even longer for demise, and another day and another clinic visit prior to the procedure. If the first injection fails, there is no medical benefit to delaying the abortion any further at this point, but there is increased risk of uterine infection, extramural delivery, or digoxin toxicity. Under the Act, physicians in such a scenario would be forced to choose between: attempting a second digoxin injection, which is untested and experimental; waiting for the woman's health to decline to the point where the physician felt the law's narrow health exception applied; or completing the D&E without demise, protecting the patient's health but subjecting themselves to prosecution.

36. *Fourth*, though it is rare, some women have medical contraindications to digoxin injections. Digoxin injections are dangerous for women with certain cardiac conditions, like

---

[20] J. Diedrich & E. Drey, *supra* note 16.

[21] It is my understanding that this is not required for compliance with the PBA bans because unlike the Act, those bans have been interpreted to *not* criminalize physicians who *attempt* to comply with the fetal demise requirement but fail to cause demise.

arrhythmias. Digoxin injections are also less likely to be successful or achievable for obese women when a needle cannot safely reach the inside of the uterus; obesity is common. Uterine fibroids, which are benign growths in the uterus, likewise make it difficult or impossible to administer digoxin because they thicken the uterine wall and distort the shape making it challenging to pass a needle into the uterine cavity; fibroids likewise are common.

37. In short, digoxin would be entirely experimental, and thus not feasible, in the early weeks of the second trimester, when most D&Es occur; it is contraindicated in some patients; and even in those patients for whom a physician can perform the injection, digoxin simply fails to cause demise in an unacceptably high percentage of cases—and it is impossible to know in which patients it will fail. In the case of such failures, the woman's cervix may already be dilated, but the Act would criminalize evacuating the uterus even though it is clinically indicated to do so at that time. Digoxin is thus not a reliable clinical practice for compliance with the Act: it does not allow a physician to initiate a D&E because it offers no certainty that the physician could complete it.

Potassium Chloride Injections are Not a Workaround to the Act

38. Some physicians with advanced training attempt demise prior to an abortion using an injection of potassium chloride (KCl) through the woman's abdomen into the fetal heart. As with digoxin, physicians who perform this procedure might do so for the sake of compliance with the federal or state bans on so-called "partial-birth" abortions rather than because of any established medical benefit.[22]

[22] In addition to complying with the PBA ban, KCl administration is most commonly performed for selective termination in a multifetal pregnancy or to induce fetal demise of a fetus with anomalies before labor induction, and, as discussed below, only a small number of physicians possess the requisite skill and experience. Further, unlike attempts to induce fetal demise prior to a D&E procedure, multifetal pregnancy reduction confers medical benefits by reducing risks associated with multifetal gestation.

39. This procedure is extremely difficult to perform and carries a high risk to the woman. Guided by ultrasound, the physician attempts to inject KCl into the fetal heart, which early in the second trimester is extremely small, then ultrasound is used to confirm asystole (no cardiac activity). KCL will not cause demise if it is injected into the amniotic fluid. If a physician accidentally introduces KCl into the maternal circulation, the woman could go into cardiac arrest.[23] There are also risks of intraamniotic infection or chorioamnionitis, a bacterial infection affecting the membranes surrounding the fetus. Like digoxin injections, injections of KCl can be greatly complicated or impossible in some women with common conditions such as obesity and uterine fibroids.

40. An intracardiac injection of KCl is virtually 100% effective, but it requires an extremely high level of skill to perform, and thus is typically performed only by Maternal-Fetal Medicine OB/GYNs following a specialized fellowship with extensive and lengthy advanced ultrasound training. In addition, KCl injections typically require hospital-grade equipment, and Maternal-Fetal Medicine specialists who perform KCl injections do so in a hospital setting and not in outpatient clinics. I am not aware of any abortion providers using KCl to cause demise on a routine basis. Thus, even putting aside the risk to women, KCl is not a method of demise that can be administered by the vast majority of abortion providers, most of whom do not have the extensive additional training that is, as a practical matter, unavailable outside certain Maternal-Fetal Medicine fellowships.

Umbilical Cord Transection is Not a Workaround to the D&E Ban

41. I understand that in previous challenges to similar D&E bans enacted in other states, the states have suggested that a physician could locate and transect (separate) the

[23] G.A. Coke *et al., Maternal Cardiac Arrest Associated with Attempted Fetal Injection of Potassium Chloride*, 13 Int'l J. Obstetric Anesthesia 287 (2004).

umbilical cord as another means of inducing demise prior to a D&E procedure. To transect the cord, the physician would have to rupture the amniotic membranes and insert an appropriate surgical instrument or suction into the uterus to attempt to locate and grasp the cord and divide it with gentle traction, and then wait for demise to occur, which can take approximately 10 minutes. Maternal bleeding can be on-going as the physician waits.

42. This procedure is not widely practiced, is barely researched, and has no known medical benefit.[24] Critically, in attempting to locate, grasp and transect the cord, the physician would have absolutely no way to ensure that he or she does not grasp fetal tissue instead of or in addition to the cord. Because this grasping of fetal tissue is the precise action the Act criminalizes, physicians risk violating the Act by even attempting cord transection.

43. In addition, cord transection is simply not technically feasible in some cases because it can be impossible to locate and divide the cord. While the umbilical cord may present when the fluid from the amniotic sac is removed using suction, this does not occur in every case, or even in most cases. Once the amniotic fluid has been removed, any attempt at umbilical cord transection becomes a procedure that cannot easily be guided using ultrasound technology. That is because without amniotic fluid, the uterus contracts; the fetal tissue, placenta, and cord become compressed into a single mass; and there is no way to reliably distinguish the cord from the other tissue. In the early part of the second trimester, when most D&Es occur, this is even

[24] I am aware of only one, retrospective case series discussing the use of routine umbilical cord transection as a method of inducing fetal demise, which to my knowledge constitutes level C evidence, meaning there is insufficient evidence to support the recommendation. The retrospective analysis was based on the charts of two physicians, at one clinic, which were prepared for their records, not for a research study. Further, a single retrospective study such as this, compared for example to a prospective randomized study, does not justify a change in practice. K. Tocce *et al.*, *Umbilical Cord Transection to Induce Fetal Demise Prior to Second-Trimester D & E Abortion*, 88 Contraception 712 (2013).

more difficult than it would be later, because the earlier in pregnancy the smaller the cord and the harder it is to identify. Furthermore, the cord may be blocked by the fetus or may be too small to be identified on an ultrasound. A physician has no way of knowing before starting the procedure whether it will be possible to locate the cord. Because a physician cannot start a procedure without knowing they can safely and legally complete it, cord transection is not a feasible means to comply with the Act.

44. Umbilical cord transection also subjects women to health risks over and above the risks associated with the D&E procedure itself. Additional passes of instruments through the cervix and into the uterus to try to locate the cord carries increased risks of blood loss and uterine perforation, with no medical justification, and prolongs the procedure. Even if successful, waiting for demise once the cord has been transected can as much as double the length of the procedure (this is not including the time it may take to locate and transect the cord). This goes against my medical training and judgment. Once the procedure has been started, it is best for the patient to have her surgery completed as quickly as possible, as waiting can increase the amount of blood loss, and the amount of anesthesia a woman needs, all without any medical benefit.

45. Thus, the use of umbilical cord transection is not a tested or reliable method, and in many cases may be a technically impossible method, of attempting to induce demise prior to a D&E. Moreover, the physician would know only after dilating the cervix and rupturing the membranes that he or she could not safely locate and grasp the cord, but by that point, it would be medically imperative to proceed with the D&E procedure.

46. I understand the Act contains a narrow exception that would allow a physician to complete the D&E procedure if a patient's physical health is endangered by a serious risk of the substantial and irreversible impairment of a major bodily function. It is not clear to me this

exception would allow physicians to complete the D&E procedure after the physician has attempted to cause demise but such an attempt has failed, even if completing the procedure at that point is important to protect a patient's health. Following a failed digoxin injection, the patient's cervix will already be dilated and delaying the procedure at that point exposes the patient to increased risks of infection and extramural delivery, but it is extremely unlikely that a physician could certify in this situation that the patient's health is so gravely endangered that the Act's exception is met. Similarly, if an attempted cord transection fails, the patient will already be mid-procedure, her cervix will be dilated and her amniotic sac ruptured. Failing to complete the procedure at that point subjects the patient to serious risks of infection, excessive bleeding, and extramural delivery, but again it is unlikely that a physician could certify in this situation that the Act's narrow exception is met. It would be unacceptable for a physician faced with these situations to force a patient to wait until her health deteriorated to the point where the Act's exception was met, but completing the procedure would subject the physician to criminal penalties. This places physicians in an impossible situation.

CONCLUSION

47. By banning D&Es, the Act undermines the safe provision of care to women seeking a pre-viability surgical abortion in Ohio starting early in the second trimester. As the National Academies observed, "D&E is the superior method," but by proscribing D&Es, the only available option—inductions—"are more painful for women, take significantly more time, and are more costly."[25] The demise requirement does not provide a viable or reliable workaround. Attempting to cause fetal demise forces the woman to undergo a separate, invasive procedure,

[25] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, Washington, DC, March 2018, https://doi.org/10.17226/24950.

and places physicians in an impossible position. It is clear that physicians cannot rely on demise to comply with the Act.

48. For these reasons, it is my expert opinion that the Act will cause serious harm both to Ohio physicians and the women in their care.

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

Executed this Twelfth day of February, 2019.

M Keder, MD

Lisa Keder, M.D., M.P.H.

Academic Office:
The Ohio State University
Department of Obstetrics and Gynecology
Room 572
395 W. 12th Ave.
Columbus, OH 43210
614-293-4929
Fax: 614-293-5877

Research Office:
456 W. 10th Avenue Room 2960
Columbus, OH 43210
614-293-0075

Patient Office:
160 W. Wilson Bridge Rd
Suite 2101
Worthington, OH 43085

Lisa M. Keder

Education

B.A., June 1982
Oberlin College, Department of Biology

M.D., June 1989
Ohio State University, College of Medicine

M.P.H., June 1995
University of Pittsburgh, School of Public Health, Epidemiology

Residency

July 1989 – June 1993
Obstetrics and Gynecology
University of Pittsburgh, Magee-Womens Hospital

Fellowship

September 1993 – September 1995
Family Planning and Contraception
University of Pittsburgh, Magee-Womens Hospital

Academic Appointments

Jul 2017 – present
Professor, Department of Obstetrics and Gynecology
The Ohio State University College of Medicine

Jul 2004 – Jun 2017
Associate Professor, Department of Obstetrics and Gynecology
The Ohio State University College of Medicine

Oct 1995 – June 2004
Assistant Professor, Department of Obstetrics and Gynecology
The Ohio State University College of Medicine

Sept 1993 - Sept 1995
Instructor, Department of Obstetrics, Gynecology, and Reproductive Sciences
University of Pittsburgh

Administrative Positions

2015 – Present
Vice Chair, Department of Obstetrics and Gynecology
The Ohio State University College of Medicine, Wexner Medical Center

2010 - Present
Director, Division of General Obstetrics and Gynecology
Department of Obstetrics and Gynecology,
The Ohio State University College of Medicine, Wexner Medical Center

2015 – Present
Chair, Credentials Committee
Ohio State University Wexner Medical Center

2010 - 2015
Vice Chair, Credentials Committee
Ohio State University Wexner Medical Center

2010 - 2011
Acting Director, The Ohio State University Outpatient Ob/Gyn Clinic
Ohio State University Wexner Medical Center

1998 –2010
Medical Director, Planned Parenthood of Central Ohio, Columbus, OH

1999 -2010
Ryan Program Director, Department of Obstetrics and Gynecology
The Ohio State University College of Medicine, Wexner Medical Center

1999 - Present
Director, Clinical Trials and Research Program
Division of General Obstetrics and Gynecology
The Ohio State University College of Medicine, Wexner Medical Center

Other employment

1991 – 1992
Staff Physician, University of Pittsburgh Student Health Services

1984 – 1985
Director, Women's Health Program, Ohio Department of Health

1983 – 1984
Health Educator, Family Planning and Adolescent Health Program, Ohio Department of Health

1982 – 1983
Research Assistant, Clinical Microbiology Laboratory, Columbus Children's Hospital

Honors

2018 Ohio State University College of Medicine Distinguished Mentor Award

2018 Mazzaferri-Ellison Society of Master Clinicians

2018 Warrior Award, Fellowship in Family Planning

2017 America's Best Doctors

2016 Best Teaching and Learning Method Award Endocrinology/Reproduction, *Lead.Serve. Inspire* Curriculum. Ohio State University College of Medicine

2016 America's Best Doctors, Best Doctors

2015 America's Best Doctors, Best Doctors

2014 America's Best Doctors, Best Doctors

2013 America's Best Doctors, Best Doctors

2014 Ohio State University Faculty Leadership Institute Graduate

2013 Resident Teaching Award, Department of Obstetrics and Gynecology, The Ohio State University

2012 Council on Resident Education in Obstetrics and Gynecology Residency Teaching Award

2012 America's Best Doctors, Best Doctors

2011 Resident Teaching Award, Department of Obstetrics and Gynecology, The Ohio State University

2011 America's Best Doctors, Best Doctors

2010 America's Best Doctors, Best Doctors

2009 Golden Apple Award for Excellence in Teaching, Ohio State University College of Medicine

2008 America's Best Doctors, Best Doctors

2007 America's Best Doctors, Best Doctors

2006 Excellence in Teaching Award, Department of Obstetrics and Gynecology, The Ohio State University

2006 Ohio Medical Education Network Award

2002 Council on Resident Education in Obstetrics and Gynecology Residency Teaching Award

2003 - 2005 Solvay Scholar, Association of Professors of Gynecology and Obstetrics

2001 Student Teaching Award, Association of Professors of Gynecology and Obstetrics

1997 Resident Teaching Award, Department of Obstetrics and Gynecology, The Ohio State University

1992 - 1993 Assistant Chief Administrative Resident, University of Pittsburg, Magee-Women's Hospital

1989 Alpha Omega Alpha, Honorary Society, Ohio State University College of Medicine

Publications

Keder LM. Ed Topics of Interest to Specialists in General Obstetrics and Gynecology. Clin Obstet Gynecol. 2018 Jan 5.

Courtney A. Schreiber, Stephanie B. Teal, Paul D. Blumenthal, Lisa M. Keder, Andrea I. Olariu & Mitchell D. Creinin (2018) Bleeding patterns for the Liletta® levonorgestrel 52 mg intrauterine system, The European Journal of Contraception & Reproductive Health Care, DOI: 10.1080/13625187.2018.1449825

Loewenberg Weisband Y, Keder LM, Keim SA, Gallo MF. Postpartum intentions on contraception use and method choice among breastfeeding women attending a university hospital in Ohio: a cross-sectional study. Reprod Health. 2017 Mar 20;14(1):45

Loewenberg Weisband Y, Keim SA, Keder LM, Geraghty SR, Gallo MF. "Early Breast Milk Pumping Intentions Among Postpartum Women." *Breastfeed Med*. Vol. 12, (Jan 2017): 28-32

Eskander R, Berman M, Keder L. "Evaluation and management of adnexal masses." *Obstet Gynecol*. Vol. 128, no. 5. (Nov 2016): 210-226. ACOG Practice Bulletin

Upadhyay UD, Johns NE, Combellick SL, Kohn JE, Keder LM, Roberts SCM. Comparison of Outcomes before and after Ohio's Law Mandating Use of the FDA-Approved Protocol for Medication Abortion: A Retrospective Cohort Study. *PLOS Medicine*. Vol. 13, no. 8. (Aug 2016)

Turok,David,K; Eisenberg,David,L; Teal,Stephanie,B; et al. "A prospective assessment of pelvic infection risk following same-day sexually transmitted infection testing and levonorgestrel intrauterine system placement." *American journal of obstetrics and gynecology*. Vol. 215, no. 5. (Nov 2016): 599 e1-599 e6

Raymond,Elizabeth; Pradhan,Archana; Keder,Lisa. "Emergency Contraception." *Obstetrics and Gynecology*. Vol. 126, no. 3. (Sep 2015): E1-E11

Keder, LM. "Extrauterine pregnancy detection and management." *Contemporary OB/GYN*.

Vol. 58, no. 3. (Mar 2013): 22-33.

Keder, LM; Sanfilippo, JS; Zanotti, K. "Adnexal Masses Through the Ages: Prenatal to the Postmenopause." *ACOG Update*. Vol. 38, no. 7. (Jan 2013): Audio. http://www.acogupdate.com/?gp_page=p_onecourse&gp_skey=335.

Keder,Lisa,M. "A New estradiol-dienogest oral contraceptive marks "The Pill's" 50th Anniversary." *American Journal of Therapeutics*. Vol. 18, no. 1. (Jan 2011): 38-44.

Connolly A; Davis K; Casey P; et al. "Multicenter Trial of the Clinical Activities Tool to Document the Comparability of Clinical Experiences in Obstetrics-Gynecology Clerkships." *Academic Medicine*. Vol. 85, no. 4. (Apr 2010): 716-20.

Keder, Lisa M. "Best practices in surgical abortion." *American Journal of Obstetrics and Gynecology*. Vol. 189, no. 2. (Jan 2003): 418-22.

Keder,LM. "New developments in contraception." *Journal of Pediatric and Adolescent Gynecology*. Vol. 15, no. 3. (Jun 2002): 179-181.

Keder, LM. "Norplant insertion and removal." *Journal of Reproductive Medicine: Operative Techniques in Gynecololgic Surgery*. Vol. 4, (Apr 1999): 176-180.

Keder,LM; Rulin,MC; Gruss,J. "Compliance with depot medroxyprogesterone acetate: A randomized, controlled trial of intensive reminders." *American Journal of Obstetrics and Gynecology*. Vol. 179, no. 3. (Sep 1998): 583-585. (2.63)

Ness, RB; Keder, LM; Soper, DE; et al. "Oral contraception and the recognition of endometritis." *American Journal of Obstetrics and Gynecology*. Vol. 176, no. 3. (Mar 1997): 580-5. (2.56)

Creinin,MD; Vittinghoff, E; Keder, L; et al. "Methotrexate and misoprostol for early abortion: A multicenter trial .1. Safety and efficacy." *Contraception*. Vol. 53, no. 6. (Jun 1996): 321-327. (0.87)

Cromer,BA, Frankel, ME, Keder, LM. "Compliance with Breast Self-examination Instruction in Healthy Adolescents." *Journal of Adolescent Health*. Vol. 10, no. 2. (Mar 1989): 105-109. (0.69) (Published).

Books edited

Keder LM and Olsen M eds. *Gynecologic Care.* Cambridge University Press, 2018

Chapters authored

Keder, LM. "Contraception." In *The Physiologic Basis of Gynecology and Obstetrics*. 1st ed. Edited by Seifer, D; Samuels, P; Kniss, D. Philadelphia: Lippincott Williams and Wilkins, 2001. (Published).

Keder, LM, Isley, MM. "Spontaneous Abortion." In *The 5-Minute Obstetrics and Gynecology Consult*. 426-427. Philadelphia: Lippincott Williams & Wilkins, 2008. (Published).

Keder, LM, Isley, MM. "Uterine Perforation." In *The 5-Minute Obstetrics and Gynecology Consult*. 608-9. Philadelphia: Lippincott Williams & Wilkins, 2008. (Published).

Keder, LM. ""Abnormal First Trimester Pregnancy"." In *Office-Based Women's Health Care*. Olsen M ed. Cambridge University Press, 2016

Keder LM "Pregnancy of Undetermined Location" In Office Gynecology: A Case Based Approach Chelmow D ed Cambridge University Press, (Forthcoming)

Scholarly presentations

Oral presentation. «Assessement of expulsions in nulliparous and multiparous women during the first year of use of Liletta™, a new 52 mg levonorgestrel-releasing intrauterine system » Lisa Keder, Philip D. Darney, Paul D. Blumenthal, Lisa Perriera, Gretchen Stuart, Mitchell D. Creinin North American Forum on Family Planning, Nov 2015

Poster Presenter. "Multi-center Trial of Clinical Activities Tool to Document OB/GYN Clerkship Clinical Experience Comparability." Presented at Association Of Professors of Obstetrics and Gynecology, Orlando (Mar 2008)

Oral Presentation. "A Review of Abstracts and Oral Presentations from APGO annual meetings." Presented at Association of Professors of Obstetrics and Gynecology (Jan 2007)

Oral Presentation. "Interpreter evaluations of obstetrics and gynecology residents." Presented at Association of Professors of Obstetrics and Gynecology, Salt Lake City (Jan 2005)

Abstracts coauthored

Weisband YL; Keder LM; Keim SA; et al. Postpartum intentions on contraceptive use and method choice among breastfeeding women *North American Forum on Family Planning 2016*

Physician knowledge, attitude and confidence with emergency contraception. Fok WK, Keder LM Poster presentation. American College of Ob/GYN Annual Clinical Meeting May 2016

Evaluation of pelvic infection in women using the Levosert 52 mg levonorgestrel-releasing intrauterine system for up to 2 years Stephanie B. Teal, David K. Turok, David L. Eisenberg, Carolyn L. Westhoff, Lisa M. Keder, Mitchell D. Creinin
Oral presentation North American Forum on Family Planning, Nov 2015

Bleeding patterns in women using the Levosert 52 mg levonorgestrel-releasing intrauterine system for up to 2 years Stephanie B. Teal, Carolyn L. Westhoff, Lisa M. Keder, Philip D. Darney, Paul D. Blumentha[5], Mitchell D. Creinin
Oral presentation North American Forum on Family Planning, Nov 2015

Amenorrhea rates in women using the Levosert 52 mg levonorgestrel intrauterine system for up to 4 years Mitchell D. Creinin, Carolyn L. Westhoff, Lisa M. Keder, Philip D. Darney, Paul D. Blumenthal, Lisa K. Perriera
Oral presentation North American Forum on Family Planning, Nov 2015

Upadhyay UD, Combellick s, Johns, NE, Kohn J, Keder LM, Roberts SDM. Evaluating the impact of Ohio's law mandating use of the FDA-approved protocol for medication abortion. Poster presentation National Abortion Federation April 2014

Research funded

Ongoing Co-investigator, OPEN: The Ohio Policy Evaluation Network Anonymous foundation funded $223, 000.

Ongoing Co-investigator Postpartum Family Planning NICHD,$388,000

Ongoing Co-investigator "An open-label, non randomized, prospective observational cohort study to assess post procedural outcomes in two cohorts of women who chose to undergo either hysteroscopic sterilization or laparoscopic tubal sterilization" Bayer HealthCare $36,000

Ongoing Co-investigator, Evaluation of the effectiveness, safety, and tolerability of levocept (levonorgestrel- releasing intrauterine system for long-acting reversible contraception ContraMed $113,000

2014-2016 Keder, LM "A single-arm, open-label, multicenter phase 3 study of the contraceptive efficacy, safety and tolerability of the AG200-15 transdermal contraceptive delivery system (TCDS)", $ 39,181 Principal Investigator at Ohio State

Jun 2010 – present Keder, LM, "A Phase 3, randomized, multi-center, open-label study of a levonorgestrel-releasing, intrauterine system (20mcg/d) and Mirena for long-term, reversible contraception up to five years" Medicines 360. $237,671. Principal Investigator at Ohio State.

Oct 2010 – Nov 2012 Keder, LM, "A multicenter, open-label study to evaluate the efficacy and safety of a combination oral contraceptive regime (DR-102) for the prevention of pregnancy in women" Teva Women's Health Research, Inc. $160,004. Principal Investigator at Ohio State.

Nov 2009 – Dec 2011 Keder LM A multicenter, open-label study to evaluate the efficacy and safety of a combination oral contraceptive regimen (DR-103) for the prevention of pregnancy in women Teva Women's Health Research, Inc. $126,962, Principal Investigator at Ohio State

Oct 2008 – Apr 2010 Isley M "Blood loss at the time of first trimester surgical abortion in anticoagulated women." Oregon Health Sciences Center, 2615. Co-investigator at Ohio State

Jul 2007 - Dec 2008 Keder, LM, "A multicenter, open-label study on the efficacy , cycle control and safety of a contraceptive vaginal ring delivering a daily dose of 150AUG of NestoroneA,A and 15AUG of Ethinyl Estradiol (150/15 NES/EE CVR)" Eastern Virginia Medical School(sub contract for NICHD Contraceptive Clinical Trials Network)) $67,704. Principal Investigator at Ohio State

Sept 2006- Dec 2007:"A prospective, multicenter, open-label study to evaluate the safety and efficacy of the 28-day oral contraceptive DR-1021", Duramed Research, Inc $19,020 Principal Investigator at Ohio State

May 2005 - Dec 2007 Keder, LM, "DR-PSE-309 A multicenter, open-label study to evaluated the efficacy and safety of an extended cycle low does combination oral contraceptive regimen, DP3-LO 84/10, which utilizes Ethinyl Estradiol during the seven day interval between each 84-day cycle of combination therapy for the prevention of pregnancy in women" Duramed Research, Inc. $47,398. Principal Investigator at Ohio State

Jun 2005 –Aug 2007 Keder LM “Treatment of iron deficiency anemia secondary to heavy uterine bleediing” Pediatric Clinical Trials International $11,686 Primary Investigator at Ohio State

Mar 2005 – Dec 2007 Keder LM “Treatment of postpartum anemia” Pediatric Clinical Trials $5701.50 Principal Investigator at Ohio State

Apr 2004 - Sep 2007 Keder, LM, "C31 G Contraceptive Clinical Trial" Eastern Virginia Medical School. (sub contract for NICHD Contraceptive Clinical Trials Network) $110,450. Principal Investigator at Ohio State

Nov 2003 - Jan 2006 Dr Lisa Keder, "Evaluation of NuvaRing for the treatment of abnormal bleeding patterns in the perimenopause." Organon, Inc. $23,726. Principal Investigator at Ohio State

Jul 2001 - Jul 2004 Dr Lisa Keder, "Comparison of Lunelle (TM) and Depo-Provera (R) on bone mineral density." Pharmacia & Upjohn, $174,600. Prinicipal Investigator at Ohio State

Aug 1999- Oct 2002 WC Trout “Compare the perioperative administration of Procrit{R} with iron supplementation in patients undergoing hysterectomy” Orthobiotech Products, LP, $13,510, Co-investigator at Ohio State.

Sept 1997- Sept 2000 LM Keder, “A comparative study of safety, patient acceptability, and efficacy of CYCLO-PROVERA” Pharmacia & Upjohn, $97, 191 Principal Investigator at Ohio State

Service to National Professional Societies

American Board of Obstetrics and Gynecology, Oral Board Examiner
Nov 2010- present.

Society for Academic Specialist in General Obstetrics and Gynecology, Treasurer
May 2016 – May 2018, August 2018-present

Society for Academic Specialist in General Obstetrics and Gynecology, Board Member
May 2014 - 2016

American College of Obstetrics and Gynecology Clinical Document Review Panel
April 2016- Present

American Congress of Obstetricians and Gynecologists, Gynecology Practice Bulletin Committee, Vice Chair
May 2015 – Mar 2016

American College of Obstetricians and Gynecologists, Gynecology Practice Bulletin Committee, Member
May 2013 – Mar 2016

Kennedy Shriver National Institute of Child Health Human Development, Contraceptive Clinical Trials Network, Invited Grant Reviewer
Nov 2012 - Dec 2012.

American College of Obstetrics and Gynecology, Prolog Gynecology Committee
Jul 2006 - Jun 2008

Society for Family Planning, Grant Review Committee, Invited Grant Reviewer
2012 - present

Fellowship in Family Planning, Grant Review Committee, Invited Grant Reviewer
2010 - present

Planned Parenthood Federation of North America, National Medical Committee, Member
Jul 2005 - Jun 2009

Committee Service

The Ohio State University College of Medicine Compensation Committee, 2018- present

The Ohio State University Medical Center, Center, Ohio State University Credentials Committee, Chair, 2015- present

The Ohio State University Medical Center, Center, Ohio State University Credentials Committee, Vice Chair, 2010 - 2015.

The Ohio State University Medical Center, Center, Practitioner Evaluation Committee, Member, 2010 - present.

The Ohio State University Medical Center, Operating Room Management Committee, Member, 2013 - present.

The Ohio State University Wexner Medical Center, Surgical Executive Committee, Member, 2016 - present.

Ohio State University College of Medicine, College, COM Admissions Committee, Member, 2007 – present

Ohio State University Health Plan Buckeye Babies Advisory Committee, Member, 2017- present

The Ohio State University Medical Center, Department, OB Operations Council, Member, 2011 - present.

Ohio State University College of Medicine, College, Emergency Medicine Chair Search Committee, Member, 2012.

Ohio State University College of Medicine, College, Promotion and Tenure, Ad Hoc Revision Committee, Member, 2010.

The Ohio State University Medical Center, Center, Medical Center Ob/Gyn Quality Management Committee, Member, 2010 - 2014.

The Ohio State University, University, University Health Plan Medical Advisory Board, Member, 2009 - 2016

The Ohio State University Medical Center, Center, Ohio State University Credentials Committee, Member, 2002 - present.

Ohio State University College of Medicine, College, Promotion for Academic Clinicians Task Force, Member, 2009 - 2010.

The Ohio State University Medical Center, Center, Patient Satisfaction Task Force, Member, 2009 - 2010.

The Ohio State University Medical Center, Center, Sentinel Event Evaluation Committee, Member, 2009 - 2010.

The Ohio State University Medical Center, Center, Medical Staff Administrative Committee, Elected Representative, 2006 - 2009.

Ohio State University College of Medicine, College, COM General Objectives Task Force, Member, 2007 - 2008.

The Ohio State University Medical Center, Center, Ad Hoc Medical Staff Appeal review committee, Chair, 2006 - 2007.

The Ohio State University Medical Center, Center, Ohio State University Medical Center Ethics Committee, Member, 1999 - 2007.

The Ohio State University Medical Center, Department, Ohio State University Outpatient Clinic, Wait Time Reduction Committee, Member, 2000 - 2001.

Ohio State University College of Medicine, College, Medical Humanities Committee, Member, 1999 - 2001.

Ohio State University College of Medicine, College, Behavioral Sciences Committee, Member, 1999 - 2001.

Ohio State University College of Medicine, College, Ohio State University College of Medicine, Introduction to Clinical Medicine, None, Member, 1995 - 1999.

Clinical Service

Chief, Division of General OB/GYN, Ohio State University Wexner Medical Center. Responsible for oversight of gynecologic services and general obstetrics services.

Ohio State University Faculty Practice: General Obstetrics and Gynecology (Outpatient clinic, inpatient care, and night call)

Inpatient Gynecology Service: Ohio State University Wexner Medical Center, Obstetrics and Gynecology, (one week per quarter, inpatient gynecology service and night call supervising resident MDs)

Inpatient Obstetric Service: Ohio State University Wexner Medical Center, (in-hospital call 2-3 sessions per month)

Resident Obstetrics and Gynecology Clinic: Ohio State University Wexner Medical Center, (supervision of residents in outpatient clinic)

Volunteer, Columbus Free Clinic, Columbus, Ohio (Monthly to quarterly)

Research Supervision

2015 – Wing Kay Fok, MD, Resident research project. “Physician Attitude Knowledge and confidence with emergency contraception”

2104 – Samantha Nadella, MD, Resident research project “Social determinants of US women’s disagreement with affordable care act”

2013 – Loriana Newman, MD, Resident research project “Correlation between antenatal plan for and postpartum choice contraception in the OSU OB/GYN clinic”

2012 – Kate McCracken, MD, Resident research project “Injectable Contraception: Characteristics of Successful Versus Inconsistent Users”

Jan 2008 - Jun 2010 Research Advisor, Tina Falika-King, Masters Student, “Relationship of Obesity to obstetrical complications among teen mothers”

2006 – Shavonne Ramsey Coleman, MD, Resident research project “ Factors associated with access to postpartum tubal ligation”

2003 – Cherie Richey, MD, Resident research project “Predicting Infection with Chlamydia Trachomatis and Neisseria Gonorrhea at the time of Elective Abortion: A retrospective case control chart review” Winner of resident research award

Student Teaching Activities

Ohio State University College of Medicine, "Contraception" e-learning module, Med II Reproduction Health Block, developed Jul 2013. Recipient of Best teaching and learning method, 2016

Ohio State University College of Medicine, Reproductive Health Block in Med III, Clinical Correlation Lecture "Menarche to Menopause" lecture given yearly, Jul 2011 - Jun 2015.

Ohio State University College of Medicine, Second Year Medical School Curriculum, "Control of Reproduction" lecture given yearly, Jul 1999 - Jun 2010.

Ohio State University College of Medicine, Third Year Ambulatory Clerkship "Contraceptive Counseling" lecture given every 6 weeks. Jul 1999 - Jun 2010.

Ohio State University College of Medicine, Obstetrics and Gynecology Core Lecture Series, "Contraception" lecture given every 6 weeks, Jul 1995 - Jun 1999.

Ohio State University College of Medicine, Department of Ob/Gyn Journal Club Discussant, yearly.

Ohio State University College of Medicine, First Year Medical School "Doctor Patient Relationship" weekly student teaching session for 8 weeks per year, Jul 1999 - Jun 2001.

