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*Application for admission *pro hac vice* filed

Additional Co-Counsel listed on signature page

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Paul A. Isaacson, M.D., et. al.,

Plaintiffs,

vs.

Tom Horne, Attorney General of Arizona, et. al.,

Defendants.

Case No.

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND EXPEDITED CONSIDERATION, OR, IN THE ALTERNATIVE, FOR A TEMPORARY RESTRAINING ORDER, WITH ACCOMPANYING DECLARATIONS, MEMORANDUM OF LAW AND PROPOSED FORM OF ORDER

(Oral Argument Requested)

Plaintiffs hereby move this Court pursuant to Rule 65 of the Federal Rules of Civil Procedure for a preliminary injunction, or in the alternative, for a temporary restraining order, restraining Defendants from enforcing one provision of recently enacted Arizona House Bill 2036 (hereinafter "the ban" or "the Act"), which bans abortions at or after 20 weeks of pregnancy. *See* H.B. 2036, 50th Leg., 2d Reg. Sess. § 7 (Ariz. 2012) (creating new A.R.S. § 36-2159). This provision is scheduled to take effect on August 2, 2012.

As more fully explained in the accompanying memorandum of law, a preliminary injunction is warranted because: 1) Plaintiffs are likely to succeed on their claim that the ban, which prohibits previability abortions, violates the constitutional rights of their patients; 2) Plaintiffs' and their patients will suffer irreparable harm if the Act takes effect; 3) the balance of equities tips strongly in favor of Plaintiffs and their patients; and 4) the public interest will be served by an injunction. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011) (quoting *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 20 (2008)). Moreover, a preliminary injunction will preserve the status quo while the serious constitutional issues raised by this case are resolved. *See U.S. Philips Corp. v. KBC Bank N.V.*, 590 F.3d 1091, 1094 (9th Cir. 2010) (citations omitted) ("[T]he very purpose of a preliminary injunction . . . is to preserve the status quo and the rights of the parties until a final judgment issues in the cause.").

Given the effective date of August 2, 2012, Plaintiffs further request that the Court issue an expedited briefing schedule so that the motion for preliminary injunction can be decided before the Act's effective date. In the alternative, Plaintiffs request that the Court issue a temporary restraining order prohibiting enforcement of the ban pending determination of Plaintiffs' preliminary injunction motion.

Plaintiffs further request that, given the nature of the relief sought, bond be waived should the court grant preliminary injunctive relief. *See Johnson v. Couturier*, 572 F. 3d

1067, 1086 (9th Cir. 2009) (District Court has discretion to waive bond requirement of Fed. R. Civ. Pro. 65(c)); *see also Cal. Hosp. Ass'n v. Maxwell-Jolly*, 776 F. Supp. 2d 1129, 1160 (E.D. Cal. 2011) (waiving bond requirement; "courts have recognized the propriety of waiving the bond requirement where, as here, [plaintiffs] bring suit to enforce important federal and public interests").

Plaintiffs further request that the Court convene a status or scheduling conference to establish a schedule for further briefing and oral argument.

Plaintiffs will make every effort to ensure that each of the Defendants has notice of and copies of the documents associated with this motion as soon as possible after filing. Immediately after the filing of the Complaint and this motion, and receipt of a case number, attorneys for the Plaintiffs will attempt to reach all of the Defendants by phone to alert them to the motion and request for expedited consideration. Plaintiffs' attorney will also attempt to provide copies of the Complaint, motion, and all supporting documents by email as soon as possible, in addition to formal service.

This motion is based upon the Complaint filed in this case, the memorandum of law filed herewith, and the attached declarations of William Clewell, M.D. and Paul Isaacson, M.D. A proposed form of order is filed herewith for the convenience of the court.

RESPECTFULLY SUBMITTED this 12th day of July, 2012.

LAVOY & CHERNOFF, PC

By: /s/ Christopher A. LaVoy

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EXHIBIT 1

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Case No.

DECLARATION OF PAUL A. ISAACSON, M.D.

1. I am a Plaintiff in this lawsuit.

2. I have reviewed Arizona House Bill 2036.

3. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction or Temporary Restraining Order sought to prevent enforcement of the ban on abortions beginning at 20 weeks gestational age, contained in Arizona House Bill 2036 (Section 7), to be codified as Ariz. Rev. Stat. § 36-2159.

