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SUPERIOR COURT OF ARIZONA

MARICOPA COUNTY

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

Plaintiffs,

v.

State of Arizona, a body politic,

Defendant.

No. CV2025-017995

MOTION FOR PRELIMINARY INJUNCTION

(Assigned to the Honorable Randall Warner)

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INTRODUCTION

On November 5, 2024, by a decisive majority, Arizonans voted to enshrine a fundamental right to abortion in the state constitution. Any state action denying, restricting, or interfering with this fundamental right is subject to **the highest level of constitutional scrutiny**.

Plaintiffs seek preliminary injunctive relief against a web of Arizona laws that infringe on this fundamental right. They comprise of: (1) the Reason Ban Scheme, which wholly prohibits providing pre-viability abortion care where sought by patients for certain reasons; (2) the Two-Trip Scheme, which forces patients to attend an extra, medically unnecessary appointment before obtaining an abortion, needlessly delaying their care; and (3) the Telemedicine Ban Scheme, which prohibits patients from obtaining safe, effective, and accessible medication abortion care through telemedicine (collectively, the "Challenged Laws").

The Challenged Laws can be sustained only if the State can prove that they (1) serve the limited purpose of advancing or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine, *and* (2) *do not* infringe on an individual's autonomous decision making. And they must do so using the least restrictive means necessary.

Plaintiffs are likely to succeed on the merits of their claims because the Challenged Laws individually and collectively fail this standard. They interfere with—and in some instances deny—Arizonans' fundamental right to abortion. They also delay access to time-sensitive care while increasing health risks. And they interfere with the patient-physician relationship, undermining—and in some cases eliminating—patients' decisional autonomy. These laws irreparably harm Arizonans, including Plaintiffs, their members, and their patients, each day that they remain in effect. This continuing constitutional infringement is also contrary to the public interest. For these reasons, the Challenged Laws must be enjoined.

FACTUAL BACKGROUND

I. Abortion Care in Arizona

Abortion is safe and common. Approximately one in four women in the United States has an abortion by age 45. Decl. of Laura T. Mercer, M.D., M.P.H., M.B.A, attached as Ex. 1 ("Mercer"), ¶ 14.[1] More than half of Arizona abortion patients have at least one child. *Id.*[2] People choose to have an abortion for a variety of reasons that are informed by their beliefs, desires, family, and economic circumstances; resource access; reproductive history; and physical and mental health. *Id.* ¶ 15; Decl. of Mark D. Nichols, M.D., attached as Ex. 2 ("Nichols"), ¶ 20.[3] Often, people express multiple reasons for seeking an abortion. Mercer ¶ 15. Some decide they do not want to have children at all, whereas others determine they cannot add to their existing family. *Id.* ¶ 15; Nichols ¶ 20. Others have an abusive partner to whom they fear being tethered if they have a child. Mercer ¶¶ 15, 52. For some, continuing a pregnancy would impair their health. *Id.* ¶ 15; Nichols ¶ 20. And some people may end a wanted pregnancy after learning of a fetal condition. Mercer ¶¶ 15, 37; Decl. of Katharine D. Wenstrom, M.D., attached as Ex. 3 ("Wenstrom"), ¶ 42.[4]

There are two main abortion methods: medication abortion and procedural abortion. Mercer ¶ 16. In a medication abortion, the patient takes the first medication, mifepristone, followed by a second medication, misoprostol, 24 to 48 hours later, causing the patient to expel

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[1] Dr. Mercer is a board-certified OB/GYN with more than fifteen years of experience providing reproductive healthcare, including abortion, in Arizona. Mercer ¶ 1. Dr. Mercer is a board member of Plaintiff Arizona Medical Association ("ArMA"). *Id.* ¶ 2.

[2] Ariz. Dep't of Health Servs. (hereinafter "ADHS"), *Abortions in Arizona: 2023 Abortion Report*, 11 (Dec. 18, 2024), https://tinyurl.com/ymwydn73; *see also* Mercer ¶ 14.

[3] Dr. Nichols is a board-certified OB/GYN with forty years of experience providing the full range of gynecological and obstetric care to patients, including abortion care. Nichols ¶ 1.

[4] Dr. Wenstrom is board-certified in genetics, OB/GYN, and maternal-fetal medicine, with over three decades of experience providing specialized obstetric care to high-risk pregnant patients. Wenstrom ¶¶ 1–8.

the pregnancy. *Id.* ¶ 17; Nichols ¶ 22; *see also* Decl. of William Richardson, M.D., attached as Ex. 4 ("Richardson"), ¶ 10.[5] Indeed, the same regimen is offered to miscarriage patients. Nichols ¶ 22. Medication abortion is safe and effective and is available in Arizona up to 11 weeks from the first day of a person's last menstrual period ("LMP"). *Id.*; Richardson ¶ 8; Decl. of Paul A. Isaacson, M.D., attached hereto as Ex. 5 ("Isaacson"), ¶ 5.[6] Patients can safely self-administer both medications in a location of their choosing, outside the presence of a medical provider. Mercer ¶ 18; Nichols ¶ 22.

Some patients choose medication abortion because it can be done privately at home when the patient chooses, may feel more natural, and/or does not involve inserting instruments into the body, which can be traumatic for victims of sexual violence or abuse. Mercer ¶ 19; Nichols ¶¶ 22–23; Richardson ¶ 11. In addition, medication abortion may be the safer method for some patients. Nichols ¶ 23; Richardson ¶ 11. Most clinician-provided abortions in Arizona are medication abortions.[7] The complication rate for medication abortion is exceedingly low, whether provided in-person or by telemedicine. Nichols ¶ 66.

Procedural abortion involves dilation of the cervix and the use of suction and/or instruments to empty the uterus. Mercer ¶ 20; Nichols ¶ 27. It is one of the safest, most common medical procedures performed today. Nichols ¶ 28.

Complications from abortion, whether medication or procedural, are extremely rare. Nichols ¶ 28; Mercer ¶ 21. And in those rare cases, they can be safely and effectively managed in an outpatient setting or emergency room. Nichols ¶ 29. Abortion is also far safer than its only

[5] Plaintiff Dr. Richardson is the owner of Choices Women's Center in Tucson, a licensed abortion clinic where he provides abortion care up to 11 weeks LMP. He has been providing abortion care to Arizonans for 25 years. Richardson ¶¶ 1, 4.

[6] Plaintiff Dr. Isaacson is the co-owner of Family Planning Associates (FPA) in Phoenix, a licensed abortion clinic where he provides abortion care up to 23 weeks and 6 days LMP. He has been providing abortion care to Arizonans for nearly 30 years. Isaacson ¶¶ 2, 4–5.