Ohio State University College of Medicine, Ambulatory Preceptor, Second Year Medical Students, 1995 - present

Oral Exams. Ohio State University College of Medicine, Obstetrics & Gynecology. 2-3 times yearly administer oral exams

Med 3: Clinical Medicine (Ground School). Ohio State University College of Medicine, Obstetrics & Gynecology. 2015-present

"Infertility and Amenorrhea" Medical Student Small Group. Ohio State University College of Medicine, Obstetrics & Gynecology. Sep 2015

"Normal Delivery" Med 3: Clinical Medicine (Ground School). Ohio State University College of Medicine, Obstetrics & Gynecology. Sep 2015

PUL/Ectopic Resident Lecture. Ohio State University College of Medicine, Obstetrics & Gynecology. Sep 2015

"Family Planning/ Pregnancy Termination and 1st Trimester Bleeding" Med 3: Clinical Medicine (Ground School). Ohio State University College of Medicine, Obstetrics & Gynecology. Jul 2015

"Preterm Birth/PPROM/Third Trimester Bleeding in Pregnancy" Med 3: Clinical Medicine (Ground School). Ohio State University College of Medicine, Obstetrics & Gynecology. Jun 2015

Medical Student Small Group. Ohio State University College of Medicine, Obstetrics & Gynecology. Apr 2015

Oral Exams. Ohio State University College of Medicine, Obstetrics & Gynecology. Apr 2015

Selected Continuing Education Instruction

Implanon insertion. The Ohio State University, Obstetrics & Gynecology. Jul 2007

Medical and Surgical Abortion. The Ohio State University, Obstetrics & Gynecology. Jul 2004

Sexually Transmitted Diseases and PID. The Ohio State University, Obstetrics & Gynecology. Jul 2001

Contraception. The Ohio State University, Obstetrics & Gynecology. Jul 1997

Family Planning. The Ohio State University, Obstetrics & Gynecology. Jan 1996

Nexplanon Insertion. Ohio State University Department of Obstetrics and Gynecology. Nov 2013, 2014, 2015

Contraception Update. Wright State University School of Medicine, Obstetrics and Gynecology. Nov 2007

Extended Cycle Oral Contraceptives. Dayton Obstetrics and Gynecology Society, The, Obstetrics and Gynecology. Nov 2007

Mednet: Contraception Update. The Ohio State University, Obstetrics & Gynecology. Sep 2007

Complications of Abortion. West Virginia University, Obstetrics and Gynecology. May 2007

Pregnancy Termination. Ohio State University College of Medicine, Obstetrics & Gynecology. Jul 1998

Contraception and Sterilization. Columbus Comprehensive Review, Oct 2004

Contraceptive Review. Dept. of Obstretrics and Gynecology, Oct 2003

Elective Abortion and Emergency Contraception. Riverside Methodist Hospital, Obstetrics and Gynecology. Sep 2003

Control of Reproduction. The Ohio State University, Obstetrics & Gynecology. Jul 2000

New Developments in Contraception. Marshall University, Obstetrics and Gynecology. Apr 2003

Elective Abortion. The Ohio State University, Obstetrics & Gynecology. Feb 2003

Steroidal Contraceptives. The Ohio State University, Obstetrics & Gynecology. Feb 2003

New Developments in Contraception. Philippine Medical Association of West Virginia, Obstetrics and Gynecology. Jan 2003

Contraceptive Review. Columbus Comprehensive Review, Nov 2002

New Developments in Contraception. Ohio Academy of Family Physicians, Obstetrics and Gynecology. Nov 2002

Elective Abortion and Emergency Contraception. Riverside Methodist Hospital, Obsetrics and Gynecology. Sep 2002

Emergency Contraception. The Ohio State University, Obstetrics & Gynecology. Sep 2002

New Developments in Contraception. The Ohio State University, Obstetrics & Gynecology. Jul 2002

New Developments in Contraception. Riverside Methodist Hospital, Obstetrics and Gynecology. Jun 2002

New Developments in Contraception. Ohio Medical Education Network, Obstetrics and Gynecology. 2001

Oral Contraceptive Selection. Mount Carmel Medical Center, Obstetrics and Gynecology. Sep 2001

Complications of Dilation and Curettage. The Ohio State University, Obstetrics & Gynecology. Aug 2001

Contraceptive Review. Ohio State University College of Medicine, Obstetrics & Gynecology. Jun 2003

New Developments in Contraception: New Contraceptive Methods. The Ohio State University, Obstetrics & Gynecology. Jul 2001

Ectopic Pregnancy. The Ohio State University, Obstetrics & Gynecology. Apr 2001

Contraception in the United States. The Ohio State University, Obstetrics & Gynecology. Nov 2000

Contraceptive Update.Oct 2000, Ohio Academy of Family Physicians

New Developments in Contraception: Lunelle. The Ohio State University, Obstetrics & Gynecology. Aug 2000

IUDs. The Ohio State University, Obstetrics & Gynecology. Jun 2000

Norplant Insertion and Removal. The Ohio State University, Obstetrics & Gynecology. Apr 2000

Contraceptive Update. Columbus Comprehensive Review, Oct 1999

Men and Women's Sexual Health. Ohio Medical Education Network, Obstetrics and Gynecology. Apr 1999

Contraception: The Basics. The Ohio State University, Obstetrics & Gynecology. Jul 2003

Abortion. The Ohio State University, Obstetrics & Gynecology. Mar 1997

Gynecologic Examination. The Ohio State University, Obstetrics & Gynecology. Feb 1997

Dyspareunia. The Ohio State University, Obstetrics & Gynecology. Nov 1996

Emergency Contraception. American College Health Association, Obstetrics and Gynecology. Mar 1996

Update on Contraception. Ohio Medical Education Network, Obstetrics and Gynecology. Dec 1995

Licensure

National Board of Medical Examiners, December 1996

American Board of Obstetrics and Gynecology, December 1996

State of Ohio, License 35-06-9022, August 1995

Memberships

Fellow, American College of Obstetrics and Gynecology

Society of Academic Specialists in Obstetrics and Gynecology

American Medical Association

Ohio State Medical Association

Association of Reproductive Health Professionals

Society for Family Planning

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,

Plaintiffs,

v.

DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*,

Defendants.

Case No. 1:19-cv-118

DECLARATION OF SHARON A. LINER, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Sharon A. Liner, M.D., declare as follows:

1. I am a board-certified family physician with 15 years of experience in women's health. I am licensed to practice medicine in the state of Ohio. For 12 years, I have been the Director of Surgical Services and since October 2018, the Medical Director of Planned Parenthood Southwest Ohio Region (PPSWO) in Cincinnati, Ohio. I previously worked as a physician at PPSWO from 2004 to 2007.

2. I earned a B.S. in Medical Technology from Michigan State University and graduated from medical school at Michigan State University, College of Human Medicine. I completed my residency in Family Medicine at the University of Cincinnati.

3. In my current roles as the Director of Surgical Services and Medical Director at PPSWO, I supervise physicians and clinicians and provide direct reproductive health care to patients. This includes supervision of the other physicians who perform abortions, including D&E procedures. I also supervise and manage the provision of all surgical services at PPSWO,

research and the most up-to-date standards and best practices for providing reproductive and family planning care.

7. PPSWO provides affordable, respectful, and high-quality health care to tens of thousands of patients in southwest Ohio. We operate seven health centers in the greater Cincinnati and Miami Valley regions. Those health centers provide a wide range of reproductive health services, including well-woman exams, screening for breast and cervical cancer, contraception and contraceptive counseling, and STD testing and treatment. Approximately 75 percent of the patients treated at our health centers are low-income.

8. PPSWO also operates a surgery center in Cincinnati that provides abortion services. This surgery center is the only abortion provider serving Cincinnati, northern Kentucky, and southern Indiana. The nearest abortion provider is 50 miles away in Dayton, Ohio.

CURRENT ABORTION PRACTICES AT PPSWO

9. All procedures performed at PPSWO start with a patient evaluation and ultrasound to determine the gestational age of the pregnancy as measured from the first day of the patient's last menstrual period. The method used for the abortion will then depend on the patient's gestational age, as well as other factors, like any complicating medical conditions and the patient's preference.

10. During the first trimester, PPSWO provides two methods of abortion. *First*, we provide medication abortion in which two different medications (pills) are used to induce termination of pregnancy in a process similar to a miscarriage, up to 10 weeks LMP. *Second*, we provide surgical abortions in which we use suction aspiration to perform the procedure, an option that is available throughout the entire first trimester. With this procedure, we first dilate the

14. D&E involves two steps: dilating the cervix and then completing the procedure with instruments. First, we dilate the cervix using medications such as misoprostol, placing dilators in the cervix that slowly absorb moisture and swell, or a combination of the two. In the early part of the second trimester, up to about 16 weeks, we almost always perform the cervical preparation and the evacuation on the same day. Later in the second trimester, we typically begin the dilation process the day before. Second, we begin the evacuation phase by using suction to drain the amniotic sac and then use forceps to remove any remaining fetal tissue, placenta, and other contents of the uterus. Because the fetus is larger than the opening of the cervix, the fetal tissue generally comes apart as the physician removes it through the cervix.[3] We then use suction again to ensure that the uterus is empty. The procedure typically takes under 10 minutes.

15. Starting at 18 weeks LMP, but never sooner, PPSWO physicians attempt to cause fetal demise before proceeding to the evacuation process of a D&E with an injection of the drug digoxin. PPSWO uses digoxin to ensure compliance with the federal and state bans on so-called "partial birth abortions" (PBA), not for any evidence-based medical reason. We generally perform a transvaginal injection, which requires us to use a long spinal needle passed through the woman's vaginal wall, or cervix into the uterus. We attempt to inject digoxin into the fetus, if possible or, if not, into the amniotic fluid. If we are unable to inject the digoxin transvaginally, we will attempt to do the injection through her abdomen, which is more painful and often more distressing, since patients are able to see the long needle we must use. The drug can take up to 24 hours to work.

---

[3] We do not dilate the cervix further out of patient safety concerns; we aim to dilate the cervix only enough to safely remove fetal tissue in the manner that is best for the woman.

digoxin sometimes simply does not work. As noted above, there is no research on performing a second injection; doing them would entail subjecting our patients to an experimental and medically unnecessary procedure. Performing a second injection could also delay the procedure for another day for no medical reason. Such a delay poses risks to the patient, since a patient's cervix will already be dilated following the first injection, and there is no guarantee that a second injection would work.

20. I am aware that the Act contains a narrow exception for cases in which a patient faces a serious risk of the substantial and irreversible impairment of a major bodily function if the D&E is not completed, but a digoxin failure is extremely unlikely to rise to this level, even though the best thing to do for the patient's health in the case of a failure is to go ahead and complete the D&E procedure. Digoxin simply does not allow us to reliably comply with the Act in all cases, and we cannot know before we begin a procedure whether it will work or not.

21. While we at times have attempted to cause fetal demise by transecting the umbilical cord in the case of digoxin failures, this procedure is not feasible in many cases and cannot be relied upon to comply with the Act's requirement to cause demise before every D&E. Even if we perform cord transections, we do not currently wait to ensure demise has occurred before completing the procedure, as we would need to do if the Act went into effect; doing so would significantly lengthen the evacuation procedure and thus increase the risk to the patient. Further, in some cases, access to the cord is blocked by the fetus and it would be difficult and risky (if not altogether impossible) to reach it. A physician cannot know before beginning a procedure whether she will be able to safely transect the cord. If not, the physician will be faced with an impossible situation. At this point, the patient's procedure has already begun, her cervix is dilated, and her amniotic fluid has been drained; the D&E must be completed because failing

attempting a second digoxin injection in the event the first injection failed is wholly unstudied and would be experimental. Providing digoxin injections prior to 18 weeks LMP is inconsistent with the standard of care and is not a workable way for us to comply with the Act.

25. Umbilical cord transection is similarly more difficult at earlier gestational ages. The cord is smaller and harder to identify on ultrasound, particularly after the amniotic fluid has been drained out, and thus it would be more difficult to locate and grasp. In some cases, it would be virtually impossible to grasp the cord without accidentally grasping fetal tissue, thereby violating the Act. Again, cord transection does not provide a way for us to reliably comply with the Act at any gestational age.

CONCLUSION

26. I am extremely concerned about the impact the Act would have on women seeking second-trimester abortions in Ohio. Because it is not possible to ensure fetal demise in every case, and PPSWO physicians cannot know when starting a D&E procedure whether demise will be possible in that particular case, we would risk violating the Act and being subject to criminal prosecution with every D&E procedure we provide. Attempting to comply would require us to subject our patients to untested, experimental procedures that would increase risk and prolong the procedure. This goes against my best clinical judgment and would harm my patients to whom I currently provide safe abortion care.

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

Executed this 13th day of February, 2019.

Sharon A. Liner, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,

Plaintiffs,

v.

DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*,

Defendants.

Case No. 1:19-cv-118

DECLARATION OF KATHERINE RIVLIN, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION AND/OR A TEMPORARY INJUNCTION

I, Katherine Rivlin, M.D., declare as follows:

1. I am a board-certified Obstetrician and Gynecologist (OB/GYN) licensed to practice in the state of Ohio. I completed medical school at the University of Mississippi, my OB/GYN residency at New York University Medical Center, and my fellowship in Family Planning at Columbia University Medical Center. I have been practicing at Ohio State University Wexner Medical Center as an obstetrician and gynecologist for the past two and one-half years and have been a staff physician at Planned Parenthood of Greater Ohio (PPGOH) for the past two years.

2. In my practice, I provide general early pregnancy care including preconception counseling, early prenatal care including ultrasound, miscarriage counseling and management, and abortion. I also provide comprehensive gynecologic care including preventive care, cancer and STI screening, family planning and contraceptive counseling, and gynecologic surgery

including minimally invasive surgery. During my fellowship, I provided abortions in both hospital and outpatient settings. I currently provide at PPGOH in the outpatient setting both medication abortion up to 10 weeks of pregnancy, as measured from the first day of the patient's last menstrual period (LMP), and surgical abortions up to 19 weeks 6 days LMP.

3. I understand Senate Bill 145 (S.B. 145 or the Act) criminalizes the performance of dilation and evacuation (D&E) abortion procedures, the safest and most common method of second-trimester abortions, unless the D&E is necessary to avert "a serious risk of the substantial and irreversible physical impairment of a major bodily function." I understand that the only way around the Act's ban on D&E is to first perform a separate, invasive procedure to cause fetal demise. PPGOH physicians, including myself, do not provide these demise procedures in our current practices—whether at PPGOH or elsewhere—and most of us are not trained in, nor do we have any experience with, these procedures. If the Act were to take effect, I would require additional training and cannot speculate as to how long it would take me to become comfortable with methods of demise. This training would require time away from my patients when they need care.

4. More importantly, the Act's demise requirement jeopardizes patients' health and safety by subjecting them to a medically unnecessary procedure that exposes them to additional risk. And even if I attempt demise, it may fail. Delaying completion of the D&E procedure to make another attempt at demise is untested, unreliable, and puts the woman's health at risk. After demise failure, the patient may have passed the state's legal gestational limit and/or have undergone cervical dilation. I would have no plan of action for this patient nor could I counsel her on the risks to her pregnancy should she be forced to carry it to term. This scenario is a very

real potential outcome if I abandon her care in order to comply with the law, as proceeding without causing demise could subject me to felony charges.

5. The Act therefore places PPGOH in an impossible position: either abandon our patients by ceasing abortions after approximately 15 weeks gestation, or administer an additional, medically unnecessary procedure that carries risks to our patients' health, and that doesn't even guarantee that we can comply with the Act.

6. The information in this declaration is based on my personal knowledge unless otherwise noted, and my opinions are based on my education, training, and expertise. If called and sworn as a witness, I could and would testify competently thereto.

PPGOH AND ITS SERVICES

7. PPGOH provides high-quality, comprehensive reproductive health care to the people of Ohio, including contraception, gynecological examinations, cervical pap smears, breast cancer screening, testicular cancer screenings, diagnosis and treatment of vaginal infections, testing and treatment for sexually transmitted infections (STIs), HIV testing and counseling, pregnancy testing, and abortion. In addition, PPGOH provides extensive health education programs for teens and young adults as well as infant mortality reduction programs.

8. Although PPGOH is an independent entity, it is a member affiliate of Planned Parenthood Federation of America. PPGOH was formed in 2012 through a merger of several local and regional Planned Parenthood affiliates in Ohio. PPGOH serves patients in northern, eastern, and central Ohio and operates 19 health centers. At two of its health centers, located in Columbus and Bedford Heights, PPGOH provides abortions to women who seek to terminate their pregnancy.

9. PPGOH serves populations that have historically faced significant barriers to care,

including communities of color and people with low incomes.

ABORTION SERVICES PROVIDED BY PPGOH

10. At both PPGOH's Columbus and Bedford Heights health centers we provide medication abortions up to 10 weeks LMP. At the Columbus health center, we provide surgical abortions, including D&Es, up to 19 weeks 6 days LMP, and at the Bedford Heights health center we provide surgical abortion, including D&Es, up to 18 weeks 6 days LMP. There are three physicians at PPGOH's Columbus location (including me) who provide D&E procedures, and one at the Bedford Heights location who provides D&E procedures. At all stages of pregnancy, PPGOH's primary concern is providing safe, evidence-based abortion care that protects the patient's health and safety. Every patient is unique and every situation is different. Physicians must decide—in conjunction with their patients—the procedure that is the safest and best based on medicine and medical judgment.

11. Medication abortion early in pregnancy involves patients taking two different medications (pills) at least one day apart, which induce uterine contractions and expulsion of the pregnancy, in a process similar to a miscarriage. Surgical abortions in the first trimester are performed by dilating (opening) the cervix and then using gentle suction to remove the pregnancy.

12. Early in the second trimester, starting at approximately 15 weeks LMP, suction alone is not always sufficient, and so physicians at PPGOH may switch to the procedure known as D&E. D&E involves two steps: dilating the cervix and then evacuating the uterine contents with instruments. There are no incisions. In order to perform the procedure safely and reduce risk of injury to the cervix or uterus, and because the pregnancy may be larger than the opening of the cervix, the pregnancy may separate as it is removed through the cervix. Using ultrasound

guidance, we dilate the cervix only enough to safely remove the pregnancy. We may then use suction to ensure that the uterus is empty. The procedure typically takes under 10 minutes. As physicians, our job is to make sure we do not cause injury to the woman or the woman's uterus and cervix, and D&E is the safest way to provide this care in the second trimester.[1]

13. We do not currently provide any fetal demise procedures prior to D&E procedures at PPGOH.

THE D&E BAN'S IMPACT ON PPGOH'S PRACTICES

14. I understand S.B. 145 bans D&E procedures unless the physician first causes fetal demise. This demise requirement is not based on medical evidence. It is my understanding that a physician who violates the law will be committing a fourth-degree felony, as well as possibly facing suits for civil damages. I am concerned that providing D&Es while trying to comply with the Act in every case would jeopardize patient health and violate best practices by exposing patients to risk with no medical benefit.

15. D&E is the most common and safest method of abortion after approximately 15 weeks. Indeed, the National Academies of Sciences, Engineering, and Medicine recently conducted a systematic review of the safety and quality of care of abortion in the United States, including D&E, and found that D&Es are safe and effective.[2] The report similarly found that non-evidence based laws and restrictions, interfere with quality of care and abortion access, particularly for underserved women.[3]

[1] Although there are alternatives to D&E that are not commonly used, such as labor induction or hysterotomy (cutting the uterus), which are potentially more invasive, emotionally challenging, costly and higher risk, those procedures are not provided in outpatient settings in Ohio such as PPGOH.
[2] National Academies of Sciences, Engineering, and Medicine, The Safety and Quality of Abortion Care in the United States 8, 63–65 (2018).
[3] *Id.*

16. I am aware that some physicians attempt to cause fetal demise prior to D&E procedures, but according to the American College of Obstetricians and Gynecologists: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion."[4] Indeed, each possible demise method carries risks to the patient in addition to those from the D&E procedure itself, while offering no health benefits. For these reasons, we do not currently provide any demise procedures at PPGOH. These additional procedures, moreover, are not foolproof: they have known failure rates, and thus would not provide us a way to reliably comply with the Act in every case.

17. Injecting the fetus or the amniotic sac with digoxin is one possible demise method, but it is not a feasible means of complying with the Act. Using digoxin adds risks of extramural delivery (delivery outside a medical facility), infection, and hospitalization, and comes with side effects. For patients with certain cardiac conditions, digoxin may be contraindicated, and, digoxin can be difficult or impossible to administer for some patients, including those with obesity, fibroids, or cesarean scars from previous deliveries. The procedure may also cause pain or stress for patients, as it involves injection with a long spinal needle. In the face of these risks, digoxin injections provide no medical benefit to patients. Therefore, PPGOH physicians do not recommend them to our patients and we would not provide them unless compelled to do so by law.

18. In addition, while I understand some doctors, including some in Ohio, use digoxin at or after 18 weeks LMP in order to ensure compliance with federal and state laws that ban intact D&Es, there is virtually no support for the use of digoxin before 18 weeks LMP in the

[4] Am. Coll. Obstetricians & Gynecologists, Practice Bulletin Number 135: Second-Trimester Abortion (June 2013).

medical literature. Its use at these earlier gestational ages would subject PPGOH's patients to an experimental and unstudied procedure with uncertain and unnecessary risks.

19. Digoxin also has a known failure rate, so even if PPGOH physicians were willing to subject our patients to the additional risks associated with its use, it would not be effective in every case. Attempting a second digoxin injection if the first failed is wholly unstudied and would be experimental for patients at all stages of pregnancy. It is not clear what recourse both we physicians and our patients would have under the Act in the situation where digoxin fails. I may be compelled by the Act to abandon my patient whose pregnancy has undergone a lethal injection, leaving her with unstudied risks to herself and to the fetus, when the safest thing for patients at that point would be to complete the procedure. But to continue with the procedure could violate the Act. As a result, digoxin would not provide us with a reliable way to comply and could require me to violate my professional and ethical duty not to abandon my patients until treatment is completed.

20. Moreover, I and most of my colleagues at PPGOH have no experience or training with digoxin, and have no experience or training providing transvaginal injections. Similarly, I would require additional training to provide transabdominal injections. Such procedures are most commonly provided by specialists in the field of Maternal-Fetal Medicine (MFM).

21. I also understand that a transabdominal potassium chloride (KCl) injection into the fetus's heart has been suggested as a viable method of demise. While effective if done correctly, intracardiac KCl injections are not a feasible way to comply with the statute because these injections require great skill and training given only to MFM subspecialists. Inadvertent injection of KCl into the woman's bloodstream places her at serious risk of cardiac arrest and fatality. During my fellowship, we used KCl injections into the umbilical cord after 20 weeks

LMP in order to comply with the federal intact D&E ban. But this was only possible because we provided care in a hospital setting and achieved significant dilation—far more dilation than we seek to achieve at PPGOH in the outpatient setting—while the patient was under deep sedation in the operating room. Only under these conditions and in a pregnancy after 20 weeks gestation was it possible to locate the cord and inject the KCl. Indeed, before 20 weeks, it is virtually impossible to view the cord and thus impossible to grasp the cord for the injection. To be clear, this method was only possible in a subset of pregnancies who had sufficient cervical dilation to grasp the cord. It was not a reliable method for all pregnancies—and certainly not possible to do at an outpatient facility like PPGOH. I am not trained to administer KCl transabdominally and could not perform the injection into the umbilical cord at PPGOH because at our outpatient facility, we dilate the cervix only as much as needed to safely perform the D&E, we do not use deep sedation, and I have no experience performing this procedure in a pregnancy before 20 weeks gestation like those we treat at PPGOH.

22. I understand that proponents of similar D&E bans in other states have suggested that physicians could transect (separate) the umbilical cord to cause demise and comply with the statute, but we do not currently undertake this procedure at PPGOH and it is not a feasible option because it cannot be safely and reliably done. Transecting the cord would require making additional and unnecessary passes of instruments into the woman's uterus to try to locate and transect the cord—increasing the risk of uterine perforation, cervical injury, heavy bleeding, and infection. The procedure would significantly prolong the D&E process because of the time spent searching for and attempting to grasp the cord and waiting for demise once the cord is transected—potentially taking as long or longer than the D&E procedure itself. The safety and reliability of such a procedure is unstudied and would require our patients to undergo

experimental procedures with real potential risk. As I explained above, in fellowship I performed KCl procedures for some terminations after 20 weeks that required locating the umbilical cord, and at times I transected the cord in these cases as well, but those were done under entirely different conditions (in a hospital operating with the patient under deep sedation and with significant cervical dilation) compared to our practice at PPGOH. As I noted above, it is not possible to reliably locate the cord in an outpatient setting with less dilation and sedation.

23. If a physician is unable to locate the cord and complete transection, it would be necessary for the safety of the patient to complete the procedure at that point, given that her cervix would already be dilated and the amniotic fluid drained. However, completing the procedure could violate the Act. It is unclear what physicians are to do in this situation. Further, once the amniotic fluid has been drained (which is necessary to perform a cord transection), the cord is virtually impossible to visualize on ultrasound. I have never used instruments to attempt to grasp the cord to transect it. If I were to do so, there is a good chance I would accidentally grasp fetal tissue, which could also violate the Act.

24. I understand the Act has an exception that allows the performance of a D&E procedure without demise if the patient faces a serious risk of substantial and irreversible impairment of a major bodily function, but I do not see how that exception would help us in the case of a failed demise procedure because the exception requires the patient's condition to be extremely serious. We would never as physicians allow a patient's condition to deteriorate to this point before completing a procedure to protect a patient's health and safety.

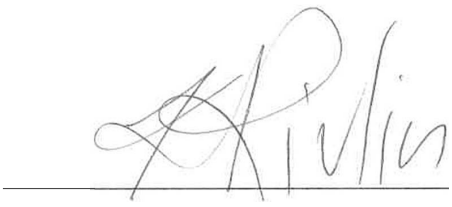
CONCLUSION

25. The D&E Ban makes it illegal for PPGOH to offer our patients the safe abortion procedures we currently provide. Instead, it would require us to subject each and every one of

our patients seeking an abortion after approximately 15 weeks of pregnancy to an additional, medically unnecessary procedure that increases risks and will not ensure that we are complying with the Act. For patients under 18 weeks LMP these procedures not only add risks but would require subjecting patients to experimental procedures that do not comply with medical standards of care. Further, I would have serious medical and ethical concerns with a legal requirement that I achieve demise on every patient without accounting for each patient's unique circumstances, especially when demise techniques could compromise my patients' health. For some women, attempting demise could be dangerous or impossible. Demise may also fail, leaving me with the choice of trying again (which is untested and adds further risk), continuing the procedure and violating the Act, or abandoning a patient who has come to me seeking a pregnancy termination and undergone a lethal fetal injection with unknown long-term risk. Should the Act take effect, I would need to weigh my professional duty to safeguard the health and wellbeing of my patients against the significant risk of felony prosecution for providing that care.

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

Executed this Twelfth day of February, 2019.



Katherine Rivlin, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*,

Plaintiffs,

v.

DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*,

Defendants.

Case No. 1:19-cv-118

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

I, W.M. Martin Haskell, declare as follows:

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

2. I have read the complaint in this action and verify that all of the facts regarding WMGPC and WMCD are true based either on my personal knowledge or my personal investigation of those facts.

3. I am a physician with 40 years' experience in women's health. I have been a licensed physician in the state of Ohio since 1974.

4. I earned a B.A. from Ohio Wesleyan University in 1968 and a Doctorate of Medicine from the University of Alabama in 1972. I received five and one-half years of

residency (post graduate) training in anesthesia, general surgery and family practice, completing my residency and passing my Board exam in family medicine in Cincinnati in 1978.

5. I have been the Medical Director of WMCD since 1983. As Medical Director I supervise physicians and clinicians and provide direct reproductive health care to patients. I also supervise and manage the provision of all surgical abortion services at WMGPC, and am responsible for developing WMGPC's policies and procedures. I provided abortions in an outpatient setting from 1978 until recently in 2019.

6. I understand Senate Bill 145 (S.B. 145 or the Act) makes it a felony to provide the most common method of second-trimester abortion[1]—dilation and evacuation (D&E)—unless fetal demise has already occurred. The requirement that physicians must successfully cause demise before every D&E (or risk prosecution) is simply not feasible for every woman because demise procedures are not reliable or safe in every case.

7. The information in this declaration is based on my personal knowledge unless otherwise noted, and my opinions are based on my education, training, and expertise. If called and sworn as a witness, I could and would testify competently thereto.

WMGPC AND ITS SERVICES

8. WMGPC is a corporation organized under the laws of the State of Ohio. WMGPC and its predecessor organizations have provided women's reproductive care in Ohio since 1973. WMGPC has operated a licensed ambulatory surgical facility providing abortions as WMCD at 1401 E. Stroop Road in Kettering, Ohio, since 2008.

---

[1] The second trimester of pregnancy begins at approximately 14.0 weeks since the woman's last menstrual period (LMP).

9. WMGPC provides affordable, respectful, and high-quality health care to thousands of patients a year in the Greater Dayton area. WMGPC provides pregnancy testing, surgical abortions (including pre-operative and post-operative care) in an outpatient setting, and birth control. Approximately 50% of our patients are low-income.

CURRENT ABORTION PRACTICES AT WMGPC

10. WMGPC provides two methods of abortion during the first trimester of pregnancy. The method used depends on the patient's gestational age and other factors, such as complicating medical conditions and patient preference. We provide medication abortion up to 10 weeks of pregnancy as measured from the first day of the patient's LMP, and surgical abortion, which is available throughout the first trimester. For first-trimester surgical abortion, we first dilate the cervix enough to insert a suction cannula into the uterus, and then complete the procedure by suctioning the contents of the uterus.

11. WMCD also provides surgical abortions in the second trimester, up to 21 weeks 6 days LMP. Women seek second-trimester abortion for any number of reasons, including costs; discovery of fetal or maternal health conditions, which may not be diagnosed until later in the pregnancy (or become complicated later); late detection of pregnancy; and abortion access barriers that have caused delay, among other reasons.

12. When suction is no longer sufficient to complete the abortion, at approximately 15 weeks LMP, WMGPC uses D&E. D&E is a quick and safe procedure, which can be performed in an outpatient clinic.

13. A D&E is performed in two steps: *first*, the physician dilates the cervix using medications such as misoprostol, or dilators, which are placed in the cervix and slowly swell as they absorb moisture from the body, or a combination of the two. We do not dilate more than

necessary to safely complete the procedure. At 15 weeks or earlier, we nearly always prepare the cervix and complete the evacuation on the same day; later in the second trimester, at 16 weeks or later, we typically start the cervical preparation the day before the evacuation procedure. *Second*, after the cervix is sufficiently dilated, we can begin evacuating the uterus by using suction to remove the amniotic fluid, and then use forceps to remove the remaining contents of the uterus, including fetal tissue and placenta. Finally, we use suction again to ensure the uterus has been emptied. The D&E procedure typically takes under 10 minutes.

14. It is the practice of WMGPC's physicians not to cause fetal demise before 18 weeks LMP. At 18 weeks LMP and later, WMGPC physicians use an injection of a drug called digoxin in an attempt to cause fetal demise before starting the evacuation phase of the D&E. We do this to comply with the federal and state bans on so-called "partial birth abortions" (PBA). I am not aware of any medical reason for doing this that is supported by published research. We do not use digoxin before 18 weeks because there is very little risk of violating the PBA ban at these earlier gestational ages and there is no medical benefit of doing so.

15. An injection of digoxin requires the use of a long spinal needle, which can be passed through the woman's abdominal (transabdominal) or through her vaginal wall or cervix (transvaginal). WMGPC physicians attempt to inject the digoxin transvaginally into the fetus. If that is not possible, we attempt an injection transabdominally, which is often more distressing and painful for the patient.

16. Digoxin can take up to 24 hours to work, but it is not always effective, and it is impossible to know before beginning the D&E whether the digoxin will work. If the first injection failed, WMGPC physicians do not perform a second injection of digoxin to cause

demise because such an additional procedure is unstudied. I am not aware of any physicians in Ohio who administer second digoxin injections.

THE ACT'S IMPACT ON WMGPC'S PRACTICES

17. My understanding is that the law makes it a felony to perform a D&E abortion unless a physician can confirm, before using instruments to evacuate the uterus, that fetal demise has occurred. WMGPC's physicians are committed to providing safe abortion care, and we are concerned that S.B. 145 will harm our patients and their access to abortion because we cannot ensure that we can cause fetal demise before every D&E procedure without risking harm to our patients' health. While WMGPC physicians currently attempt to cause demise before D&Es at 18 weeks LMP and above using digoxin to comply with PBA bans, this practice does not allow us to reliably comply with the Act because we cannot safely ensure fetal demise before every D&E with digoxin, as we would have to do if the Act went into effect. Digoxin sometimes fails to cause fetal demise, and there is no research on giving a second injection. Giving a second digoxin injection would therefore mean requiring our patients to undergo a medically unnecessary and experimental procedure. A second injection would also delay the procedure for another day while we waited for the medication to work, for no medical reason. Because a patient's cervix will have already been dilated after the first injection, a delay to wait for a second injection to effect demise would introduce additional risks for the patient. And, the second injection may also fail to cause fetal demise. In addition, digoxin can be dangerous for patients with cardiac issues, including arrhythmia, and can be difficult or impossible to administer for some patients, like those are earlier gestational ages.

18. I understand that the Act has an exception when a patient faces a serious risk of the substantial and irreversible impairment of a major bodily function if the D&E is not

completed. This exception is very narrow and requires a patient to be very sick. If digoxin fails to cause demise, the best thing to do for the patient's safety is to complete the D&E procedure, but a digoxin failure is very unlikely to rise to the level of the Act's exception to protect a patient's health. WMGPC cannot rely upon digoxin injections to comply with the Act because it does not always work and we cannot know ahead of time for which patients it will fail.

19. I understand it has also been suggested that injections of potassium chloride (KCl) could be used as a means to comply with the Act. It would not be possible to use KCl at WMGPC. While I am aware that some maternal-fetal-medicine subspecialist at times use KCl to cause fetal demise, these physicians have extensive special training that WMGPC physicians do not have, making KCl injections impossible to incorporate into our practice. I am not aware of any outpatient abortion providers in Ohio who perform KCl injections.

20. I further understand it has been suggested that we could comply with the law by transecting the umbilical cord to cause fetal demise before evacuating the uterus, but this would not allow us to reliably comply either because it is not always possible. Depending upon the position of the fetus, it may be difficult, risky, or just impossible to access the umbilical cord in a given patient. And it is impossible to know before beginning a procedure whether the physician will be able to safely locate and transect the cord. A physician cannot attempt to transect the cord until the patients' procedure has already been started, her cervix is dilated, and the amniotic fluid has been removed. If a transection fails, the D&E must be completed at that point because if it is not, the patient would be at serious risk of infection, extramural delivery and excessive bleeding. If the Act went into effect, however, a physician faced with this situation could not complete the procedure without breaking the law. And the health exception would be very unlikely to apply in this situation. Another problem with umbilical cord transection is that it

requires a physician to try to locate and grasp the cord with instrument, and the physicians risks accidentally grasping fetal parts when he or she does this because it is very hard to see the cord clearly on ultrasound after the amniotic fluid has been removed from the uterus. If the physician accidentally grasped and removed fetal tissue while trying to locate the cord, he or she would be violating the law. Umbilical cord transection simply does not provide us with a way to comply with the law.