4. I am a physician licensed to practice medicine in Arizona and Nevada. I graduated from Tufts University School of Medicine in 1991. I am board-certified in obstetrics and gynecology. I hold privileges at Banner Good Samaritan Medical Center in Phoenix.

5. I offer this declaration as an expert in obstetrics and gynecology. My statements herein are based on my training, years of practice, and my ongoing review of literature and other sources of information generally relied on by those in my field. A copy of my *curriculum vitae* is attached as Exhibit A.

6. I co-own a private reproductive healthcare facility in Phoenix called Family Planning Associates Medical Group ("FPA"). At FPA, I provide a variety of services, including gynecological services, family planning, well-woman exams, STD testing, and abortions.

7. I provide abortions to women seeking previability abortions at or after 20 weeks on a regular basis, and see such patients approximately 50 times per year. Previability refers to that point in pregnancy before "there is a reasonable probability of the fetus' sustained survival outside the uterus, with or without artificial support." Ariz. Rev. Stat. § 36-2301.01 C. 3. Gestational age, as defined in HB 2036, means the duration of the pregnancy as dated from the woman's last menstrual period,

8. Abortions as I perform them, including those performed at or after 20 weeks gestational age, are safe procedures that pose no greater risks to my patients than carrying to term.

9. There are well documented and significant risks associated with carrying any pregnancy to term. For individual women, these risks may be much higher due to a preexisting condition or a condition that arises during pregnancy.

10. In my experience, while women sometimes consider the comparative medical risks of abortion and carrying a pregnancy to term, that is only one factor among many other important factors that go into their decision whether or not to continue with a pregnancy.

11. Approximately 70% of my patients seeking abortions at or after 20 weeks do so due to a serious or lethal fetal abnormality. These patients have received this diagnosis from their obstetrician or a specialist who deals with high risk pregnancies, and the vast majority of these patients have been referred to me from another physician. Among my patients, the most common types of fetal anomalies are neural tube defects, including anencephaly, meinigomyeloceles and holoprosencephaly; trisomy 18 and 13; Potters syndrome; diaphragmatic hernia; Down's syndrome; cystic hygromas, and fetal cardiac anomalies.

12. Many of the patients I see for an abortion due to fetal anomalies come to me following detection of the problem through a full obstetric ultrasound, which usually occurs after 18 weeks. When the obstetric ultrasound indicates a problem, it is routine practice to conduct an additional ultrasound or other tests. Thus, it may be several days or a few weeks before the woman has all of the information she needs and desires in order to make an informed decision as to whether to continue or terminate the pregnancy.

Typically, these patients have reached the decision to terminate the pregnancy after multiple consultations with specialists and/or loved ones.

13. Many of my remaining patients seeking abortions at or after 20 weeks do so because they are experiencing a medical condition that is either caused by or exacerbated by the pregnancy or because they wish to obtain treatment for a condition but cannot do so while pregnant. Women in these circumstances have presented with, among other conditions, diabetes, kidney disease, cardiac disease, history of severe pre-eclampsia or eclampsia and maternal hematologic diseases that cause abnormal blood clotting.

14. For example, I have treated patients with preexisting conditions that have made the pregnancy high-risk. In one such circumstance I performed a procedure for a patient at high risk of stroke during pregnancy due to a cardiac abnormality. The pregnancy prevented her cardiologist from providing the recommended treatment.

15. Based on my training and experience, at 20 weeks, no fetus is viable. It is commonly accepted in the field of obstetrics and gynecology that a normally developing fetus will attain viability at approximately 24 weeks.

16. Not all fetuses will attain viability at 24 weeks, however, due to a variety of factors such as maternal nutrition, health, and lifestyle or problems with fetal development or fetal anomalies. Some fetuses never attain viability due to anomalies.

17. The 20 week ban therefore prohibits previability abortions that I perform for my patients beginning at 20 weeks gestational age.

18. Due to the criminal penalties and provisions allowing for suspension or revocation of my license if I violate the ban, I will have no choice, absent an injunction, but to stop providing previability abortions beginning at 20 weeks gestational age.