[7] ADHS Report, *supra* note 2, at 12.

alternative, carrying a pregnancy to term, as to both morbidity and mortality. Nichols ¶¶ 30–35; Mercer ¶¶ 22–33.

Arizona has a shortage of OB/GYN physicians, and those in rural areas face a lack of access to care. Decl. of Nadeem Kazi, M.D., attached as Ex. 6 ("Kazi"), ¶ 11.[8] Abortion providers in Arizona are concentrated in Phoenix and Tucson. Mercer ¶ 57; Isaacson ¶ 9; Richardson ¶ 13. Few providers offer abortion care beyond 16 weeks LMP, all of whom are located in Phoenix. Isaacson ¶ 39. As a result, Arizonans residing in other areas of the state must travel significant distances for abortion care. Mercer ¶ 57 (describing eight- or ten-hour round-trip drive for rural patients); Isaacson ¶ 9; Richardson ¶ 13.

II. Impact of Delayed Abortion Care

Although abortion is extremely safe, delaying abortion care unnecessarily increases medical risk—both the increased risks associated with remaining pregnant and the marginal increased risks associated with abortion later in pregnancy. Nichols ¶ 84; Richardson ¶ 62. Delay also exacerbates existing logistical burdens to accessing care; for example, the cost of an abortion typically increases as pregnancy progresses and the procedure becomes more complex. Isaacson ¶ 13; Richardson ¶ 28; Mercer ¶ 49. Delays can also push patients past the gestational point at which medication abortion is available or even the limit for abortion availability in Arizona altogether. Isaacson ¶ 34; Richardson ¶¶ 28, 56; Mercer ¶ 49. When patients are told about the mandatory delay imposed by Arizona law, they often express anger, frustration, and sadness. Isaacson ¶ 33; Richardson ¶ 25; Mercer ¶ 55. In sum, delays limit Arizonans' healthcare options and impose substantial tolls on their physical and mental health.

[8] Dr. Kazi is the current President of ArMA. Kazi ¶ 1.

III. Fetal Testing and Pregnancy Decision-Making

There are a variety of tests and exams during pregnancy that screen for or may diagnose a fetal genetic condition. Wenstrom ¶¶ 28–36. Guidelines from leading authorities in obstetrics and maternal-fetal medicine make clear that *all* pregnant patients should be offered genetic testing, as it may provide relevant information for prenatal treatment and optimal delivery staffing and location, as well as inform consideration of abortion if that is an option the patient is weighing. *Id.* ¶¶ 26–27, 48–49. Testing should be coupled with non-directive counseling that provides detailed factual information about the test(s), fetal condition(s) at issue, range of possible outcomes, community resources, etc., while answering questions and providing information to facilitate the patient's own decision-making. *Id.* ¶¶ 27, 32–36, 38–39, 42–43; *see also* Decl. of Steven Joffe, M.D., M.P.H., attached as Ex. 7 ("Joffe"), ¶ 21.[9] Without this counseling, pregnant patients may have misconceptions about fetal conditions. Wenstrom ¶¶ 44–45. In all cases, patients' ability to speak openly and freely with their providers is critical to ensuring that they fully understand the implications of the diagnosis and their options. *Id.* ¶ 42; *see also id.* ¶ 64 (providers must give "information to support [patients'] autonomous decision making," not judge their reasons and make them feel "as though they must lie or conceal their reasons to access care"); *see also* Joffe ¶ 26.

To support patients who have received a fetal diagnosis in accordance with the accepted clinical standards, healthcare providers must be free to offer, provide, or facilitate abortion care, if that is what the patient decides, without fear of retribution. Wenstrom ¶ 49.

[9] Dr. Joffe is a Professor of Medical Ethics & Health Policy and Pediatrics at the University of Pennsylvania Perelman School of Medicine. Joffe ¶ 1.

THE CHALLENGED LAWS

I. Reason Ban Scheme

The Reason Ban Scheme, A.R.S. § 13-3603.02, and A.R.S. §§ 36–2157, -2158(A)(2)(d), -2161(A)(25), prohibit the provision of pre-viability abortions depending on the patient's reasons for seeking the abortion. Specifically, the Reason Ban Scheme prohibits any person from "perform[ing] an abortion knowing that the abortion is sought ***solely because of*** a genetic abnormality of the child," and from "accept[ing] monies to finance . . . an abortion ***because of*** a genetic abnormality of the child," A.R.S. § 13-3603.02(A)(2), (B)(2) (emphases added).[10] It also requires the physician who is to provide the abortion to complete an affidavit prior to *every* abortion swearing that they have "no knowledge that the" pregnancy is being terminated "***because of*** a genetic abnormality of the child." A.R.S. § 36-2157 (emphasis added).[11]

The Reason Ban Scheme defines "[g]enetic abnormality" as "the presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression." A.R.S. § 13-3603.02(G). It excludes a "lethal fetal condition," *id*., which is defined as "a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth," A.R.S. § 36-2158(G)(1). The Reason Ban Scheme provides no further guidance on which conditions qualify as "lethal" or how to determine "with reasonable certainty" that the condition will result in death within three months after birth. Wenstrom ¶¶ 60–62; Isaacson ¶¶ 43–45. Nor does it state whether potential medical interventions are to be considered when determining lethality. Isaacson ¶ 44; Wenstrom ¶ 62.

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[10] Because physicians do not provide services without compensation, A.R.S. § 13-3603.02(B)(2) effectively operates as an independent, unconstitutional pre-viability abortion ban.

[11] *See also* A.R.S. § 36-2161(A)(25), (D) (genetic testing reporting provisions).

Violation of the Reason Ban Scheme carries severe penalties. Any person who provides an "abortion knowing that the abortion is sought **solely because of** a genetic abnormality of the child" is guilty of a class 6 felony, A.R.S. § 13-3603.02(A)(2) (emphasis added), and faces imprisonment of at least four months and up to two years, *id.* § 13-702(D), as well as loss of professional licensure, *see id*. §§ 32-1401(27), -1403(A)(2), (A)(5), -1451(A), -1403.01(A), -1451(D)–(E), (I), (K). Any person who "accepts monies to finance . . . an abortion **because of** a genetic abnormality of the child" is guilty of a class 3 felony, A.R.S. § 13-3603.02(B)(2) (emphasis added), and faces imprisonment of at least 2 years and up to 8.75 years, *id.* § 13-702(D), as well as loss of professional licensure, *see id*. §§ 32-1401(27), -1403(A)(2), (A)(5), -1451(A), -1403.01(A), -1451(D)–(E), (I), (K).[12] A violation of either of the above provisions also risks civil liability. *See* A.R.S. § 13-3603.02(D). Finally, any physician, nurse, or other statutorily defined provider who fails to report a "known violation[]" to "appropriate law enforcement authorities" faces a civil fine of up to $10,000. *Id.* § 13-3603.02(E).