21. It is WMGPC's practice not to attempt any demise procedures prior to 18 weeks LMP, but if the Act went into effect we would have no choice but to require our physicians to subject all of our patients between approximately 15 and 18 weeks LMP to an additional demise procedure for no medical reason. At these earlier gestational ages, demise procedures are particularly problematic because there is no medical literature supporting their use.

22. For pregnancies earlier than 18 weeks LMP, there is virtually no literature supporting the use of digoxin, and doing so would mean doing experimental and medically unnecessary procedures on our patients. We would have to do this even if we thought in our best medical judgment that the procedure was not best for the patient; our only other option would be to turn her away. Before 18 weeks LMP, there would also be greater risk associated with the procedure because the fetus and uterus are so small and it would be harder to ensure correct needle placement. Second digoxin injections pose the same problems for patients before 18 weeks LMP as they do for patient at or above 18 weeks LMP: it is unstudied and would be experimental. Digoxin injections prior to 18 weeks LMP are not a feasible way for us to comply with the law.

23. Umbilical cord transection would also be more difficult and less reliable prior to 18 weeks LMP given the small size of the umbilical cord. It would be even more difficult to

identify on ultrasound after the amniotic fluid has been removed than at later gestational ages, and so would be even harder to locate and grasp. Physicians would therefore run an even higher risk of accidentally grasping and removing fetal parts and therefore violating the law. Cord transection is not a feasible means of complying with the Act at any gestational age.

CONCLUSION

24. Because we cannot guarantee that we can cause fetal demise for every patient, and we cannot know before we begin a procedure whether we will be able to safely cause demise, I am extremely concerned that WMGPC's physicians would risk criminal prosecution with every D&E procedure they provide if the law goes into effect. I am extremely concerned about how this would impact Ohio women seeking second-trimester abortions, because, in order to try to comply with the law, we would have no choice but to subject our patients to untested, experimental procedures that would add additional risks and lengthen procedures, against our medical judgment.

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

Executed this 14th day of February 2019.

W. M. Martin Haskell, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

PLANNED PARENTHOOD SOUTHWEST OHIO REGION, *et al.*, Plaintiffs, v. DAVID YOST, in his official capacity as Attorney General of the State of Ohio, *et al.*, Defendants.	Case No. 1:19-cv-118

DECLARATION OF JENNIFER BRANCH IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Jennifer Branch, hereby declare:

1. All facts set forth herein are based on my personal knowledge, and if called upon to testify as to the contents of this Declaration, I could and would do so.

2. I am an attorney with the law firm of Gerhardstein & Branch Co. LPA and am serving as counsel for Plaintiffs in the above-captioned matter.

3. Attached hereto as **Exhibit A** is a true and correct copy of Ohio Senate Bill 145, to be codified at Ohio Revised Code § 2919.15.

4. Attached hereto as **Exhibit B** is a true and correct copy of Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence on Abortion: United States, 2008-2014*, 107 American Public Health Association 1904 (Dec. 2017), obtained from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5678377/pdf/AJPH.2017.304042.pdf.

5. Attached hereto as **Exhibit C** is a true and correct copy of *Induced Abortions in Ohio* (2017), published by the Ohio Department of Health and obtained from the website

https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/vital-statistics/resources/vs-abortionreport2017.

6. Attached hereto as **Exhibit D** is a true and correct copy of O'Connell et al., *Second-trimester surgical abortion practices: a survey of National Abortion Federation members*, 78 Contraception 492 (Dec. 2008).

7. Attached hereto as **Exhibit E** is a true and correct copy of ACOG, *ACOG statement regarding abortion procedure bans* (Oct. 9, 2015), https://www.acog.org/About-ACOG/News-Room/Statements/2015/ACOG-Statement-Regarding-Abortion-Procedure-Bans?IsMobileSet=false.

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

Date: February 14, 2019

Respectfully submitted,

By /s/ Jennifer L. Branch

JENNIFER L. BRANCH (OHIO BAR. NO. 0038893)
Trial Attorney for Plaintiffs
Gerhardstein & Branch Co. LPA
441 Vine Street, Suite 3400
Cincinnati, OH 42502
(513) 621-9100
(513) 345-5543 (fax)

EXHIBIT A

(132nd General Assembly)
(Substitute Senate Bill Number 145)

AN ACT

To amend sections 2305.114, 2307.53, 2901.01, 2903.09, 2919.123, 2919.151, and 2967.193 and to enact section 2919.15 of the Revised Code to criminalize and create a civil action for dismemberment abortions.

Be it enacted by the General Assembly of the State of Ohio:

SECTION 1. That sections 2305.114, 2307.53, 2901.01, 2903.09, 2919.123, 2919.151, and 2967.193 be amended and section 2919.15 of the Revised Code be enacted to read as follows:

Sec. 2305.114. A civil action pursuant to section 2307.53 of the Revised Code for partial birth feticide or dismemberment feticide shall be commenced within one year after the commission of ~~that~~ the offense.

Sec. 2307.53. (A) As used in this section:

(1) "Dismemberment abortion" has the same meaning as in section 2919.15 of the Revised Code.

(2) "Frivolous conduct" has the same meaning as in section 2323.51 of the Revised Code.

~~(2)~~ (3) "Partial birth procedure" has the same meaning as in section 2919.151 of the Revised Code.

(B) A woman upon whom a partial birth procedure is performed in violation of division (B) or (C) of section 2919.151 of the Revised Code, a woman upon whom a dismemberment abortion is performed in violation of division (B) of section 2919.15 of the Revised Code, the father of the child if the child was not conceived by rape, or the parent of the woman if the woman is not eighteen years of age or older at the time of the violation has and may commence a civil action for compensatory damages, punitive or exemplary damages if authorized by section 2315.21 of the Revised Code, and court costs and reasonable attorney's fees against the person who committed the violation.

(C) If a judgment is rendered in favor of the defendant in a civil action commenced pursuant to division (B) of this section and the court finds, upon the filing of a motion under section 2323.51 of the Revised Code, that the commencement of the civil action constitutes frivolous conduct and that the defendant was adversely affected by the frivolous conduct, the court shall award in accordance with section 2323.51 of the Revised Code reasonable attorney's fees to the defendant.

Sec. 2901.01. (A) As used in the Revised Code:

(1) "Force" means any violence, compulsion, or constraint physically exerted by any means upon or against a person or thing.

(2) "Deadly force" means any force that carries a substantial risk that it will proximately result in the death of any person.

(3) "Physical harm to persons" means any injury, illness, or other physiological impairment, regardless of its gravity or duration.

(4) "Physical harm to property" means any tangible or intangible damage to property that, in any degree, results in loss to its value or interferes with its use or enjoyment. "Physical harm to property" does not include wear and tear occasioned by normal use.

(5) "Serious physical harm to persons" means any of the following:

(a) Any mental illness or condition of such gravity as would normally require hospitalization or prolonged psychiatric treatment;

(b) Any physical harm that carries a substantial risk of death;

(c) Any physical harm that involves some permanent incapacity, whether partial or total, or that involves some temporary, substantial incapacity;

(d) Any physical harm that involves some permanent disfigurement or that involves some temporary, serious disfigurement;

(e) Any physical harm that involves acute pain of such duration as to result in substantial suffering or that involves any degree of prolonged or intractable pain.

(6) "Serious physical harm to property" means any physical harm to property that does either of the following:

(a) Results in substantial loss to the value of the property or requires a substantial amount of time, effort, or money to repair or replace;

(b) Temporarily prevents the use or enjoyment of the property or substantially interferes with its use or enjoyment for an extended period of time.

(7) "Risk" means a significant possibility, as contrasted with a remote possibility, that a certain result may occur or that certain circumstances may exist.

(8) "Substantial risk" means a strong possibility, as contrasted with a remote or significant possibility, that a certain result may occur or that certain circumstances may exist.

(9) "Offense of violence" means any of the following:

(a) A violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.11, 2903.12, 2903.13, 2903.15, 2903.21, 2903.211, 2903.22, 2905.01, 2905.02, 2905.11, 2905.32, 2907.02, 2907.03, 2907.05, 2909.02, 2909.03, 2909.24, 2911.01, 2911.02, 2911.11, 2917.01, 2917.02, 2917.03, 2917.31, 2919.25, 2921.03, 2921.04, 2921.34, or 2923.161, of division (A)(1) of section 2903.34, of division (A)(1), (2), or (3) of section 2911.12, or of division (B)(1), (2), (3), or (4) of section 2919.22 of the Revised Code or felonious sexual penetration in violation of former section 2907.12 of the Revised Code;

(b) A violation of an existing or former municipal ordinance or law of this or any other state or the United States, substantially equivalent to any section, division, or offense listed in division (A)(9)(a) of this section;

(c) An offense, other than a traffic offense, under an existing or former municipal ordinance or law of this or any other state or the United States, committed purposely or knowingly, and involving physical harm to persons or a risk of serious physical harm to persons;

(d) A conspiracy or attempt to commit, or complicity in committing, any offense under division (A)(9)(a), (b), or (c) of this section.

(10)(a) "Property" means any property, real or personal, tangible or intangible, and any interest or license in that property. "Property" includes, but is not limited to, cable television service, other telecommunications service, telecommunications devices, information service, computers, data,

computer software, financial instruments associated with computers, other documents associated with computers, or copies of the documents, whether in machine or human readable form, trade secrets, trademarks, copyrights, patents, and property protected by a trademark, copyright, or patent. "Financial instruments associated with computers" include, but are not limited to, checks, drafts, warrants, money orders, notes of indebtedness, certificates of deposit, letters of credit, bills of credit or debit cards, financial transaction authorization mechanisms, marketable securities, or any computer system representations of any of them.

(b) As used in division (A)(10) of this section, "trade secret" has the same meaning as in section 1333.61 of the Revised Code, and "telecommunications service" and "information service" have the same meanings as in section 2913.01 of the Revised Code.

(c) As used in divisions (A)(10) and (13) of this section, "cable television service," "computer," "computer software," "computer system," "computer network," "data," and "telecommunications device" have the same meanings as in section 2913.01 of the Revised Code.

(11) "Law enforcement officer" means any of the following:

(a) A sheriff, deputy sheriff, constable, police officer of a township or joint police district, marshal, deputy marshal, municipal police officer, member of a police force employed by a metropolitan housing authority under division (D) of section 3735.31 of the Revised Code, or state highway patrol trooper;

(b) An officer, agent, or employee of the state or any of its agencies, instrumentalities, or political subdivisions, upon whom, by statute, a duty to conserve the peace or to enforce all or certain laws is imposed and the authority to arrest violators is conferred, within the limits of that statutory duty and authority;

(c) A mayor, in the mayor's capacity as chief conservator of the peace within the mayor's municipal corporation;

(d) A member of an auxiliary police force organized by county, township, or municipal law enforcement authorities, within the scope of the member's appointment or commission;

(e) A person lawfully called pursuant to section 311.07 of the Revised Code to aid a sheriff in keeping the peace, for the purposes and during the time when the person is called;

(f) A person appointed by a mayor pursuant to section 737.01 of the Revised Code as a special patrolling officer during riot or emergency, for the purposes and during the time when the person is appointed;

(g) A member of the organized militia of this state or the armed forces of the United States, lawfully called to duty to aid civil authorities in keeping the peace or protect against domestic violence;

(h) A prosecuting attorney, assistant prosecuting attorney, secret service officer, or municipal prosecutor;

(i) A veterans' home police officer appointed under section 5907.02 of the Revised Code;

(j) A member of a police force employed by a regional transit authority under division (Y) of section 306.35 of the Revised Code;

(k) A special police officer employed by a port authority under section 4582.04 or 4582.28 of the Revised Code;

(l) The house of representatives sergeant at arms if the house of representatives sergeant at

arms has arrest authority pursuant to division (E)(1) of section 101.311 of the Revised Code and an assistant house of representatives sergeant at arms;

(m) The senate sergeant at arms and an assistant senate sergeant at arms;

(n) A special police officer employed by a municipal corporation at a municipal airport, or other municipal air navigation facility, that has scheduled operations, as defined in section 119.3 of Title 14 of the Code of Federal Regulations, 14 C.F.R. 119.3, as amended, and that is required to be under a security program and is governed by aviation security rules of the transportation security administration of the United States department of transportation as provided in Parts 1542. and 1544. of Title 49 of the Code of Federal Regulations, as amended.

(12) "Privilege" means an immunity, license, or right conferred by law, bestowed by express or implied grant, arising out of status, position, office, or relationship, or growing out of necessity.

(13) "Contraband" means any property that is illegal for a person to acquire or possess under a statute, ordinance, or rule, or that a trier of fact lawfully determines to be illegal to possess by reason of the property's involvement in an offense. "Contraband" includes, but is not limited to, all of the following:

(a) Any controlled substance, as defined in section 3719.01 of the Revised Code, or any device or paraphernalia;

(b) Any unlawful gambling device or paraphernalia;

(c) Any dangerous ordnance or obscene material.

(14) A person is "not guilty by reason of insanity" relative to a charge of an offense only if the person proves, in the manner specified in section 2901.05 of the Revised Code, that at the time of the commission of the offense, the person did not know, as a result of a severe mental disease or defect, the wrongfulness of the person's acts.

(B)(1)(a) Subject to division (B)(2) of this section, as used in any section contained in Title XXIX of the Revised Code that sets forth a criminal offense, "person" includes all of the following:

(i) An individual, corporation, business trust, estate, trust, partnership, and association;

(ii) An unborn human who is viable.

(b) As used in any section contained in Title XXIX of the Revised Code that does not set forth a criminal offense, "person" includes an individual, corporation, business trust, estate, trust, partnership, and association.

(c) As used in division (B)(1)(a) of this section:

(i) "Unborn human" means an individual organism of the species Homo sapiens from fertilization until live birth.

(ii) "Viable" means the stage of development of a human fetus at which there is a realistic possibility of maintaining and nourishing of a life outside the womb with or without temporary artificial life-sustaining support.

(2) Notwithstanding division (B)(1)(a) of this section, in no case shall the portion of the definition of the term "person" that is set forth in division (B)(1)(a)(ii) of this section be applied or construed in any section contained in Title XXIX of the Revised Code that sets forth a criminal offense in any of the following manners:

(a) Except as otherwise provided in division (B)(2)(a) of this section, in a manner so that the offense prohibits or is construed as prohibiting any pregnant woman or her physician from

performing an abortion with the consent of the pregnant woman, with the consent of the pregnant woman implied by law in a medical emergency, or with the approval of one otherwise authorized by law to consent to medical treatment on behalf of the pregnant woman. An abortion that violates the conditions described in the immediately preceding sentence may be punished as a violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.05, 2903.06, 2903.08, 2903.11, 2903.12, 2903.13, 2903.14, 2903.21, or 2903.22 of the Revised Code, as applicable. An abortion that does not violate the conditions described in the second immediately preceding sentence, but that does violate section 2919.12, division (B) of section 2919.13, or section 2919.15, 2919.151, 2919.17, or 2919.18 of the Revised Code, may be punished as a violation of section 2919.12, division (B) of section 2919.13, or section 2919.15, 2919.151, 2919.17, or 2919.18 of the Revised Code, as applicable. Consent is sufficient under this division if it is of the type otherwise adequate to permit medical treatment to the pregnant woman, even if it does not comply with section 2919.12 of the Revised Code.

(b) In a manner so that the offense is applied or is construed as applying to a woman based on an act or omission of the woman that occurs while she is or was pregnant and that results in any of the following:

(i) Her delivery of a stillborn baby;

(ii) Her causing, in any other manner, the death in utero of a viable, unborn human that she is carrying;

(iii) Her causing the death of her child who is born alive but who dies from one or more injuries that are sustained while the child is a viable, unborn human;

(iv) Her causing her child who is born alive to sustain one or more injuries while the child is a viable, unborn human;

(v) Her causing, threatening to cause, or attempting to cause, in any other manner, an injury, illness, or other physiological impairment, regardless of its duration or gravity, or a mental illness or condition, regardless of its duration or gravity, to a viable, unborn human that she is carrying.

(C) As used in Title XXIX of the Revised Code:

(1) "School safety zone" consists of a school, school building, school premises, school activity, and school bus.

(2) "School," "school building," and "school premises" have the same meanings as in section 2925.01 of the Revised Code.

(3) "School activity" means any activity held under the auspices of a board of education of a city, local, exempted village, joint vocational, or cooperative education school district; a governing authority of a community school established under Chapter 3314. of the Revised Code; a governing board of an educational service center, or the governing body of a school for which the state board of education prescribes minimum standards under section 3301.07 of the Revised Code.

(4) "School bus" has the same meaning as in section 4511.01 of the Revised Code.

Sec. 2903.09. As used in sections 2903.01 to 2903.08, 2903.11 to 2903.14, 2903.21, and 2903.22 of the Revised Code:

(A) "Unlawful termination of another's pregnancy" means causing the death of an unborn member of the species homo sapiens, who is or was carried in the womb of another, as a result of injuries inflicted during the period that begins with fertilization and that continues unless and until live birth occurs.

(B) "Another's unborn" or "such other person's unborn" means a member of the species homo sapiens, who is or was carried in the womb of another, during a period that begins with fertilization and that continues unless and until live birth occurs.

(C) Notwithstanding divisions (A) and (B) of this section, in no case shall the definitions of the terms "unlawful termination of another's pregnancy," "another's unborn," and "such other person's unborn" that are set forth in division (A) of this section be applied or construed in any of the following manners:

(1) Except as otherwise provided in division (C)(1) of this section, in a manner so that the offense prohibits or is construed as prohibiting any pregnant woman or her physician from performing an abortion with the actual consent of the pregnant woman, with the consent of the pregnant woman implied by law in a medical emergency, or with the approval of one otherwise authorized by law to consent to medical treatment on behalf of the pregnant woman. An abortion that violates the conditions described in the immediately preceding sentence may be punished as a violation of section 2903.01, 2903.02, 2903.03, 2903.04, 2903.05, 2903.06, 2903.08, 2903.11, 2903.12, 2903.13, 2903.14, 2903.21, or 2903.22 of the Revised Code, as applicable. An abortion that does not violate the conditions described in the second immediately preceding sentence, but that does violate section 2919.12, division (B) of section 2919.13, or section 2919.15, 2919.151, 2919.17, or 2919.18 of the Revised Code, may be punished as a violation of section 2919.12, division (B) of section 2919.13, or section 2919.15, 2919.151, 2919.17, or 2919.18 of the Revised Code, as applicable.

(2) In a manner so that the offense is applied or is construed as applying to a woman based on an act or omission of the woman that occurs while she is or was pregnant and that results in any of the following:

(a) Her delivery of a stillborn baby;

(b) Her causing, in any other manner, the death in utero of an unborn that she is carrying;

(c) Her causing the death of her child who is born alive but who dies from one or more injuries that are sustained while the child is an unborn;

(d) Her causing her child who is born alive to sustain one or more injuries while the child is an unborn;

(e) Her causing, threatening to cause, or attempting to cause, in any other manner, an injury, illness, or other physiological impairment, regardless of its duration or gravity, or a mental illness or condition, regardless of its duration or gravity, to an unborn that she is carrying.

Sec. 2919.123. (A) No person shall knowingly give, sell, dispense, administer, otherwise provide, or prescribe RU-486 (mifepristone) to another for the purpose of inducing an abortion in any person or enabling the other person to induce an abortion in any person, unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the RU-486 (mifepristone) is a physician, the physician satisfies all the criteria established by federal law that a physician must satisfy in order to provide RU-486 (mifepristone) for inducing abortions, and the physician provides the RU-486 (mifepristone) to the other person for the purpose of inducing an abortion in accordance with all provisions of federal law that govern the use of RU-486 (mifepristone) for inducing abortions. A person who gives, sells, dispenses, administers, otherwise provides, or prescribes RU-486 (mifepristone) to another as described in division (A) of this section shall not be prosecuted

based on a violation of the criteria contained in this division unless the person knows that the person is not a physician, that the person did not satisfy all the specified criteria established by federal law, or that the person did not provide the RU-486 (mifepristone) in accordance with the specified provisions of federal law, whichever is applicable.

(B) No physician who provides RU-486 (mifepristone) to another for the purpose of inducing an abortion as authorized under division (A) of this section shall knowingly fail to comply with the applicable requirements of any federal law that pertain to follow-up examinations or care for persons to whom or for whom RU-486 (mifepristone) is provided for the purpose of inducing an abortion.

(C)(1) If a physician provides RU-486 (mifepristone) to another for the purpose of inducing an abortion as authorized under division (A) of this section and if the physician knows that the person who uses the RU-486 (mifepristone) for the purpose of inducing an abortion experiences during or after the use an incomplete abortion, severe bleeding, or an adverse reaction to the RU-486 (mifepristone) or is hospitalized, receives a transfusion, or experiences any other serious event, the physician promptly must provide a written report of the incomplete abortion, severe bleeding, adverse reaction, hospitalization, transfusion, or serious event to the state medical board. The board shall compile and retain all reports it receives under this division. Except as otherwise provided in this division, all reports the board receives under this division are public records open to inspection under section 149.43 of the Revised Code. In no case shall the board release to any person the name or any other personal identifying information regarding a person who uses RU-486 (mifepristone) for the purpose of inducing an abortion and who is the subject of a report the board receives under this division.

(2) No physician who provides RU-486 (mifepristone) to another for the purpose of inducing an abortion as authorized under division (A) of this section shall knowingly fail to file a report required under division (C)(1) of this section.

(D) Division (A) of this section does not apply to any of the following:

(1) A pregnant woman who obtains or possesses RU-486 (mifepristone) for the purpose of inducing an abortion to terminate her own pregnancy;

(2) The legal transport of RU-486 (mifepristone) by any person or entity and the legal delivery of the RU-486 (mifepristone) by any person to the recipient, provided that this division does not apply regarding any conduct related to the RU-486 (mifepristone) other than its transport and delivery to the recipient;

(3) The distribution, provision, or sale of RU-486 (mifepristone) by any legal manufacturer or distributor of RU-486 (mifepristone), provided the manufacturer or distributor made a good faith effort to comply with any applicable requirements of federal law regarding the distribution, provision, or sale.

(E) Whoever violates this section is guilty of unlawful distribution of an abortion-inducing drug, a felony of the fourth degree. If the offender previously has been convicted of or pleaded guilty to a violation of this section or of section 2919.12, 2919.121, 2919.13, 2919.14, 2919.15, 2919.151, 2919.17, or 2919.18 of the Revised Code, unlawful distribution of an abortion-inducing drug is a felony of the third degree.

If the offender is a professionally licensed person, in addition to any other sanction imposed by law for the offense, the offender is subject to sanctioning as provided by law by the regulatory or

licensing board or agency that has the administrative authority to suspend or revoke the offender's professional license, including the sanctioning provided in section 4731.22 of the Revised Code for offenders who have a certificate to practice or certificate of registration issued under that chapter.

(F) As used in this section:

(1) "Federal law" means any law, rule, or regulation of the United States or any drug approval letter of the food and drug administration of the United States that governs or regulates the use of RU-486 (mifepristone) for the purpose of inducing abortions.

(2) "Personal identifying information" has the same meaning as in section 2913.49 of the Revised Code.

(3) "Physician" has the same meaning as in section 2305.113 of the Revised Code.

(4) "Professionally licensed person" has the same meaning as in section 2925.01 of the Revised Code.

Sec. 2919.15. (A) As used in this section:

"Dismemberment abortion" means, with the purpose of causing the death of an unborn child, to dismember a living unborn child and extract the unborn child one piece at a time from the uterus through use of clamps, grasping forceps, tongs, scissors, or similar instruments that, through the convergence of two rigid levers, slice, crush, or grasp a portion of the unborn child's body to cut or rip it off. "Dismemberment abortion" does not include a procedure performed after the death of the unborn child to extract any remaining parts of the unborn child.

"Serious risk of the substantial and irreversible impairment of a major bodily function" has the same meaning as in section 2919.151 of the Revised Code.

"Unborn child" has the same meaning as in section 2919.16 of the Revised Code.

(B) No person shall knowingly perform or attempt to perform a dismemberment abortion when the dismemberment abortion is not necessary, in reasonable medical judgment, to preserve the life or physical health of the mother as a result of the mother's life or physical health being endangered by a serious risk of the substantial and irreversible physical impairment of a major bodily function.

(C) Whoever violates division (B) of this section is guilty of dismemberment feticide, a felony of the fourth degree.

(D) None of the following are guilty of committing, attempting to commit, complicity in the commission of, or conspiracy in the commission of a violation of division (B) of this section:

(1) A pregnant woman upon whom a dismemberment abortion is performed in violation of division (B) of this section;

(2) An individual who is employed by the person who violates division (B) of this section and who acts at the direction of the person who violates division (B) of this section;

(3) A pharmacist or other individual who fills a prescription or provides instruments or materials used in violating division (B) of this section.

(E) This section does not prohibit the suction curettage procedure of abortion or the suction aspiration procedure of abortion.

Sec. 2919.151. (A) As used in this section:

(1) ~~"Dilation and evacuation procedure of abortion" does not include the dilation and extraction procedure of abortion.~~

~~(2)~~ "From the body of the mother" means that the portion of the fetus' body in question is beyond the mother's vaginal introitus in a vaginal delivery.

~~(3)~~ (2) "Partial birth procedure" means the medical procedure that includes all of the following elements in sequence:

(a) Intentional dilation of the cervix of a pregnant woman, usually over a sequence of days;

(b) In a breech presentation, intentional extraction of at least the lower torso to the navel, but not the entire body, of an intact fetus from the body of the mother, or in a cephalic presentation, intentional extraction of at least the complete head, but not the entire body, of an intact fetus from the body of the mother;

(c) Intentional partial evacuation of the intracranial contents of the fetus, which procedure the person performing the procedure knows will cause the death of the fetus, intentional compression of the head of the fetus, which procedure the person performing the procedure knows will cause the death of the fetus, or performance of another intentional act that the person performing the procedure knows will cause the death of the fetus;

(d) Completion of the vaginal delivery of the fetus.

~~(4)~~ (3) "Partially born" means that the portion of the body of an intact fetus described in division (A)(3)(b) of this section has been intentionally extracted from the body of the mother.

~~(5)~~ (4) "Serious risk of the substantial and irreversible impairment of a major bodily function" means any medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function.

~~(6)~~ (5) "Viable" has the same meaning as in section 2901.01 of the Revised Code.

(B) When the fetus that is the subject of the procedure is viable, no person shall knowingly perform a partial birth procedure on a pregnant woman when the procedure is not necessary, in reasonable medical judgment, to preserve the life or health of the mother as a result of the mother's life or health being endangered by a serious risk of the substantial and irreversible impairment of a major bodily function.

(C) When the fetus that is the subject of the procedure is not viable, no person shall knowingly perform a partial birth procedure on a pregnant woman when the procedure is not necessary, in reasonable medical judgment, to preserve the life or health of the mother as a result of the mother's life or health being endangered by a serious risk of the substantial and irreversible impairment of a major bodily function.

(D) Whoever violates division (B) or (C) of this section is guilty of partial birth feticide, a felony of the second degree.

(E) A pregnant woman upon whom a partial birth procedure is performed in violation of division (B) or (C) of this section is not guilty of committing, attempting to commit, complicity in the commission of, or conspiracy in the commission of a violation of those divisions.

(F) This section does not prohibit the suction curettage procedure of abortion~~,~~ or the suction aspiration procedure of abortion~~, or the dilation and evacuation procedure of abortion~~.

(G) This section does not apply to any person who performs or attempts to perform a legal abortion if the act that causes the death of the fetus is performed prior to the fetus being partially born even though the death of the fetus occurs after it is partially born.

Sec. 2967.193. (A)(1) Except as provided in division (C) of this section and subject to the maximum aggregate total specified in division (A)(3) of this section, a person confined in a state correctional institution or placed in the substance use disorder treatment program may provisionally earn one day or five days of credit, based on the category set forth in division (D)(1), (2), (3), (4), or (5) of this section in which the person is included, toward satisfaction of the person's stated prison term for each completed month during which the person, if confined in a state correctional institution, productively participates in an education program, vocational training, employment in prison industries, treatment for substance abuse, or any other constructive program developed by the department with specific standards for performance by prisoners or during which the person, if placed in the substance use disorder treatment program, productively participates in the program. Except as provided in division (C) of this section and subject to the maximum aggregate total specified in division (A)(3) of this section, a person so confined in a state correctional institution who successfully completes two programs or activities of that type may, in addition, provisionally earn up to five days of credit toward satisfaction of the person's stated prison term for the successful completion of the second program or activity. The person shall not be awarded any provisional days of credit for the successful completion of the first program or activity or for the successful completion of any program or activity that is completed after the second program or activity. At the end of each calendar month in which a person productively participates in a program or activity listed in this division or successfully completes a program or activity listed in this division, the department of rehabilitation and correction shall determine and record the total number of days credit that the person provisionally earned in that calendar month. If the person in a state correctional institution violates prison rules or the person in the substance use disorder treatment program violates program or department rules, the department may deny the person a credit that otherwise could have been provisionally awarded to the person or may withdraw one or more credits previously provisionally earned by the person. Days of credit provisionally earned by a person shall be finalized and awarded by the department subject to administrative review by the department of the person's conduct.

(2) Unless a person is serving a mandatory prison term or a prison term for an offense of violence or a sexually oriented offense, and notwithstanding the maximum aggregate total specified in division (A)(3) of this section, a person who successfully completes any of the following shall earn ninety days of credit toward satisfaction of the person's stated prison term or a ten per cent reduction of the person's stated prison term, whichever is less:

(a) An Ohio high school diploma or Ohio certificate of high school equivalence certified by the Ohio central school system;

(b) A therapeutic drug community program;

(c) All three phases of the department of rehabilitation and correction's intensive outpatient drug treatment program;

(d) A career technical vocational school program;

(e) A college certification program;

(f) The criteria for a certificate of achievement and employability as specified in division (A)(1) of section 2961.22 of the Revised Code.

(3) Except for persons described in division (A)(2) of this section, the aggregate days of credit provisionally earned by a person for program or activity participation and program and activity

completion under this section and the aggregate days of credit finally credited to a person under this section shall not exceed eight per cent of the total number of days in the person's stated prison term.

(B) The department of rehabilitation and correction shall adopt rules that specify the programs or activities for which credit may be earned under this section, the criteria for determining productive participation in, or completion of, the programs or activities and the criteria for awarding credit, including criteria for awarding additional credit for successful program or activity completion, and the criteria for denying or withdrawing previously provisionally earned credit as a result of a violation of prison rules, or program or department rules, whichever is applicable.

(C) No person confined in a state correctional institution or placed in a substance use disorder treatment program to whom any of the following applies shall be awarded any days of credit under division (A) of this section:

(1) The person is serving a prison term that section 2929.13 or section 2929.14 of the Revised Code specifies cannot be reduced pursuant to this section or this chapter or is serving a sentence for which section 2967.13 or division (B) of section 2929.143 of the Revised Code specifies that the person is not entitled to any earned credit under this section.

(2) The person is sentenced to death or is serving a prison term or a term of life imprisonment for aggravated murder, murder, or a conspiracy or attempt to commit, or complicity in committing, aggravated murder or murder.

(3) The person is serving a sentence of life imprisonment without parole imposed pursuant to section 2929.03 or 2929.06 of the Revised Code, a prison term or a term of life imprisonment without parole imposed pursuant to section 2971.03 of the Revised Code, or a sentence for a sexually oriented offense that was committed on or after September 30, 2011.

(D) This division does not apply to a determination of whether a person confined in a state correctional institution or placed in a substance use disorder treatment program may earn any days of credit under division (A) of this section for successful completion of a second program or activity. The determination of whether a person confined in a state correctional institution may earn one day of credit or five days of credit under division (A) of this section for each completed month during which the person productively participates in a program or activity specified under that division shall be made in accordance with the following:

(1) The offender may earn one day of credit under division (A) of this section, except as provided in division (C) of this section, if the most serious offense for which the offender is confined is any of the following that is a felony of the first or second degree:

(a) A violation of division (A) of section 2903.04 or of section 2903.03, 2903.11, 2903.15, 2905.01, 2907.24, 2907.25, 2909.02, 2909.09, 2909.10, 2909.101, 2909.26, 2909.27, 2909.29, 2911.01, 2911.02, 2911.11, 2911.12, 2919.13, 2919.15, 2919.151, 2919.22, 2921.34, 2923.01, 2923.131, 2923.162, 2923.32, 2925.24, or 2927.24 of the Revised Code;

(b) A conspiracy or attempt to commit, or complicity in committing, any other offense for which the maximum penalty is imprisonment for life or any offense listed in division (D)(1)(a) of this section.

(2) The offender may earn one day of credit under division (A) of this section, except as provided in division (C) of this section, if the offender is serving a stated prison term that includes a prison term imposed for a sexually oriented offense that the offender committed prior to September

30, 2011.

(3) The offender may earn one day of credit under division (A) of this section, except as provided in division (C) of this section, if the offender is serving a stated prison term that includes a prison term imposed for a felony other than carrying a concealed weapon an essential element of which is any conduct or failure to act expressly involving any deadly weapon or dangerous ordnance.

(4) Except as provided in division (C) of this section, if the most serious offense for which the offender is confined is a felony of the first or second degree and divisions (D)(1), (2), and (3) of this section do not apply to the offender, the offender may earn one day of credit under division (A) of this section if the offender committed that offense prior to September 30, 2011, and the offender may earn five days of credit under division (A) of this section if the offender committed that offense on or after September 30, 2011.

(5) Except as provided in division (C) of this section, if the most serious offense for which the offender is confined is a felony of the third, fourth, or fifth degree or an unclassified felony and neither division (D)(2) nor (3) of this section applies to the offender, the offender may earn one day of credit under division (A) of this section if the offender committed that offense prior to September 30, 2011, and the offender may earn five days of credit under division (A) of this section if the offender committed that offense on or after September 30, 2011.