19. Enforcement of the 20 week ban will harm my patients by preventing them from obtaining previability abortions. Some of my patients may, as a result, be forced to carry a pregnancy they wish to terminate to term.

20. Among these patients, some will be seeking to terminate in order to preserve their health. These patients will be precluded from doing so altogether or will be forced to delay the procedure until their conditions worsen to the point where they clearly come within the narrow definition of "medical emergency" in HB 2036. In the absence of HB 2036, and consistent with the standard of care, I would otherwise perform the abortion without delay.

21. Other patients will be seeking an abortion because the fetus has been diagnosed with a lethal or serious anomaly. It is cruel to deny women access to abortion in these circumstances. What purpose is served by forcing a woman to carry a pregnancy for months when the unavoidable outcome is that the baby will die during birth or shortly thereafter?

22. This delay or denial of care is contrary to the good practice of medicine and imposes unconscionable burdens on women seeking abortions.

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

Dated this 9th day of July, 2012.

Paul A. Isaacson, M.D.

Exhibit A

CURRICULUM VITAE FOR PAUL A. ISAACSON, M.D.

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Phoenix, AZ 85006
Telephone 602.553.0440

Professional History

2007 to present	Birth Control Care Center Las Vegas, NV
2004 to 2009	Summit Family Planning Las Vegas, NV
1997 to Present	Family Planning Associates Phoenix, AZ
1998 to 2004	Private Practice - Ob/Gyn East Valley Ob/Gyn, P.L.C. Chandler, AZ
1997 to 1998	Planned Parenthood of Southern Arizona - Staff Physician
1995 to 1997	Private Practice - OB/GYN Women's Health Care Associates Chandler, Arizona
1994 - 1995	Planned Parenthood of Greater Boston Brookline, Massachusetts
1994 - 1995	Women's Health Service Chestnut Hill, Massachusetts
1991 - 1995	Resident, OB/GYN Brigham and Women's Hospital Boston, Massachusetts and Massachusetts General Hospital Boston, Massachusetts
1988 - 1989	Chemistry Lab Technician, St. Elizabeth's Hospital Boston, Massachusetts [Part-time during Medical School]

Education

1991 - 1995	Brigham and Women's Hospital Boston, Massachusetts Intern and Resident, Obstetrics and Gynecology and Massachusetts General Hospital Boston, Massachusetts Intern and Resident, Gynecology

1987 - 1991	Tufts University School of Medicine Boston, Massachusetts Medical Doctorate
1983 - 1987	Boston College Chestnut Hill, Massachusetts B.S., Biochemistry [summa cum laude]

Appointments and Hospital Affiliation

1994 - 1995	Administrative Chief Resident, Obstetrics and Gynecology Brigham and Women's Hospital, Boston, Massachusetts Massachusetts General Hospital, Boston, Massachusetts
1991 - 1995	Clinical Fellow in Obstetrics, Gynecology, and Reproductive Biology, Harvard Medical School, Boston, Massachusetts
2003 – present	Banner Good Samaritan Medical Center, Phoenix, AZ – Active Staff

Awards

Phi Beta Kappa
Alpha Sigma Nu National Jesuit Honor Society
Alpha Omega Alpha Medical Honor Society
Society of Laproendoscopic Surgeons,
Outstanding Laproendoscopic Resident Surgeon - 1995

Licensure and Certification

State of Arizona Board of Medical Examiners License #23227
State of Nevada Board of Medical Examiners License #10490
National Board of Medical Examiners - Diplomate
American Board of Obstetrics and Gynecology - Diplomate

Professional Associations

Massachusetts Medical Society
National Abortion Federation

Exhibit 2

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Case No.

DECLARATION OF WILLIAM H. CLEWELL, M.D.

WILLIAM H. CLEWELL, M.D., declares and states the following:

1. I am a perinatologist licensed to practice medicine in the state of Arizona, where I am engaged in the practice of obstetrics and gynecology and maternal-fetal medicine. I am a Plaintiff in this lawsuit, and I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction and/or Temporary Restraining Order against enforcement of that part of Section 7 of House Bill 2036, to be codified as Ariz. Rev. Stat. § 36-2159 ("the ban"), that bans pregnancy termination care starting at 20 weeks as measured from the first day of the woman's last menstrual period ("LMP"). I offer this declaration as an expert in obstetrics and gynecology and in maternal-fetal medicine, which is the sub-specialty of perinatologists, the doctors who care for women with high-risk pregnancies.