II. Two-Trip Scheme

The Two-Trip Scheme forces patients to travel to their provider for at least two in-person appointments and to delay their abortion by at least 24 hours—and often longer—regardless of their circumstances. *See, e.g.*, Mercer ¶ 48; Isaacson ¶¶ 18–21, 31–32. Failure to comply with the Two-Trip Scheme's requirements risks severe professional and civil penalties, including loss or suspension of a physician's license. A.R.S. §§ 36-2153(J)–(L), -2156(B)–(D), -2158(C)–(E).[13]

[12] Violations of other elements of the Reason Ban Scheme, *i.e.*, disclosure and reporting requirements, also risk criminal and/or civil liability, as well as license suspension or revocation. *See, e.g.*, A.R.S. §§ 36-2158(C)–(F), -2163(H)–(J).

[13] The only exception to the requirements of A.R.S. §§ 36-2153, -2156, and -2158 is for cases of "medical emergency," narrowly defined as applying only if an "immediate" abortion is necessary due to a pregnancy complication, *id.* § 36-2151(9). The requirement to tell the patient that the "father" is liable for child support also has an exception for cases of rape or incest. A.R.S. § 36-2153(A)(2)(b).

The Two-Trip Scheme operates through four requirements.[14] **First**, A.R.S. § 36-2156(A)(1) requires every patient seeking abortion care to undergo an ultrasound at least 24 hours before "any part of an abortion [is] performed," including "the administration of any . . . medication in preparation for the abortion." The ultrasound can be performed only by "the physician who is to perform the abortion, the referring physician or a qualified person working in conjunction with either physician." *Id.* There is no medical reason to require an ultrasound for every patient, let alone at least a day *before* an abortion. Mercer ¶ 45; Nichols ¶ 39. If anything, it is preferable to perform an ultrasound as close in time to the abortion as possible. Isaacson ¶ 19; Nichols ¶ 39–40; Mercer ¶ 45.[15]

Second, A.R.S. § 36-2153(A) forces every patient to make an in-person visit at least 24 hours before receiving an abortion, solely to receive irrelevant, stigmatizing, and/or misleading state-mandated information. For example, the physician must describe "[t]he probable anatomical and physiological characteristics" of the fetus at the time the abortion is to be performed, *id.* § 36-2153(A)(1)(f), regardless of whether the patient wants this information and even if it is harmful to them. Further, in almost all cases and during the same visit, a qualified person[16] must recite the following to every patient, regardless of the patient's decisional certainty: that "[m]edical assistance benefits may be available for prenatal care, childbirth and

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[14] Some of the requirements set forth below are also incorporated into regulation. *See* A.A.C. R9-10-1509(A)(3)(b), (A)(4), (B), (E)(1).

[15] Additionally, regardless of their circumstances, the patient must be informed that they can view an "active ultrasound image" and "hear the heartbeat [if audible] of the unborn child," A.R.S. § 36-2156(A)(1)(b); be offered "a simultaneous explanation of what the ultrasound is depicting" and "picture of the ultrasound," *id.* § 36-2156(A)(1)(c), (d); and certify in writing whether they received such offerings and whether they elected to view the ultrasound or listen to fetal or embryonic cardiac activity, *id.* § 36-2156(A)(2).

[16] This includes the "physician who is to perform the abortion, the referring physician or a qualified physician, physician assistant, nurse, psychologist or licensed behavioral health professional to whom the responsibility has been delegated by either physician." *Id.* § 36-2153(A)(2).

neonatal care"; that "[t]he father of the unborn child is liable to assist in the support of the child, even if he has offered to pay for the abortion"; and that "[p]ublic and private agencies and services are available to assist the woman during her pregnancy and after the birth of her child if she chooses not to have an abortion, whether she chooses to keep the child or place the child for adoption." *Id*. § 36-2153(A)(2)(a)–(c).

Providers must also refer every patient to a state-created website[17] and pamphlet[18] that contain inaccurate and misleading information about fetal development and abortion and require each patient to certify in writing that the offer was made. A.R.S. § 36-2153(A)(2)(f)–(g). For example, these materials describe a vastly outdated medication abortion regimen and inaccurately state the gestational limits of certain abortion methods. Nichols ¶¶ 48–50; Isaacson ¶¶ 21–25. They also exaggerate the risks of abortion care. Nichols ¶ 51; Mercer ¶ 60. In addition, the state-created website provides contact information for "Crisis Pregnancy Centers" ("CPCs"),[19] which "represent themselves as legitimate reproductive health care clinics" but are "unregulated and often nonmedical facilities" that "aim to dissuade people from accessing . . . abortion care."[20] *See also* Isaacson ¶ 25; Richardson ¶¶ 39–40. The biased-counseling requirements thereby force providers to refer their patients to organizations that oppose abortion, spread medical misinformation, and seek to change patients' minds about their constitutionally protected medical decisions. Isaacson ¶ 25; Richardson ¶ 40.

[17] ADHS, *Woman's Right to Know Act*, https://tinyurl.com/35uzsvay (last accessed May 20, 2025).

[18] ADHS, *A Women's Right to Know, Arizona*, https://tinyurl.com/mrx7e76v (last accessed May 20, 2025).

[19] ADHS, *A Woman's Right to Know, Statewide Resources Arizona – 2014* (Aug. 2016), https://tinyurl.com/2wppfv8h.

[20] Am. Coll. of Obstetricians & Gynecologists (hereinafter "ACOG"), *Issue Brief: Crisis Pregnancy Centers* 1 (Oct. 2022), https://tinyurl.com/2evd7e9n.

Third, A.R.S. § 36-2158(A)(1), (2) compels patients who are seeking an abortion after the fetus has been diagnosed with a lethal or nonlethal condition, to the extent they can even access such care considering the Reason Ban Scheme described above, to receive additional state-mandated information at least 24 hours before the abortion. Thus, even though patients who seek abortion care after a fetal diagnosis have undergone extensive testing and counseling, *see* Wenstrom ¶¶ 27–49, the Two-Trip Scheme would force them to sit through yet another recitation of information about the fetus's condition, available services, and potential outcomes.