(E) The department annually shall seek and consider the written feedback of the Ohio prosecuting attorneys association, the Ohio judicial conference, the Ohio public defender, the Ohio association of criminal defense lawyers, and other organizations and associations that have an interest in the operation of the corrections system and the earned credits program under this section as part of its evaluation of the program and in determining whether to modify the program.

(F) As used in this section:

(1) "Sexually oriented offense" has the same meaning as in section 2950.01 of the Revised Code.

(2) "Substance use disorder treatment program" means the substance use disorder treatment program established by the department of rehabilitation and correction under section 5120.035 of the Revised Code.

SECTION 2. That existing sections 2305.114, 2307.53, 2901.01, 2903.09, 2919.123, 2919.151, and 2967.193 of the Revised Code are hereby repealed.

_____

Speaker _____ of the House of Representatives.

_____

President _____ of the Senate.

Passed _____, 20____

Approved _____, 20____

_____

Governor.

The section numbering of law of a general and permanent nature is complete and in conformity with the Revised Code.

_____

Director, Legislative Service Commission.

Filed in the office of the Secretary of State at Columbus, Ohio, on the ____ day of _____, A. D. 20____.

_____

Secretary of State.

File No. _____ Effective Date _____

EXHIBIT B

Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014

Rachel K. Jones, PhD, and Jenna Jerman, MPH

Objectives. To assess the prevalence of abortion among population groups and changes in rates between 2008 and 2014.

Methods. We used secondary data from the Abortion Patient Survey, the American Community Survey, and the National Survey of Family Growth to estimate abortion rates. We used information from the Abortion Patient Survey to estimate the lifetime incidence of abortion.

Results. Between 2008 and 2014, the abortion rate declined 25%, from 19.4 to 14.6 per 1000 women aged 15 to 44 years. The abortion rate for adolescents aged 15 to 19 years declined 46%, the largest of any group. Abortion rates declined for all racial and ethnic groups but were larger for non-White women than for non-Hispanic White women. Although the abortion rate decreased 26% for women with incomes less than 100% of the federal poverty level, this population had the highest abortion rate of all the groups examined: 36.6. If the 2014 age-specific abortion rates prevail, 24% of women aged 15 to 44 years in that year will have an abortion by age 45 years.

Conclusions. The decline in abortion was not uniform across all population groups. (*Am J Public Health.* 2017;107:1904–1909. doi:10.2105/AJPH.2017.304042)

See also Foster, p. 1860.

Abortion is a common medical procedure and an important component of public health.[1,2] In 2014, 926 190 abortions were performed in the United States; the abortion rate was 14.6 abortions per 1000 women aged 15 to 44 years, meaning that in that year 1.5% of women of reproductive age had an abortion.[3] In 2008, it was estimated that 30% of women aged 15 to 44 years would have an abortion by age 45 years if the prevailing rate continued,[4] and this figure is often used to demonstrate the commonality of abortion.[2,5] However, the abortion rate has declined substantially since that time—14% between 2011 and 2014 alone[3]—and it is likely that the estimate of the lifetime incidence of abortion has also declined.

In addition to fewer women having abortions, the characteristics of the women who obtained them has changed. In 2014, 49% of abortion patients had family incomes below 100% of the federal poverty level, a significant increase from 42% in 2008.[6] Adolescents accounted for a significantly smaller share of abortion patients: 12% in 2014 compared with 18% in 2008. Low-income and younger women have traditionally been at increased risk for unintended pregnancy and, in turn, abortion. Changes in the prevalence of abortion for these and other groups, as measured by the abortion rate, could inform strategies to reduce disparities in access to family planning services and other types of reproductive health care.

We combined information on abortion rates and the characteristics of women who have abortions to determine if declines in abortion were experienced by all populations of women. Specifically, we estimated abortion rates in 2014 according to age, income, race and ethnicity, and other characteristics, and we also examined changes in population rates since 2008, the last year these measures were generated. Finally, we provide an updated estimate of the lifetime incidence of abortion.

METHODS

We used secondary data from multiple sources to construct 2 measures: population group abortion rates, for comparisons between 2008 and 2014, and the lifetime incidence of abortion for 2014. We relied on 3 data sets to calculate these estimates: the Guttmacher Institute's 2014 Abortion Patient Survey (APS), the American Community Survey (ACS), and the National Survey of Family Growth (NSFG). We used Stata 14.2 (StataCorp, College Station, TX) to analyze these data. The US federal government makes ACS and NSFG publicly available. The APS is currently available only to the study team and provides information about a hard-to-reach population; thus, we have summarized the data collection, and we provide more detailed information in Appendix A (available as a supplement to the online version of this article at http://www.ajph.org).

The 2014 APS provides information on the characteristics of US women obtaining abortions (including both medical and surgical) in that year. This was the Guttmacher Institute's fifth national survey of abortion patients. As in past surveys, patients at facilities that reported fewer than 30 abortions in 2011 were excluded because of the high likelihood that these facilities would perform few or no abortions during the survey period. Their exclusion can cause little bias

ABOUT THE AUTHORS

Rachel K. Jones and Jenna Jerman are with the Research Division of the Guttmacher Institute, New York, NY.

Correspondence should be sent to Rachel K. Jones, Guttmacher Institute, 125 Maiden Lane, New York, NY 10038 (e-mail: rjones@guttmacher.org). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted July 23, 2017.

doi: 10.2105/AJPH.2017.304042

because these facilities accounted for less than 1% of all reported procedures in 2014.[3] The 2014 APS used the same methodology as previous surveys with 1 exception: it did not include patients obtaining abortions at hospital facilities. We excluded these facilities because of past recruitment and logistical challenges. In 2014, hospitals with caseloads of 30 or more abortions accounted for 4% of all abortions.[3]

The 2014 APS survey design randomly sampled 113 US nonhospital facilities selected from a database of all clinics and physician's offices where abortions were known to be performed in 2011,[7] with updates for new facilities known to have started providing abortion services between 2011 and 2014. We stratified the database by provider type (clinics and private physicians' offices) and caseload (30–399; 400–1999; 2000–4999; and 5000 or more abortions) and then listed them by census region and state within each stratum to ensure that the sample was geographically representative. Every nth facility was sampled. Facilities were asked to administer the questionnaire to all women who obtained an abortion during the fielding period, which ranged from 2 to 12 weeks. If a facility declined to participate or did not obtain usable questionnaires from at least half of the target population, it was replaced by the next facility in its stratum, which was usually in the same state or in a neighboring state in the same region. Between April 2014 and June 2015, 87 facilities participated in the study.

The survey collected information directly from abortion patients, using a 4-page, paper-and-pencil, self-administered questionnaire available in English and Spanish. Envelopes were provided so that staff could not see patients' responses.

Participating facilities reported performing 11 024 abortions during the sampling period; usable data were collected from 8380 women, for a response rate of 76%. We constructed weights to correct for any bias produced by patient nonresponse and deviation from the original sampling plan. We used survey items on age, union status, race and ethnicity, foreign-born status, education, number of previous births, and poverty.

Information on the characteristics of all women aged 15 to 44 years comes from 2 surveys: the ACS and the NSFG. The ACS is a monthly government survey of more than 2 million households conducted by the US Census Bureau, and the sample is selected to represent the civilian noninstitutional population.[8] We used the 2014, 1-year supplemental file of the ACS to estimate distributions of age group, race and ethnicity, education (among women aged 20 years and older), foreign-born status, and poverty for US women aged 15 to 44 years. We used the 2013 to 2015 NSFG to estimate union status and number of previous births because this information was not available in the ACS. The NSFG, which is overseen by the National Center for Health Statistics, collected data on pregnancy, childbearing, and related measures from a nationally representative sample of 5699 US women aged 15 to 44 years between July 2013 and July 2015.[9]

We applied weights to the APS, ACS, and NSFG data to generate frequency distributions. We applied these patient and population characteristics to the total number of abortions and total number of US women aged 15 to 44 years. Estimates of the total number of abortions in 2014 come from the Guttmacher Institute, which conducts a periodic census of all known abortion providers.[3] Population figures for the total number of women aged 15 to 44 years come from the US Census Bureau July 1, 2014, estimates.[10]

We calculated population group abortion rates by dividing the number of abortions in a specific group by the number of women in that group in the US population; we then multiplied this figure by 1000. We rounded population figures for both abortion patients and all women to the nearest tenth.

Our analysis focused on changes in abortion rates by demographic characteristic for the period between 2008 and 2014, because 2008 was the next most recent APS. Abortion rates for 2008 were published,[4] but we adjusted them to be comparable with the 2014 analysis. The previous study relied on the 2008 Current Population Survey to estimate population characteristics. However, the ACS is now considered more accurate than the Current Population Survey, so we reestimated population characteristics used to construct the 2008 abortion rates using the 2008 ACS. Additionally, on the basis of the 2010 Census, the Census Bureau retrospectively adjusted population totals for the years 2006 through 2010; thus, we relied on the updated 2008 count of women aged 15 to 44 years. Finally, the 2008 APS included hospital abortion patients, and the 2014 survey did not. To make the data comparable, we excluded the 402 patients in the 2008 APS (4.2% of the sample) obtaining abortions at hospitals.

As a sensitivity analysis, we compared the demographic profiles of hospital and nonhospital patients in 2008 to determine whether their exclusion appeared to bias the sample (Table A, available as a supplement to the online version of this article at http://www.ajph.org). The 2 groups differed significantly on 2 of the 8 characteristics we examined. Relative to patients obtaining abortions at clinics and physicians' offices, a larger proportion of hospital patients were aged 25 to 29 years (28.2% compared with 24.2%). They were also less educated: 22.7% had not graduated from high school compared with 11.9% of nonhospital abortion patients. Despite these differences, the nonhospital sample was very similar to the full sample on these 2 characteristics, and it is unlikely that the exclusion of the hospital patients biased the sample.

To estimate the lifetime incidence of abortion, or the proportion of women of reproductive age who will have an abortion by age 45 years, we adopted the methodology developed by Forrest.[11] We used data from the 2014 APS to determine the proportion of women who were obtaining first abortions in each of the following age groups: younger than 15, 15 to 17, 18 to 19, 20 to 24, 25 to 29, 30 to 34, 35 to 39, and 40 years and older. Because first abortion rates for the youngest abortion patients are traditionally lower than are those for older adolescents, we estimated age-specific abortion rates separately for adolescents younger than 15 years.

Although standard demographic analyses restrict the population denominator to women aged 15 to 44 years, this component of the analysis estimates abortion rates for adolescents younger than 15 years, using those aged 14 years as the denominator. (We did not calculate an overall abortion rate for those younger than 15 years because this group is so small.) We applied these proportions to the age-specific abortion rates to obtain age-specific first abortion rates.

We obtained the cumulative first abortion rate, or proportion of women estimated to have had an abortion by the time they reach the end of a specified age range, by multiplying each age-specific first abortion rate by the number of years in that age group (e.g., the 15–17 years age group had a multiplier of 3) and summing all age groups up to that age group.

RESULTS

Between 2008 and 2014 the national abortion rate declined 25%, from 19.4 to 14.6 abortions per 1000 women aged 15 to 44 years (Table 1). Abortion rates decreased among all groups of women examined in the analysis. However, the degree of change within and among groups varied considerably.

When examined by age group, women aged 20 to 24 years accounted for the largest share of abortions and also had the highest abortion rate: 28.0 per 1000. The second highest abortion rate was among those aged 25 to 29 years: 22.8 per 1000. The drop in abortion rates between 2008 and 2014 was particularly marked for individuals aged 15 to 19 years, declining 56% among those aged 15 to 17 years and 41% among women aged 17 to 19 years.

When examined by union status, never married women accounted for the largest proportion of abortions in 2014 (45.9%) and had an abortion rate of 16.9 per 1000. Women cohabiting with but not married to their partners had the highest abortion rate: 31.0 per 1000. Between 2008 and 2014, declines in abortion were most pronounced for cohabitating women (39%) and lowest for married women (21%), although the latter group had a low abortion rate in both periods.

White women accounted for the largest share of abortions among the 4 racial and ethnic groups examined (38.7%), although they had the lowest abortion rate: 10.0 per 1000. Black women were overrepresented among abortion patients and had the highest abortion rate: 27.1 per 1000. The decline in the abortion rate among non-Hispanic Black women (32%) was greater than that for that non-Hispanic White women (14%); declines were also substantial for Hispanic women (36%) and non-Hispanic women who

TABLE 1—Number of US Abortions and Population Characteristics of Women Aged 15–44 Years in 2014 and Estimated Abortion Rates and Percentage Change in Estimated Rates Between 2008 and 2014: United States

Characteristic	Abortions in 2014		All Women in 2014, No. (%)	No. Abortions per 1000 Women		
	No.	% (95% CI)		2008[a]	2014	% Change
Total	926 190		63 397 514	19.4	14.6	–25
Age group, y						
< 15	2 220	0.2 (0.2, 0.4)	NA	NA	NA	NA
15–19	108 360	11.7 (10.9, 13.0)	10 333 790 (16.3)	19.4	10.5	–46
15–17	31 610	3.4 (3.0, 3.9)	6 086 160 (9.6)	11.8	5.2	–56
18–19	76 360	8.2 (7.5, 9.0)	4 247 630 (6.7)	30.3	18.0	–41
20–24	310 980	33.6 (32.3, 34.9)	11 094 560 (17.5)	39.9	28.0	–30
25–29	245 260	26.5 (25.4, 27.5)	10 777 580 (17.0)	28.8	22.8	–21
30–34	147 450	15.9 (14.9, 16.9)	10 714 180 (16.9)	17.2	13.8	–20
35–39	84 060	9.1 (8.2, 10.0)	10 016 810 (15.8)	9.5	8.4	–11
≥ 40[b]	28 300	3.1 (2.7, 3.5)	10 460 590 (16.5)	3.2	2.7	–16
Union status						
Married	132 540	14.3 (13.2, 15.5)	24 167 130 (38.1)	7.0	5.5	–21
Cohabiting, not married	287 120	31.0 (29.8, 32.3)	9 256 040 (14.6)	50.9	31.0	–39
Never married, not cohabiting	425 210	45.9 (44.2, 47.7)	25 175 150 (39.7)	23.1	16.9	–27
Previously married, not cohabiting	81 500	8.8 (7.9, 9.7)	4 803 000 (7.6)	23.4	17.0	–28
Race/ethnicity						
Non-Hispanic White	358 810	38.7 (34.6, 43.0)	36 009 790 (56.8)	11.6	10.0	–14
Non-Hispanic Black	255 630	27.6 (23.6, 32.1)	9 446 230 (14.9)	39.8	27.1	–32
Non-Hispanic other	81 960	8.8 (7.7, 10.1)	5 033 760 (7.9)	26.6	16.3	–39
Hispanic	229 790	24.8 (20.8, 29.3)	12 679 500 (20.0)	28.4	18.1	–36
Foreign-born						
No	776 800	83.9 (81.5, 86.1)	52 493 140 (82.8)	19.7	14.8	–25
Yes	149 390	16.1 (13.9, 18.5)	10 904 370 (17.2)	19.0	13.7	–28
Hispanic and foreign-born	73 910	8.0 (6.4, 9.8)	5 078 140 (8.0)	16.5	14.6	–12
Education[c]						
< high school	71 700	8.8 (7.6, 10.1)	5 041 050 (9.5)	21.2	14.2	–33
High school graduate or GED	227 920	27.9 (26.4, 29.6)	11 408 700 (21.5)	23.6	20.0	–15
Some college or associate degree	337 930	41.4 (39.8, 43.1)	19 209 070 (36.2)	21.5	17.6	–18
≥ college graduate	178 550	21.9 (20.0, 23.9)	17 351 840 (32.7)	13.4	10.3	–23
Previous births						
0	376 770	40.7 (38.1, 43.2)	29 086 780 (45.9)	17.3	13.0	–25
1	242 750	26.2 (25.0, 27.5)	11 031 170 (17.4)	32.0	22.0	–31
≥ 2	306 660	33.1 (31.1, 35.2)	23 273 230 (36.7)	17.3	13.2	–24
Family income as % of federal poverty level						
< 100	457 070	49.4 (46.6, 52.1)	12 489 310 (19.7)	49.5	36.6	–26
100–199	237 730	25.7 (24.5, 26.8)	12 463 960 (19.7)	28.0	19.1	–32
≥ 200	231 360	25.0 (22.6, 27.4)	38 482 290 (60.7)	9.4	6.0	–36

Note. CI = confidence interval; GED = general equivalency diploma; NA = not available.
[a]On the basis of previously published abortion rates (Jones and Kavanaugh[4]) and adjusted to account for updated population figures and to exclude nonhospital abortions.
[b]Denominator is women aged 40–44 years.
[c]Among women aged 20 years and older.

identified with a race other than Black or White (39%).

The majority of abortions in 2014 (83.9%) were obtained by women born in the United States. Foreign-born women had an abortion rate that was slightly lower than that of US-born women, 13.7 and 14.8 per 1000, respectively, and rates for both groups declined approximately the same amount. The abortion rate for foreign-born Hispanic women, 14.6 per 1000, was lower than was the abortion rate for all Hispanic women, 18.1 per 1000.

In 2014, 1 in 5 abortion patients (aged 20 years and older) had a college degree, and this group had the lowest abortion rate, 10.3 per 1000, compared with 14.2 to 20.0 per 1000 for the other education groups. Declines in abortion were steepest for women aged 20 years and older who had not graduated from high school (33%).

The majority of abortion patients in 2014 had previously given birth. Women with only 1 previous birth had a higher abortion rate, 22.0 per 1000, than did both women with more than 1 previous birth, 13.2 per 1000, and nulliparous women, 13.0 per 1000. The decline in abortion among women with 1 child (31%) was slightly higher than was that for women with no (25%) or 2 or more children (24%).

Women with family incomes less than 100% the federal poverty level accounted for almost half of all abortion patients in 2014, and this group had the highest abortion rate of all groups we examined; 36.6 per 1000. As income levels increased, the abortion rate decreased; women in the highest income group had an abortion rate less than half the national rate: 6.0 per 1000. Although abortion declined for all income groups between 2008 and 2014, poor women experienced the smallest decline (26%), and the declines grew greater with income.

We used age-specific first abortion rates to estimate the lifetime incidence of abortion (Table 2). In 2014, almost all abortion patients younger than 15 years were obtaining a first abortion (96.1%) and, the first abortion rate was the same as their age-specific abortion rate: 1.1 per 1000 (Figure A, available as a supplement to the online version of this article at http://www.ajph.org). The overwhelming majority of adolescents aged 15 to 17 years were also obtaining their first abortion (93.1%), resulting in a first abortion rate that was only slightly lower than was their age-specific abortion rate (4.8 compared with 5.2 [per 1000]). We obtained the cumulative first abortion rate for those aged 15 to 17 years by multiplying their first abortion rate by 3 (to account for the 3 years in the age group) and adding this to the first abortion rate for adolescents younger than 15 years.

Women aged 40 years and older had a cumulative first abortion rate of 236.7 per 1000, meaning that an estimated 23.7% of women aged 15 to 44 years in 2014 will have an abortion by age 45 years if the 2014 abortion rates continue throughout their reproductive lives. Correspondingly, an estimated 4.6% of women will have had an abortion by age 20 years and 19% by aged 30 years.

TABLE 2—Abortion Rate, Percentage of First Abortions, First Abortion Rate, and Cumulative First Abortion Rate of Women Aged 15–44 Years, All by Age: United States, 2014

Age at Outcome, Years	No. Abortions per 1000 Women	% Obtaining First Abortion (95% CI)	No. First Abortions per 1000 Women	Cumulative First Abortion Rate
< 15[a]	1.1	96.1 (77.5, 99.4)	1.1	1.1
15–17	5.2	93.1 (89.8, 95.5)	4.8	15.6
18–19	18.0	84.7 (81.8, 87.2)	15.2	46.0
20–24	28.0	61.9 (59.2, 64.5)	17.4	132.8
25–29	22.8	47.0 (44.3, 49.6)	10.7	186.2
30–34	13.8	41.2 (38.3, 44.2)	5.7	214.6
35–39	8.4	39.9 (35.4, 44.7)	3.4	231.3
≥ 40[b]	2.7	39.9 (32.9, 47.3)	1.1	236.7
Total	14.6	55.0 (53.2, 56.9)	8.0	236.7

Note: CI = confidence interval.
[a]Denominator is women aged 14 years.
[b]Denominator is women aged 40–44 years.

DISCUSSION

The US abortion rate fell 25% between 2008 and 2014, but this decline was not uniform across all population groups.

The decline in the abortion rate was largest, 46%, for young women aged 15 to 19 years. This parallels the 23% drop in the adolescent birth rate over the same period.[12,13] Recent research suggests that most of the decline in adolescent fertility between 2007 and 2012 was a result of changes in contraceptive use, including increased reliance on long-acting reversible contraception (LARC) such as the IUD (intrauterine device) and implants.[14]

Changes in contraceptive use were likely an important factor behind the steep drop in abortion among adult women, as well.[15] Reliance on LARC among all contraceptive users increased 130% between 2007 and 2009 and continued into 2011, although at a slower pace.[16] Between 2011 and 2014, LARC use increased 48% among clients at federally funded family planning clinics,[17] and this pattern may apply to all women of reproductive age. A recent study found that, for the first time in 2 decades, typical use failure rates for condoms improved.[18] This may also have contributed to the decline in abortion because it is the second most common reversible contraceptive method.[19]

For the first time in 2 decades, the abortion rate declined among women with incomes less than 100% the federal poverty level.[20] Still, the abortion rate for this group was the highest of all the groups examined, and the decrease in abortion was less pronounced than was that for higher income women. Between 2008 and 2014, the number of state abortion restrictions increased,[21] and research suggests that some of these restrictions made abortion more difficult for women to access in at least some states.[3,22–24] We might expect these types of laws to

have the greatest impact on low-income women, resulting in even more of a decline in abortion for this group relative to others. That this was not the case may be because of several factors. The most recent research available suggests that in 2009 through 2012 reliance on LARC was as common for women with family incomes less than 100% the federal poverty level as for higher income women.[16] However, if LARC or other highly effective contraceptive methods became less accessible to low-income women in recent years, this could have led to differential declines in unintended pregnancy and abortion.

Another factor potentially contributing to the trends in abortion by income is health reform. Although federal Medicaid can be used to pay for abortion only under very limited circumstances, 15 states use their own funds to pay for abortions for women with coverage.[6] All but 2 of these 15 states expanded Medicaid eligibility under the Affordable Care Act. Previous research using the 2014 APS found that Medicaid coverage increased among abortion patients in states where Medicaid covers abortion, and the proportion using Medicaid to pay for the procedure also increased significantly: from 44% in 2008 to 52% in 2014.[6] It is possible that more poor women in states where Medicaid pays for abortion acquired coverage and were able to use it to pay for their procedures. This, in turn, could have increased access to abortion for economically disadvantaged women in these states.

We found that White women had the lowest abortion rate of all the racial and ethnic groups examined, although the decline in abortion was greater for women of color. It is possible that increased reliance on LARC and more consistent use of condoms were more pronounced for non-White women. For example, previous research found that the increase in LARC use was significantly higher among Latina (but not Black) women than among Whites.[16] Alternately, the decline could reflect reduced access to care. For example, a disproportionate share of women of color may have lived in states where abortion restrictions successfully reduced access to care,[3,22,23] or they may have been disproportionately affected by restrictions in those and other states. If this was the case, the larger decline in abortion would actually be an indicator of racial and ethnic disparities. More research is needed to better understand the dynamics behind these declines.

The proportion of women expected to have an abortion by age 45 years declined from 30% in 2008 to 24% in 2014. This pattern parallels, but was less pronounced than, the decline in the abortion rate during that same period. That nearly 1 in 4 women is anticipated to have an abortion during her reproductive years demonstrates that it is not an uncommon experience.

Limitations

Our study has several limitations. The APS data contain some amount of measurement error. For example, imputation was used to assign values on key demographic measures when they were not provided by respondents. Social desirability may have affected responses to survey items about family income, previous abortion, and other measures. Owing, in part, to the fact that patients of similar racial and ethnic backgrounds tend to be concentrated within facilities, estimates for this characteristic were more imprecise and had larger confidence intervals. Thus, the abortion numbers and rates we calculated should be considered estimates and not precise measures.

The information from patients did not include women who obtained abortions in a hospital setting. Our analysis of the 2008 APS suggests that their exclusion did not bias the findings, but it is possible that we would have detected differences between these 2 populations in 2014 had we been able to make the same comparisons. Our estimate of the lifetime incidence of abortion is on the basis of patients' reports of previous terminations. Underreporting of abortions is common in nationally representative surveys.[25,26] Because the study questionnaire was filled out by women obtaining abortions, we expect that underreporting was less common. Still, if some women obtaining abortions failed to report previous abortions, this would mean that the estimate of the lifetime incidence of abortion is artificially high.

Conclusions

Disparities in abortion rates correspond with disparities in unintended pregnancy.[15] Not only do women of color and those with family incomes less than 100% of the federal poverty level have higher rates of abortion than do White women and those with higher incomes, but they also have higher rates of unintended birth. Equitable access to wide-range family planning and contraceptive services would better allow women in underserved populations to avoid unintended pregnancy, but these efforts alone will not eliminate these disparities. Efforts should also be devoted to making sure that women who want abortions are able to have them without having to overcome financial and logistical barriers.

Laws and policies that make abortion more difficult to access have a disproportionate impact on groups overrepresented among abortion patients, particularly those who are poor or low income. Future research and interventions focused on abortion and unintended pregnancy should seek to understand the underlying causes of disparities in these outcomes, because this information could inform a comprehensive set of policies and programs that benefit all women. AJPH

CONTRIBUTORS

R. K. Jones was the lead analyst and drafted the article. J. Jerman oversaw data collection and contributed to the writing and editing of the article.

ACKNOWLEDGMENTS

The analysis was funded by an anonymous donor. Additional support was provided by the Guttmacher Center for Population Research Innovation and Dissemination (National Institutes of Health grant 5 R24 HD074034).

We thank our colleagues Rachel Benson Gold, Megan Kavanaugh, Kathryn Kost, and Elizabeth Nash for providing feedback on earlier drafts of this article.

HUMAN PARTICIPANT PROTECTION

The Abortion Patient Survey questionnaire and survey procedures were approved by the Guttmacher Institute's federally registered institutional review board; no approval was needed for our analyses because we relied on secondary data.

REFERENCES

1. American Public Health Association. Restricted access to abortion violates human rights, precludes reproductive justice, and demands a public health intervention. 2015. Available at: http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights. Accessed February 1, 2017.

2. American College of Obstetricians and Gynecologists. Increasing access to abortion. 2014. Available at: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion. Accessed February 1, 2017.

3. Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2014. *Perspect Sex Reprod Health*. 2017;49(1):17–27.

4. Jones RK, Kavanaugh ML. Changes in abortion rates between 2000 and 2008 and lifetime incidence of abortion. *Obstet Gynecol*. 2011;117(6):1358–1366.

5. Steinberg JR, McCulloch CE, Adler NE. Abortion and mental health: findings from the National Comorbidity Survey-replication. *Obstet Gynecol*. 2014;123(2 pt 1): 263–270.

6. Jerman J, Jones RK, Onda T. Characteristics of US abortion patients in 2014 and changes since 2008. 2016. Available at: https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014. Accessed February 1, 2017.

7. Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. *Perspect Sex Reprod Health*. 2014;46(1):3–14.

8. US Census Bureau. *American Community Survey Design and Methodology*. Washington, DC: US Government Printing Office; 2014.

9. National Center for Health Statistics. *2013–2015 National Survey of Family Growth Public Use Data and Documentation*. Hyattsville, MD; 2016.

10. National Center for Health Statistics. *Vintage 2014 Postcensal Estimates of the Resident Population of the United States*. Hyattsville, MD; 2015.

11. Forrest JD. Unintended pregnancy among American women. *Fam Plann Perspect*. 1987;19(2):76–77.

12. Hamilton BE, Martin JA, Osterman MJK, Curtin SC, Matthews TJ. Births: final data for 2014. *Natl Vital Stat Rep*. 2015;64(12):1–18.

13. Martin JA, Hamilton BE, Ventura SJ, Osterman MJ, Mathews TJ. Births: final data for 2011. *Natl Vital Stat Rep*. 2013;62:1–69, 72.

14. Lindberg L, Santelli J, Desai S. Understanding the decline in adolescent fertility in the United States, 2007–2013. *J Adolesc Health*. 2016;59(5):577–583.

15. Finer LB, Zolna MR. Declines in unintended pregnancy in the United States, 2008–2011. *N Engl J Med*. 2016;374(9):843–852.

16. Kavanaugh ML, Jerman J, Finer LB. Changes in use of long-acting reversible contraceptive methods among United States women, 2009–2012. *Obstet Gynecol*. 2015; 126(5):917–927.

17. Fowler CI, Gable J, Wang J, Lasater B. *Family Planning Annual Report: 2015 National Summary*. Research Triangle Park, NC: RTI International; 2016.

18. Sundaram A, Vaughan B, Kost K, et al. Contraceptive failure in the United States: estimates from the 2006–2010 National Survey of Family Growth. *Perspect Sex Reprod Health*. 2017;49(1):7–16.

19. Guttmacher Institute. Contraceptive use in the United States. Available at: https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states. Accessed June 8, 2017.

20. Jones RK, Darroch JE, Henshaw SK. Patterns in the socioeconomic characteristics of women obtaining abortions in 2000–2001. *Perspect Sex Reprod Health*. 2002; 34(5):226–235.

21. Guttmacher Institute. Last five years account for more than one-quarter of all abortion restrictions enacted since Roe. 2016. Available at: https://www.guttmacher.org/article/2016/01/last-five-years-account-more-one-quarter-all-abortion-restrictions-enacted-roe. Accessed August 21, 2017.

22. Grossman D, Baum S, Fuentes L, et al. Change in abortion services after implementation of a restrictive law in Texas. *Contraception*. 2014;90(5):496–501.

23. Gerdts C, Fuentes L, Grossman D, et al. Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas. *Am J Public Health*. 2016;106(5):857–864.

24. Upadhyay UD, Johns NE, Combellick SL, Kohn JE, Keder LM, Roberts SC. Comparison of outcomes before and after Ohio's law mandating use of the FDA-approved protocol for medication abortion: a retrospective cohort study. *PLoS Med*. 2016;13(8):e1002110.

25. Jones RK, Kost K. Underreporting of induced and spontaneous abortion in the United States: an analysis of the 2002 National Survey of Family Growth. *Stud Fam Plann*. 2007;38(3):187–197.

26. Fu H, Darroch JE, Henshaw SK, Kolb E. Measuring the extent of abortion underreporting in the 1995 National Survey of Family Growth. *Fam Plann Perspect*. 1998; 30(3):128–133, 138.

EXHIBIT C

OHIO 2017

Induced Abortions in Ohio

Ohio Department of Health

Ohio Department of Health

Prepared by:

Statistical Analysis Unit
Bureau of Vital Statistics

John Paulson
Health Services Policy Supervisor

Donna L. Smith
Researcher

September, 2018

Induced Abortion Program Contact Persons

Statistical Analysis Unit

Data Analysis

John Paulson
614-644-8507

Donna L. Smith
614-466-7545

Quality Assurance

Fetal Development Resources Directory on Request

Rick Hoover
614-752-6855

Office of General Counsel

Legislation

Rachel Belenker
614-466-4882

Table of Contents

Table of Contents

Background

The 2017 Annual Abortion Report presents information derived from both the "Confidential Abortion Reports" and "Post-Abortion Care Reports for Complications" in Ohio (reporting forms are included as Appendices I and II). Readers should note that abortion statistics in this report are limited to terminations occurring in Ohio; they do not include Ohio residents who obtained abortions outside the state.

Characteristics of Induced Abortions Reported in Ohio, 2017

Induced abortion statistics have been prepared in Ohio since 1976. Several trend comparisons in the 2017 Annual Abortion Report date back to 2003. A total of 20,893 induced pregnancy terminations were reported in Ohio for 2017, including 19,615 obtained by Ohio resident women (93.9%). This represents a 1% increase in induced pregnancy terminations from 2016 to 2017. Overall, since 2001 there has been a steady decline in terminations. When examined from 2001 to 2017, the annual decline averaged approximately 830 per year (Figure 1).

Approximately one in ten women who obtained abortions in 2017 were under 20 years of age, with another one-third between the ages of 20-24 years of age (Table 2). While the age distribution of women obtaining abortions has remained relatively unchanged since 2001, the age-specific abortion rates for women under age 25 have steadily decreased (Figure 5). Approximately 85% of women with known marital status who obtained abortions were never married, divorced, or widowed (Table 2). Fifteen percent of women who obtained abortions and whose marital status was known were married or separated (Table 2).

Forty-nine percent of resident women who obtained abortions and for whom race was reported were White; 44% were African American; 4% were Asian/ Pacific Islander; and 4% reported more than one race (Figure 2). Five percent of women with known ethnicity who obtained abortions were of Hispanic origin (Table 1).

The 2017 Ohio abortion rate was 8.9 per 1,000 resident women ages 15-44 years old; unchanged from the rate in 2016 (Figure 4). The 2017 Ohio resident abortion ratio was 144 abortions per 1,000 live births; slightly increased from the ratio in 2016 (Figure 4).

More than half of all induced abortions involved pregnancies of less than nine weeks (56%), with approximately 29% involving pregnancies of nine to 12 weeks (Table 2). The proportion involving abortions of less than nine weeks increased from 49% in 1997, while the proportion between nine and 12 weeks declined from 35% to 29% (Figure 7). There were 454 abortions in 2017 involving pregnancies of 19 or more completed weeks of gestation (Table 2). That represents a decrease from the 508 reported in 2016. The abortion reporting form requests method used to determine gestational age: ultrasound was used in 92% of cases (Table 8b). The vast majority of reported abortions were obtained in six major metropolitan areas of Ohio.

Curettage was the most used method of termination in 2017 (58%) (Table 7). That method has decreased since 2001, when 87% of terminations were by curettage. Mifepristone was reported as the medication for non-surgical termination for 5,279 abortions, followed by 489 terminations using misoprostol, and 40 terminations using methotrexate (Table 7).