2. I am Director of Fetal Medicine and Surgery and Director of Obstetrical Ultrasound at Banner Good Samaritan Medical Center in Phoenix; a faculty member in the Division of Maternal-Fetal Medicine at Good Samaritan Regional Medical Center; a partner in a perinatology practice group; and Clinical Professor of Obstetrics and Gynecology at the University of Arizona College of Medicine in Tucson. I was previously Director of the Obstetrics Section at the University of Colorado School of Medicine and Visiting Professor of Obstetrics and Gynecology at Kings College Hospital School of Medicine and Dentistry in London.

3. I received my medical degree from Stanford University School of Medicine in 1970; did an internship in Pediatrics at Strong Memorial Hospital in Rochester, New

York, from 1970-1971; did my residency in Obstetrics and Gynecology at Stanford from 1971-1974; and did my fellowship in Perinatal Medicine at the University of Colorado School of Medicine from 1974-1976. I am board-certified both in Obstetrics & Gynecology and in Maternal-Fetal Medicine.

4. My medical association memberships include the American College of Obstetrics and Gynecology, the Phoenix Obstetrical and Gynecological Society, and the Society of Maternal-Fetal Medicine, and I am a founding member of the International Fetal Medicine and Surgery Society. I have authored numerous articles in peer-reviewed journals and book chapters. The topics on which I have published include gynecological emergencies, premature labor, fetal diagnosis, fetal therapy, fetal surgery, hypertensive emergencies and neurological disorders in pregnancy.

5. The facts I state here are based on my many years of medical practice, my personal knowledge, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession. A copy of my *curriculum vitae* is attached as Exhibit A.

My Patients and My Practice Subject to the Ban

6. I provide my patients with comprehensive care for high-risk pregnancies. This care includes pre-conception counseling; prenatal care; prenatal diagnosis of fetal anomalies; fetal assessment; and fetal treatment including fetal transfusion, shunt placement and other therapeutic procedures that I undertake before birth to allow medically compromised fetuses to survive and / or to improve their outcomes after birth. I have pioneered several such in utero therapies. I also provide labor and delivery care, as

well as induced pregnancy terminations in cases of maternal medical indications, cases of lethal or severe fetal anomalies, and/or cases of pregnancy failure. That care includes pregnancy terminations at and after 20 weeks LMP.

7. In my role as Director of Fetal Medicine and Surgery at Banner Good Samaritan Hospital, I perform Maternal-Fetal Medicine consultations on other physicians' patients with high-risk pregnancies who are either hospitalized or are out-patients in the Banner Maternal Fetal Center. I also regularly provide in-hospital care for the antepartum patients, meaning those admitted for complications of pregnancy before birth. This includes patients with preterm labor, antepartum bleeding, uncontrolled diabetes and other conditions requiring close monitoring of fetal and maternal wellbeing. This entails making teaching rounds with medical students and OB GYN residents on the service at the hospital, as well as personal rounds on all the antepartum patients. As Director of Obstetric Ultrasound at Banner Good Samaritan Hospital, I spend a good deal of time interpreting ultrasound images, and I also occasionally consult on other physicians' patients in a private perinatology office setting.

8. I have provided a limited number of pregnancy terminations as part of my practice since 1971, when I started my residency. Each year, I perform, teach, or supervise a small number of induced pregnancy terminations, approximately half of which are for women experiencing pregnancy failure. Although these procedures comprise a very small part of my practice, they are an important part of the comprehensive care I offer my patients.

9. My colleagues and I perform pregnancy terminations only in cases of serious or lethal fetal anomaly and/or maternal medical complications; for pregnancy

terminatons in other instances, we refer our patients to other respected physicians in the community. Approximately 90% of induced pregnancy terminations in the U.S. take place during the first trimester of pregnancy, through approximately the 13th week. Given the nature of my practice, however, most of those that I perform or supervise occur after that point: first, diagnoses of fetal anomaly are almost never possible earlier in pregnancy; second, the maternal health conditions that prompt the pregnancy terminations I perform or supervise often emerge or are exacerbated after that point.