Fourth, A.R.S. § 36-449.03(D)(3) requires the promulgation of rules regarding laboratory tests for Rh typing, which in turn require that, prior to an abortion, all patients receive a test for Rh typing unless they have "written documentation of blood type acceptable to the physician," A.A.C. R9-10-1509(A)(3)(b); *see also* A.A.C. R9-10-1509(B) (requiring providers to offer treatment based on test results within 72 hours after abortion and document patient refusal); A.R.S. § 36-449.03(G)(5) (same). Requiring Rh testing for every abortion patient "is an outdated practice that is not in line with evidence-based medicine." Mercer ¶ 46; *see also* Isaacson ¶ 20; Richardson ¶ 30; Nichols ¶ 57. Moreover, the Arizona Department of Health Services ("ADHS"), which conducts laboratory inspections for federal compliance, has taken the position that Rh testing must be performed at specialized labs, which typically take at least a day to return results. Nichols ¶ 56; Isaacson ¶ 20; Richardson ¶ 30. This requirement acts as a mandatory delay for some patients. Isaacson ¶ 20; Richardson ¶ 30.

III. Telemedicine Ban Scheme

Telemedicine is used nationwide to provide healthcare services across many disciplines and in a variety of settings because it ensures patients can access time-sensitive, comprehensive care, while also eliminating unnecessary in-person interactions for both patients and clinicians. Nichols ¶¶ 59, 72; Richardson ¶¶ 46–47; Mercer ¶¶ 64, 66. Thirty years ago, the Arizona

legislature established one of the nation's first telemedicine programs. Richardson ¶ 46. Today, the Arizona Telemedicine Program ("ATP") is an award-winning leader in the field of telehealth, empowering physicians to diagnose, consult, and treat patients from remote locations.[21] Telemedicine has greatly expanded access to care in Arizona. Mercer ¶ 64. For example, a 2022 study revealed that more than one in five Phoenix area households are using telehealth services, and "usage is even higher among the aging population, women, lower-income brackets, Black communities, and those who are more likely to report depression and difficulties with physical mobility."[22] Given the success and popularity of ATP, in 2021, Arizona passed comprehensive legislation making telemedicine a permanent feature of Arizona's healthcare system, which included a telemedicine parity law. H.B. 2454, 55th Leg., 1st Reg. Sess. (Ariz. 2021); A.R.S. § 20-1057.13.

An extensive body of literature shows that medication abortion can be provided as safely and effectively via telemedicine as it can in person.[23] Nichols ¶¶ 25, 64, 66; Richardson ¶¶ 50–51; Mercer ¶ 67. Telemedicine has proven critical for access to abortion. It expands services to people who have difficulty accessing care—including people living in areas with few or no abortion providers—thereby minimizing delays, enhancing patient health and safety, and enabling people to obtain care in their own communities. Nichols ¶¶ 73, 75; Richardson ¶¶ 49, 56; Mercer ¶ 69. It offers patients flexibility and privacy and reduces the travel, financial, and logistical burdens that in-person visits can entail. Nichols ¶¶ 54, 76. Additionally, it has high

[21] *Awards, Arizona Telemedicine Program*, The University of Arizona, https://tinyurl.com/279f997n (last accessed May 20, 2025).

[22] Amanda Hagerman, *Who Is Using Teleheath?*, The Goldwater Institute (Jan. 31, 2024), https://tinyurl.com/4weas3uy.

[23] Ushma D. Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion in the USA*, 30 Nature Med. 1191, 1191 (2024).

satisfaction and acceptability rates among both patients and providers. *Id.* ¶¶ 66–67, 73–74; Mercer ¶ 68.

Despite these benefits and Arizona's affirmative promotion of telehealth in other contexts, Arizona prohibits telemedicine abortion care through a collection of statutory and regulatory provisions (the "Telemedicine Ban Scheme"). **First**, A.R.S. § 36-3604 states that "[a] health care provider shall not use telehealth to provide an abortion." **Second**, elements of the Two-Trip Scheme preclude telemedicine for abortion because they compel patients to make a separate in-person visit as a condition of obtaining care. A.R.S. §§ 36-2156(A), -2153(A), -2158(A) (mandatory ultrasound and in-person receipt of state-mandated information); *see also* A.A.C. R9-10-1509(A)(4), (E)(1). **Third**, Arizona mandates, irrespective of medical necessity, a series of in-person examinations and tests before a physician can even prescribe abortion medications to a patient. A.R.S. § 36-449.03(D); A.A.C. R9-10-1509(A)–(D); *see also* A.A.C. R9-10-1501(8).

Finally, A.R.S. § 36-2160(B) prohibits "[a] manufacturer, supplier or physician or any other person . . . from providing an abortion-inducing drug via courier, delivery or mail service." Due to this mailing ban, even if a patient seeking medication abortion could meet virtually with their provider for a telehealth consultation, they would still have to make an unnecessary trip to pick up their medications in person—which they would then take at home or another location of their choosing. Only three other states enforce such a mailing ban, and each of those states have strict abortion bans in place.[24]

The Telemedicine Ban Scheme subjects providers to severe licensing and other civil penalties, including fines of up to $1,000 per violation, per patient affected, and for an abortion

[24] Fla. Stat. § 390.0111; Okla. Stat. tit. 63, § 1-756.3; Tex. Health & Safety Code Ann. § 171.063.

clinic, termination of services and revocation, denial, or suspension of its facility license. *See, e.g.*, A.R.S. §§ 32-1401(27), 32-1451(A), 36-3604, 36-449.02(D), 36-449.03(J)(1).

But for the Telemedicine Ban Scheme, Plaintiffs Dr. Richardson and other ArMA members would offer medication abortion through telemedicine as an option to eligible patients. Richardson ¶¶ 43, 47; Mercer ¶ 70. This would expand abortion access to significant portions of the state where there is no known abortion provider.

ARGUMENT

A party "seeking a preliminary injunction must establish four factors: (1) a strong likelihood of success on the merits, (2) irreparable harm, (3) the balance of hardships favors that party, and (4) public policy supports an injunction." *Toma v. Fontes*, 553 P.3d 881, 888 (Ariz. App. 2024), *review granted* (Jan. 7, 2025). Alternatively, a party can seek to prove one of the following: "(1) probable success on the merits and the possibility of irreparable harm, or (2) the presence of serious questions and the balance of hardships tipping sharply in the movant's favor." *City of Flagstaff v. Ariz. Dep't of Admin*., 255 Ariz. 7, 12 (App. 2023). As detailed below, under all possible standards, Plaintiffs satisfy their burden and are entitled to preliminary relief.