Figure 1. Resident Induced Abortions, Ohio, 1976–2017

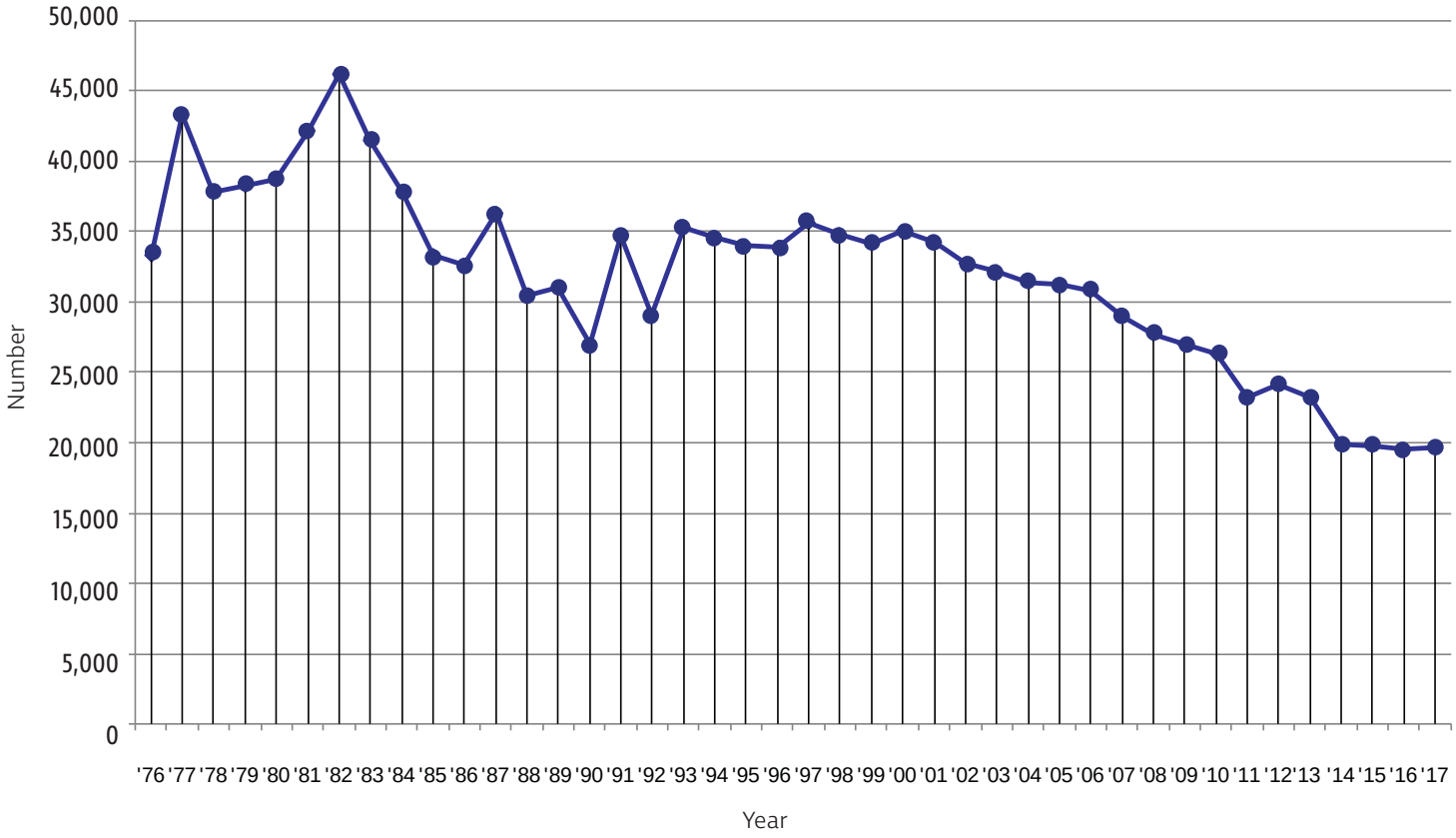
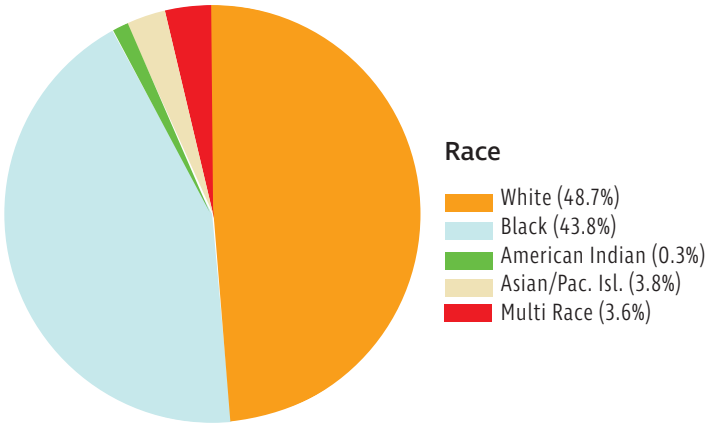
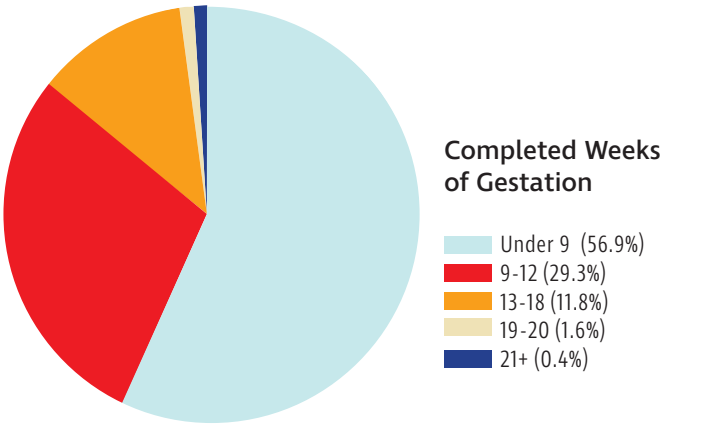
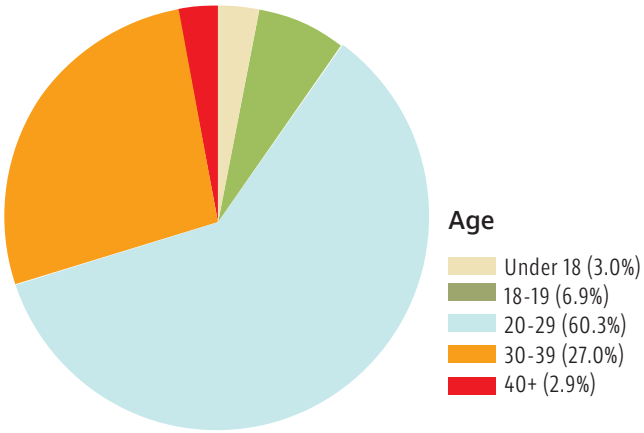
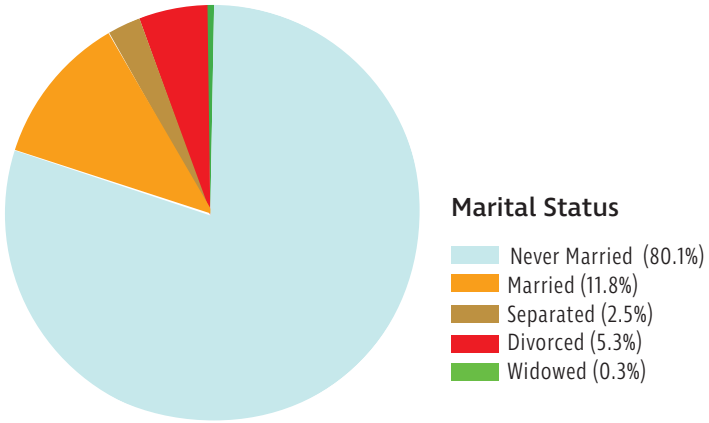


Figure 2. Selected Characteristics of Resident Induced Abortions in Ohio, 2017









Excludes unknown unless otherwise stated.

Figure 3. Induced Abortions Reported in Ohio, by County of Occurrence, 2017

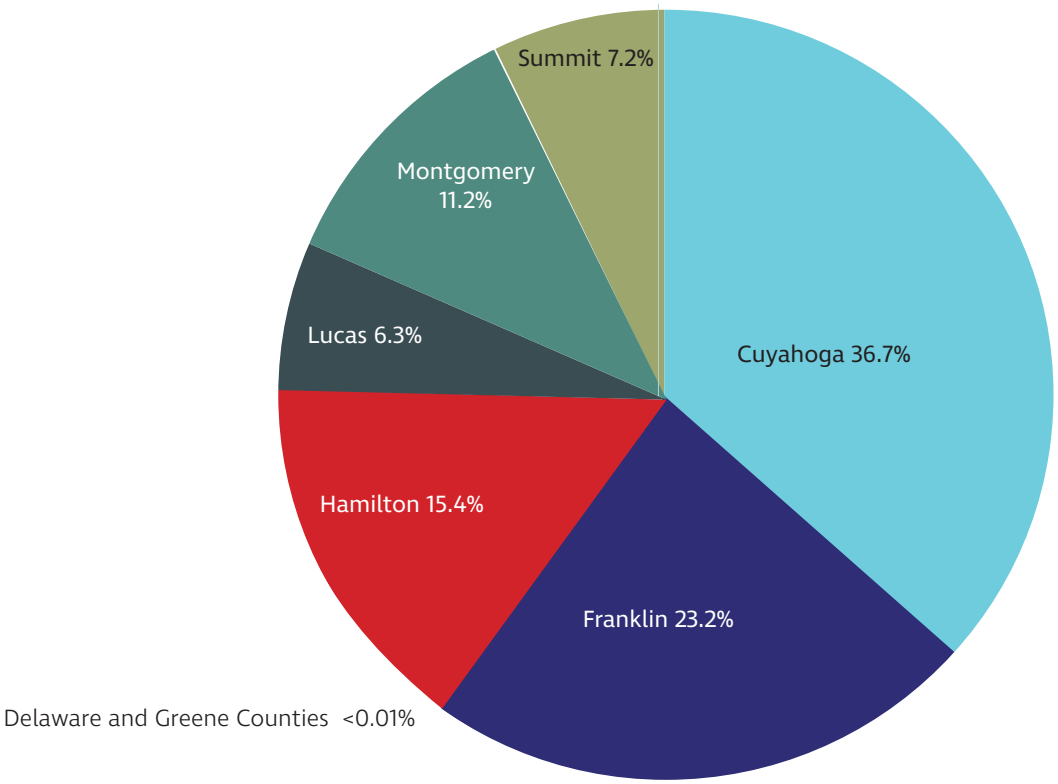
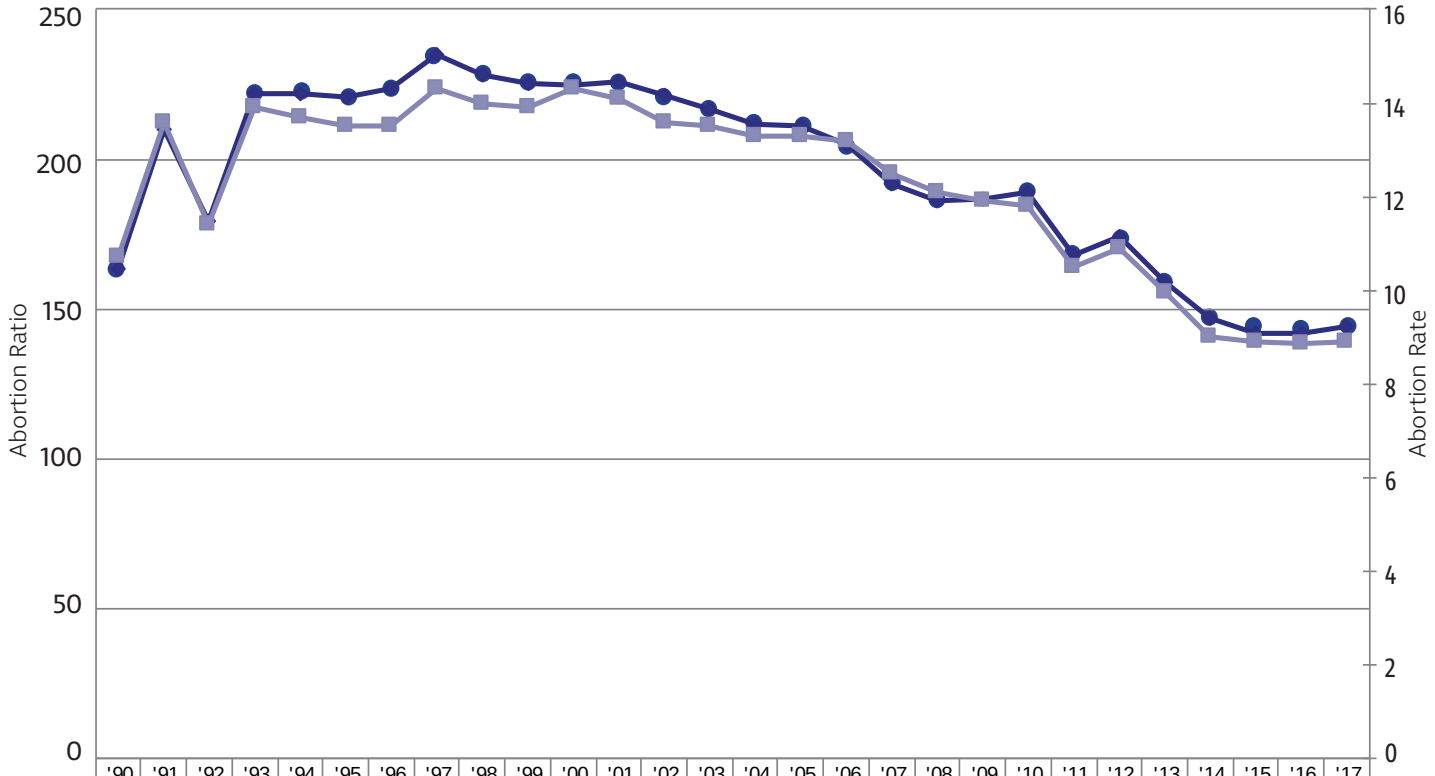


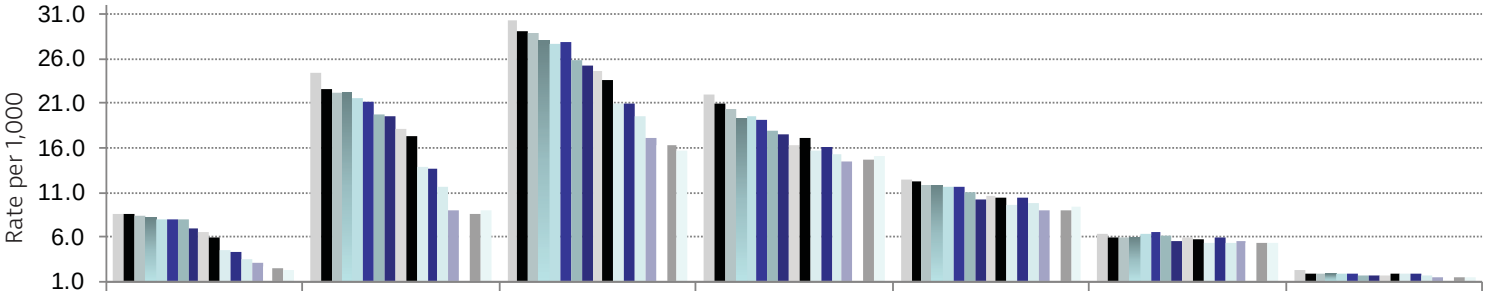
Figure 4. Abortion Ratios and Abortion Rates, by Year, Ohio Residents, 1990-2017



	'90	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17
Abor. Ratio	163	210	179	222	222	221	223	235	228	225	225	226	221	217	211	211	205	192	186	187	189	168	174	159	147	142	142	144
Abor. Rate	10.7	13.6	11.4	13.9	13.7	13.5	13.5	14.3	14.0	13.9	14.3	14.1	13.6	13.5	13.3	13.3	13.2	12.5	12.1	11.9	11.8	10.5	10.9	9.9	9.0	8.9	8.9	8.9

Abortion ratio is number of abortions per 1,000 live births.
Abortion rate is number of abortions per 1,000 women ages 15-44.

Figure 5. Induced Abortion Rates per 1,000 Women, by Age Group and Year, Ohio Residents, 2001-2017

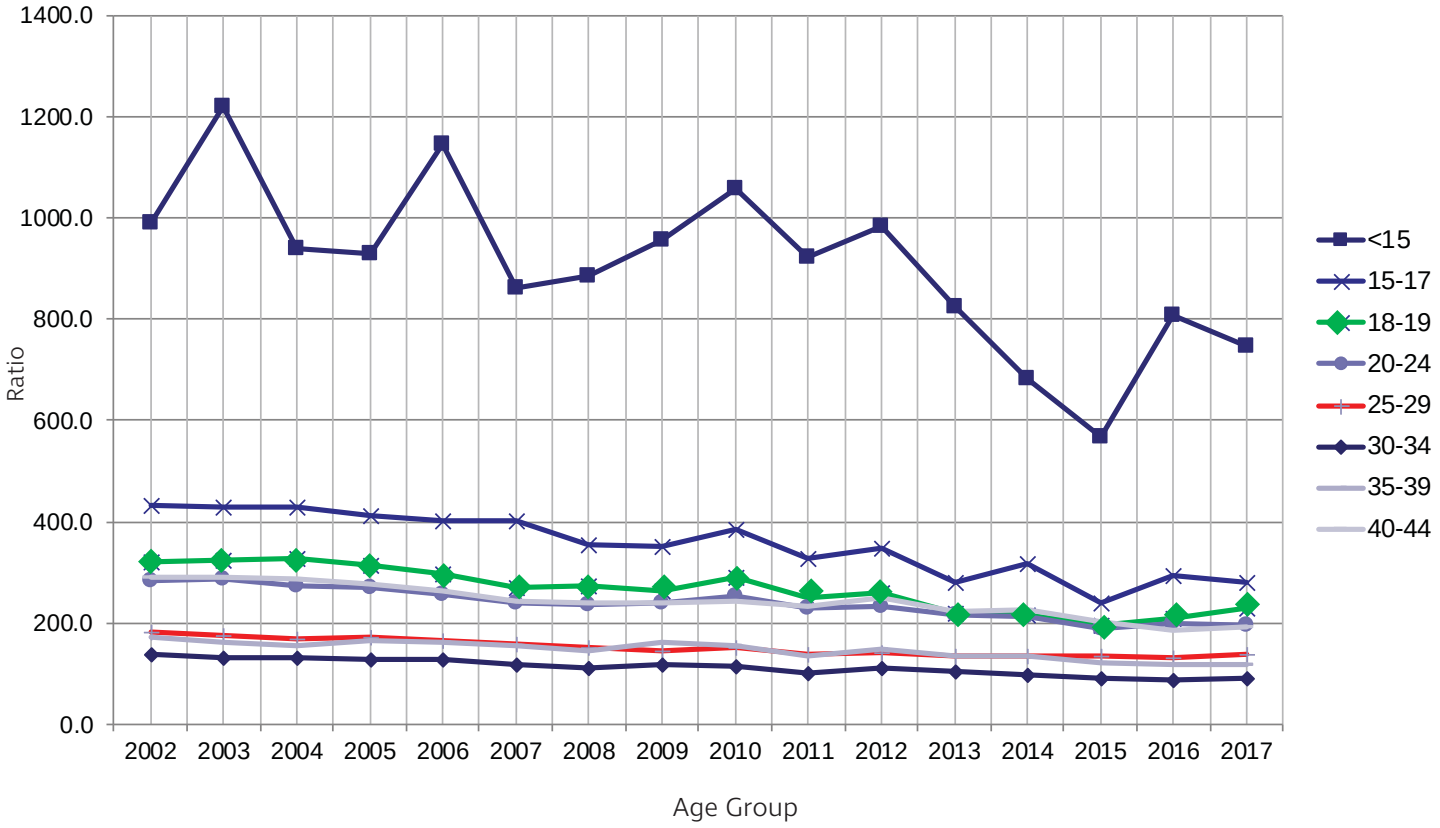


	15-17	18-19	20-24	25-29	30-34	35-39	40-44
2001	8.6	24.4	30.3	22.1	12.4	6.3	2.3
2002	8.6	22.6	29.1	20.9	12.2	6.0	1.9
2003	8.5	22.2	29.0	20.3	11.8	6.0	2.0
2004	8.2	22.3	28.0	19.4	11.9	6.0	2.0
2005	8.0	21.7	27.7	19.6	11.7	6.3	2.0
2006	7.9	21.1	27.9	19.1	11.6	6.5	1.9
2007	7.9	19.8	25.8	18.0	11.1	6.1	1.8
2008	6.9	19.6	25.3	17.5	10.3	5.5	1.8
2009	6.5	18.1	24.6	16.3	10.6	6.0	1.8
2010	6.0	17.3	23.6	17.2	10.5	5.8	1.9
2011	4.6	13.8	20.9	15.7	9.6	5.3	1.9
2012	4.4	13.7	21.0	16.2	10.5	6.0	2.0
2013	3.6	11.7	19.5	15.3	9.8	5.4	1.8
2014	3.1	9.1	17.2	14.5	9.0	5.5	1.5
2015	2.8	9.2	16.3	15.5	9.0	5.3	1.5
2016	2.6	8.6	16.3	14.7	9.0	5.4	1.5
2017	2.3	9.1	15.7	15.2	9.4	5.3	1.6

Age Group

Abortion rate is number of abortions per 1,000 female population in a specified age group.

Figure 6. Induced Abortion Ratios, by Age Group and Year, Ohio Residents, 2002-2017



Abortion ratio is number of abortions per 1,000 live births in a specified age group.

Figure 7. Total Induced Abortions, by Weeks of Gestation and Year, 1997-2017

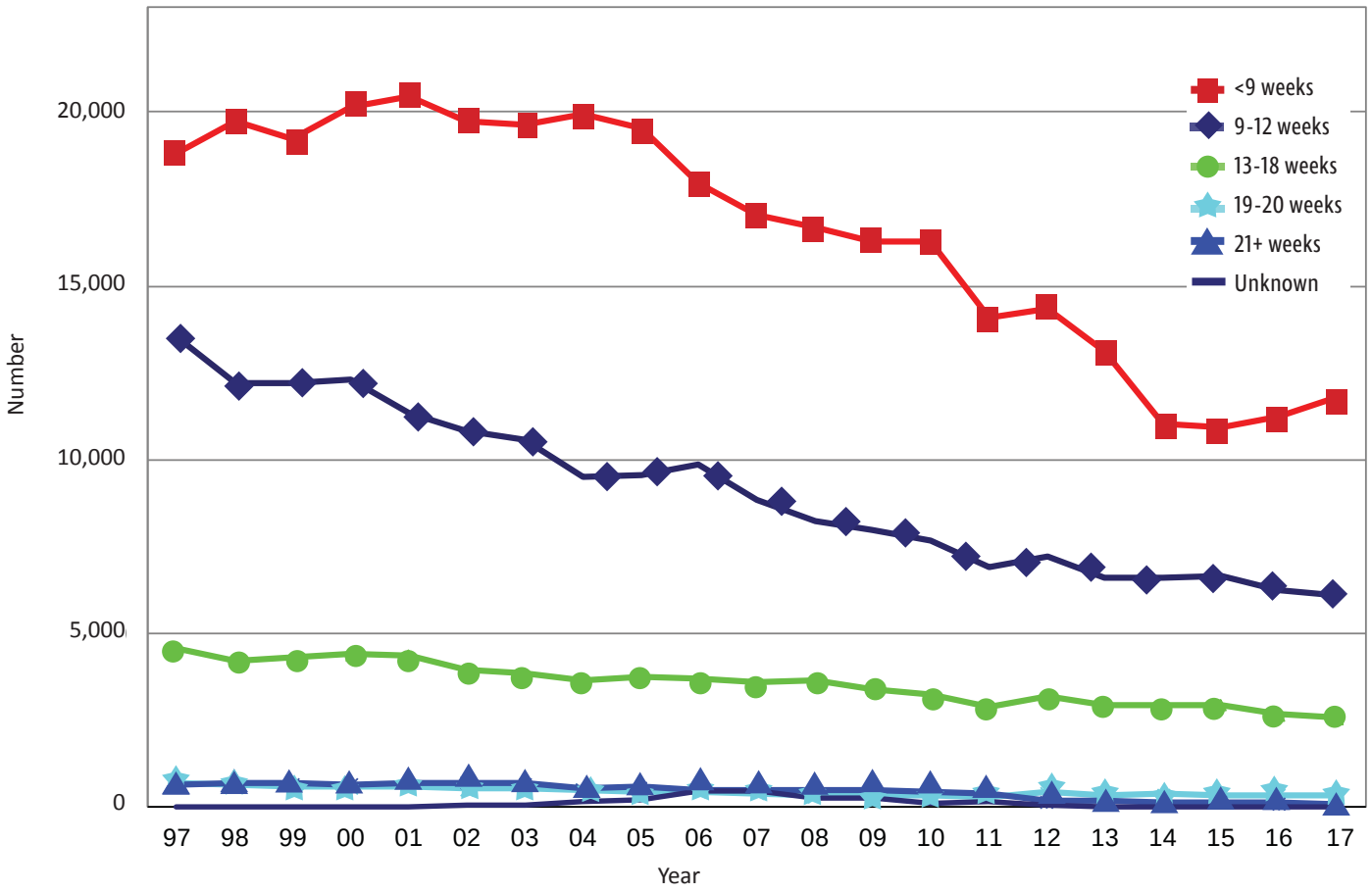


Table 1. Induced Abortions Summary Table, Ohio, 2017

CHARACTERISTICS	2017	PERCENT
TOTAL INDUCED ABORTIONS	**20,893**	**100.0**
RESIDENCE:		
Ohio Resident	19,615	93.9
Out-of-State Resident	1,278	6.1
Not Reported	0	0.0
AGE:		
Under 18 Years	637	3.1
18 - 19 Years	1,448	6.9
20 - 24 Years	6,323	30.3
25 - 55 Years	12,485	59.8
Age is outside of fertility range	0	0.0
Not Reported	0	0.0
RACE GROUP:		
White	9,988	47.8
Black	8,340	39.9
American Indian	55	0.3
Asian/Pacific Islander	732	3.5
More than one race	715	3.4
Unknown	679	3.3
Not Reported	384	1.8
HISPANIC:		
Non-Hispanic	17,865	85.5
Hispanic	973	4.7
Unknown	2,055	9.8
Not Reported	0	0.0
LEVEL OF EDUCATION:		
8th grade or less	190	0.9
9 to 12th grade, no diploma	2,429	11.6
High School graduate or GED	7,465	35.7
Some college credit, no degree	5,166	24.7
Associate Degree	1,541	7.4
Bachelor Degree	2,099	10.1
Masters Degree	570	2.7
Doctorate or Professional Degree	162	0.8
Unknown	1,271	6.1
Not Reported	0	0.0

MARITAL STATUS:		
Never Married	15,079	72.2
Married	2,274	10.9
Separated	486	2.3
Divorced	1,055	5.1
Widowed	54	0.3
Unknown	1,945	9.3
Not Reported	0	0.0
NUMBER OF LIVING CHILDREN:		
None	7,620	36.5
One	5,307	25.4
Two or More	7,748	37.1
Not Reported	218	1.0
COMPLETED WEEKS OF GESTATION:		
Less than 9 Weeks	11,784	56.4
9 - 12 Weeks	6,084	29.1
13 - 18 Weeks	2,571	12.3
19 - 20 Weeks	364	1.7
21 Weeks and Over	90	0.4
Not Reported	0	0.0

Table 2. Selected Characteristics of Induced Abortions Reported in Ohio, 2007-2017

Characteristic		2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
NUMBER OF ABORTIONS												
TOTAL INDUCED ABORTIONS		20,893	20,672	20,976	21,186	23,216	25,473	24,764	28,123	28,721	29,613	30,859
Residence	Ohio Resident	19,615	19,543	19,765	20,018	22,011	24,080	23,250	26,322	26,959	27,672	28,921
	Out-of-State Resident	1,278	1,129	1,211	1,168	1,205	1,393	1,511	1,801	1,762	1,941	1,938
Age	Under 15 Years	61	76	73	77	111	130	125	182	190	188	207
	15 - 17 Years	576	622	615	753	863	1,074	1,132	1,500	1,629	1,781	2,059
	18 - 19 Years	1,448	1,373	1,499	1,500	1,936	2,255	2,367	3,009	3,114	3,363	3,317
	20 - 24 Years	6,323	6,651	6,809	7,157	8,004	8,623	8,545	9,562	9,739	9,945	10,182
	25 - 29 Years	6,216	5,921	5,975	5,590	5,806	6,204	6,014	6,636	6,547	7,192	7,355
	30 - 34 Years	3,646	3,457	3,441	3,459	3,693	3,993	3,640	3,937	4,021	3,835	4,081
	35 - 39 Years	2,013	1,968	1,909	1,967	1,919	2,163	1,949	2,244	2,389	2,245	2,535
	40 - 44 Years	575	558	602	611	675	759	730	752	716	723	755
	45 Years & Older	35	46	53	48	37	46	48	43	50	53	53
	Age is Outside of Fertility Range	0	0	0	3	27						
	Not Reported	0	0	0	21	145	226	214	258	326	288	315
Education	Less than Grade 9	190	179	194	213	272	334	342	445	533	479	579
	Grade 9 - 12	9,894	9,995	9,738	10,161	12,321	13,932	15,155	17,276	17,830	18,389	18,880
	One Or More College Years	9,538	9,425	9,403	9,390	9,566	10,177	8,789	9,857	8,956	10,105	10,719
	None/Unknown	1,271	1,073	1,641	1,422	1,057	1,030	478	545	685	640	681
Race	White	9,988	9,975	10,338	10,775	11,796	13,109	13,340	15,127	15,683	16,019	17,221
	Black	8,340	8,387	8,421	8,253	9,075	9,694	9,178	10,528	10,647	11,064	11,073
	Asian/Pacific Islander	732	636	615	635	636	697	610	654	610	600	693
	Other/Unknown/ Not Reported	1,833	1,674	1,602	1,523	1,709	1,973	1,636	1,814	1,781	1,930	1,872
Marital Status	Never Married	15,079	13,115	12,512	14,552	17,738	19,618	19,224	21,876	22,078	22,630	23,157
	Married	2,274	1,978	1,855	2,145	2,295	2,514	2,632	2,813	2,990	3,172	3,621
	Separated	486	480	503	558	591	626	681	716	781	749	881
	Divorced	1,055	1,008	984	1,153	1,282	1,405	1,334	1,558	1,630	1,712	1,826
	Widowed	54	49	48	53	49	60	67	59	71	66	88
	Unknown	1,945	4,042	5,074	2,725	1,261	1,250	826	1,101	1,171	1,284	1,286
Number of Living Children	No Children	7,620	7,417	7,694	7,464	7,871	8,323	7,657	9,598	9,890	10,211	10,974
	One Child	5,307	5,403	5,532	5,676	6,168	6,841	6,658	7,578	7,932	8,210	8,499
	Two or More Children	7,748	7,584	7,600	7,562	8,168	9,027	8,577	9,709	9,888	10,093	10,233
	Not Reported	218	268	150	484	1,009	1,282	1,872	1,238	1,011	1,099	1,153
Completed Weeks of Gestation	Less than 9 Weeks	11,784	11,230	10,910	11,088	13,128	14,364	14,105	16,283	16,264	16,663	17,023
	9-12 Weeks	6,084	6,250	6,632	6,624	6,624	7,220	6,909	7,672	7,971	8,257	8,855
	13 - 18 Weeks	2,571	2,684	2,956	2,964	2,925	3,176	2,897	3,223	3,390	3,629	3,589
	19-20 Weeks	364	368	333	377	359	445	318	345	340	339	410
	21 Weeks and Over	90	140	145	133	173	180	378	458	480	480	502
	Not Reported	0	0	0	0	7	88	157	142	276	245	480

Table 2. Selected Characteristics of Induced Abortions Reported in Ohio, 2007-2017 (Part 2)