10. No fetus is viable at 20 weeks; a healthy singleton fetus becomes viable by about the 24th week; some medically compromised fetuses become viable only later in pregnancy; and others can never become viable because of a lethal anomaly. I am not aware of any physician in Arizona who performs induced abortions where the fetus is viable, that is, when it has a reasonable probability of sustained survival outside the uterus.

11. Legal induced pregnancy termination is extremely safe, and presents far lower risks for a woman than does carrying a pregnancy to term. (Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Ob. & Gyn. 215-19 (Feb. 2012)) (legal induced pregnancy termination is 14 times safer than carrying to term in terms of the woman's risk of death, and also carries a lower risk of complications short of death). As pregnancy progresses, the risks of induced pregnancy termination increase, so that starting at 21 weeks LMP, legal induced termination and carrying to term entail comparable risks of death for the woman. (Linda A. Bartlett *et al.*, *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Ob. & Gyn. 729-37 (Apr. 2004)). However, for

certain of my patients with medical conditions or carrying fetuses with anomalies that increase the risks to the woman, pregnancy termination past 21 weeks clearly remains far safer for the woman than carrying to term.

12. Several times each year, my colleagues and I provide termination care to a patient at or after 20 weeks LMP. This happens in cases of fetal anomaly, maternal medical complication, and pregnancy failure.

13. In some patients, we cannot diagnose a fetal anomaly until very close to, or after, 20 weeks. Amniocentesis – a procedure to detect and diagnose chromosomal anomalies – is usually performed at about 16 weeks, but may occur later, and requires 10 - 12 days for the results to be available. Detailed anatomic ultrasound exams are generally done after 18 weeks (and among obese women, whose numbers are increasing, these exams may not be reliable until later). In other words, even if a patient starts out receiving prenatal care from a perinatologist, she will not get a diagnosis of many fetal anomalies until close to or at 20 weeks. A definitive diagnosis will generally occur later still if the patient began her prenatal care with an obstetrician who is not a perinatologist. After doing an initial exam, such an obstetrician who suspects a fetal anomaly will often refer the patient to my practice for a more detailed assessment. This entails at least some delay, and the final consultation often does not occur until after 20 weeks. Even if the patient has the final consultation and receives the diagnosis in the 19th week, she and her family need time to make the extremely difficult decision whether to continue the pregnancy, which means that termination, if that is their decision, will occur after 20 weeks.

14. I have performed pregnancy terminations at and after 20 weeks for women

who have received the devastating diagnosis that the fetuses they were carrying had lethal anomalies: anencephaly, a significant malformation of the brain which results in death before birth or very soon thereafter; renal agenesis, in which the fetus lacks kidneys and where the child, if born, usually dies of respiratory failure within twenty-four hours of birth; severe structural anomalies such as limb-body wall complex, in which the organs are often outside the body cavity; certain congenital heart defects; body stalk anomaly, in which the anterior body wall of the fetus fails to develop and the fetus is attached directly to the placenta; ectopia cordis, in which the fetal heart is outside the chest; certain combinations of malformations that individually would not be lethal but that in combination cannot be overcome; chromosomal anomalies such as trisomy 13 and 18 (three copies of chromosomes 13 and 18); and many other, less common lethal chromosomal, single gene defects or lethal structural anomalies.

15. Others of my patients decide to end their pregnancies at or after 20 weeks after learning the potentially equally devastating news that their fetuses have severe but not necessarily lethal anomalies. These include severe cardiac anomalies, such as hypoplastic left heart syndrome, critical aortic stenosis, and various complex cardiac malformations, and neural tube defects such as encephalocele (the protrusion of brain tissue through an opening in the skull) and severe hydrocephaly (severe accumulation of excessive fluid within the brain that almost completely destroys the brain). There are numerous other lethal and severe anomalies which individually are very rare, but when referrals come from a large population (i.e., the state of Arizona and beyond), in aggregate amount to a significant number of pregnancies affected.