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claim That the Challenged Laws Individually and Collectively Violate Amendment Section (A)(1).

A. Arizona's Constitutional Right to Abortion

Under Arizona's fundamental right to abortion, the State "shall not enact, adopt or enforce any law, regulation, policy or practice" that "[d]enies, restricts or interferes with that right before fetal viability unless justified by a compelling state interest that is achieved by the least restrictive means." Ariz. Const. art. II, § 8.1(A)(1) (the "Amendment"). The Amendment further prohibits the state from "[p]enaliz[ing] any individual or entity for aiding or assisting a pregnant individual in exercising the individual's right to abortion." *Id.* § 8.1(A)(3).

A law or regulation serves a compelling state interest only if it meets two requirements: (1) it "[i]s enacted or adopted for the limited purpose of improving or maintaining the health of an individual seeking abortion care, consistent with accepted clinical standards of practice and evidence-based medicine," *and* (2) it "[d]oes not infringe on that individual's autonomous decision making." *Id*. § 8.1(B)(1). Thus, the Amendment only permits regulating pre-viability abortion in a way that *both* respects patient's ability to make autonomous decisions regarding their healthcare *and* makes the abortion safer (according to clinically accepted standards and evidence-based medicine) for the person seeking it, using the least restrictive means. The State has the burden of proving that the Challenged Laws survive constitutional review under the Amendment. *See Ruiz v. Hull*, 191 Ariz. 441, 448, 457 (1998). For the reasons below, it cannot.

B. The Reason Ban Scheme Violates the Amendment.

The Reason Ban Scheme violates the Amendment for two reasons. First, it outright denies certain Arizonans' right to pre-viability abortion solely because of their reason for seeking care. Second, even where it does not outright deny abortion care, it restricts and interferes with access to it.[25] This plainly infringes Arizonans' fundamental right to abortion. Ariz. Const. art. II, § 8.1.

This Scheme cannot be justified by a compelling state interest. Prohibiting physicians from providing abortion care where the State disapproves of a patient's reason for seeking that care squarely targets the very act of decision-making, overriding individuals' autonomy to determine what is best for themselves and their families. The Reason Ban Scheme is *per se* unconstitutional under the Amendment for this reason alone. *See id.*, art. II, § 8.1(A)(1), (B)(1)(b); *Reuss v. State*, No. CV2024-034624 (Ariz. Super. Ct. Mar. 5, 2025) (entering

[25] While the law's confusing and internally inconsistent provisions make it difficult to discern the precise parameters of what is banned, *see* Wenstrom ¶¶ 54–63, Isaacson ¶¶ 41–46, there is no question that the law prohibits the provision of at least some pre-viability abortion care.

declaration of unconstitutionality and permanent injunction against pre-viability abortion ban and related provisions under the Amendment).

Even if the Reason Ban Scheme survived the autonomous decision-making prong of the compelling state interest test—which it cannot—it nevertheless fails the patient health prong. The evidence makes plain that this Scheme does nothing to "improv[e] or maintain[] the health of an individual seeking abortion care" nor is it "consistent with accepted clinical standards of practice and evidence-based medicine." Ariz. Const. art. II, § 8.1(B)(1)(a). *See* Wenstrom ¶ 53 (restricting abortion based on reason "is not medically appropriate and endangers the health of women" (quoting ACOG, *ACOG Statement of Abortion Reason Bans* (Mar. 10, 2016)[26])). Like any abortion ban, the Reason Ban Scheme forces patients who are unable to access care to continue their pregnancies against their will, not only exposing them to the compounding risks of continued pregnancy and/or childbirth but also to severe emotional and psychological harm. Wenstrom ¶¶ 64–65; Isaacson ¶ 46; Joffe ¶¶ 19–20; Mercer ¶¶ 22–29, 39, 42. This is so even if a patient is ultimately able to obtain an abortion. *See supra* p. 4.

The Reason Ban Scheme also "represent[s] gross interference with the patient-physician relationship." Wenstrom ¶ 53 (quoting ACOG Statement on Reason Bans); *see also* Joffe ¶¶ 21, 26; Mercer ¶ 40. It stifles the essential communication and counseling that is the standard of care by creating perverse incentives: the more open and honest a patient is with their provider, the harder it may be, if not impossible, for that patient to obtain the abortion they seek and to which they are constitutionally entitled. Mercer ¶¶ 38–40; *see also* Isaacson ¶¶ 47–49; Wenstrom ¶¶ 49–53, 64 (preventing physicians from following accepted clinical standards "compels them to break their vow to do no harm"); *cf. Stuart v. Camnitz*, 774 F.3d 238, 253 (4th Cir. 2014) ("We

[26] Available at https://tinyurl.com/3dbrfddc (hereinafter "ACOG Statement on Reason Bans").

can perceive no benefit to state interests from walling off patients and physicians in a manner antithetical to the very communication that lies at the heart of the informed consent process."). And those patients who refuse or fail to self-censor, or to conceal their medical history, may pay a heavy price: some patients have elected to leave the state for abortion care to avoid concealing their reasons for seeking that care, Mercer ¶ 39, and others have been turned away from a clinic after disclosing their fetal condition, Isaacson ¶ 46.

The Reason Ban Scheme similarly restricts and interferes with Arizonans' rights by preventing Arizona physicians, including Plaintiffs and their members, from providing the compassionate, individualized abortion care they used to offer patients seeking abortions under these circumstances. Isaacson ¶¶ 46–52; Mercer ¶¶ 37–42; *see also* Nichols ¶ 84; Joffe ¶ 26. Indeed, prior to the Scheme taking effect in 2022, FPA, where Dr. Isaacson is a physician and co-owner, was the foremost medical practice in Arizona providing abortion care to patients referred by other physicians, including following fetal diagnoses. Isaacson ¶¶ 37–39. These patients often experienced stigmatization, guilt, and/or sadness at terminating a wanted pregnancy and, as Dr. Isaacson explains, it was as much a part of his job to "offer[] support and empathy to patients" as it was to perform the abortion itself. *Id.* ¶¶ 48–49; *see also* Wenstrom ¶¶ 50, 65; Joffe ¶ 26.