CHARACTERISTIC		2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
PERCENTAGE DISTRIBUTION												
TOTAL INDUCED ABORTIONS		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Residence	Ohio Resident	93.9	94.5	94.2	94.5	94.8	94.5	93.9	93.6	93.9	93.4	93.7
	Out-of-State Resident	6.1	5.5	5.8	5.5	5.2	5.5	6.1	6.4	6.1	6.6	6.3
Age:	Under 15 Years	0.3	0.4	0.3	0.4	0.5	0.5	0.5	0.6	0.7	0.6	0.7
	15-17 Years	2.8	3.0	2.9	3.6	3.7	4.2	4.6	5.3	5.7	6.0	6.7
	18-19 Years	6.9	6.6	7.1	7.1	8.3	8.9	9.6	10.7	10.8	11.4	10.7
	20-24 Years	30.3	32.2	32.5	33.8	34.5	33.9	34.5	34.0	33.9	33.6	33.0
	25-29 Years	29.8	28.6	28.5	26.4	25.0	24.4	24.3	23.6	22.8	24.3	23.8
	30-34 Years	17.5	16.7	16.4	16.3	15.9	15.7	14.7	14.0	14.0	13.0	13.2
	35-39 Years	9.6	9.5	9.1	9.3	8.3	8.5	7.9	8.0	8.3	7.6	8.2
	40-44 Years	2.8	2.7	2.9	2.9	2.9	3.0	2.9	2.7	2.5	2.4	2.4
	45 Years & Older	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
	Age is Outside of Fertility Range	0.0	0.0	0.0	0.0	0.1						
	Not Reported	0.0	0.0	0.0	0.1	0.6	0.9	0.9	0.9	1.1	1.0	1.0
Education	Less than Grade 9	0.9	0.9	0.9	1.0	1.2	1.3	1.4	1.6	1.9	1.6	1.9
	Grade 9-12	47.4	48.4	46.4	48.0	53.1	54.7	61.2	61.4	62.1	62.1	61.2
	One or More College Years	45.7	45.6	44.8	44.3	41.2	40.0	35.5	35.0	31.2	34.1	34.7
	None/Unknown	6.1	5.2	7.8	6.7	4.6	4.0	1.9	1.9	2.4	2.2	2.2
Race	White	47.8	48.3	49.3	50.8	50.8	51.5	53.9	53.8	54.6	54.1	55.8
	Black	39.9	40.6	40.1	39.0	39.1	38.1	37.1	37.4	37.1	37.4	35.9
	Asian/Pacific Islander	3.5	3.1	2.9	3.0	2.7	2.7	2.5	2.3	2.1	2.0	2.2
	Other/Unknown/ Not Reported	8.8	8.1	7.6	7.2	7.4	7.7	6.6	6.5	6.2	6.5	6.1
Marital Status	Never Married	72.2	63.4	59.6	68.7	76.4	77.0	77.6	77.8	76.9	76.4	75.0
	Married	10.9	9.6	8.8	10.1	9.9	9.9	10.6	10.0	10.4	10.7	11.7
	Separated	2.3	2.3	2.4	2.6	2.5	2.5	2.7	2.5	2.7	2.5	2.9
	Divorced	5.1	4.9	4.7	5.4	5.5	5.5	5.4	5.5	5.7	5.8	5.9
	Widowed	0.3	0.2	0.2	0.3	0.2	0.2	0.3	0.2	0.2	0.2	0.3
	Unknown	9.3	19.6	24.2	12.9	5.4	4.9	3.3	3.9	4.1	4.3	4.2
Number of Living Children	No Children	36.5	35.9	36.7	35.2	33.9	32.7	30.9	34.1	34.4	34.5	35.6
	One Child	25.4	26.1	26.4	26.8	26.6	26.9	26.9	26.9	27.6	27.7	27.5
	Two or More Children	37.1	36.7	36.2	35.7	35.2	35.4	34.6	34.5	34.4	34.1	33.2
	Not Reported	1.0	1.3	0.7	2.3	4.3	5.0	7.6	4.4	3.5	3.7	3.7
Completed Weeks of Gestation	Less than 9 Weeks	56.4	54.3	52.0	52.3	56.5	56.4	57.0	57.9	56.6	56.3	55.2
	9 - 12 Weeks	29.1	30.2	31.6	31.3	28.5	28.3	27.9	27.3	27.8	27.9	28.7
	13 - 18 Weeks	12.3	13.0	14.1	14.0	12.6	12.5	11.7	11.5	11.8	12.3	11.6
	19-20 Weeks	1.7	1.8	1.6	1.8	1.5	1.7	0.9	1.2	1.2	1.1	1.3
	21 Weeks & Over	0.4	0.7	0.7	0.6	0.7	0.7	1.5	1.6	1.7	1.6	1.6
	Not Reported	0.0	0.0	0.0	0.0	0.0	0.3	0.6	0.5	1.0	0.8	1.6

Table 3. Resident Induced Abortions Reported in Ohio, by County of Residence, 2007 - 2017

Table Restricted to Abortions Obtained by Ohio Residents

RESIDENCE	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
OHIO	19,615	19,543	19,765	20,018	22,011	24,080	23,250	26,322	26,955	27,672	28,921
Adams	17	11	10	15	18	11	17	22	20	16	14
Allen	105	93	98	78	90	142	146	191	173	129	121
Ashland	31	42	44	54	34	42	42	47	53	45	52
Ashtabula	116	110	108	129	147	149	157	175	200	149	185
Athens	77	74	82	66	79	89	83	109	112	101	112
Auglaize	19	25	24	23	32	22	28	28	28	36	32
Belmont	6	13	14	10	14	18	7	18	13	12	27
Brown	27	22	33	34	38	28	32	37	36	42	48
Butler	515	454	528	527	580	624	559	690	707	754	720
Carroll	15	20	24	25	21	24	28	23	34	32	35
Champaign	19	30	38	34	34	29	33	44	45	49	48
Clark	143	149	166	152	182	191	202	232	198	245	219
Clermont	201	202	195	213	233	269	233	258	293	321	289
Clinton	32	36	34	32	31	30	40	40	63	62	48
Columbiana	60	44	67	62	83	73	86	100	124	125	157
Coshocton	20	23	16	24	25	17	20	19	31	20	35
Crawford	47	34	35	32	32	30	33	32	46	41	33
Cuyahoga	4,721	4,921	4,895	5,185	5,499	5,663	5,828	6,598	6,794	7,056	6,986
Darke	24	25	25	22	21	36	27	32	28	36	44
Defiance	19	14	11	14	16	29	33	34	38	28	26
Delaware	149	132	149	141	145	155	164	144	140	135	174
Erie	131	123	111	96	161	151	101	161	157	139	160
Fairfield	118	149	141	136	144	163	149	163	157	155	205
Fayette	23	20	19	25	33	34	26	37	32	29	32
Franklin	3,258	3,158	3,333	3,376	3,448	3,771	3,529	3,448	3,604	3,526	4,381
Fulton	28	27	18	11	23	35	42	35	28	41	39
Gallia	6	9	7	8	7	5	10	6	16	5	17
Geauga	78	69	63	69	92	89	89	94	104	106	113
Greene	207	150	208	182	200	242	218	267	290	274	306
Guernsey	32	33	31	36	33	22	22	45	23	42	58
Hamilton	2,114	2,067	2,225	2,151	2,232	2,500	2,374	2,785	2,728	3,125	2,990
Hancock	52	45	49	30	72	74	51	76	90	105	86
Hardin	14	24	16	11	26	26	22	20	32	23	29
Harrison	3	3	9	1	5	7	6	10	10	7	14
Henry	13	7	15	7	22	13	17	28	32	27	24
Highland	24	18	36	23	27	27	24	38	45	38	51
Hocking	17	18	13	15	23	19	26	26	18	28	33
Holmes	5	6	7	15	10	8	16	22	25	9	19
Huron	44	52	51	36	71	67	59	64	81	60	79
Jackson	16	25	18	13	21	17	23	24	24	13	30
Jefferson	8	8	12	5	12	14	9	9	15	13	15
Knox	43	46	39	35	42	65	43	59	54	45	72
Lake	339	361	336	339	395	443	460	492	479	516	525
Lawrence	10	4	7	6	15	13	6	16	11	15	8

Table 3. Resident Induced Abortions Reported in Ohio, by County of Residence, 2007-2017 (Part 2)

Table Restricted to Abortions Obtained by Ohio Residents

RESIDENCE	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
Licking	161	156	162	153	177	188	205	203	201	186	252
Logan	33	26	29	36	34	32	23	38	51	45	42
Lorain	524	545	508	537	554	653	570	695	679	699	726
Lucas	866	774	705	528	949	1,189	1,239	1,565	1,565	1,434	1,356
Madison	42	44	43	34	21	40	35	53	46	34	54
Mahoning	378	403	383	391	413	460	422	528	572	630	713
Marion	56	48	50	60	67	85	69	69	68	71	93
Medina	209	200	169	186	219	240	210	223	293	266	270
Meigs	3	9	6	7	9	10	7	13	5	19	12
Mercer	17	19	17	21	32	19	20	27	24	19	18
Miami	82	86	74	90	94	103	107	120	113	122	119
Monroe	3	8	3	9	26	31	22	46	41	20	11
Montgomery	1,054	1,035	1,038	1,018	1,158	1,101	1,096	1,367	1,394	1,439	1,420
Morgan	9	1	6	9	9	6	4	10	10	5	7
Morrow	20	24	17	11	21	26	32	28	27	29	34
Muskingum	80	66	83	75	82	91	81	85	102	75	100
Noble	9	5	7	6	6	3	9	8	6	2	11
Ottawa	28	26	21	23	36	37	37	47	32	39	48
Paulding	8	5	1	5	7	5	3	7	8	7	12
Perry	19	20	23	25	22	29	41	33	21	22	32
Pickaway	34	42	39	47	39	54	39	50	67	52	76
Pike	16	7	15	10	12	25	19	26	15	15	27
Portage	202	230	208	265	269	316	325	354	367	379	360
Preble	21	38	38	38	37	36	29	33	32	53	46
Putnam	9	6	14	9	12	17	17	20	27	19	14
Richland	131	107	100	118	122	157	161	156	170	194	177
Ross	54	41	57	80	69	68	57	83	79	86	94
Sandusky	50	35	28	38	59	72	72	96	110	106	79
Scioto	34	27	38	36	30	42	53	47	61	57	60
Seneca	43	32	19	23	42	61	53	55	73	56	50
Shelby	33	43	56	32	40	35	34	45	45	27	53
Stark	506	569	556	615	573	636	634	745	771	752	840
Summit	1,135	1,156	1,048	1,150	1,229	1,301	1,352	1,428	1,469	1,601	1,660
Trumbull	272	267	248	275	293	333	339	370	382	445	501
Tuscarawas	60	75	108	84	110	116	97	109	97	132	121
Union	44	38	53	27	47	45	45	58	49	52	59
Van Wert	15	8	10	9	8	11	0	0	0	7	9
Vinton	4	7	6	6	6	5	9	5	12	8	8
Warren	173	182	198	208	186	277	216	265	244	270	272
Washington	18	20	21	20	18	16	18	28	23	22	27
Wayne	84	92	88	106	92	119	121	115	125	142	115
Williams	13	13	12	8	20	31	22	35	31	33	32
Wood	104	101	85	63	146	166	172	222	203	204	207
Wyandot	13	11	15	8	12	23	14	14	18	22	13
Not Reported	0	0	0	21	136	294	0	0	0	0	0

Table 4. Resident Induced Abortions Reported in Ohio, by County of Residence and Age, 2017

Table Restricted to Abortions Obtained by Ohio Residents

	AGE GROUP													
RESIDENCE	Total	<15	15	16	17	18	19	20-24	25-29	30-34	35-39	40-44	45+	*Not Rep/ Unclassifiable
OHIO TOTAL	19,615	59	93	174	258	544	811	5,935	5,884	3,427	1,864	532	34	0
Adams	17	0	0	1	0	0	0	6	5	3	2	0	0	0
Allen	105	0	2	2	1	3	10	36	24	20	5	2	0	0
Ashland	31	0	1	0	0	0	2	10	8	7	3	0	0	0
Ashtabula	116	1	1	2	2	3	5	36	38	12	12	3	1	0
Athens	77	1	0	0	1	1	5	42	14	5	6	2	0	0
Auglaize	19	0	0	0	1	0	0	8	1	7	1	1	0	0
Belmont	6	0	0	1	1	0	1	1	1	0	0	1	0	0
Brown	27	0	2	0	2	2	3	7	6	3	2	0	0	0
Butler	515	2	3	6	10	18	28	157	125	89	52	24	1	0
Carroll	15	0	0	0	0	0	1	6	6	1	0	1	0	0
Champaign	19	1	0	0	0	1	1	7	3	3	3	0	0	0
Clark	143	1	1	4	0	6	3	46	39	25	15	3	0	0
Clermont	201	0	1	2	4	5	14	57	49	38	24	7	0	0
Clinton	32	0	0	0	0	2	2	9	14	3	1	1	0	0
Columbiana	60	1	1	0	2	3	5	16	23	5	2	2	0	0
Coshocton	20	0	0	0	0	0	1	7	9	3	0	0	0	0
Crawford	47	0	0	1	0	2	3	21	9	8	2	1	0	0
Cuyahoga	4,721	19	20	41	68	135	169	1,431	1,508	771	432	119	8	0
Darke	24	0	0	1	0	3	2	8	3	4	3	0	0	0
Defiance	19	0	0	0	0	1	1	5	5	5	2	0	0	0
Delaware	149	0	0	1	2	6	2	26	27	34	44	7	0	0
Erie	131	1	0	2	1	4	8	40	41	24	9	1	0	0
Fairfield	118	0	0	0	3	3	8	29	41	14	16	4	0	0
Fayette	23	1	0	0	0	0	1	4	9	6	1	1	0	0
Franklin	3,258	5	9	19	35	54	110	909	1,030	652	346	80	9	0
Fulton	28	0	0	0	1	1	1	5	8	7	4	1	0	0
Gallia	6	0	0	0	0	0	1	2	3	0	0	0	0	0
Geauga	78	0	0	0	2	1	5	28	19	15	4	3	1	0
Greene	207	0	0	0	2	5	10	66	58	39	24	3	0	0
Guernsey	32	1	2	1	1	0	3	6	13	4	0	1	0	0
Hamilton	2,114	6	8	24	17	59	93	605	650	403	188	56	5	0
Hancock	52	0	0	0	0	2	6	23	11	7	1	0	2	0
Hardin	14	1	0	0	0	2	0	6	4	0	0	1	0	0
Harrison	3	0	0	1	0	0	1	1	0	0	0	0	0	0
Henry	13	0	0	0	0	0	1	5	3	3	0	1	0	0
Highland	24	0	0	0	1	1	1	3	10	5	1	2	0	0
Hocking	17	0	0	0	0	0	0	5	5	4	2	0	1	0
Holmes	5	0	0	0	0	0	0	3	1	1	0	0	0	0
Huron	44	0	0	0	0	0	2	15	16	6	2	2	1	0
Jackson	16	0	0	0	0	0	0	4	3	4	4	1	0	0
Jefferson	8	0	0	0	0	0	1	3	2	1	1	0	0	0
Knox	43	0	0	0	1	2	1	17	12	8	1	0	1	0
Lake	339	0	1	2	6	7	5	102	106	63	34	13	0	0
Lawrence	10	0	1	0	0	1	0	5	3	0	0	0	0	0

Table 4. Resident Induced Abortions Reported in Ohio, by County of Residence and Age, 2017 (Part 2)

Table Restricted to Abortions Obtained by Ohio Residents

	AGE GROUP													
RESIDENCE	Total	<15	15	16	17	18	19	20-24	25-29	30-34	35-39	40-44	45+	*Not Rep/ Unclassifiable
Licking	161	1	0	2	1	6	13	45	36	40	11	6	0	0
Logan	33	0	0	2	0	1	1	11	10	3	3	2	0	0
Lorain	524	0	4	7	7	15	24	170	147	81	49	20	0	0
Lucas	866	4	10	3	10	26	33	273	277	146	68	15	1	0
Madison	42	0	0	0	0	0	0	16	13	11	2	0	0	0
Mahoning	378	3	5	3	10	12	14	101	115	69	29	17	0	0
Marion	56	1	0	1	0	3	1	13	15	12	7	3	0	0
Medina	209	0	1	1	0	8	8	55	60	40	27	9	0	0
Meigs	3	0	0	0	0	0	0	1	0	2	0	0	0	0
Mercer	17	0	0	0	0	2	0	5	5	3	1	1	0	0
Miami	82	0	1	1	0	2	7	22	21	18	8	2	0	0
Monroe	3	0	0	1	0	0	0	2	0	0	0	0	0	0
Montgomery	1,054	2	2	3	16	28	50	322	333	176	103	19	0	0
Morgan	9	0	0	1	1	0	1	2	2	1	1	0	0	0
Morrow	20	0	0	0	0	1	1	7	6	3	0	2	0	0
Muskingum	80	0	0	1	0	3	5	31	21	9	10	0	0	0
Noble	9	0	0	0	1	0	0	2	4	0	2	0	0	0
Ottawa	28	0	0	0	1	0	3	9	9	2	4	0	0	0
Paulding	8	0	0	0	0	0	0	2	2	4	0	0	0	0
Perry	19	0	0	0	0	1	1	7	5	2	0	3	0	0
Pickaway	34	0	0	1	0	3	0	12	7	3	3	5	0	0
Pike	16	0	0	0	0	3	0	3	5	2	3	0	0	0
Portage	202	0	3	1	2	7	9	68	56	31	20	5	0	0
Preble	21	0	0	0	0	0	1	8	7	3	0	2	0	0
Putnam	9	0	0	0	0	0	1	4	2	2	0	0	0	0
Richland	131	0	1	4	2	7	11	47	29	20	7	3	0	0
Ross	54	0	0	0	0	3	1	17	13	8	10	2	0	0
Sandusky	50	0	0	0	2	1	2	15	17	7	5	1	0	0
Scioto	34	0	1	1	2	1	3	12	7	5	2	0	0	0
Seneca	43	0	1	0	0	0	1	19	10	9	1	2	0	0
Shelby	33	0	0	0	0	1	0	13	8	7	3	1	0	0
Stark	506	2	3	3	8	13	31	175	134	77	41	19	0	0
Summit	1,135	3	5	19	15	36	38	353	348	173	119	25	1	0
Trumbull	272	2	2	6	4	10	10	95	62	54	20	6	1	0
Tuscarawas	60	0	0	2	1	3	2	24	15	9	3	1	0	0
Union	44	0	0	0	4	1	2	7	10	12	7	1	0	0
Van Wert	15	0	0	0	1	1	1	3	7	2	0	0	0	0
Vinton	4	0	0	0	0	0	0	2	1	1	0	0	0	0
Warren	173	0	1	0	1	6	10	41	37	35	29	12	1	0
Washington	18	0	0	0	0	0	1	7	5	3	2	0	0	0
Wayne	84	0	0	0	2	1	2	32	27	11	9	0	0	0
Williams	13	0	0	0	1	0	1	6	5	0	0	0	0	0
Wood	104	0	0	0	1	6	6	43	22	18	4	4	0	0
Wyandot	13	0	0	0	1	0	0	5	4	1	2	0	0	0
Not Reported	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table 5a. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Broad Age Groups, 2017

Table Restricted to Abortions Obtained by Ohio Residents

		Age Group							
County of Residence	Race*	Total	Under 18	18-19	20-29	30-39	40-49	50 +	Not Rep/ Unclassifiable
OHIO	TOTAL	19,615	584	1,355	11,819	5,291	566	0	0
	White	9,052	231	628	5,317	2,537	339	0	0
	Black	8,141	268	552	5,152	2,019	150	0	0
	Oth/Unk	2,422	85	175	1,350	735	77	0	0
Allen	TOTAL	105	5	13	60	25	2	0	0
	White	62	5	11	28	17	1	0	0
	Black	31	0	2	24	4	1	0	0
	Oth/Unk	12	0	0	8	4	0	0	0
Ashtabula	TOTAL	116	6	8	74	24	4	0	0
	White	96	6	5	59	22	4	0	0
	Black	8	0	1	7	0	0	0	0
	Oth/Unk	12	0	2	8	2	0	0	0
Athens	TOTAL	77	2	6	56	11	2	0	0
	White	55	2	6	37	8	2	0	0
	Black	9	0	0	7	2	0	0	0
	Oth/Unk	13	0	0	12	1	0	0	0
Butler	TOTAL	515	21	46	282	141	25	0	0
	White	280	13	23	158	71	15	0	0
	Black	136	3	9	76	45	3	0	0
	Oth/Unk	99	5	14	48	25	7	0	0
Clark	TOTAL	143	6	9	85	40	3	0	0
	White	97	3	5	53	33	3	0	0
	Black	32	3	3	20	6	0	0	0
	Oth/Unk	14	0	1	12	1	0	0	0
Clermont	TOTAL	201	7	19	106	62	7	0	0
	White	173	6	14	93	53	7	0	0
	Black	15	1	1	9	4	0	0	0
	Oth/Unk	13	0	4	4	5	0	0	0
Columbiana	TOTAL	60	4	8	39	7	2	0	0
	White	53	3	8	34	6	2	0	0
	Black	2	0	0	2	0	0	0	0
	Oth/Unk	5	1	0	3	1	0	0	0
Cuyahoga	TOTAL	4,721	148	304	2,939	1,203	127	0	0
	White	1,232	27	63	740	346	56	0	0
	Black	3,028	108	202	1,937	722	59	0	0
	Oth/Unk	461	13	39	262	135	12	0	0
Delaware	TOTAL	149	3	8	53	78	7	0	0
	White	104	2	7	37	53	5	0	0
	Black	16	0	1	6	8	1	0	0
	Oth/Unk	29	1	0	10	17	1	0	0

Table 5a. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Broad Age Groups, 2017 (Part 2)

Table Restricted to Abortions Obtained by Ohio Residents

			Age Group						
County of Residence	Race*	Total	Under 18	18-19	20-29	30-39	40-49	50 +	Not Rep/ Unclassifiable
Erie	TOTAL	131	4	12	81	33	1	0	0
	White	77	2	7	49	19	0	0	0
	Black	38	2	3	20	12	1	0	0
	Oth/Unk	16	0	2	12	2	0	0	0
Fairfield	TOTAL	118	3	11	70	30	4	0	0
	White	76	2	9	43	18	4	0	0
	Black	27	0	1	17	9	0	0	0
	Oth/Unk	15	1	1	10	3	0	0	0
Franklin	TOTAL	3,258	68	164	1,939	998	89	0	0
	White	1,190	13	65	711	366	35	0	0
	Black	1,465	39	71	925	400	30	0	0
	Oth/Unk	603	16	28	303	232	24	0	0
Greene	TOTAL	207	2	15	124	63	3	0	0
	White	127	2	10	75	39	1	0	0
	Black	47	0	5	30	11	1	0	0
	Oth/Unk	33	0	0	19	13	1	0	0
Hamilton	TOTAL	2,114	55	152	1,255	591	61	0	0
	White	711	15	44	407	213	32	0	0
	Black	1,195	33	87	740	311	24	0	0
	Oth/Unk	208	7	21	108	67	5	0	0
Hancock	TOTAL	52	0	8	34	8	2	0	0
	White	37	0	6	25	5	1	0	0
	Black	2	0	0	2	0	0	0	0
	Oth/Unk	13	0	2	7	3	1	0	0
Jefferson	TOTAL	8	0	1	5	2	0	0	0
	White	6	0	1	4	1	0	0	0
	Black	2	0	0	1	1	0	0	0
	Oth/Unk	0	0	0	0	0	0	0	0
Knox	TOTAL	43	1	3	29	9	1	0	0
	White	39	1	3	26	8	1	0	0
	Black	0	0	0	0	0	0	0	0
	Oth/Unk	4	0	0	3	1	0	0	0
Lake	TOTAL	339	9	12	208	97	13	0	0
	White	254	6	8	158	70	12	0	0
	Black	47	3	0	27	17	0	0	0
	Oth/Unk	38	0	4	23	10	1	0	0

Table 5a. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Broad Age Groups, 2017 (Part 3)

Table Restricted to Abortions Obtained by Ohio Residents

			Age Group						
County of Residence	Race*	Total	Under 18	18-19	20-29	30-39	40-49	50 +	Not Rep/ Unclassifiable
Licking	TOTAL	161	4	19	81	51	6	0	0
	White	132	3	14	67	43	5	0	0
	Black	14	1	3	6	4	0	0	0
	Oth/Unk	15	0	2	8	4	1	0	0
Lorain	TOTAL	524	18	39	317	130	20	0	0
	White	319	12	22	185	85	15	0	0
	Black	129	3	11	80	31	4	0	0
	Oth/Unk	76	3	6	52	14	1	0	0
Lucas	TOTAL	866	27	59	550	214	16	0	0
	White	349	9	20	228	84	8	0	0
	Black	363	8	32	234	84	5	0	0
	Oth/Unk	154	10	7	88	46	3	0	0
Mahoning	TOTAL	378	21	26	216	98	17	0	0
	White	172	10	10	80	61	11	0	0
	Black	172	7	12	113	34	6	0	0
	Oth/Unk	34	4	4	23	3	0	0	0
Marion	TOTAL	56	2	4	28	19	3	0	0
	White	41	1	2	22	13	3	0	0
	Black	9	1	1	4	3	0	0	0
	Oth/Unk	6	0	1	2	3	0	0	0
Medina	TOTAL	209	2	16	115	67	9	0	0
	White	178	1	14	97	60	6	0	0
	Black	13	0	1	10	2	0	0	0
	Oth/Unk	18	1	1	8	5	3	0	0
Miami	TOTAL	82	2	9	43	26	2	0	0
	White	70	2	8	40	18	2	0	0
	Black	1	0	0	0	1	0	0	0
	Oth/Unk	11	0	1	3	7	0	0	0
Montgomery	TOTAL	1,054	23	78	655	279	19	0	0
	White	399	1	26	253	108	11	0	0
	Black	543	19	45	334	139	6	0	0
	Oth/Unk	112	3	7	68	32	2	0	0
Portage	TOTAL	202	6	16	124	51	5	0	0
	White	140	6	9	83	39	3	0	0
	Black	40	0	4	25	10	1	0	0
	Oth/Unk	22	0	3	16	2	1	0	0
Richland	TOTAL	131	7	18	76	27	3	0	0
	White	87	2	16	48	18	3	0	0
	Black	32	4	2	19	7	0	0	0
	Oth/Unk	12	1	0	9	2	0	0	0

Table 5a. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Broad Age Groups, 2017 (Part 4)

Table Restricted to Abortions Obtained by Ohio Residents

		Age Group							
County of Residence	Race*	Total	Under 18	18-19	20-29	30-39	40-49	50 +	Not Rep/ Unclassifiable
Sandusky	TOTAL	50	2	3	32	12	1	0	0
	White	42	1	3	27	10	1	0	0
	Black	3	0	0	3	0	0	0	0
	Oth/Unk	5	1	0	2	2	0	0	0
Scioto	TOTAL	34	4	4	19	7	0	0	0
	White	28	3	4	15	6	0	0	0
	Black	2	0	0	2	0	0	0	0
	Oth/Unk	4	1	0	2	1	0	0	0
Seneca	TOTAL	43	1	1	29	10	2	0	0
	White	33	1	1	20	9	2	0	0
	Black	0	0	0	0	0	0	0	0
	Oth/Unk	10	0	0	9	1	0	0	0
Stark	TOTAL	506	16	44	309	118	19	0	0
	White	336	9	27	202	84	14	0	0
	Black	116	5	10	76	24	1	0	0
	Oth/Unk	54	2	7	31	10	4	0	0
Summit	TOTAL	1,135	42	74	701	292	26	0	0
	White	521	10	32	307	156	16	0	0
	Black	477	22	33	312	104	6	0	0
	Oth/Unk	137	10	9	82	32	4	0	0
Trumbull	TOTAL	272	14	20	157	74	7	0	0
	White	183	6	14	102	56	5	0	0
	Black	71	6	5	46	13	1	0	0
	Oth/Unk	18	2	1	9	5	1	0	0
Warren	TOTAL	173	2	16	78	64	13	0	0
	White	134	2	12	64	46	10	0	0
	Black	8	0	1	6	1	0	0	0
	Oth/Unk	31	0	3	8	17	3	0	0
Wayne	TOTAL	84	2	3	59	20	0	0	0
	White	78	2	2	54	20	0	0	0
	Black	3	0	1	2	0	0	0	0
	Oth/Unk	3	0	0	3	0	0	0	0
Wood	TOTAL	104	1	12	65	22	4	0	0
	White	83	1	9	51	19	3	0	0
	Black	11	0	3	7	1	0	0	0
	Oth/Unk	10	0	0	7	2	1	0	0

* "Oth/Unk'" includes "Not Reported."
Not all counties are displayed in this table in order to prevent disclosure of confidential information.

Table 5b. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Age Group, 2017

Table Restricted to Abortions Obtained by Ohio Residents

		Age Group																	
County	Race*	Total	<15	15	16	17	15-17	18	19	18-19	20	21	20-24	25-29	30-34	35-39	40-44	45+	Not Rep/ Unclassi-fiable
OHIO	TOTAL	19,615	59	93	174	258	525	544	811	1,355	967	1,095	5,935	5,884	3,427	1,864	532	34	0
	White	9,052	22	40	69	100	209	247	381	628	491	503	2,745	2,572	1,599	938	324	15	0
	Black	8,141	28	42	79	119	240	226	326	552	355	458	2,496	2,656	1,381	638	138	12	0
	Oth/Unk	2,422	9	11	26	39	76	71	104	175	121	134	694	656	447	288	70	7	0
Butler	TOTAL	515	2	3	6	10	19	18	28	46	30	30	157	125	89	52	24	1	0
	White	280	1	3	3	6	12	9	14	23	17	15	90	68	38	33	15	0	0
	Black	136	1	0	0	2	2	5	4	9	5	8	37	39	34	11	2	1	0
	Oth/Unk	99	0	0	3	2	5	4	10	14	8	7	30	18	17	8	7	0	0
Cuyahoga	TOTAL	4,721	19	20	41	68	129	135	169	304	234	250	1,431	1,508	771	432	119	8	0
	White	1,232	2	2	10	13	25	30	33	63	64	64	379	361	202	144	53	3	0
	Black	3,028	16	17	27	48	92	86	116	202	143	160	928	1,009	489	233	55	4	0
	Oth/Unk	461	1	1	4	7	12	19	20	39	27	26	124	138	80	55	11	1	0
Franklin	TOTAL	3,258	5	9	19	35	63	54	110	164	131	174	909	1,030	652	346	80	9	0
	White	1,190	1	1	5	6	12	22	43	65	50	57	318	393	240	126	33	2	0
	Black	1,465	3	7	10	19	36	20	51	71	59	88	433	492	282	118	26	4	0
	Oth/Unk	603	1	1	4	10	15	12	16	28	22	29	158	145	130	102	21	3	0
Greene	TOTAL	207	0	0	0	2	2	5	10	15	17	9	66	58	39	24	3	0	0
	White	127	0	0	0	2	2	5	5	10	11	5	38	37	24	15	1	0	0
	Black	47	0	0	0	0	0	0	5	5	4	3	21	9	5	6	1	0	0
	Oth/Unk	33	0	0	0	0	0	0	0	0	2	1	7	12	10	3	1	0	0

Table 5b. Resident Induced Abortions Reported in Ohio, by Selected Counties, Race and Age Group, 2017 (Part 2)

Table Restricted to Abortions Obtained by Ohio Residents

			Age Group																
County	Race*	Total	<15	15	16	17	15-17	18	19	18-19	20	21	20-24	25-29	30-34	35-39	40-44	45+	Not Rep/ Unclassi-fiable
Hamilton	TOTAL	2,114	6	8	24	17	49	59	93	152	98	94	605	650	403	188	56	5	0
	White	711	4	3	4	4	11	19	25	44	48	35	212	195	142	71	29	3	0
	Black	1,195	1	4	17	11	32	31	56	87	43	50	339	401	216	95	22	2	0
	Oth/Unk	208	1	1	3	2	6	9	12	21	7	9	54	54	45	22	5	0	0
Lorain	TOTAL	524	0	4	7	7	18	15	24	39	27	33	170	147	81	49	20	0	0
	White	319	0	3	4	5	12	9	13	22	17	23	107	78	48	37	15	0	0
	Black	129	0	1	1	1	3	3	8	11	7	7	39	41	22	9	4	0	0
	Oth/Unk	76	0	0	2	1	3	3	3	6	3	3	24	28	11	3	1	0	0
Lucas	TOTAL	866	4	10	3	10	23	26	33	59	45	62	273	277	146	68	15	1	0
	White	349	1	4	1	3	8	8	12	20	18	21	112	116	58	26	7	1	0
	Black	363	0	3	2	3	8	16	16	32	20	29	118	116	58	26	5	0	0
	Oth/Unk	154	3	3	0	4	7	2	5	7	7	12	43	45	30	16	3	0	0
Montgomery	TOTAL	1,054	2	2	3	16	21	28	50	78	44	57	322	333	176	103	19	0	0
	White	399	0	0	0	1	1	8	18	26	18	24	130	123	60	48	11	0	0
	Black	543	2	2	3	12	17	18	27	45	22	27	166	168	98	41	6	0	0
	Oth/Unk	112	0	0	0	3	3	2	5	7	4	6	26	42	18	14	2	0	0
Summit	TOTAL	1,135	3	5	19	15	39	36	38	74	59	70	353	348	173	119	25	1	0
	White	521	1	2	4	3	9	16	16	32	30	29	145	162	93	63	16	0	0
	Black	477	1	3	8	10	21	16	17	33	24	31	168	144	62	42	6	0	0
	Oth/Unk	137	1	0	7	2	9	4	5	9	5	10	40	42	18	14	3	1	0

* "Oth/Unk" includes "Not Reported."
Not all counties are displayed in this table in order to prevent disclosure of confidential information.

Table 6. Induced Abortions Reported in Ohio, by County of Occurrence, 2003 - 2017

County of Occurrence	2017	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003
TOTAL	20,893	20,672	20,976	21,186	23,216	25,473	24,764	28,123	28,721	29,613	30,859	32,936	34,128	34,242	35,319
Allen County	0	0	0	0	1	0	6	33	0	0	0	0	0	0	0
Brown County	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0
Clark County	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Cuyahoga County	7,662	7,745	7,505	8,548	9,037	9,201	8,908	10,352	10,317	10,038	9,700	10,161	10,797	10,989	11,486
Delaware County	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Erie County	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
Franklin County	4,844	4,476	4,715	4,137	4,966	5,698	5,640	5,391	5,581	5,222	6,594	6,778	6,728	6,856	6,869
Greene County	1	1	0	0	1	0	19	335	432	140	312	424	218	270	0
Hamilton County	3,225	3,057	3,303	3,890	4,171	4,601	4,363	4,995	4,825	5,663	5,114	5,583	6,051	6,431	6,392
Henry County	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Lake County	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Licking County	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Lucas County	1,320	1,144	986	733	1,511	1,960	2,318	2,563	2,548	2,338	2,212	2,851	2,691	2,425	2,383
Mahoning County	0	0	0	0	0	0	0	20	572	690	817	820	835	912	955
Montgomery County	2,339	2,358	2,599	1,855	1,798	1,931	1,701	2,078	2,088	2,411	2,403	2,618	2,752	2,688	2,976
Shelby County	0	2	0	1	1	2	0	0	0	0	0	0	0	0	0
Stark County	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Summit County	1,501	1,886	1,864	2,022	1,730	2,075	1,808	2,355	2,358	3,109	3,667	3,701	4,056	3,671	4,257
Trumbull County	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Wayne County	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0
Ohio County Unknown	0	0	0	0	0	0	0	0	0	0	39	0	0	0	0

Total 2017 abortions reported in Ohio by source:
- Ambulatory Surgical Facility = 20,710
- Hospital = 102
- Non-Surgical Clinic = 81

Table 7. Induced Abortions Reported in Ohio, by Method of Termination and County of Occurrence, 2017

		Surgical						Non-surgical					
County of Occurrence	Total	Curettage Suction	D & Ext	D & Evac	Hysterot-omy	Hysterec-tomy	Other Surg	Total Non-Sur	Mife-Pristone	Metho-Trexate	Miso-Prostol	Other Non-Surg	Not Reported
OHIO TOTAL	20,893	12,141	0	3,441	3	4	9	5,345	5,279	40	489	5	0
Cuyahoga	7,662	4,526	0	1,235	3	1	2	1,905	1,900	0	3	2	0
Delaware	1	0	0	0	0	0	1	0	0	0	0	0	0
Franklin	4,844	2,080	0	1,159	0	1	4	1,637	1,634	0	469	1	0
Greene	1	0	0	0	0	0	0	1	0	0	1	0	0
Hamilton	3,225	2,071	0	518	0	0	1	637	635	0	2	0	0
Lucas	1,320	775	0	42	0	0	0	503	501	0	2	0	0
Montgomery	2,339	1,706	0	416	0	1	0	216	209	1	5	2	0
Summit	1,501	983	0	71	0	1	1	446	400	39	7	0	0

Note: More than one method can be reported for a procedure.