16. Likewise, some of my patients with medical conditions that make

pregnancy particularly dangerous for them may not be referred to me until almost 20 weeks or even after that point. To preserve their health, some of these patients end their pregnancies after getting a definitive diagnosis; others try to continue the pregnancy at least until the fetus becomes viable, and of those, some succeed, while others ultimately decide to end their pregnancies. These conditions include maternal heart disease, pulmonary hypertension, and Eisenmenger's syndrome – in all of which the increase in cardiac output that occurs in pregnancy dramatically increases maternal mortality, that is, the woman's risk of death. Hence, some of my patients with severe cardiac disease and worsening cardiovascular status – or rheumatic heart disease with worsening cardiac function – terminate their pregnancies because continued pregnancy is likely to exacerbate their conditions, with serious consequences, including the risk of irreversible heart damage or death. Other patients have had end stage renal (kidney) disease; mechanical heart valve; and Marfan's Syndrome with dilatation of the aorta, which dramatically increases the woman's risk of sudden death due to aortic rupture. Some cancers, including some breast cancers, require radiation therapy or chemotherapy, which are extremely toxic to the fetus. Most patients, if they are to undergo such treatment, choose to terminate rather than have the fetus die in utero as a consequence of treatment.

17. Finally, some of my patients experience pregnancy failure close to or after 20 weeks. These scenarios include advanced cervical dilation with "hour glassing" of membranes into the vagina, premature rupture of membranes, and placental abruption (premature separation of the placenta) with serious bleeding. Some such patients opt to terminate fairly quickly, to minimize the risks to their health. Others try to carry the pregnancy until the fetus becomes viable. We do everything we can to help them;

sometimes we succeed and the woman has a baby. Other times, the risks to the woman become so high, and the chances for a live birth so remote, that she and her family ultimately decide to end the pregnancy some period of time after the condition first arises.

The Effect of the Ban

18. I have read the ban and I am gravely concerned for my practice and most of all for my patients and their families. This law would force some of my patients to carry to term against their will, even when doing so presents shocking risks to their lives and health, and even where there is no hope of giving birth to a child who will survive. This is medically brutal and emotionally cruel.

19. Because this care is critical to my patients' health, I fear enforcement of the ban for my patients' sake as well as for my own. Because my patients include women with grave medical indications for terminating pregnancy, I fear prosecution under the ban all the more because instead of a straightforward exception for procedures necessary to preserve my patient's life or health, it has only an extremely narrow medical emergency exception.

20. The ban's medical emergency exception is an affirmative danger to my patients. Starting at 20 weeks LMP, it allows me to terminate a pregnancy only if an "immediate" termination or a termination with no "delay" is necessary to avert death or serious medical harm. As I outlined above, the instances in which pregnancy clearly jeopardizes a woman's life and health are many, but the instances in which a patient will die or suffer such harm absent an "immediate" termination or a termination with no delay

are far less frequent. Only when a patient is, for example, hemorrhaging or extremely severely infected could I feel comfortable that I would not face prosecution for ending the pregnancy.

21. For example, I saw a patient this year at 22 weeks with an ongoing placental abruption, which means that the placenta had prematurely detached from the uterine wall. Because of the abruption, she had been bleeding for weeks; to replace lost blood, we had transfused her – with 7 units of blood in 3 days; and we ultimately advised the family to consider termination. The woman was initially unsure of her decision, which was an excruciating one. Several days into the process, when she ultimately decided to terminate, she was clearly at risk from the pregnancy and the chance of a viable outcome was remote, but she just as clearly did not need an "immediate" pregnancy termination to avert death or preserve her health: I could have continued transfusing her for days or weeks, and indeed, some women in those circumstances choose that route, hoping for the slight chance that they will be able to continue the pregnancy until the fetus becomes viable.

22. This illustrates one of several awful perversions this ban would impose on women and their doctors. My duty is to offer my patients care before they face "immediate" death or damage; I cannot let them get to that point without at least offering them care to save their lives and preserve their health. But under the ban, that is exactly what I would have to do: wait and let my patient deteriorate until an "immediate" termination – or a termination without delay – was necessary. That's the worst medicine imaginable and contrary to well established obstetric principles.