Finally, the Reason Ban Scheme can prevent some patients who would benefit from post-abortion fetal testing from accessing that medical care. Isaacson ¶ 51. In certain circumstances where a fetal condition has been detected, testing of the products of conception after an abortion can provide information about recurrence risks in future pregnancies. *Id.* But because patients are reticent to share any fetal diagnosis with their abortion provider due to the Reason Ban Scheme, that provider will not know to offer or arrange for the testing. *Id.*

In effect, the Reason Ban Scheme has created a "culture of silence" that limits physicians'

ability to provide certain care, Isaacson ¶¶ 51–52, and emotional support to these patients, which "runs counter to every instinct [Dr. Isaacson has] as a physician," *id.* ¶ 49; *see also* Wenstrom ¶ 65 ("[F]orcing [patients] to conceal information highly relevant to their care . . . in order to access abortion care serves no purpose" but to endanger their health and "inflict further pain."). This "culture of silence" also makes it more difficult to develop a trusting relationship with patients seeking abortion care, Isaacson ¶¶ 48–49, Nichols ¶ 84, Mercer ¶ 40, and to engage in a fulsome informed-consent process, Isaacson ¶ 50. This is antithetical to both informed consent and fundamental principles of medical ethics. Joffe ¶ 26.

Accordingly, because the Reason Ban Scheme does not improve or maintain the health of the person seeking the abortion and indeed is contrary to accepted clinical standards and evidence-based care, it fails constitutional review on this basis as well.

C. The Two-Trip Scheme Violates the Amendment.

Forcing patients to delay and to make multiple trips to their provider to obtain an abortion—regardless of their medical circumstances and decisional certainty—denies, restricts, and interferes with their fundamental right to abortion. Ariz. Const. art. II, § 8.1. Every court to consider these restrictions under similar constitutional amendments has concluded the same. *See generally Preterm-Cleveland v. Yost*, No. 24 CV 2634, 2024 WL 3947516 (Ohio C.P. Aug. 23, 2024); *Northland Family Planning Ctr. v. Nessel*, No. 24-000011-MM, slip op. (Mich. Ct. of Claims May 13, 2025), attached as Ex. 8.

To start, mandatory delay laws compel people who have already decided to have an abortion to postpone time-sensitive medical care. Isaacson ¶¶ 26, 34; Richardson ¶ 25; Mercer ¶ 48. While Arizona law mandates a 24-hour delay, in practice it often extends beyond that because patients are not always able to take consecutive days off work or afford the travel, lodging, and childcare to attend appointments over consecutive days. Isaacson ¶ 32; Richardson

¶ 18; Mercer ¶ 48; *see also* Isaacson ¶ 31 (stating first appointment alone can take up to four hours). Requiring multiple visits also increases the risk that patients will have to disclose their abortion to others, exposing some to stigma, retaliation, and/or violence. Mercer ¶¶ 50, 52 (describing patient crying for an hour after learning she had to return for second visit due to fear her abusive partner would find out); *see also* Isaacson ¶ 13; *Preterm*, 2024 WL 3947516, at *12.

This delay and additional travel push some patients past the point at which medication abortion is available, forcing them to proceed with a more invasive procedure, which may require travel to another clinic. Richardson ¶ 28; Isaacson ¶ 34; Mercer ¶ 49; *see also* Nichols ¶ 76. These barriers may prevent some from obtaining an abortion altogether. Isaacson ¶ 34. Moreover, forcing patients to remain pregnant longer than necessary poses health threats arising from the risks of pregnancy itself and the fact that abortion, while very safe, increases in risk as pregnancy progresses. Nichols ¶ 84; Mercer ¶ 49; *see also Preterm*, 2024 WL 3947516, at *11.

The Two-Trip Scheme's state-mandated information requirements further interfere with the fundamental right to abortion. Requiring providers to deliver the state-mandated speech takes time that could otherwise be spent on patient care, further limiting access. Isaacson ¶ 35 (stating he could see up to twice as many patients absent Two-Trip Scheme). It also undermines the informed consent process. Informed consent is an individualized process where practitioners inform their patients about the risks and benefits of, and alternatives to, the medical care being considered. *See* Joffe ¶¶ 12–14, 32; Nichols ¶¶ 41–43; Mercer ¶ 59. "[T]he amount and complexity of information" shared as part of the informed consent process should "be tailored to the desires of the individual patient and to the patient's ability to understand this information."[27] Laws that "interfere with the patient's right to be counseled by a physician

[27] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021), https://tinyurl.com/3smzh6tu.

according to the best currently available medical evidence and the physician's professional medical judgment" are contrary to informed consent.[28] *See* Joffe ¶¶ 32, 39–41. These "include state-mandated consent forms" and "laws that require physicians to give, or withhold, specific information when counseling patients before undergoing an abortion."[29]

The Two-Trip Scheme runs counter to these basic ethical principles. *See* Joffe ¶ 32. It requires providers to recite information that is not tailored to the patient's individual circumstances and refer patients to state-sponsored materials that contain inaccurate and misleading information and convey disapproval of abortion. *See* Isaacson ¶¶ 18, 21–25; Richardson ¶¶ 32–34, 39–40; Joffe ¶¶ 32, 34, 39–40; Nichols ¶¶ 47–51; Mercer ¶¶ 59–60; *supra* p. 9. In addition, the forced delay between receiving the information and obtaining the abortion, paired with a wholly unnecessary in-person requirement, further differentiates the Scheme from a true informed consent process.

Receiving biased and inapplicable information also interferes with the right to abortion in ways that can be especially harmful for some patients, particularly when paired with the mandatory delay. For example, it can be particularly distressing for those who are pregnant as a result of rape or incest to have their provider describe "[t]he probable anatomical and physiological characteristics" of the fetus "at the time the abortion is to be performed," A.R.S. § 36-2153(1)(f); *see* Joffe ¶ 36. So too for patients with wanted pregnancies who have already undergone multiple rounds of testing and consultation relating to a fetal diagnosis and are then forced to listen to a description of their fetus's development. Isaacson ¶¶ 27–28; Mercer ¶ 61. And it can be further upsetting for those patients to then have to hear about the availability of "[m]edical assistance benefits . . . for prenatal care, childbirth and neonatal care," A.R.S. § 36-

[28] *Id.*
[29] *Id.*

2153(2)(a), and "[p]erinatal hospice services," *id.* § 36-2158(A)(1)(a); *see also* Isaacson ¶¶ 27–30; Richardson ¶ 20; *Preterm*, 2024 WL 3947516, at *12.

In sum, by requiring patients to delay time-sensitive healthcare, forcing them to incur increased risks and physical, emotional, and financial harm, and distorting and undermining foundational principles of medical ethics and informed consent, the Two-Trip Scheme denies, restricts, and/or interferes with the fundamental right to abortion.