Table 8a. Total Induced Abortions Reported in Ohio, by Gestational Age, 2017

Gestational Age	Number	Percent
Total Abortions Reported	20,893	100.0
Less than 9 Weeks	11,784	56.4
9 - 12 Weeks	6,084	29.1
13 - 18 Weeks	2,571	12.3
19 - 20 Weeks	364	1.7
21 - 24 Weeks	89	0.4
25 - 36 Weeks	1	0.0
Not Reported	0	0.0

Table 8b. Method Used to Determine Gestational Age of Fetus, Ohio, 2017

Method	Number	Percent
Clinical Exam	716	3.4
Last Menstrual Period	2,483	11.9
Ultrasound	19,190	91.9
Other Reported Method	3	0.0
Not Reported	0	0.0

Note: More than one method of estimation can be reported.

Table 9: Resident Induced Abortions Reported in Ohio, by Age of Women Obtaining Abortion and by Number of Prior Induced Abortions, 2017

Table Restricted to Abortions Obtained by Ohio Residents

	Prior Induced Abortion							
Age Group	Total	0	1	2	3	4	5+	Not Reported
Total Abortions	19,615	11,404	4,839	1,951	733	254	183	251
Under 18	584	559	17	3	0	0	0	5
18-19	1,355	1,172	146	19	1	0	0	17
20-24	5,935	4,020	1,332	381	80	24	12	86
25-29	5,884	3,015	1,654	718	271	93	64	69
30-34	3,427	1,541	988	480	240	77	64	37
35-39	1,864	815	555	270	113	45	40	26
40-44	532	266	138	75	27	14	3	9
45-59	34	16	9	5	1	1	0	2
Age is Outside of Fertility Range	0	0	0	0	0	0	0	0
Not Reported	0	0	0	0	0	0	0	0

Table 10a. Total Induced Abortions in Ohio with Post-Abortion Complications, by Type of Complication, 2017

(Data Source: Confidential Abortion Reporting Form, Box 23)

Complication Type	Number of Complications	Percent of Abortions with Complications
Perforation of Uterus	3	11.5%
Cervical Laceration	1	3.8%
Hemorrhage	7	26.9%
Incomplete Abortion	7	26.9%
Hematometra	4	15.4%
Anesthetic	1	3.8%
Failed Abortion	2	7.7%
Infection	0	0.0%
Death	0	0.0%
Other	5	19.2%
Ureteral Injury	1	3.8%
Uterine Rupture	1	3.8%
Diagnosis and Observation	2	7.7%
Unknown Complication	1	3.8%
Total Number of Complications*	30	Not Applicable
Total Abortions with One or More Complications	26	100.00%

Note: One termination may have more than one reported complication.

Table 10b. Total Induced Abortions in Ohio with Post-Abortion Complications, by Type of Complication, 2017

(Data Source: Post-Abortion Care Report for Complications, Box 8)

Complication Type	Number of Complications	Percent of Abortions with Complications
Perforation of Uterus	1	0.7%
Cervical Laceration	0	0.0%
Hemorrhage	14	9.2%
Incomplete Abortion	56	36.8%
Hematometra	25	16.4%
Anesthetic	0	0.0%
Failed Abortion	57	37.5%
Infection	7	4.6%
Death	0	0.0%
Failure of Amniotic Fluid Ex	0	0.0%
RH Incompatibility	0	0.0%
Other	2	1.3%
Total Number of Complications*	162	Not Applicable
Total Abortions with One or More Complications	152	100%

Note: An abortion may have more than one reported complication.

Table 11. Total Induced Abortions in Ohio with Post-Abortion Complications, by Type of Complication and Gestation Period, 2017

(Data Source: Post-Abortion Care Report for Complications, Box 4 and Box 8)

		Gestation Period				
Complication Type	Total	< 9 Wks	9-12 Wks	13-19 Wks	20+ Wks	Not Reported
		(Number of Complications)				
Perforation of Uterus	1	1	0	0	0	0
Cervical Laceration	0	0	0	0	0	0
Hemorrhage	14	7	3	3	1	0
Incomplete Abortion	56	38	10	5	1	2
Hematometra	25	10	15	0	0	0
Anesthetic	0	0	0	0	0	0
Failed Abortion	57	28	28	0	0	1
Infection	7	7	0	0	0	0
Death	0	0	0	0	0	0
Failure of Amniotic Fluid Ex	0	0	0	0	0	0
RH Incompatibility	0	0	0	0	0	0
Other/Unreported	2	1	0	1	0	0
Total Number of Complications*	162	92	56	9	2	3
Total Abortions with One or More Complications	152	86	55	7	1	3

Note: An abortion may have more than one reported complication.

Table 12. Resident Induced Abortions by Zip Code of Patient, Ohio, 2017

Zip Code	Total	Zip Code	Total	Zip Code	Total	Zip Code	Total
43001	3	43086	2	43218	2	43360	4
43003	1	43087	1	43219	116	43371	1
43004	64	43101	1	43220	50	43402	46
43006	1	43102	2	43221	44	43403	7
43008	3	43103	10	43222	7	43406	2
43010	1	43105	2	43223	61	43410	8
43011	7	43106	1	43224	160	43412	3
43013	1	43107	2	43225	3	43416	2
43014	9	43110	110	43226	2	43420	26
43015	54	43112	2	43227	88	43430	1
43016	68	43113	14	43228	152	43431	5
43017	44	43114	1	43229	182	43437	1
43018	1	43115	1	43230	108	43440	1
43019	5	43117	1	43231	61	43442	1
43021	10	43119	44	43232	210	43443	2
43022	1	43123	90	43233	2	43445	1
43023	11	43125	23	43235	80	43447	2
43024	2	43130	45	43237	1	43449	2
43025	2	43135	2	43238	3	43450	2
43026	52	43136	1	43240	20	43451	2
43028	3	43137	5	43246	1	43452	15
43029	1	43138	15	43252	1	43455	2
43031	18	43140	24	43284	1	43456	2
43035	42	43141	2	43287	1	43457	1
43039	1	43142	1	43302	45	43460	12
43040	30	43143	4	43306	1	43469	2
43044	8	43145	1	43311	16	43502	2
43045	1	43146	4	43314	1	43506	8
43046	2	43147	48	43315	7	43510	1
43050	18	43148	1	43316	5	43512	15
43054	26	43154	1	43318	2	43515	4
43055	69	43158	1	43319	1	43517	1
43056	14	43160	15	43320	1	43521	2
43060	2	43162	4	43324	1	43526	1
43061	2	43201	112	43326	6	43527	2
43062	28	43202	44	43329	1	43528	17
43063	1	43203	46	43331	2	43529	1
43064	11	43204	99	43332	3	43532	1
43065	33	43205	58	43333	1	43533	1
43066	1	43206	72	43334	3	43534	2
43068	169	43207	112	43338	4	43537	25
43071	1	43208	2	43340	2	43540	1
43072	2	43209	62	43342	1	43542	2
43074	4	43210	15	43343	3	43543	3
43075	1	43211	89	43344	3	43545	9
43076	5	43212	46	43346	1	43549	2
43078	8	43213	139	43348	2	43551	20
43080	4	43214	44	43351	4	43554	1
43081	121	43215	46	43356	2	43558	13
43082	21	43216	3	43357	1	43560	23
43085	39	43217	11	43358	1	43566	4

Table 12. Resident Induced Abortions by Zip Code of Patient, Ohio, 2017 (Part 2)

Zip Code	Total	Zip Code	Total	Zip Code	Total	Zip Code	Total
43567	8	43784	1	44038	1	44111	139
43569	1	43787	1	44039	45	44112	128
43570	1	43793	1	44040	2	44113	64
43571	4	43802	1	44041	16	44114	28
43604	37	43811	1	44044	15	44115	82
43605	70	43812	14	44045	1	44116	36
43606	66	43821	1	44046	2	44117	44
43607	77	43822	3	44047	11	44118	135
43608	29	43829	1	44048	2	44119	67
43609	59	43830	6	44050	6	44120	210
43610	12	43832	7	44052	92	44121	193
43611	39	43837	1	44053	35	44122	90
43612	92	43844	2	44054	28	44123	98
43613	76	43845	4	44055	44	44124	93
43614	64	43900	1	44056	9	44125	161
43615	91	43901	1	44057	25	44126	17
43616	24	43906	1	44059	1	44127	45
43617	5	43912	2	44060	75	44128	257
43619	6	43913	1	44062	4	44129	78
43620	12	43917	1	44064	1	44130	117
43623	25	43920	7	44065	4	44131	16
43626	1	43945	1	44067	23	44132	96
43635	2	43952	1	44068	1	44133	47
43662	1	43968	3	44070	59	44134	78
43701	63	43973	1	44072	2	44135	107
43707	1	43988	1	44074	17	44136	28
43713	2	44001	22	44076	2	44137	171
43719	1	44003	2	44077	78	44138	34
43720	1	44004	53	44081	5	44139	38
43723	7	44005	2	44084	3	44140	14
43724	7	44006	1	44085	4	44141	12
43725	15	44007	1	44086	3	44142	49
43727	1	44010	1	44087	38	44143	77
43728	1	44011	25	44089	17	44144	60
43731	2	44012	19	44090	9	44145	42
43732	3	44014	1	44092	37	44146	138
43739	2	44017	31	44093	1	44147	19
43748	2	44019	1	44094	73	44149	11
43749	1	44020	2	44095	53	44153	1
43750	1	44021	5	44096	1	44154	1
43755	1	44022	14	44098	1	44157	1
43756	3	44023	23	44099	2	44160	2
43758	1	44024	29	44101	5	44167	1
43762	3	44026	7	44102	187	44170	1
43764	1	44027	2	44103	93	44177	1
43766	1	44028	9	44104	204	44178	1
43767	1	44030	14	44105	249	44180	1
43772	2	44032	1	44106	91	44185	1
43773	1	44033	1	44107	161	44186	1
43780	2	44035	160	44108	164	44195	1
43782	1	44036	1	44109	160	44201	6
43783	5	44037	2	44110	124	44202	17

Table 12. Resident Induced Abortions by Zip Code of Patient, Ohio, 2017 (Part 3)

Zip Code	Total	Zip Code	Total	Zip Code	Total	Zip Code	Total
44203	52	44306	101	44445	3	44621	2
44206	1	44307	55	44446	33	44622	12
44208	1	44308	6	44447	1	44626	4
44210	1	44310	81	44448	1	44629	1
44212	63	44311	36	44449	1	44632	9
44214	2	44312	44	44451	5	44634	1
44215	7	44313	64	44452	1	44641	16
44216	5	44314	58	44457	2	44643	1
44217	2	44315	1	44460	24	44644	2
44221	71	44317	1	44461	1	44646	72
44223	28	44319	27	44470	2	44647	25
44224	48	44320	86	44471	14	44649	1
44226	1	44321	18	44472	1	44653	1
44229	1	44325	1	44473	4	44654	5
44230	8	44326	1	44475	1	44656	2
44231	13	44331	2	44480	1	44657	7
44233	8	44333	21	44481	8	44662	4
44234	3	44346	1	44482	1	44663	21
44235	1	44355	1	44483	55	44667	7
44236	17	44367	1	44484	28	44669	1
44240	78	44370	1	44485	43	44672	3
44241	19	44389	1	44488	1	44675	1
44242	1	44401	1	44489	1	44676	4
44243	1	44402	4	44490	1	44677	1
44244	1	44403	2	44491	5	44680	2
44250	2	44404	4	44501	1	44681	1
44253	2	44405	16	44502	29	44683	6
44254	8	44406	19	44503	2	44685	22
44255	15	44408	6	44504	8	44688	3
44256	76	44410	14	44505	44	44691	38
44260	9	44411	4	44506	5	44695	1
44262	5	44412	3	44507	14	44699	1
44264	4	44413	9	44508	1	44700	1
44266	47	44416	1	44509	46	44701	2
44270	7	44417	1	44510	7	44702	2
44272	3	44420	13	44511	32	44703	19
44273	4	44423	1	44512	61	44704	12
44274	1	44425	14	44513	1	44705	40
44275	5	44427	1	44514	20	44706	27
44276	3	44428	1	44515	47	44707	21
44278	20	44429	1	44541	2	44708	39
44279	1	44430	5	44572	2	44709	38
44280	6	44431	3	44574	1	44710	16
44281	33	44432	7	44601	31	44714	21
44286	5	44434	1	44605	1	44718	13
44287	11	44436	2	44608	4	44720	29
44288	4	44437	2	44612	6	44721	6
44301	42	44440	8	44614	14	44730	4
44302	17	44441	1	44615	9	44768	1
44303	17	44442	2	44616	1	44803	1
44304	22	44443	1	44618	1	44805	20
44305	67	44444	11	44619	1	44809	2

Table 12. Resident Induced Abortions by Zip Code of Patient, Ohio, 2017 (Part 4)

Zip Code	Total	Zip Code	Total	Zip Code	Total	Zip Code	Total
44810	4	45036	22	45174	1	45251	48
44811	9	45039	23	45176	6	45252	4
44813	8	45040	49	45177	16	45255	26
44814	3	45041	1	45192	1	45257	2
44817	1	45042	22	45201	1	45277	1
44818	3	45043	1	45202	58	45285	1
44820	13	45044	76	45203	12	45302	1
44821	1	45045	1	45204	21	45303	3
44822	6	45047	1	45205	69	45304	2
44824	2	45049	1	45206	35	45305	10
44826	1	45050	16	45207	36	45306	1
44827	11	45052	3	45208	21	45307	1
44830	19	45054	1	45209	26	45308	1
44833	15	45056	44	45211	148	45309	9
44836	1	45064	2	45212	63	45310	1
44837	1	45065	4	45213	49	45311	6
44839	7	45066	20	45214	38	45312	2
44840	1	45067	14	45215	68	45313	2
44842	3	45068	8	45216	23	45314	3
44843	1	45069	40	45217	13	45315	7
44846	2	45102	31	45218	6	45316	1
44847	1	45103	40	45219	73	45317	1
44851	3	45106	9	45220	36	45320	8
44854	1	45107	6	45221	1	45322	27
44857	18	45111	1	45222	1	45323	5
44864	2	45113	4	45223	74	45324	84
44865	2	45118	6	45224	67	45326	1
44866	2	45120	2	45225	45	45327	2
44870	89	45121	5	45226	15	45330	1
44875	13	45122	9	45227	35	45331	15
44878	1	45123	6	45229	40	45333	1
44882	2	45130	2	45230	34	45335	6
44883	27	45132	1	45231	163	45338	1
44890	16	45133	10	45232	42	45339	1
44902	6	45135	3	45233	18	45340	1
44903	27	45140	55	45234	1	45341	5
44904	7	45142	4	45235	3	45342	55
44905	15	45144	2	45236	50	45343	2
44906	28	45146	1	45237	96	45344	15
44907	19	45148	3	45238	104	45345	6
44925	1	45150	31	45239	81	45347	4
44960	1	45152	7	45240	96	45349	1
45001	2	45154	11	45241	29	45356	17
45002	16	45155	1	45242	22	45358	1
45004	1	45157	14	45243	16	45359	1
45005	34	45158	1	45244	22	45365	28
45011	111	45159	1	45245	22	45368	9
45013	58	45162	1	45246	37	45369	2
45014	110	45168	2	45247	24	45370	2
45015	15	45169	3	45248	32	45371	23
45030	12	45170	1	45249	21	45373	32
45034	2	45171	2	45250	1	45375	1

Table 12. Resident Induced Abortions by Zip Code of Patient, Ohio, 2017 (Part 5)

Zip Code	Total	Zip Code	Total	Zip Code	Total	Zip Code	Total
45377	16	45523	1	45730	1	45898	1
45380	1	45530	1	45732	4	45906	1
45381	1	45601	41	45734	1	99999	65
45382	1	45606	1	45742	2		
45383	2	45609	1	45750	11		
45384	3	45612	1	45764	6		
45385	57	45613	2	45766	1		
45387	7	45619	1	45768	1		
45390	1	45620	1	45769	2		
45395	2	45628	2	45776	1		
45400	1	45629	2	45780	1		
45402	36	45631	3	45786	2		
45403	33	45638	5	45801	35		
45404	18	45640	9	45804	17		
45405	65	45643	1	45805	25		
45406	73	45644	1	45806	5		
45407	2	45645	1	45807	7		
45409	8	45647	1	45810	7		
45410	36	45648	3	45813	1		
45412	2	45651	4	45814	1		
45414	44	45653	3	45817	3		
45415	26	45654	1	45821	1		
45416	24	45656	1	45822	9		
45417	114	45658	1	45827	1		
45418	1	45660	8	45828	2		
45419	18	45661	6	45830	3		
45420	43	45662	17	45832	1		
45422	1	45663	3	45833	11		
45424	88	45669	1	45840	43		
45426	85	45672	2	45843	2		
45429	34	45673	2	45845	1		
45430	4	45674	1	45846	2		
45431	38	45680	1	45850	2		
45432	19	45681	1	45853	1		
45434	5	45690	5	45854	1		
45435	2	45692	5	45856	5		
45436	1	45693	7	45858	1		
45439	20	45694	8	45861	1		
45440	19	45695	1	45863	1		
45449	35	45697	1	45865	2		
45450	1	45698	1	45867	1		
45458	41	45701	55	45872	4		
45459	17	45702	1	45873	2		
45463	1	45707	2	45874	1		
45469	2	45710	5	45879	4		
45476	1	45711	2	45881	2		
45484	1	45714	2	45883	1		
45502	10	45715	1	45885	7		
45503	37	45716	1	45887	5		
45504	9	45723	1	45891	5		
45505	23	45724	1	45895	8		
45506	23	45727	1	45896	1		

Table 13. Contraceptive History at Time of Conception and Contraception Recommendations Provided at Discharge, Ohio, 2017

Type of Contraception	History (at conception)	Recommended (after procedure)
Yes, Any Type	4,402	20,879
Cervical Cap	2	0
Hormone Implant	35	1,356
IUD	116	2,247
Condom, Male	1,510	7,239
Oral Contraceptive	1,763	5,577
Vaginal Ring	219	1,418
Contraceptive Injection	355	0
Condom, Female	19	21
Foam	20	21
Diaphragm	7	7
Hormone Patch	83	1,160
Rhythm	51	13
DepoProvera	2	2,043
Plan B	36	0
Abstinence	1	174
Withdrawal	87	4
Vasectomy	22	69
Tubal Ligation	7	184
Emergency Contraceptive	1	1
Essure	4	1
Own MD	0	366
Own Plans	0	1
Other	69	5,214
None	12,577	14
Unknown	3,914	0

Table 14. Pregnancy History of Women who Obtained Induced Terminations in Ohio, 2017

Number of specified pregnancies	Number of women with specified number of previous pregnancies	Number of women with specified number of prior spontaneous abortions	Number of women with specified number of prior induced abortions
0	5,428	16,558	12,293
1	3,880	3,065	5,098
2	3,680	738	2,040
3	2,888	189	760
4	2,007	51	259
5	1,204	21	95
6	758	7	51
7	385	7	14
8	203	3	9
9	102	3	4
10	61	0	9
11	28	1	1
12	25	0	2
13	9	1	2
14	2	0	0
15	3	0	0
16	2	1	0
17	1	0	0
18	1	0	0
19	1	0	0
20	0	0	0
Not Reported	225	248	256
Total Number of Previous Pregnancies of Specified Type	45,231	5,599	13,632

Table 15. Selected Medical Information from Confidential Abortion Reports, Ohio, 2017

Discharge instruction given as per O.A.C. 3701-47-02 (Restricted to women obtaining procedure at 14+ weeks gestation)	
Yes	2,373
No	2
Not Reported	0
Medical condition of the woman at time of abortion	
Good	20,879
Other	14
Type of procedure done immediately after the abortion	
None	20,884
Other	9

Table 16. Type of Counseling Provided to Women Obtaining Terminations, Ohio, 2017

Type of Counseling	Number
Psychological	38
Social Services	2,436
Pastoral	36
Medical	14,395
Other	15
None	6,463

Note: A single patient could receive one or more counseling types.

Table 17. Timing of Medical Exam for Terminations Performed, Induced, or Attempted After 19 Completed Weeks Gestation, Ohio, 2017

Medical Exam performed within 48 hours	
Yes	454
No	0
Not Reported	0

Table 18. Viability Determination and Type of Testing Used to Determine Viability for Terminations Performed, Induced or Attempted After 19 Completed Weeks Gestation, Ohio, 2017

Viability Judgement	
Viable	1
Not Viable	453
Not Reported	0
Type of Viability Testing	
Ultrasound	453
Lung Maturity Testing	0
Genetic Testing	0
Amniocentesis	5
Chorionic Villus Sampling	0
Cordocentesis	0
Weight (Ultrasound Estimate)	102
Maternal Serum Alpha-Fetoprotein	0
Actual Fetal Biometrics	0
Other	3

Note: More than one type of test to determine viability may be reported.

Table 19. Probable Post-Fertilization Age (PPFA) Determination and Type of Method Used to Determine PPFA for Terminations Performed, Induced or Attempted After 19 Completed Weeks Gestation, Ohio, 2017

Probable Post-Fertilization Age (PPFA) Judged to be 20 Weeks or Greater	
Yes	9
No	372
Method Used to Determine Probable Post-Fertilization Age (PPFA)	
Composite Ultrasound (Fourteen days after LMP)	325
LMP (Fourteen days after LMP)	16
Clinical Exam	1
Other	5
No Reported Method	47

Note: Includes data for 381 terminations induced after 19 completed weeks of gestation and which occurred on or after March 14, 2017 (Effective date of Sub. S. B. 127)

More than one method to determine PPFA my be reported

Confidential Abortion Report

Ohio Department of Health

(Required pursuant to R.C.3701.79)

1. Facility Name:

For State Use Only

2. Address:

Zip Code of Facility:

General Information

3. Zip code of address of the woman:

County of Residence (specify):

State of Residence:

4. Woman's Identification number:

5. Age of woman:

6. Specify highest degree or level of school completed:

☐ 8th grade or less ☐ 9th-12th grade ☐ High School Grad/GED
☐ Some College/No degree ☐ Associate's Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ Doctorate Degree ☐ Unknown

7. Marital status, please select one:

☐ Never Married ☐ Divorced
☐ Married ☐ Widowed
☐ Separated ☐ Unknown

8a. Race or ethnic group, please select all that apply:

☐ White ☐ Asian
☐ Black ☐ Pacific Islander
☐ American Indian ☐ Unknown
☐ Other (specify)_____

8b. Is the woman of Hispanic origin?

☐ Yes
☐ No
☐ Unknown

Medical History, Physical, & Assessment

9. Number of living children: ☐☐

10. Date of last live birth: M M D D Y Y

☐ Unknown _____/ _____/ _____

11.a Number of prior spontaneous abortions: ☐☐

11.b Number of prior induced abortions: ☐☐

12. Date of last induced abortion: M M D D Y Y

☐ Unknown _____/ _____/ _____

13. Number of previous pregnancies: ☐☐

14. Contraceptive History: Was the woman practicing contraception at the time of conception? ☐ Yes ☐ No ☐ Unknown

15. Method. If yes to number 14, what was the method used?

☐ Cervical Cap ☐ Hormone Implant ☐ IUD
☐ Condom (male) ☐ Oral Contraceptive ☐ Vaginal Ring
☐ Contraceptive Injection ☐ Condom (female) ☐ Foam
☐ Diaphragm ☐ Hormone Patch ☐ Rhythm
☐ Other _____

16. First day of last menstrual period:

M M D D Y Y

_____/ _____/ _____

☐ Unknown

Medical Procedure

17. Date of Termination:

M M D D Y Y

_____/ _____/ _____

18a. Clinical Estimate of Gestational Age:

Weeks ☐☐

Days ☐☐

18b. Method used to determine gestational age of the fetus:

☐ Clinical Exam
☐ LMP
☐ Ultrasound
☐ Other_____

19. If 18a is 14 weeks or greater, were discharge instructions given as per O.A.C. 3701-47-02?

☐ Yes ☐ No

20. Method of Termination:

☐ Suction Dilation & Curettage ☐ Dilation & Evacuation (D&E) ☐ Medical (NonSurgical) (specify)
☐ Hysterectomy ☐ Hysterectomy ☐ Mifepristone (RU 486)
☐ Other (specify) _____ ☐ Dilation Extraction ☐ Methotrexate
☐ Other (specify) _____

21. Medical condition of the woman at the time of abortion:

☐ Good ☐ Other (specify)_____

22. Type of procedure done immediately after the abortion:

☐ None ☐ Other (specify) _____

23. Post Abortion Complications (Indicate all):

☐ None
☐ Hemorrhage ☐ Perforation of Uterus ☐ Cervical Laceration
☐ Infection ☐ Anesthetic ☐ Failed Abortion
☐ Incomplete Abortion ☐ Hematometra ☐ Death
☐ Other (specify) _____

24. Type of family planning recommended:

☐ Cervical Cap ☐ Hormone Implant ☐ Condom (male)
☐ Oral Contraceptive ☐ Depo Provera ☐ Condom (female)
☐ Diaphragm ☐ Hormone Patch ☐ IUD
☐ Vaginal Ring ☐ Other (specify)_____

25. Type of Counseling given: ☐ None ☐ Psychological ☐ Social Service ☐ Pastoral ☐ Medical ☐ Other (specify) _____

26. Physician's Name (Type or print)

27. Physician's Signature: Date:

Send completed forms to: Ohio Department of Health Confidential Reports A
HEA 1802 (Rev. 03/2017) PO Box 118 Columbus, Ohio 43216 Fax: 614.728.6936

Medical Information for Abortions Performed, Induced or Attempted after 19 Completed Weeks of Gestation

(Required pursuant to R. C. 2919.171, 2919.201-2919.203, and O.A.C. 3701-47-03)

Woman's Identification number:

For State Use Only

Please respond to questions 30b-d and 31a-b and initial the document ONLY if you responded "YES" to question 29a, 29c or 30a.

28a. Did you perform a medical examination of the pregnant woman within 48 hours before the performance of the abortion or the attempt to perform or induce the abortion?

☐ Yes ☐ No

28b. Date of medical examination:

M M D D Y Y

_____/ _____/ _____

29a. In your good faith judgment, was the unborn child viable as defined in ORC 2919.16, paragraph M?

☐ Yes ☐ No

29b. Type of testing performed to determine viability:

- ☐ Ultrasound
- ☐ Lung Maturity Testing
- ☐ Genetic Testing
- ☐ Amniocentesis
- ☐ Other _____
- ☐ Chorionic Villus Sampling
- ☐ Cordocentesis
- ☐ Weight (Ultrasound Estimate)
- ☐ Maternal Serum Alpha-Fetoprotein (MSAFPI)

29c. Based on inquires of the woman and performance of medical exeminations or tests, is the Probable Post-Fertilization Age (PPFA). as defined in RC. 2919.20, twenty (20) weeks or greater, in the physciian's reasonable medical judgement?

☐ Yes ☐ No

29d. Method used to determine PPFA

- ☐ Composite Ultrasound (Fourteen(14) days after LMP)
- ☐ LMP (Fourteen (14) days after LMP)
- ☐ Clinical Exam
- ☐ Other (specify) _____

30a. The abortion was induced, performed or attempted because of a medical necessity or medical emergency (i.e. to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman):

☐ Yes ☐ No

30b. Please have the physician, who is not professionally related to the attending physician, certify the information in Question #30a. by printing and signing their name: By signing below, I certify that I am not professionally related to the attending physician and that the abortion was induced, performed or attempted because of a medical necessity or medical emergency (i.e. to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman).

Print Name_____

Signature _____ M.D./ D.O.

30c. Medical condition of the pregnant woman that constitutes medical necessity or medical emergency:

- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Hemorrhage
- ☐ Respiratory Failure
- ☐ Preeclampsia (Toxemia)
- ☐ Eclampsia
- ☐ Inevitable Abortion
- ☐ Acute Fatty Liver of Pregnancy
- ☐ Infection
- ☐ Premature Rupture of the Membrane
- ☐ Cardiac Disease
- ☐ Other_____

_____

30d. Method or techniques considered when inducing or performing the abortion (check all that apply):

- ☐ Suction Dilation & Curettage
- ☐ Dilation Extraction (specify)
- ☐ Hysterectomy
- ☐ Other (specify) _____
- ☐ Dilation & Evacuation (D&E)
- ☐ Hysterectomy
- ☐ Medical (NonSurgical)
  - ☐ Mifepristone (RU 486)
  - ☐ Methotrexate
  - ☐ Other (specify) _____

31a. Method or technique employed when inducing or performing the abortion:

- ☐ Suction Dilation & Curettage
- ☐ Dilation Extraction (specify)
- ☐ Hysterectomy
- ☐ Other (specify) _____
- ☐ Dilation & Evacuation (D&E)
- ☐ Hysterectomy
- ☐ Medical (NonSurgical)
  - ☐ Mifepristone (RU 486)
  - ☐ Methotrexate
  - ☐ Other (specify) _____

31b. Reason for choice of method or technique:

- ☐ Gestational Age
- ☐ Patient Safety
- ☐ Patient Choice
- ☐ Availability of Services
- ☐ Other (specify) _____

_____

_____ By initialing I certify that the abortion was not based on a claim or diagnosis that the pregnant woman will engage in conduct that would result in the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman or on any reason related to the woman's mental health.

A physician who fails to submit the report described in Paragraph (A) of OAC 3701-47-03 more than thirty days after the fifteen-day deadline, shall be subject to a late fee of five hundred dollars for each additional thirty-day period or portion of a thirty-day period the report is overdue.

Appendix II

Post Abortion Care Report For Complications
Ohio Department of Health

(Required Pursuant to O. A.C. 3701-47-03)
To be completed by the physician providing post-abortion care

State Use Only

Facility Where Post-Abortion Care was Provided			
Street or Post Number	City	State	Zip

Date of Abortion: Month Date Year	Weeks of Gestation

Facility Where Abortion was Performed:			
Address of Facility: Street or Post Number	City	State	Zip

Date Post Abortion Care Began: Month Day Year	Patient Number:

Complication(s) (Please check all that apply):

☐ Hemorrhage	☐ Anesthetic	☐ Hematometra	☐ Perforation of Uterus
☐ Failure of Amniotic Fluid Ex	☐ RH Incompatibility	☐ Cervical Laceration	☐ Failed Abortion
☐ Infection	☐ Incomplete Abortion	☐ Death	☐ Other (Specify)_____

Duration of Treatment: (indicate Number of Hours or Days)
_____ Hours _____ Days

Remarks
_____
_____
_____
_____
_____
_____

Physician's Name Providing Care (Type or Print)	Physicians Signature ☐ M.D. ☐ D.O.	Date

Send Completed Form to: Ohio Department of Health
Confidential Reports A
PO Box 118
Columbus, Ohio 43216

HEA 1806 Rev. 9/2014

Ohio
Department of Health

John R. Kasich, Governor
Lance D. Himes, Director of Health

EXHIBIT D

ELSEVIER

Contraception 78 (2008) 492–499

Contraception

Original research article

Second-trimester surgical abortion practices: a survey of National Abortion Federation members☆

Katharine O'Connell[a,*], Heidi E. Jones[a], E. Steve Lichtenberg[b], Maureen Paul[c]

[a]*Department of OB/GYN, Columbia University, New York, NY 10032, USA*
[b]*Department of OB/GYN, Northwestern University Feinberg School of Medicine, Chicago, IL 60611, USA*
[c]*Department of OB/GYN, Mount Sinai School of Medicine, New York, NY 10029, USA*

Received 5 March 2008; revised 22 July 2008; accepted 22 July 2008

Abstract

Background: The objective of this analysis was to assess the second-trimester surgical abortion practices of National Abortion Federation (NAF) members in North America and Australia.
Study Design: In 2002, questionnaires were mailed to 364 active member clinics of NAF for completion by their clinic administrators and individual providers.
Results: Two hundred eighty-nine (79%) clinics responded. Most NAF clinics (72%) offer second-trimester abortion services. The majority of second-trimester providers are obstetrician/gynecologists (63%), male (62%) and at least 50 years old (63%). We describe second-trimester surgical abortion practices in terms of patient eligibility, cervical ripening, ultrasound use, anesthesia and postoperative care.
Conclusions: Surgical techniques and postoperative practices for second-trimester abortions are similar among these respondents, suggesting that NAF's efforts to promulgate best practices using evidence-based guidelines are succeeding. The aging of skilled practitioners raises concerns about the future availability of second-trimester abortion.

Keywords: Abortion; Second-trimester surgical abortion; Dilation and evacuation; United States; Canada

1. Introduction

Pregnancy termination is one of the most common surgical procedures performed in the United States, with most occurring in the first trimester. The Guttmacher Institute estimated that 1.31 million abortions were performed in the United States in 2000, with no estimate by gestational age [1]. However, the Centers for Disease Control and Prevention (CDC) estimates that about 12% of abortions are performed at gestation ages of 13 weeks or more, resulting in 157,200 second-trimester abortions performed in 2000 [2]. Abortion in the second trimester is technically more difficult than that in the first trimester, and fewer trained clinicians perform the procedure. To date, no published study has examined the clinical practice patterns of these abortion providers.