23. In an equally ugly distortion, the ban would force women to make a

decision before they would otherwise have to, and some of those women may well feel compelled to terminate. For example, the patient with the bleeding abruption may have felt compelled to terminate sooner, knowing that she wouldn't be able to do so to preserve her health if she waited until after 20 weeks. Some patients in that situation might otherwise try to continue the pregnancy, and of those, some might succeed. The ban will thus rush some women to terminate who would otherwise try to continue their pregnancies, and of those, some would have ended up having babies.

24. The same is true of women with medical conditions such as heart disease: a woman at 19 weeks may decide to try to carry the pregnancy as long as possible, but only if she knows that if the risks grow too large in her view, she can terminate the pregnancy. But if she knows that that option will not be available to her at 20 weeks, she may well terminate at 19 weeks, to save her heart and possibly her life. That is because with maternal heart disease, just as with bleeding from placental abruption, the cases in which a pregnancy termination with no delay is necessary to preserve the woman's life or health are rare. Far more frequent are cases of maternal heart disease in which continued pregnancy poses a clear and significant threat to the woman's life or health, but she could decide either to bear the risk by continuing the pregnancy or to protect herself against the risk by ending it. The ban would deny her the latter option at 20 weeks, when no fetus is viable.

25. The same is true of the woman grappling with the shocking news that her fetus has a severe or lethal anomaly. That patient needs time to resolve her feelings, to consult with those she loves and trusts, and to come to her decision. Under the ban, a family that gets the diagnosis at 19 weeks and 5 days would not have time to consider,

discuss, pray – whatever process they deem necessary to make this terribly hard decision. The upshot might be that the woman requests a termination within a few hours simply to avoid being denied the option at 20 weeks. It is inappropriate to rush a patient in making this decision. Usually the diagnosis has come like a "bolt from the blue," in that the family had no suspicion of the problem prior to the ultrasound or other test. The woman and her family are in a moment of crisis and grief, and deserve the time they need to make their decision. A "right" decision is more important than a quick one.

26. Some women facing such grave circumstances decide to continue their pregnancies. That is the right decision for them, and I provide them with the best medical care possible. But under the ban, my patients who did not terminate before 20 weeks would have no option. Some would carry to term – against their will – notwithstanding the risk to their lives; some would do so notwithstanding the risk to their health; and still others would unwillingly remain pregnant notwithstanding the impossibility of giving birth to a child who would survive, either because of a lethal anomaly or because of pregnancy failure. Some other women may attempt a self induced termination or seek a non-medical one: I began my medical training in the era when illegal pregnancy terminations were a major cause of maternal mortality and morbidity.

27. This ban would be devastating for my patients and for me as a physician. I am honored to provide care for women and families through some of the most joyous times in their lives, but also through what may be the hardest time in their lives. My job is to give them information and options, and then to respect and support their decision. That way, as I tell them, no matter what they decide, when they look back years later on this very difficult time, they can feel comfortable with the decision they made. That is

my ethical obligation, and under the ban, I would fear prosecution for fulfilling it. This outrageous intrusion into medical care would thus impose terrible, irreparable harm on my patients and on me.

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

Executed on July 11, 2012

William H. Clewell, M.D.

Exhibit A

CURRICULUM VITAE

WILLIAM H. CLEWELL, MD

CURRENT POSITIONS

Director, Obstetrical Ultrasound
Banner Good Samaritan Medical Center
Phoenix, AZ

Director, Fetal Medicine and Surgery
Banner Good Samaritan Medical Center
Phoenix, AZ

Faculty, Department of Obstetrics and Gynecology
Division of Maternal Fetal Medicine
Good Samaritan Regional Medical Center

Phoenix Perinatal Associates
Phoenix, AZ

ACADEMIC APPOINTMENT

Clinical Professor
Department of Obstetrics and Gynecology
University of Arizona, College of Medicine
Tucson, AZ
1990 - present

EDUCATION

University of Colorado School of Medicine
Denver, Colorado
Fellow, Perinatal Medicine
1974-1976

Academic Training Fellow
American College of Obstetrics and Gynecology-Ortho
1974-1975

Stanford University School of Medicine
Stanford, California
Resident in Obstetrics and Gynecology
1971-1974

Strong Memorial Hospital
Rochester, New York
Intern, Pediatrics
1970-1971

Stanford University School of Medicine
Stanford, California
Doctor of Medicine
1970

University of California, Berkeley
Honors in Biochemistry
1965

MEDICAL LICENSURE

Arizona	1987
Colorado	1976
California	1971

BOARD CERTIFICATION

Board Certified in Obstetrics and Gynecology
American Board of Obstetrics and Gynecology, 1977

Board Certified in Maternal-Fetal Medicine, Subspecialty Board, 1981

PAST POSITIONS

Visiting Professor, Obstetrics and Gynecology
Kings College Hospital School of Medicine and Dentistry
London, United Kingdom
July 7, 1985-July 6, 1986

Director, Obstetrics Section, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1982 – 1987

Associate Professor, Division of Perinatal Medicine
University of Colorado School of Medicine
1982 – 1987

Associate Professor, Division of Perinatal Medicine
University of Colorado School of Medicine
1981 – 1987

Associate Professor, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1981

Assistant Professor, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1976 – 1981

MAJOR SCIENTIFIC INTEREST:

Role of estrogen in the control of uterine circulation.
Antepartum management of fetal diseases.

PROFESSIONAL MEMBERSHIPS

Phi Beta Kappa
Alpha Omega Alpha
Fellow, American College of Obstetrics and Gynecology, 1980
Phoenix Obstetrical and Gynecological Society
International Fetal Medicine and Surgery Society
Society of Maternal-Fetal Medicine

ABSTRACTS

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LETTERS:

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2. **Clewell WH**. "Control of uterine circulation", in Uterine Physiology, Proceedings of a Brook Lodge Workshop, eds. Greeman EA, Noah ML, Work BA. PGS Publishing Co., Littleton, Massachusetts.

3. **Clewell WH**, Stys SJ, Battaglia FC. "Fetal pathophysiology", in Fetal and Maternal Medicine, eds. Quilligan EJ, Krechmer N. John Wiley and Sons, New York.

4. Stys SJ, Clark KE, **Clewell WH**, Meschia G. "Hormonal effects on cervical compliance in sheep", in Biology of Cervical Dilatation, eds. Naftolin N, Stubblefield PG. Raven Press, New York.

5. **Clewell WH**, Meschia G. "Effects of estrogen on uterine blood flow", In Uterine and Placental Blood Flow. New York.

6. **Clewell WH**, Makowski EL. "Premature labor and breech presentation", in Perinatal Medicine in Primary Practice, eds. Warshaw and Hobbins. Addison-Wesley, Menlo Park, California.

7. Johnson ML, **Clewell WH**, Pretorius D, Meier P, Manchester D. "Fetal Therapy", in The Principles and Practice of Ultrasonography in Obstetrics and Gynecology, eds. Sanders RC, James AE. Appleton-Century-Crofts, East Norwalk, Connecticut.

8. **Clewell WH**. "The fetus with ventriculomegaly: Selection and treatment", in The Unborn Patient—Prenatal Diagnosis and Treatment, eds. Harrison MR, Golbus MS, Filly RA., W.B. Saunders Company, Philadelphia, Pennsylvania.

9. **Clewell WH**. "Hydrocephalus Shunt", in Ultrasound in Obstetrics and Gynecology, eds. Chervenak FA, Isaacson GC, Campbell S, Little, Brown and Company, Boston.

10. **Clewell WH**. "Fetal shunting for hydrocephalus", in Ultrasound and the Fetal Brain, eds. Chervenak FA, Kurjak A, Comstock CH, Parthenon Publishing Group, New York.

11. **Clewell WH**. "Hypertensive Emergencies in Pregnancy", in Obstetric Intensive Care, A practical manual, eds. Foley MR, Strong TH, Jr., W. B. Saunders Company, Philadelphia, Pennsylvania.

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JOURNAL ARTICLES

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2. Goodlin RC, **Clewell WH**. "Sudden fetal death following diagnostic amniocentesis", Amer J Obstet Gynecol, 118:285, 1974.

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7. **Clewell WH**, "Prematurity", J Reprod Med, 23:237, 1979.

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