The State must demonstrate that these intrusions are constitutionally justifiable. It cannot because the Two-Trip Scheme infringes on autonomous decision-making and undermines, rather than improves or maintains, patient health.

First, as set forth above, the Two-Trip Scheme infringes on pregnant Arizonans' autonomous decision-making. The mandatory delay perpetuates the idea that pregnant Arizonans cannot be trusted to make their own decisions about abortion without a state-imposed deliberation period. *See* Joffe ¶ 40. Forcing a patient who has already decided to have an abortion to wait at least one day (and often several) and make two trips to an abortion provider before being able to obtain time-sensitive care necessarily infringes on their autonomous decision-making. *See* Ex. 8 at 67 ("delay is used solely to force the patient to further consider their choice, i.e., to dissuade the patient from securing an abortion" and "infringes upon autonomous decision-making"). Moreover, the Two-Trip Scheme creates myriad challenges for patients that push some beyond the gestational limit for medication abortion, preventing them from accessing the type of abortion that is best for their circumstances. Isaacson ¶ 34; Richardson ¶ 28; Mercer ¶ 49; Nichols ¶ 76. Others may lose the ability to have an abortion altogether. Isaacson ¶ 34.

The Two-Trip Scheme also infringes on patient autonomy by mandating the delivery of certain information regardless of the patient's decisional certainty and whether the patient actually desires such information. Joffe ¶¶ 35, 39; Isaacson ¶¶ 21, 26; Mercer ¶¶ 58–61. And it

requires providers to refer their patients to organizations that provide inaccurate information and attempt to coerce them to change their mind, *see supra* p. 9, further encroaching on their decisional autonomy. Isaacson ¶ 25; *see also Northland Family Planning Ctr. v. Nessel*, No. 24-000011-MM, 2024 WL 5468617, at *20 (Mich. Ct. Cl. June 25, 2024) ("putting [the state's] finger on the scale" infringes on "deliberative process").

Second, even if the State could show that the Two-Trip Scheme does not infringe on autonomous decision-making—which it cannot—the Scheme does not improve or maintain patient health and is inconsistent with accepted clinical standards of practice and evidence-based medicine. Ariz. Const. art. II, § 8.1(B)(1)(a)–(b). Despite the Two-Trip Scheme's blanket mandate, an ultrasound is not medically indicated for every patient, Mercer ¶ 45, and when it is, it is best practice to perform it as close in time to the abortion as possible—not days or weeks beforehand, as often occurs in practice under the Scheme. Nichols ¶¶ 39–40; Isaacson ¶ 19; Richardson ¶ 29; Mercer ¶ 45. Nor is there any medical justification for imposing a blanket Rh testing requirement, which unnecessarily delays access to care, is contrary to the standard of care, and does nothing to improve patient health and safety. Mercer ¶ 46; Isaacson ¶ 20. And there is no reason why informed consent cannot be obtained on the same day as the abortion or over phone or video conference. Richardson ¶ 51; Mercer ¶ 63; Joffe ¶¶ 30, 46; Nichols ¶ 54; *see also Northland*, 2024 WL 5468617, at *22 ("Clinical research has shown that there is no correlation between having a patient wait 24 hours and . . . better physical and psychological outcomes.").

As set forth in detail above, these requirements only serve to impose unnecessary delay, which itself undermines patient health. Delaying abortion care subjects patients to continued health risks associated with pregnancy. Nichols ¶ 84; Mercer ¶¶ 49, 55. And while abortion is safe at all gestations, delaying that care can pose incrementally greater risks and complexity.

Nichols ¶ 73; Mercer ¶ 49. Some patients may be precluded from accessing abortion altogether. Isaacson ¶ 34. This alone demonstrates that the Scheme does not advance patient health because abortion is far safer than continuing a pregnancy to term and childbirth. *See* Mercer ¶ 22; Nichols ¶ 30. The delays can also prevent patients for whom medication abortion is medically indicated or preferred, including because of past trauma, from obtaining this method of care. Nichols ¶ 76; Isaacson ¶ 34; Mercer ¶¶ 19, 49, 53. And the Two-Trip Scheme's multiple-trip requirement increases the risk of harm to those who may face violence if their decision is discovered. Mercer ¶ 52. Unsurprisingly, then, the medical consensus is that mandatory delays harm patient health and that the best medical practice is to provide care without any unnecessary delay. Nichols ¶ 37.

Arizona's biased counseling requirements likewise do not improve patient health. Providers already have legal and ethical obligations to share with each patient all the relevant information needed to make an informed decision and consent to treatment. *See supra* p. 20. The Scheme is thus a needless overlay on the informed-consent process that applies only to those seeking abortion. *See* Ex. 8 at 68 (finding "no reason to deviate from individualized informed consent," because providers will act consistent with "ethical and professional obligations without state interference"); Joffe ¶ 41; Nichols ¶¶ 41–44, 52; Isaacson ¶ 30.

The biased-counseling requirements are also at odds with the clinical standards of practice for obtaining informed consent. They "foreclose[] [providers] from exercising their own professional judgment and considering a pregnant patient's individual circumstances," which is "contrary to the applicable standard of care and informed consent practice, and . . . serves to undermine the physician-patient relationship." *Preterm*, 2024 WL 3947516, at *12; *see* Joffe ¶¶ 32, 39, 41; Nichols ¶¶ 52–53; Isaacson ¶¶ 26–30; Mercer ¶¶ 58–59. Moreover, the Scheme conflicts with medical ethics principles by forcing providers to shame their patients by providing stigmatizing information and causing them psychological and emotional distress. *See* Joffe ¶ 40;

Nichols ¶ 52; Isaacson ¶¶ 27–28; Mercer ¶ 61. For these reasons, the Two-Trip Scheme cannot survive review.

D. The Telemedicine Ban Scheme Violates the Amendment.

The Telemedicine Ban Scheme restricts, denies, and/or interferes with the fundamental right to abortion through its express prohibitions on the use of telemedicine for abortion care and the mailing of abortion medications, as well as implicit prohibitions embodied in its various in-person requirements for patients.

Because of the Telemedicine Ban Scheme, Arizonans seeking abortion must travel to one of the few cities in the state where in-person abortion care is available—even if only to pick up medications for use at home—which for some Arizonans could entail traveling hundreds of miles. Richardson ¶¶ 53–54, 46; Nichols ¶ 75; Mercer ¶¶ 57, 68–69. This Scheme thus outright denies access to pre-viability abortion for Arizonans unable to afford the costs (i.e., transportation, lodging, lost wages, childcare) of travel to a clinic. Mercer ¶ 69; Nichols ¶ 75. It also disproportionately impacts people with disabilities, among others. Mercer ¶ 69. Even for people who are ultimately able to reach a provider, the Telemedicine Ban Scheme denies them a safe, effective, and far less onerous alternative. Nichols ¶¶ 74–77. Mandating that patients travel to obtain in-person counseling, a physical examination, and lab tests regardless of medical necessity, or for receipt of abortion medication, delays access to care, which, as described *supra* p. 4, 21–22, exposes patients to unnecessary medical risks. Nichols ¶ 82; Mercer ¶¶ 49, 55.

The State cannot demonstrate that the Telemedicine Ban Scheme furthers a compelling interest. Ariz. Const. art. II, § 8.1(A). **First**, the Scheme "infringe[s] on [an] individual's autonomous decision making," *id.* § 8.1(B)(1)(b), by preventing patients who would prefer or need to use telemedicine abortion care, such as those who need more privacy and control over their abortion due to the risk of violence or retaliation, from accessing that care. For some

patients, the burdens of the Telemedicine Ban Scheme's in-person requirements may prevent them from accessing medication abortion or abortion care altogether. Nichols ¶ 76.

Second, these restrictions do not advance or maintain patient health. Delaying or denying abortion care undermines patient health. *Supra* pp. 4, 21–22. Telemedicine, by contrast, allows patients to access abortion earlier in pregnancy, closer to their home, from a location of their choosing, and in a way that reduces or eliminates the array of financial and logistical barriers involved in getting to an abortion provider. Nichols ¶ 73; Mercer ¶ 68. All these features of telemedicine abortion care can improve patient health outcomes and decrease healthcare disparities. Nichols ¶ 73; Mercer ¶ 69; Richardson ¶ 56. Telemedicine has been used to safely and effectively provide medication abortion for more than a decade and has proven to be a way of expanding access to medication abortion and offering a more patient-centered approach to care. Nichols ¶¶ 65–67, 73–74. Indeed, in essentially all relevant medical contexts except abortion, Arizona law permits physicians to use and patients to avail themselves of telemedicine to provide and obtain consultations and treatment. A.R.S. § 20-1057.13(A); Mercer ¶¶ 64–66. By banning this method of care for abortion, the Telemedicine Ban Scheme undermines the decisional autonomy and health of people seeking abortion and therefore cannot serve a compelling interest.

II. Plaintiffs Are Likely to Succeed on the Merits of Their Claim That the Challenged Laws Individually and Collectively Violate Amendment Section (A)(3).

The Challenged Laws are also unconstitutional because each Scheme establishes a comprehensive penalty framework that penalizes Plaintiffs and their members for "aiding or assisting a pregnant individual in exercising the individual's right to abortion." Ariz. Const. art. II, § 8.1(A)(3); *see supra* pp. 7–8, 13. Unless patients seek care outside the medical system, an individual's right to abortion is inextricably linked to the ability of their healthcare provider

to provide that care. Thus, it is self-evident that by imposing severe criminal, civil, and licensing penalties on providers who provide certain pre-viability abortions, the Challenged Laws directly penalize those, like Plaintiffs and their members, who aid or assist pregnant people in exercising their constitutional right to abortion. Indeed, the State has already admitted as much. Complaint ¶ 67, *Reuss v. State*, No. CV2024-034624 (Ariz. Super. Ct. Dec. 3, 2024); Answer ¶ 67, *Reuss*, No. CV2024-034624 (Ariz. Super. Ct. Jan. 21, 2025). Moreover, by forcing those who provide abortion care to ignore or violate the standard of care and their ethical obligations and to needlessly delay their patients' time-sensitive medical care as described in detail above, the Challenged Laws likewise penalize those who, like Plaintiffs and their members, aid or assist pregnant people in exercising this constitutional right.

* * * * * * *

For the foregoing reasons, each of the Challenged Laws deny, restrict, and interfere with Arizonans' fundamental right to pre-viability abortion. Because the Challenged Laws cannot be justified by any compelling state interest, they necessarily fail the exacting scrutiny required by the Amendment and no further analysis is warranted. *See* Ariz. Const. art. II, § 8.1(A)(1) (requiring that any compelling state interest also be "achieved by least restrictive means").

III. The Challenged Laws Are Inflicting Irreparable Harm.

Each of the Challenged Laws causes irreparable injury. They also reinforce and build upon each other, compounding the harms that Arizonans seeking abortion and their providers face, such that the Challenged Laws cannot be considered in isolation. This ongoing violation of constitutional rights is itself sufficient to establish irreparable harm. *See Toma*, 553 P.3d at 899.

Absent injunctive relief, Plaintiffs, their members, and patients will continue to suffer other irreparable harms that are not remediable by damages. For example, as described above, Plaintiffs' patients are experiencing physical, psychological, and emotional harms from: being

delayed in (or prevented from) accessing time-sensitive care; being forced to incur the time and expense of traveling multiple times to obtain such care; and having to receive irrelevant, biased, and distressing information beforehand. *See, e.g.*, *Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (establishing likelihood of irreparable harm where plaintiffs would experience pain, complications, and other adverse effects from delayed medical treatment). And Plaintiffs themselves are experiencing irreparable harm. Plaintiff physicians have had to turn away patients seeking abortion care as a result of the Challenged Laws. *See, e.g.*, Isaacson ¶ 46 Richardson ¶ 28. They are also forced to act contrary to their professional judgment, medical ethics, and accepted clinical standards under the threat of legal and professional penalties. *See, e.g.*, *N.Y. State Bar Ass'n v. Reno*, 999 F. Supp. 710, 716 (N.D.N.Y. 1998) (finding irreparable harm where threat of sanction compelled attorneys to violate their ethical obligations).

IV. The Remaining Factors Favor an Injunction.

The balance of harms and public interest, which "merge when the [g]overnment is the opposing party," *Nken v. Holder*, 556 U.S. 418, 435 (2009), likewise favor an injunction. While Plaintiffs and their patients are suffering due to the deprivation of their constitutional rights, a preliminary injunction would only deprive the State of its ability to enforce laws that are likely to be held unconstitutional and that further no compelling state interest. And "it is always in the public interest to prevent the violation of a party's constitutional rights." *Toma*, 553 P.3d at 899 (citation omitted).

CONCLUSION

For the reasons set forth above, the Court should grant Plaintiffs' Motion for Preliminary Injunction to enjoin the State from enforcing the Challenged Laws during this litigation and enable Arizonans to exercise the fundamental constitutional right they voted to enshrine.

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