The National Abortion Federation (NAF), the professional organization of abortion providers in North America, conducted a survey of first-trimester and second-trimester surgical abortion practices among member clinics in 2002. This survey expanded on a first-trimester surgical practices survey conducted in 1997 [3]. The purpose of this analysis was to document current second-trimester surgical abortion techniques and perioperative practices to guide future efforts in medical education, research and quality assurance.

2. Materials and methods

In 2002, NAF mailed self-administered questionnaires about both first-trimester and second-trimester abortion practices, including surgical and medical abortion, to their complete membership list of clinics consisting of 364 clinics in the United States, Canada and Australia. Awards were

☆ Financial support was provided by an anonymous foundation.
* Corresponding author.
E-mail address: ko2032@columbia.edu (K. O'Connell).

0010-7824/$ – see front matter © 2008 Elsevier Inc. All rights reserved.
doi:10.1016/j.contraception.2008.07.011

offered to increase response rates: two clinics, randomly selected from the respondent list, would receive a waiver of NAF membership dues for the following year. Telephone follow-up of nonrespondents occurred 1 month after the initial mailing and led to second mailing of the questionnaires.

Each mailed package consisted of two questionnaires: one for the clinic administrator and five copies of the second questionnaire for individual clinicians. The first (administrative) questionnaire elicited information about services and procedures offered at the surgical site; instructions to the administrator requested consultation with the medical director or other relevant personnel as needed for completion. The second (clinician) questionnaire inquired about individual surgeons' practices, preferences and opinions; administrators distributed this questionnaire to providers. Both instruments covered five major topics: facility and staff demographics; laboratory tests for abortion service patients; cervical preparation; anesthesia; and practices and instruments. The clinician instrument also included a section on second-trimester surgical abortion practices. Questions had precoded responses, although respondents were encouraged to write additional remarks if necessary. All questions asked about practices during the year 2001. The study was approved by the Northwestern University Institutional Review Board.

2.1. Statistical analysis

This work presents results only regarding surgical abortions performed past the 12th week of gestation. Tables and figures include combined data from the United States, Canada and Australia focusing on four categories: clinician characteristics, patient eligibility criteria, cervical preparation and other clinical practices. Results from the administrative survey are presented with *clinics* as the unit of analysis, whereas results from the clinician survey use *clinicians* as the unit of analysis; both are clearly delineated in the text.

Respondents reported the annual number of second-trimester abortions performed via dilation and evacuation (D&E) within predefined ranges (categories: *none*, *1–49*, *50–100*, *101–250*, *251–400*, *401–750*, *751–1000* and *>1000*). We calculated estimates of the total number of surgical abortions performed using the midpoints of these ranges. For the largest range, we estimated totals using 1000 procedures. We classified clinics by size: small clinics — those that perform less than 250 second-trimester surgical abortions per year; medium clinics — those that perform between 250 and 1000 second-trimester surgical abortions per year; and large clinics — those that perform more than 1000 second-trimester surgical abortions per year.

We explored differences in clinical practices by clinic size and clinician demographics using Student's *t* test and chi-square test to assess differences in continuous and categorical outcomes. Analysis of clinician characteristics included age, gender, years of abortion provision since training and years of D&E provision since training. We examined associations between these characteristics and clinical practices; all significant associations, as well as noteworthy nonsignificant findings, are presented.

3. Results

The response rates to the surveys are detailed in Fig. 1. Seventy-nine percent (289 of 364) of NAF member clinics responded with either the administrative survey, the clinician survey or both. Two hundred seventy-three clinics returned the administrative survey, including 258 clinics in the United States, 13 clinics in Canada and 2 clinics in Australia. One hundred eighty facilities returned clinician surveys from 293 total abortion providers.

Two hundred fifty-three US clinics reported an estimated total of 68,900 D&Es and 3643 medical inductions in 2001 (five US surveys had missing data regarding the number of cases). Thirteen Canadian clinics reported an estimated total of 1850 D&Es and no medical inductions. Two Australian clinics reported 550 D&Es and no medical inductions. We did not collect information on the gestational age distribution of these cases.

Seventy-two percent of responding clinics (192 of 268) provide second-trimester abortion services. Most of these clinics were small (60%), although 17% of clinics (n=33) performed more than 1000 second-trimester cases annually. Twenty-four percent of clinics also offer medical induction abortions. Most facilities self-identified as clinics (68%); fewer facilities self-identified as private offices (15%), surgical centers (15%) or hospital-based sites (2%). Sixty percent of facilities were for-profit entities (including private practices).

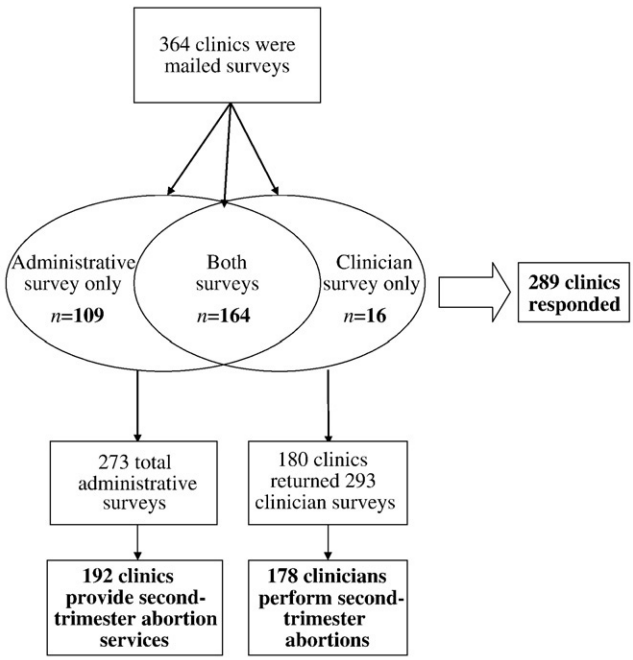


Fig. 1. Response rates to mailed surveys.

3.1. Clinician characteristics

Two hundred ninety-three clinicians from 180 clinics completed the clinician survey; 178 clinicians (61%) performed second-trimester abortions. A distribution of second-trimester providers by age cohort, gender, practice specialty and board certification is presented in Table 1. Younger clinicians (25–49 years old) were balanced by gender, while most providers aged 55 years and above were male. Eighty percent of clinicians reported at least 10 years of abortion experience after residency (53% had greater than 20 years of experience); 65% of clinicians had at least 10 years of D&E experience specifically (39% had greater than 20 years of experience). Forty-eight percent of these clinicians had performed greater than 100 D&Es in 2001.

3.2. Patient eligibility criteria

Half of the 192 clinics performed abortions more than 20 weeks from the onset of the last menstrual period (LMP), and 25% performed abortions up to 24 weeks from LMP. Most clinicians (132 of 178; 74%) had no weight or body mass index restrictions for accepting patients; among clinicians with restrictions (n=46; 26%), the most common weight limit (56%) was 300 lb. Almost all clinicians (97%) will perform a second-trimester surgical abortion for a patient with a prior uterine incision.

Table 1
Age, specialty and board certification of clinicians from 180 responding NAF clinics that provide second-trimester surgical abortion

	Men (n=122)	Women (n=55)	Total (n=178)[a]
Age in years* [n (%)]			
25–29	0 (0)	1 (2)	1
30–34	3 (2)	2 (4)	5
35–39	5 (4)	7 (13)	12
40–44	9 (8)	9 (16)	18
45–49	11 (9)	10 (18)	21
50–54	20 (17)	18 (33)	38
55–59	24 (20)	4 (7)	28
60–64	25 (21)	1 (2)	26
65+	23 (19)	3 (5)	26
Specialty** [n (%)]			
OB/GYN	95 (79)	31 (57)	126
Family practice	8 (7)	14 (26)	22
General practitioner	9 (7)	5 (9)	14
Midlevel provider	0	0	0
Other	9 (7)	4 (8)	13
Board-certified*** [n (%)]	89 (74)	42 (78)	131

[a] One case did not note gender, and three cases did not note the age, specialty or certification of the clinician. These cases are included in the total distribution, but excluded from the distribution of gender by characteristics.

* Chi-square test comparing men and women distributions significant at p<.001.

** Chi-square test comparing men and women distributions significant at p=.025.

*** Chi-square test comparing men and women distributions not significant at p=.47.

Most clinicians (62%) will localize the placenta during ultrasound evaluation prior to a second-trimester abortion. A finding of complete placenta previa often leads to hospital referral; 48% of clinicians refer patients who are between 16 and 18 weeks from LMP, and 66% refer patients above 18 weeks from LMP. Some providers (20%) also utilize more advanced testing (additional ultrasound, CT or MRI) for patients with complete placenta previa. There was no association between referral for placenta previa and operator's years of experience (p=.28 for 16–18 weeks from LMP; p=.52 for over 18 weeks from LMP).

3.3. Cervical preparation

The majority of clinicians (86%) routinely use osmotic dilators for cervical preparation; 51% and 53% begin as soon as 12–14 weeks' gestation in nulliparous and multiparous women, respectively. Dilators are placed by physicians (83%) or by advanced practice clinicians (11%). Laminaria are the most frequent osmotic dilator used (94%), followed by Lamicel (23%) and Dilapan (19%) (multiple responses permitted).

Misoprostol is used as a cervical-ripening agent by 70% of the clinicians surveyed, who routinely begin use of this agent between 12 and 15 weeks' gestation in 73% of nulliparous women and 65% of multiparous women. Sixty-seven percent of clinicians use misoprostol for cervical ripening in patients with a previous cesarean delivery. Many clinicians (74%) report combining the use of osmotic dilators and misoprostol (Fig. 2). The combined use of osmotic dilators and misoprostol was unrelated to clinician's age (p=.74), years of abortion experience (p=.94) or years of D&E experience (p=.38).

Most clinicians (64%) routinely use misoprostol instead of osmotic dilators in some patients, but rarely do so after 20 weeks' gestation (Fig. 3). In this survey of 2001 practices, clinicians varied routes of misoprostol administration, including buccal (57%), vaginal (52%) and oral (23%). The most common initial dose for cervical ripening was 400 mcg for patients both at 14–18 weeks of gestation (49%) and at greater than 18 weeks of gestation (45%), followed by 600 mcg (26% for both gestational age ranges), irrespective of route. Only 14% of clinicians employed smaller doses.

Most clinicians who use misoprostol (95%) believe that it frequently lessens the amount of force needed for dilating. Nearly two thirds of clinicians believe that misoprostol frequently reduces treatment time by one or more days; these providers are significantly more likely to use misoprostol in combination with osmotic dilators over 20 weeks' gestation (p<.001). Selecting from a checklist, clinicians agreed that misoprostol has multiple additional advantages, including enabling 1-day procedures (78%), improving patient flow (25%), omitting an additional pelvic exam (27%) and reducing surgical staff costs (14%). Most clinicians (84%) believe that the use of misoprostol as a ripening agent does not increase the risk

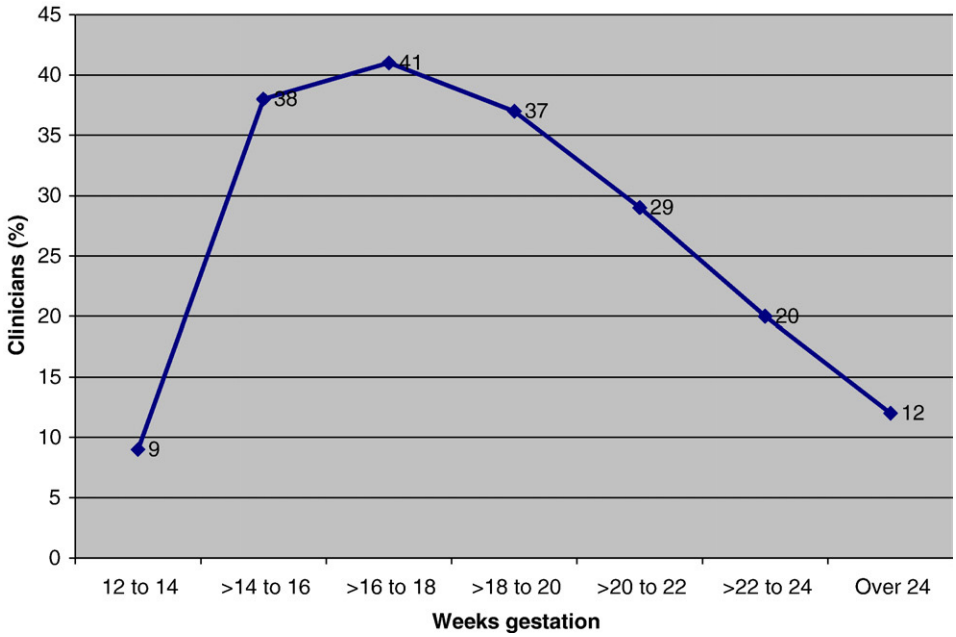


Fig. 2. Percentage of responding NAF clinicians who commonly use combined osmotic dilators and misoprostol for cervical ripening before D&E, by gestational age (n=127).

of unscheduled (extramural) deliveries if used overnight, and most (93%) believe that misoprostol is safe beyond the first trimester in those with no history of prior cesarean delivery. For patients with a prior cesarean delivery or other uterine incisions, 32% of clinicians believe that misoprostol is safe without dose alteration, 20% report that it is safe if the dose is reduced and 25% report that it is contraindicated; 14% of physicians believe that safety is dependent on clinical circumstances. No aspects of misoprostol use were related to clinician's age, years of abortion experience or years of D&E experience (data not shown).

3.4. Clinical practices and anesthesia

Clinics required confirmation of gestational age by ultrasound prior to a second-trimester surgical (99%) or medical induction (100%) abortion. In 2001, most

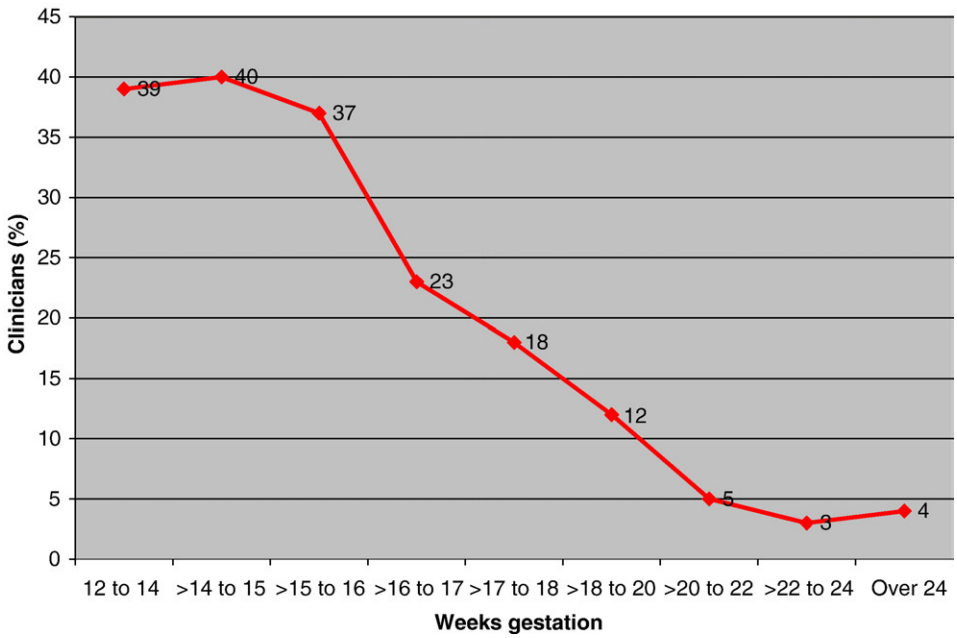


Fig. 3. Percentage of responding NAF clinicians who routinely substitute misoprostol for osmotic dilators before D&E, by gestational age (n=124).

clinicians (76%) did not routinely use preoperative feticidal techniques. If feticide was routinely employed, 69% began at 20 weeks' gestation or greater. Medical induction is used by only 10% (18 of 178) of NAF member second-trimester abortion providers.

Clinicians' use of intraoperative ultrasound varied; 51% of clinicians routinely use sonography in all cases, and 47% employ it for problem cases only. Physicians with less than 20 years of D&E experience were more likely to use ultrasound routinely (odds ratio=5.22; 95% confidence interval=2.54–10.83). Similarly, younger physicians were somewhat more likely to employ routine intraoperative ultrasound (p=.08).

We asked clinics to estimate what proportion of patients was provided different anesthesia regimens (Fig. 4). Most clinics that offered combined local and intravenous conscious sedation or general anesthesia used these methods for most (>80%) of their patients. We asked clinicians about anesthesia administration during abortion. Of clinicians performing abortions under intravenous conscious sedation (n=151), 47 (31%) administer the medication; other administrators include nurses (39%), certified nurse anesthetists (12%) and anesthesiologists (11%). Forty-seven clinicians perform abortions under general anesthesia; for their cases, either a certified nurse anesthetist (54%) or an anesthesiologist (46%) administers the anesthesia.

Most clinicians either do not give antibiotics to asymptomatic patients during cervical preparation (43%) or give a single oral antibiotic (53%). Postoperatively, 84% of clinicians prescribe a single oral antibiotic, with tetracycline being the dominant class (90%) and doxycycline being the dominant agent (87%).

Postoperative practices are uniform among clinics. Postoperative pain control is accomplished almost exclusively with nonnarcotic analgesics such as nonsteroidal anti-inflammatory agents (NSAIDs; 81%) or acetaminophen (59%). Other frequently utilized medications in the recovery room include the uterotonic agent methylergonovine (64%), antianxiolytics (24%) and parenteral narcotics (17%). Almost all clinics that perform second-trimester abortions (187 of 189 clinics that responded; 99%) give take-home oral contraceptives to medically eligible patients who request for them. Other take-home oral medications (either tablets in hand or by prescription) include methylergonovine (offered by 81% of clinics), NSAIDs (49%), misoprostol (39%) and acetaminophen with codeine (36%).

4. Discussion

This report is the first published presentation of data on second-trimester abortion practice. More than 75% of

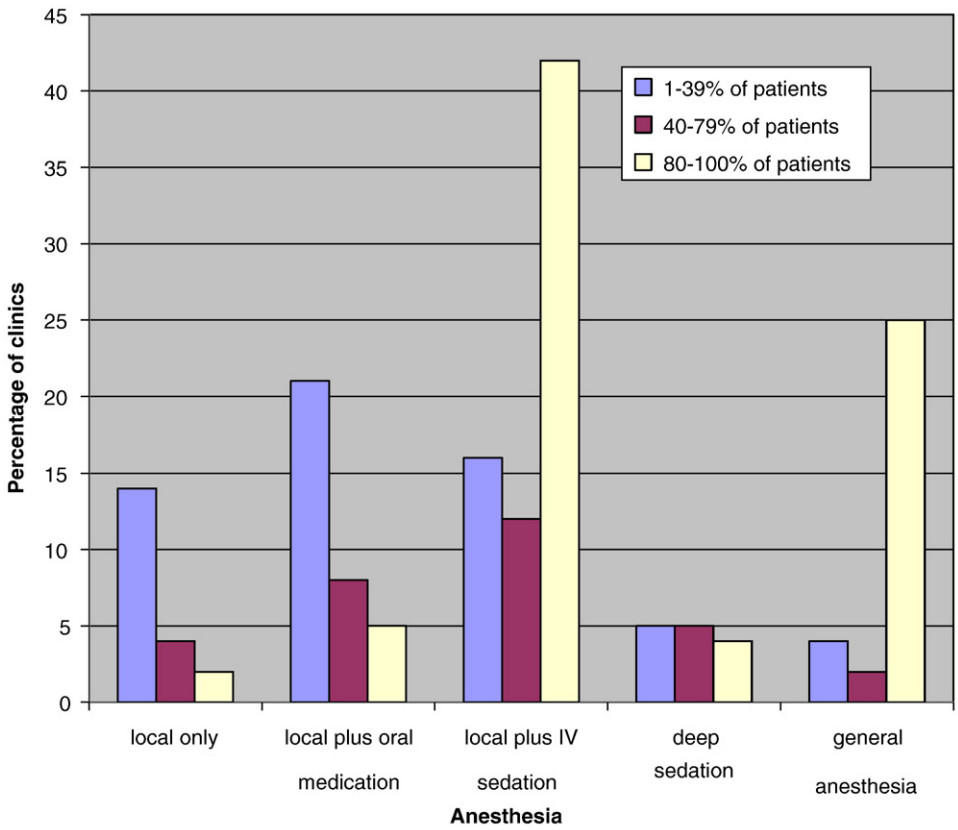


Fig. 4. Percentage of responding NAF clinics that use various methods of anesthesia during D&E (n=186).

eligible member sites of NAF responded. Our analyses indicate that these clinics provided at least 72,500 second-trimester surgical abortions in the United States in 2001 (five respondents with missing data). Based on the 2001 Guttmacher Institute and CDC estimates of 157,200 abortions performed past 12 weeks' gestation [1,2], our data describe approximately half of all second-trimester procedures performed during that time.

Our finding that the majority of United-States-based D&E providers are obstetrician/gynecologists (OB/GYNs) likely reflects both the relevant skills gained during this residency training and the requirements imposed by medical malpractice insurers. Historically, many highly regarded second-trimester surgeons have not completed OB/GYN residencies. In Canada, where OB/GYNs have a more traditional role as consultants, a greater proportion of abortion providers are not OB/GYNs.

The gender composition of our respondents mirrors changes in the gender makeup of reproductive health professionals in North America. In our survey, females represented only 14% of second-trimester abortion providers aged 55 years and older. Physicians of this age group likely completed their residencies before 1977 — a year when women comprised only 16% of graduating OB/GYN residents (American College of Obstetricians and Gynecologists, private communication). The proportion of female OB/GYN residents increased to 76% in 2005. Given these trends, a greater proportion of future second-trimester providers are likely to be female OB/GYNs.

About two thirds of the clinician respondents in our survey were at least 50 years old, reflecting a "graying of abortion providers" that threatens to exacerbate an already critical provider shortage [4–6]. This proportion of older providers exceeds that found in our earlier survey of NAF member clinics that focused on first-trimester abortion practices in which 51% of providers were at least 50 year old [3], and a 1995 nationally representative survey of US OB/GYNs that found that 58% of OB/GYNs who performed abortions were aged 50 years or older [7]. The Council on Graduate Medical Education issued guidelines in 1996 that mandated abortion training opportunities during residency training. Still, a recent survey indicates that only 51% of US OB/GYN residency programs routinely integrate abortion training into their curricula [8]. Moreover, most residents perform fewer than 10 second-trimester procedures, and only 36% of programs offer experience with D&E (vs. 51% for medical abortion), even though D&E is the most common method of second-trimester pregnancy termination in the United States [9]. Because adequate abortion training during residency is associated with the likelihood of future abortion practice [10], continuing efforts to enhance D&E training opportunities are critical.

Overall, the second-trimester abortion practices revealed in our survey agreed with Clinical Policy Guidelines updated annually by NAF to ensure high standards of care in its member clinics [11]. In keeping with these evidence-based guidelines, uniform practices tended to be those well supported by research. Nearly all second-trimester procedures were accomplished by D&E, reflecting the long-standing safety of this method in the outpatient setting [12,13]. The respondents' nearly universal use of perioperative antibiotics is supported by a meta-analysis showing that such therapy reduces the incidence of postabortal infection, regardless of risk factors [14]. Although the optimal antibiotic regimen remains unclear, the American College of Obstetricians and Gynecologists [15] refers to a two-dose doxycycline regimen as "one of the most effective and inexpensive regimens reported in meta-analysis." The uniform practice of ultrasonography for pregnancy dating before second-trimester abortion, while not rigorously assessed in clinical trials, minimizes the risk of serious complications or liability claims due to misestimation of gestational age. Other universal practices included dispensing take-home pain medication and contraceptive methods to medically eligible women who desire them.

Our survey, however, found more variability among providers in areas that lacked evidence to support best practices. Nearly all clinics employed osmotic dilating devices for cervical preparation — a practice found to decrease the risk of uterine trauma compared to mechanical dilation [16]; however, use of misoprostol as a cervical ripener varied. Many (70%) employed misoprostol as a sole agent in the range of 12–16 weeks' gestation or as an adjunctive agent, particularly at 14–20 weeks' gestation, employing varying routes and dosages. Although misoprostol was gaining popularity in OB/GYN practice at the time of our survey, no published trials were available to assess its safety and potential benefits in second-trimester abortion practice. Since then, two randomized trials have found little benefit from misoprostol in the early second trimester when used in lieu of overnight laminaria [17] or as an adjunct to overnight laminaria [18]. In the latter trial, however, use of adjunctive misoprostol (400 mcg) buccally 60–90 min preoperatively induced significantly greater initial dilation at 19–20 weeks' gestation and improved ease of dilation in the group at 16–20 weeks' gestation. Based on these limited data, current Society of Family Planning (SFP) clinical guidelines allow for the use of buccal or vaginal misoprostol in lieu of osmotic dilation before 16 weeks' gestation in low-risk women and adjunctive use of misoprostol in addition to osmotic dilation at later gestational ages [19]. In keeping with retrospective trials that have documented the safety of misoprostol use during second-trimester inductions in women with prior uterine incisions [20–22], the SFP guidelines permit its use in this setting.

Another variable practice among survey respondents involved the use of intraoperative ultrasound during second-trimester D&E, with only half of clinicians using it routinely. One early study from a teaching institution found that the rate of uterine perforation decreased from 1.4% to 0.2% after the introduction of intraoperative ultrasound during second-trimester procedures [23]. This before-and-after study

design, however, cannot account for other variables that may have affected the perforation rate, including the known risk factor of physician inexperience [24]. In the absence of rigorous efficacy and safety trials to guide practice, our results suggest that some second-trimester abortion providers, including those with less experience, prefer the routine use of intraoperative ultrasound.

Many providers are willing to accommodate patients with risk factors. For example, most clinicians do not impose weight restrictions on their patients (74%), and they feel comfortable performing procedures for women with placenta previa in whom suspicion of placenta accreta has been ruled out by radiographic means. The remarkable uniformity of practice across age, gender, experience, specialty and geography may reflect the risk management and educational efforts of NAF, as well as the respect that younger providers hold for the practice patterns of their more senior colleagues and mentors.

While this study obtained a high response rate from a diverse range of providers, the study has some limitations. We were unable to relate any clinical practices to gestational age. Our sample was primarily outpatient-based, with only 2% of respondent sites being hospital-based. As a result, sites that perform second-trimester medical inductions may be underrepresented. Only 10% of 178 clinician respondents reported employing medical induction procedures for second-trimester termination. These procedures are primarily performed in hospitals that have no access to D&E providers within their institution and that are often reluctant to refer patients outside. Furthermore, some survey questions could have been more detailed. For cervical ripening, survey questions did not allow clinicians to describe under what circumstances and how frequently they use both laminaria and artificial dilators. The survey asked clinicians about combined laminaria and misoprostol use, but did not ask about the details in practice (e.g., whether laminaria and misoprostol are used sequentially or simultaneously). It is unclear under which circumstances clinicians choose laminaria or misoprostol, or both. Similarly, anesthesia practice questions were not stratified by gestational age, making it difficult to assess patterns of use.

Our study suggests that member facilities and surgeons of NAF, who provided nearly half of second-trimester abortions in the United States in 2001, follow evidence-based recommendations for the provision of these services. The "graying" of second-trimester abortion providers calls for concerted efforts to ensure that a new generation of physicians is trained to provide high-quality abortion services that are critical to the health needs of women.

Acknowledgments

The authors gratefully acknowledge the support of Vicki Saporta and Susan Dudley of the NAF, Lynne Randall of Planned Parenthood Federation of America, Stanley Henshaw and Carolyn Westhoff. We are grateful to all of the participating NAF member clinics, their staff and providers for taking the time to complete these surveys.

References

[1] Finer LB, Henshaw SK. Abortion incidence and services in the United States in 2000. Perspect Sexual Reprod Health 2003;35:6–15.
[2] Strauss LT, Herndon J, Chang J, et al. Abortion surveillance — United States, 2001. Surveillance summaries, November 26, 2004. MMWR 2004;53(SS09):1–32.
[3] Lichtenberg ES, Paul M, Jones H. First-trimester surgical abortion practices: a survey of National Abortion Federation members. Contraception 2001;64:345–52.
[4] Henshaw SK, Finer LB. The accessibility of abortion services in the United States, 2001. Perspect Sex Reprod Health 2003;35:16–24.
[5] Grimes DA. Clinicians who provide abortions: the thinning ranks. Obstet Gynecol 1992;80:719–23.
[6] National Abortion Federation. Who will provide abortions? Washington, DC: National Abortion Federation; 1991.
[7] Kaiser Family Foundation. 1995 survey of obstetrician/gynecologists on contraception and unplanned pregnancy: attitudes and practices with regard to abortion. Menlo Park, CA: Henry J. Kaiser Family Foundation; 1999.
[8] Eastwood KL, Kacmar JE, Steinhauer J, Weitzen S, Boardman LA. Abortion training in United States obstetrics and gynecology residency programs. Obstet Gynecol 2006;108:303–8.
[9] Strauss LT, Gamble SB, Parker WY, Cook DA, Zane SB, Hamdan S. Abortion surveillance — United States, 2004. Surveillance summaries, November 23, 2007. MMWR Morb Mortal Wkly Rep 2007;56(SS-9): 1–34.
[10] Steinauer J, Landy U, Filippone H, Laube D, Darney PD, Jackson RA. Predictors of abortion provision among practicing obstetrician–gynecologists: a national survey. Am J Obstet Gynecol 2008;198:39.e1–6.
[11] National Abortion Federation. Clinical policy guidelines. Washington, DC: National Abortion Federation; 2001.
[12] Cates Jr W, Schulz KF, Grimes DA, et al. Dilatation and evacuation procedures and second-trimester abortions. The role of physician skill and hospital setting. JAMA 1982;248:559–63.
[13] Lohr PA, Hayes JL, Gemzell-Danielsson K. Surgical versus medical methods for second-trimester induced abortion. Cochrane Database Syst Rev 2008(1):CD006714.
[14] Sawaya GF, Grady D, Kerlikowske K, Grimes DA. Antibiotics at the time of induced abortion: the case for universal prophylaxis based on a meta-analysis. Obstet Gynecol 1996;87:884–90.
[15] American College of Obstetricians and Gynecologists. Antibiotic prophylaxis for gynecologic procedures. ACOG Practice Bulletin No. 74. Washington, DC: American College of Obstetricians and Gynecologists; 2006.
[16] Allen RH, Goldberg AB, Board of Society of Family Planning. Cervical dilation before first-trimester surgical abortion (<14 weeks' gestation). SFP Guideline 2007. Contraception 2007;76:139–56.
[17] Goldberg AB, Drey EA, Whitaker AK, Kang MS, Meckstroth KR, Darney PD. Misoprostol compared with laminaria before early second-trimester surgical abortion: a randomized trial. Obstet Gynecol 2005; 106:234–41.
[18] Edelman A, Buckmaster JG, Goetsch MF, Nichols MD, Jensen JT. Cervical preparation using laminaria with adjunctive buccal misoprostol before second-trimester dilation and evacuation procedures: a randomized clinical trial. Am J Obstet Gynecol 2006;194:425–30.
[19] Fox MC, Hayes JF. Cervical preparation for second-trimester abortion prior to 20 weeks of gestation. Contraception 2007;76:486–95.
[20] Dickinson JE. Misoprostol for second-trimester pregnancy termination in women with a prior cesarean delivery. Obstet Gynecol 2005;105: 352–6.
[21] Daskalakis GJ, Mesogitis SA, Papantoniou NE, Moulopoulos GG, Papapanagiotou AA, Antsaklis AJ. Misoprostol for second-trimester

pregnancy termination in women with prior caesarean section. BJOG 2005;112:97–9.
[22] Daponte A, Nzewenga G, Dimopoulos KD, Guidozzi F. The use of vaginal misoprostol for second-trimester pregnancy termination in women with previous single cesarean section. Contraception 2006;74:324–7.
[23] Darney PD, Sweet RL. Routine intraoperative ultrasonography for second-trimester abortion reduces incidence of uterine perforation. J Ultrasound Med 1989;8:71–5.
[24] Grimes DA, Schulz KF, Cates Jr WJ. Prevention of uterine perforation during curettage abortion. JAMA 1984;251:2108–211177.

EXHIBIT E

ACOG
THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Office of Communications
tel: 202-484-3321
communications@acog.org
www.acog.org

ACOG Statement Regarding Abortion Procedure Bans

October 9, 2015

Washington, DC – The following is a statement from the American Congress of Obstetricians and Gynecologists (ACOG):

"The predominant approach to abortion after 13 weeks, commonly referred to as 'dilation and evacuation,' is evidence-based and medically preferred because it results in the fewest complications for women compared to alternative procedures.

"Efforts to ban specific types of procedures will limit the ability of physicians to provide women with the medically appropriate care they need, and will likely result in worsened outcomes and increased complications. These legislative efforts are based on nonmedical, subjective language. This language will create confusion, thus putting women at risk and, in certain cases, actually leading to abortion later in pregnancy.

"Quite simply, these restrictions represent legislative interference at its worst: doctors will be forced, by ill-advised, unscientifically motivated policy, to provide lesser care to patients. This is unacceptable.

"Medical decisions about reproductive health – especially given the complex circumstances that often accompany second trimester abortions – should be made by each individual woman in consultation with those she trusts most, including her ob-gyn – not politicians.

"Ob-gyns regularly see firsthand the reasons why women may need abortion care, as well as the pain that many of these women are in when confronting these decisions. Banning specific abortion procedures would leave physicians unable to provide women with medically appropriate care; this includes women who have made the difficult decision to end pregnancies for reasons including fetal anomalies or other unexpected obstetric outcomes. This is simply cruel.

"Medical care must be guided by sound science and by each patient's individual needs – not by legislative restrictions. We continue to oppose laws that limit the ability of American women to get the reproductive health services that they need and that take medical decisions out of the hands of physicians and their patients."

To read ACOG's Committee Opinion on Access to Abortion, please click here.

The American College of Obstetricians and Gynecologists (The College), a 501(c)(3) organization, is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of more than 58,000 members, The College strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. The American Congress of Obstetricians and Gynecologists (ACOG), a 501(c)(6) organization, is its companion organization. www.acog.org

Follow us: