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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In the Supreme Court

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

Honorable Daniel Coble, Circuit Court Judge

Appellate Case No. 2024-000997

Case No. 2024-CP-40-00762

PLANNED PARENTHOOD SOUTH ATLANTIC, on behalf of itself, its patients, and its physicians and staff; KATHERINE FARRIS, M.D., on behalf of herself and her patients; TAYLOR SHELTON,.....*Appellants,*

v.

SOUTH CAROLINA; ALAN WILSON, in his official capacity as Attorney General of South Carolina; EDWARD SIMMER, in his official capacity as Interim Director of the South Carolina Department of Public Health; ANNE G. COOK, in her official capacity as President of the South Carolina Board of Medical Examiners; GEORGE S. DILTS, in his official capacity as a Member of the South Carolina Board of Medical Examiners; MARCELO HOCHMAN, in his official capacity as a Member of the South Carolina Board of Medical Examiners; RICHARD HOWELL, in his official capacity as a Member of the South Carolina Board of Medical Examiners; ROBERT KOSCIUSKO, in his official capacity as a Member of the South Carolina Board of Medical Examiners; THERESA MILLS-FLOYD, in her official capacity as a Member of the South Carolina Board of Medical Examiners; MARY J. RICHARDSON, in her official capacity as a Member of the South Carolina Board of Medical Examiners; JENNIFER R. ROOT, in her official capacity as a Member of the South Carolina Board of Medical Examiners; CHRISTOPHER C. WRIGHT, in his official capacity as a Member of the South Carolina Board of Medical Examiners; SALLIE BETH TODD, in her official capacity as Chairperson of the South Carolina Board of Nursing; SAMUEL H. McNUTT, in his official capacity as Vice Chairperson of the South Carolina Board of Nursing; BRIDGET A. ENOS, in her official capacity as a Member of the South Carolina Board of Nursing; BRIDGET J. HOLDER, in her official capacity as a Member of the South Carolina Board of Nursing; LESLIE M. LYERLY, in her official capacity as a Member of the South Carolina Board of Nursing; MELISSA MAY-ENGEL, in her official capacity as a Member of the South Carolina Board of Nursing; LINDSEY K. MITCHAM, in her official capacity as a Member of the South Carolina Board of Nursing; FRANCES C. PAGETT, in her official capacity as a Member of the South Carolina Board of Nursing; JOHN J. WHITCOMB, in his official capacity as a Member of the South Carolina Board of Nursing; ROBERT J. WOLFF, in his official capacity as a Member of the South Carolina Board of Nursing; SCARLETT A. WILSON, in her official capacity as Solicitor

for South Carolina's Ninth Judicial Circuit; and BYRON E. GIPSON, in his official capacity as Solicitor for South Carolina's Fifth Judicial Circuit,.....*Appellees*,

HENRY MCMASTER, in his official capacity as Governor of the State of South Carolina,.....*Intervenor-Appellee*.

RECORD ON APPEAL – VOLUME I OF II

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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Planned Parenthood South Atlantic, on behalf
of itself, its patients, and physicians and staff,
et al.

Plaintiffs,

v.

State of South Carolina, *et al.*

Defendants.

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Civil Action No. 2024CP4000762

ORDER DESIGNATING CASE AS COMPLEX

The Court having reviewed the pleadings in this matter,

IT IS ORDERED that this matter be designated as complex and that this case be assigned
to **the Honorable Daniel Coble** to hear and dispose of all pre-trial motions, trial, and other matters.

IT IS FURTHER ORDERED that the parties contact Judge Coble within fifteen (15) days
of this Order for purposes of scheduling a status conference and/or a hearing on pending motions.

AND IT IS SO ORDERED.



Richland Common Pleas

Case Caption: Planned Parenthood South Atlantic , plaintiff, et al vs State Of South Carolina , defendant, et al
Case Number: 2024CP4000762
Type: Order/Complex Case Designation

IT IS SO ORDERED.

Jocelyn Newman, Chief Judge for Administrative
Purposes, Court of Common Pleas, 5th Judicial
Circuit

Electronically signed on 2024-02-23 08:44:32 page 2 of 2

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)
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PLANNED PARENTHOOD SOUTH)
ATLANTIC, on behalf of itself, its)
patients, and physicians and staff, *et al.*,)
))
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Plaintiffs,)
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vs.)
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SOUTH CAROLINA, *et al.*,)
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Defendants,)
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Henry McMaster, in his official capacity as)
Governor of the State of South Carolina,)
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))
Intervenor-Defendants.)
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IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
Civil Action No. 2024-CP-40-00762

ORDER

This matter is before the Court on a Motion for Preliminary Injunction filed by Plaintiffs Planned Parenthood South Atlantic, Katherine Farris, M.D., and Taylor Shelton. Plaintiffs seek to enjoin Defendants (numerous state officials, collectively, the “State”) from enforcing South Carolina’s Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (the “Act”) as applied to abortions performed between approximately six and nine weeks last menstrual period (LMP). The Court heard this matter on May 2, 2024 and took the matter under advisement. For the reasons stated below, the Motion is **DENIED**.

I. Introduction

The issue of abortion is complex and deeply personal. The task before this Court is profound and it does not take this job lightly. This Court commends and appreciates the professionalism of counsel for both parties. South Carolinians from all backgrounds have deeply and sincerely held beliefs about this issue. As Justice Kittredge recently stated:

We recognize the tendency of many to view the divisive issue of abortion through a lens shaped by their own politics or personal preferences. To be clear, our decision today is in no way intended to denigrate or exalt any of the valid concerns on either side of the abortion debate, whether those concerns are based in privacy, morality, medicine, religion, bodily autonomy, or something else.

Planned Parenthood S. Atl. v. State, (*Planned Parenthood II*) 440 S.C. 465, 472, 892 S.E.2d 121, 125–26 (2023); *see also Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 850, 112 S. Ct. 2791, 2806, 120 L. Ed. 2d 674 (1992), *overruled by Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 142 S. Ct. 2228, 213 L. Ed. 2d 545 (2022) (“Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage.”). This Court echoes the sentiments as stated by Justice Kittredge.

However, the role of this Court is not to determine whether the law is good or bad, whether the policy should be one way or the other, or to be outcome determinative based on personal views. The role of this Court is to simply determine the intent of the legislature in the enactment of the law in question and whether the actions of the legislature are within the bounds of the Constitution as derived from the will of the people. *Planned Parenthood II*, at 472, 892 S.E.2d at 126 (“Rather, respectful of separation of powers principles and the limited (non-policy) role of the Court, we approach our solemn duty in this case with a single commitment: to honor the rule of law. In our constitutional framework, the rule of law does not bend to satisfy personal preferences.”). The

legality and regulation of abortion in the United States and in South Carolina has shifted over the years. The people, through the governmental branches at both the state and federal level, have spoken. This Court must listen.

The issue before this Court is not one of policy, preference, or personal views. If any court, much less a trial court, were allowed to substitute its views for that of the people and the elected representatives, the foundational structure that our Constitution provides would falter. First, the people and their will would be undermined and removed from the legislative and democratic process. The passage of any bill takes time, information, and input – all done through the long and deliberative legislative process. Additionally, the people can voice their views throughout the process to make known their complaints and wishes. However, the judicial process of delivering an opinion is often one of solitude and individuality. No input from the public, much less subject-matter experts, is taken into account in a deliberative and altering way. Rather, a court holds a hearing, listens to the arguments of counsel, and then makes a decision based on the facts and law presented to it – all while following the sworn oath to the Constitution. While many may disagree with the law and voice their concerns, the legislative process allows for those concerns to be heeded or not. This leads to the second reason that a court must avoid policy adventures. If a court correctly or incorrectly substitutes its policy preference for the will of the people, then the legislative branch of government is not held accountable for its actions. Rather, the court is given credit for “fixing” the problem. While some may approve of this method in one case, it surely will not work out in other cases that they would disapprove of the court’s preferences. That is why this Court must simply be a conduit of the law.

This case has been framed as a choice between two time frames: six weeks or nine weeks. However, this is **not** the question before this court. The true issue before this Court surrounds

Plaintiffs' claim that the definition of "fetal heartbeat" is unclear. Plaintiffs' proposed policy preference would be that the definition in fact entails the nine-week time frame. However, this Court first looks to the statute to determine whether the time frame envisioned is clear. If it is not clear, then the court looks to the intent of the legislature.

While the question has been framed as a binary choice between six and nine weeks, it is actually a binary choice between six weeks and nothing. As will be discussed throughout this Order, the legislature could not have been more clear that it intended a six-week time frame. Thus, if this Court agrees with Plaintiffs and finds that the legislature failed to make that clear in its definition, then it is not the Court's job to substitute in its own time frame. Because what the parties did not offer this court, but is rife throughout the legislative history and case record, is that there is a plethora of potential time frames when this ban could begin. The legislature clearly intended a biological defining moment to mark the beginning of the ban. Did it make its intent clear in the definition of "fetal heartbeat"? If so, then the six-week mark is the law. If not, then the law is struck down because this Court will not and cannot substitute its own policy preference of some biological defining moment – whether that be nine weeks or any other time frame. That is the choice before this Court.

From the outset, it must be noted that nowhere in the Act do the words "six weeks" or "nine weeks" appear. Where these two time frames come from are from two separate biological defining moments. Generally, Plaintiffs believe that the Act bans abortions at the biological defining moment of when a heart has formed with four chambers, and the State believes this moment begins when there is embryonic cardiac activity.¹ The job of this Court is not to look at the two choices

¹ The declarations from both parties' experts explain at length the medical consensus that they believe defines "fetal heartbeat." This Order uses the term "six" and "nine" weeks when referring to the two biological defining moments that the parties each argued for, and as the parties used the terms.

and pick a policy preference. It is not to substitute the will of the elected representatives with the Court's own personal choices. The job is to determine the text's meaning, what the General Assembly intended with this law, and whether it clearly defined it.

When interpreting the text of a statute or constitutional provision, this Court will always keep several maxims of constitutional interpretation in mind. First, legislative acts are presumed constitutional. Second, courts should always attempt to read a statute as constitutional rather than unconstitutional. Third, and most importantly, courts should always read a statute in congruence with the legislative intent behind the law. This in no way alleviates or removes the judiciary's sacred constitutional right of judicial review; but rather enhances it by saving it for the rare circumstances where it must be wielded. And thus, when judicial review is used and the courts check another branch, it carries a legitimacy that is so vital for our tripartite system of government.

Judicial power, as contradistinguished from the power of the laws, has no existence. Courts are the mere instruments of the law, and can will nothing. When they are said to exercise a discretion, it is a mere legal discretion, a discretion to be exercised in discerning the course prescribed by law; and, when that is discerned, it is the duty of the Court to follow it. Judicial power is never exercised for the purpose of giving effect to the will of the Judge; always for the purpose of giving effect to the will of the Legislature; or, in other words, to the will of the law.

Osborn v. Bank of U.S., 22 U.S. 738, 866, 6 L. Ed. 204 (1824).

The first step this Court will take when determining the meaning of the statute is straight forward: read and apply the clear meaning of the text. The text is the best piece of evidence in determining what the General Assembly meant when it passed a law. However, if the text is not clear, then this Court must attempt to ascertain the intent of the legislature.

It is important to note that the issue before this court is not whether the abortion ban **should** start at six weeks, nine weeks, or some other time. Even more importantly, the question is not: if the ban is at six weeks, is it unconstitutional? The Plaintiffs at oral argument specifically stated

that they are not challenging the constitutionality of the time frame and its relation to the right to privacy. The South Carolina Supreme Court has upheld the constitutionality of the Act. Rather, Plaintiffs are seeking clarity as to what did the General Assembly **intend** when it passed the Act. In addition, Plaintiffs ask for injunctive relief, a drastic measure, so that the law passed by the General Assembly and upheld by our Supreme Court can be stopped until the intent can be determined. This Court will not stop a constitutionally sound law if it is clear what it means and how it applies. The challenge brought to this Court is not whether a six-week ban is good or bad, but merely whether the General Assembly intended a six-week ban when it passed the Act.

II. Background

In 2021, the South Carolina General Assembly passed the Fetal Heartbeat and Protection from Abortion Act. Act No. 1, 2021 S.C. Acts 2. In January 2023, the South Carolina Supreme Court struck down that 2021 Act as unconstitutional. *Planned Parenthood S. Atl. v. State (Planned Parenthood I)*, 438 S.C. 188, 882 S.E.2d 770 (2023). After this ruling, the General Assembly revised the 2021 Act and passed a new version of the Fetal Heartbeat and Protection from Abortion Act. Act No. 70, 2023 S.C. Acts ---, codified at S.C. Code Ann. §§ 44-41-610 to -740 (2023).

In August 2023, this new Act was challenged facially in the Supreme Court, and the Court upheld the law as constitutional. *Planned Parenthood II*, 440 S.C. 465, 892 S.E.2d 121 (2023). However, at oral arguments and in the written opinion, the Court noted that it would “leave for another day” an as-applied challenge to the meaning of “fetal heartbeat.” *Id.* at 474, 892 S.E.2d at 126. Plaintiffs took up this invitation to challenge the Act on an as-applied basis. They asked the Supreme Court to take the case in its original jurisdiction and also sought an injunction. However, in November, the Court refused to grant a preliminary injunction:

Petitioners have filed a petition for original jurisdiction asking the Court to determine the meaning of the term “fetal heartbeat” as used in the 2023 version of the Fetal Heartbeat and Protection from Abortion Act (the Act). Petitioners further ask the Court to enjoin the enforcement of the Act. **We deny the request for injunctive relief.** The petition for original jurisdiction is otherwise denied without prejudice to Petitioners’ right to file an as-applied action in the circuit court.

See Order, South Carolina Supreme Court (Nov. 14, 2023) (emphasis added).

Plaintiffs then filed this action in the Fifth Judicial Circuit in February 2024. All parties have submitted numerous written briefs and reply briefs. In addition, the parties have submitted affidavits of their experts describing the medical consensus regarding the definition of “fetal heartbeat.” On May 2, 2024, this Court heard oral arguments from all parties and subsequently took the matter under advisement.

Recall that the South Carolina Supreme Court upheld the constitutionality of the Act. In accordance with this, Plaintiffs’ counsel did not challenge the constitutionality of the Act in regards to privacy concerns. Rather, at the May 2nd hearing, Plaintiffs requested a preliminary injunction and a declaratory judgment.

III. Discussion

Plaintiffs have moved this Court “to enjoin Defendants from enforcing [the Act] during the pendency of an injunction, as applied to abortions performed on patients whose pregnancies have detectable embryonic electrical activity but where a heart has not yet formed, or between approximately six and nine weeks LMP.” Pls.’ Mot. for Preliminary Inj. 1. In addition to and in conjunction with the requested injunctive relief, Plaintiffs ask this court to “issue a declaratory judgment finding that, consistent with the plain language of the Act: (1) ‘cardiac activity’ is modified by ‘the steady and repetitive rhythmic contraction of the fetal heart’ such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed

by the Act is the point when a heart has formed, which is after approximately nine weeks...” Pls.’
Mot. for Preliminary Inj. 2.

The question of abortion and the right to privacy is morally profound. However, the question before this Court is not the policy preferences and moral decisions that rest on the shoulders of lawmakers, but rather the legal question of statutory interpretation. The specific question in this case boils down to the interpretation of “fetal heartbeat” as defined in the Act. The term “fetal heartbeat” is defined as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” S.C. Code Ann. § 44-41-610(6). The answer to this question is not based on what the law ought to be, but rather what the intent of the law was at the time the General Assembly wrote and passed the law. This Court will only declare what the law is, not what it should be.

A preliminary injunction is used “to preserve the status quo and prevent irreparable harm to the party requesting it.” *Compton v. S.C. Dep’t of Corr.*, 392 S.C. 361, 366, 709 S.E.2d 639, 642 (2011). Before granting injunctive relief, the party seeking such relief must prove three essential elements: “Accordingly, the applicant must establish three elements to receive this relief: (1) he will suffer immediate, irreparable harm without the injunction; (2) he has a likelihood of success on the merits; and (3) he has no adequate remedy at law.” *Id.* An injunction will not be granted lightly, but is a drastic step that a court can take. “The remedy of injunction is a drastic one and ought to be applied with caution.” *Forest Land Co. v. Black*, 216 S.C. 255, 266, 57 S.E.2d 420, 426 (1950). It is important to this Court that the South Carolina Supreme Court did not grant injunctive relief on this exact case in September of 2023, but rather sent the case to the circuit court to be argued and build a record. *See Order*, South Carolina Supreme Court (Nov. 14, 2023). The Act has been in effect ever since.

Plaintiffs have claimed that the plain reading of the Act shows that the ban should be enforced at the nine-week mark. In the alternative, they ask this Court to strike down the Act because the definition of “fetal heartbeat” is unconstitutionally vague. Therefore, to succeed on the merits, Plaintiffs must prove those two issues.

This Court first looks to the second element of “likelihood of success on the merits” because that element focuses on the statutory interpretation question which is so forceful and decisive in this case. Whether Plaintiffs’ have a viable claim is a matter of law because this Court must determine whether the Act is clear or not about what the General Assembly meant in its definition of “fetal heartbeat” and if the nine-week time frame is what the General Assembly intended.

Defendants have asked this Court to dismiss the motion for injunctive relief because they claim that Plaintiffs have failed to state facts sufficient to constitute a cause of action. Rule 12(b)(6), SCRCP; *Brown v. Theos*, 338 S.C. 305, 313, 526 S.E.2d 232, 237 (Ct. App. 1999), *aff’d*, 345 S.C. 626, 550 S.E.2d 304 (2001) (“Where the dispute is not as to the underlying facts but as to interpretation of the law, and development of the record will not aid in the resolution of the issues, it is proper to decide even novel issues on a 12(b)(6) motion.”).

i. Plain Meaning

To determine what the legislature intended, a court must simply read what it wrote. *State v. Hercheck*, 403 S.C. 597, 602–03, 743 S.E.2d 798, 801 (2013) (citation omitted) (“What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will.”). If it is not clear what the legislature intended by simply reading the text, the court must then attempt to ascertain what it intended. *In re Vincent J.*, 333 S.C. 233, 235, 509 S.E.2d 261,

262 (1998) (“The primary function of the Court in interpreting a statute is to ascertain the intention of the legislature.”). While that is simply put, it is anything but. How does a court balance clarifying the ambiguity without buttressing or supplying the judge’s policy preferences or personal opinions? This Court will never supplement the will of the General Assembly with its own interpretations because that would be a direct violation of the Constitution and the sacrosanct doctrine of separation of powers. Rather, this Court will use a scalpel in determining, as best it can, the precise intent by the Act.

Figuring out the intent of the legislature is no easy feat, and is fraught with easy temptations to substitute policy preferences disguised as legislative overtures. This Court is a trial court, which means it is rarely tasked with constitutional interpretations of a first impression. Our Supreme Court is constitutionally tasked and procedurally equipped with the ability to give its final answer on pressing and important questions. However, the parties were specifically tasked with having a circuit court hear and determine this issue, and this Court does not take that responsibility lightly. As difficult as it may be to determine legislative intent, this Court will simply follow South Carolina Supreme Court precedent and look to the original understanding and intent by the General Assembly.

In *State v. Harper*, our Supreme Court held that statutes should be construed similarly to constitutional provisions. *State v. Harper*, 6 S.C. 464, 469–70 (1876) (“As with a statute, so with a Constitution; the Court must give effect, if possible, to its every provision, and render such a construction as will preserve the intention of the framer if it can be collected from the words he has employed...”); see also *City of Charleston v. Oliver*, 16 S.C. 47, 52 (1881) (“The object being to ascertain the intention of the framers of the constitution, which must be gathered from the words used, we must necessarily give to those words the sense in which they are generally used by those

who framed and those who adopted the constitution...”). This proposition was reaffirmed in 2014, when the Supreme Court again stated that “the Court applies rules of construction similar to those used to construe statutes.” *State v. Long*, 406 S.C. 511, 514, 753 S.E.2d 425, 426 (2014). “When this Court is called to interpret our Constitution, it is guided by the principle that both the citizenry and the General Assembly have worked to create the governing law.” *Id.* “The Court will look at the ‘ordinary and popular meaning of the words used,’...” *Id.*

Turning to the specific statute in question, this Court must first determine if the text is clear about when a “fetal heartbeat” begins. If it is, then the inquiry ends. *In re Vincent J.*, at 235, 509 S.E.2d at 262 (“Under the plain meaning rule, it is not the Court's place to change the meaning of a clear and unambiguous statute.”). The Plaintiffs argue that the language of the text is abundantly clear and only has one interpretation: “fetal heartbeat” begins after a heart has formed which is around nine weeks. They argue that this is made clear by the commas offsetting the term “cardiac activity” which further define exactly what that activity is: “steady and repetitive rhythmic contraction of the fetal heart[.]”

Based on the declaration of Dr. Farris, the term “heart” indicates an organ with four functioning chambers – which is not present until approximately nine weeks. Farris Decl. at ¶ 10. Additionally, Dr. Crockett stated in her affidavit that “structures representing the functional elements of a heart are not present until after approximately [9 weeks LMP].” Crockett Decl. at ¶ 24.

Contrary to Plaintiffs’ experts, the States’ expert stated that “there is medical consensus that the organ identified here as the embryonic heart contracts to circulate blood throughout the embryo around 5-6 weeks LMP. Skop Decl. at ¶ 7. Plaintiffs have stated that the definition of “cardiac activity” in the Act requires a steady and rhythmic beat, and that this is not possible until

at least nine weeks. However, the States' expert claims that this is exactly the case at the six-week mark. Skop Decl. at ¶ 18 ("The science is clear: An embryo's heart is beating steadily, repetitively, and rhythmically—and functioning as a heart should, circulating oxygen-rich blood throughout the preborn body—by the time the heartbeat can be detected around 6 weeks LMP."). Additionally, the States' expert further explains her scientific opinion and reasoning behind this conclusion:

While it is true, as Dr. Crockett stated, that the four chambers of the heart are not developed until the ninth week LMP, there is no medical consensus that a functioning blood-circulating embryonic heart does not begin to exist until it develops all four chambers. In fact, a "heart" is defined as an organ which "continuously pumps oxygen and nutrient-rich blood throughout your body to sustain life." Or as Dr. Crockett states in her Declaration, "[t]he human heart is the primary organ of the circulatory system, serving to pump blood throughout the body." Crockett Dec. at ¶ 12 (emphasis added). This is precisely what an embryonic heart does even before the time it can be detected by ultrasound technology. As Dr. Crockett acknowledges, "the organ will begin to transmit electrical impulses which causes cellular contractions on approximately day 21 of development; blood begins to circulate in the embryo on days 24-25 of development (5 weeks LMP)." *Id.* at ¶ 27 (emphasis added). As a board-certified obstetrician practicing over thirty years, I can attest this heartbeat can usually be detected by around 6 weeks LMP. The ultrasound doppler reflects the movement of blood within the contracting heart, that is, the embryonic "heartbeat."

Id. at ¶ 12-13.

The key question in confirming the presence of cardiac activity is not, "When is the heart developmentally complete?" but, "When does it perform the function of a heart?" Although the embryonic heart has not yet reached its final shape, electrical impulses generated by the cardiac conduction system cause muscular contractions to propel oxygen-carrying blood cells throughout the embryo's body beginning in the 6th week of gestation. These rhythmic contractions are not haphazard, but regular and repetitive, and if the heartbeat were to cease, the unborn child would die. The blood flow that can be detected by ultrasound at 6 weeks LPM corresponds directly with these contractions of the embryonic heart (i.e., heartbeats).

Id. at ¶ 15.

These dueling experts alone would likely call into question the clarity of the definition, but by Plaintiffs' counsel's own admission at oral argument, there is a term in the definition that is not

clear. According to Plaintiffs, the term “fetus” or “fetal” refers to a period of at least 10 weeks. Farris Decl. at ¶ 11. (“Additionally, in the field of medicine, the developing organism present in the gestational sac during pregnancy is most accurately termed an ‘embryo’ before approximately ten weeks LMP. The term ‘fetus’ is not used until after this time.”). As Plaintiffs have argued, the heart forms as early as nine weeks. Therefore, the term “fetal heart” as used in the definition would be contradictory and not clear as to what exactly time frame it is referring to. *See also* Pls.’ Mem. in Supp. 9 n. 4. (“Physicians and scientists may use different verbiage in talking about cardiac development at different stages of pregnancy. **For example, some may use the term “heartbeat” to refer to early embryonic electrical activity.** However, the medical consensus is that the four main components of a heart (four chambers, walls, valves, and conduction system) form after approximately nine weeks LMP. Crockett Decl. ¶ 32.”) (emphasis added). The only point of this line of argument that this Court is making is to illustrate that while Plaintiffs claim the definition of “fetal heartbeat” clearly indicates the nine-week time frame, this definition is in fact ambiguous.

If the definition were as clear as Plaintiffs claim, then this case would be far simpler than it is. *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) (“Where the statute's language is plain and unambiguous, and conveys a clear and definite meaning, the rules of statutory interpretation are not needed and the court has no right to impose another meaning.”) Even the South Carolina Supreme Court appears to acknowledge that the definition is not textually clear:

We leave for another day (in an as-applied constitutional challenge) the meaning of “fetal heartbeat” and whether the statutory definition—“cardiac activity, *or* the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac”—refers to one period of time during a pregnancy or two separate periods of time.

Planned Parenthood II, at n. 4; *Id.* at 497, 892 S.E.2d at 139 (“I say ‘if’ the 2023 Act is viewed as a six-week ban because the majority now states there is uncertainty about what the language even means.”) (Beatty, C.J., dissenting).

At oral arguments for *Planned Parenthood II*, the justices noted their concerns with the ambiguity of the text of the statute:

Those commas may or may not have great significance. Do you think that the phrase that is within the commas, the parenthetical within the commas, is actually a phrase that the legislature intended to define the term “cardiac activity” or to supplement the term “cardiac activity”? In other words, the question that I’m asking you is simply is “fetal heartbeat” defined simply as “any cardiac activity” or is it defined as “the steady and repetitive rhythmic contraction of the fetal heart?”

Oral Argument Video 0:07:10–0:08:10, *Planned Parenthood II*, No. 2023-000896 (S.C.) (Few, J.); *Id.* 0:09:12 – 0:09:18 (“...because you just walked yourself into a gigantic hole of ambiguity.”).

The definition of “fetal heartbeat” is not clear and unambiguous and does not convey a definite meaning on its face. Therefore, this Court must look to the intent of the General Assembly in determining, if possible, what it envisioned. *Bankers Tr. of S.C. v. Bruce*, 275 S.C. 35, 37, 267 S.E.2d 424, 425 (1980) (“The cardinal rule of statutory interpretation is to ascertain and effectuate the legislative intent wherever possible.”). It must be noted, however, that at oral arguments, counsel for both parties conceded that the definition of “fetal heartbeat” refers to one point in time and not two.

ii. Ambiguity

If a statute is ambiguous, as they often are, then that simply means that this Court must continue its inquest into the intent behind the legislation so that it can give meaning to the words in the law. *Lambries v. Saluda Cnty. Council*, 409 S.C. 1, 10, 760 S.E.2d 785, 789 (2014) (“If a statute is ambiguous, the courts must construe its terms.”) This Court will look to the intent and

understanding by those who proposed, wrote, and passed the law: the General Assembly. As a trial court, this Court will also be persuaded and guided by how the South Carolina Supreme Court has approached this complex and heavy issue.

As has been well said, “in interpreting an ambiguous statute the question is what the words meant to those using them, and to ascertain this the courts should examine the statute in the light of the history of its enactment, the contemporary history of the conditions and situation of the people, the economic and sociological policy of the state, its Constitution and laws, and all other matters of common knowledge within the limits of their jurisdiction.”

Crescent Mfg. Co. v. Tax Comm'n, 129 S.C. 480, 124 S.E. 761, 767 (1924)

i. Legislative Intent

Because the text is not clear, this Court must further delve into the legislative intent behind the definition. Did the General Assembly intend to ban abortions at six weeks or some other point? This Court believes that there is no doubt as to what the General Assembly meant when it passed the Act. This Court cannot locate one instance of legislative history indicating a time frame of any other period other than the six-week mark, much less nine weeks. The legislative record of this Act is rife with references to the six-week time frame.

- “a heartbeat can be detected between six and seven weeks.” S.C. Senate, Video of Floor Proceedings, at 1:31:00 (Feb. 7, 2023) (Sen. Massey).
- Arguing against S. 474, Senator Senn insisted that a “six-week ban, as the Court actually started calling it and as most people call it,” “was already held unconstitutional one time” in *Planned Parenthood I*. S.C. Senate, Video of Floor Proceedings, at 3:45:10 (Feb. 9, 2023) (Sen. Senn).
- S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 1:40:34 (May 9, 2023) (Rep. Brittain).
- “six weeks is six weeks. It’s the heartbeat bill.” S.C. House Judiciary Comm, Constitutional Laws Subcomm., Video of Comm. Hearing, at 46:08 (May 9, 2023) (Rep. Wheeler).
- S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 3:16:40–3:21:20 (May 9, 2023) (Rep. Wheeler).

- “the very crux of this piece of legislation surrounds time” and “it’s a six-week ban.” S.C. House, Video of Floor Proceedings Part 1, at 8:49:44 (May 16, 2023) (Rep. Bamberg).
- “the General Assembly passed the act which prohibits an abortion after around the sixth week of gestation, which we are here discussing again” with S. 474. *Id.* at 12:28:54 (Rep. Bauer).
- “now cutting off abortion—or the access to abortion—at six weeks.” *Id.* at 2:35:15 (Rep. Dillard).
- “still ha[s] the six weeks.” S.C. House Judiciary Comm., Video of Comm. Hearing Part 1, at 0:13:30 (May 9, 2023) (Rep. Bernstein)
- S. 474 prohibits abortion at “six weeks.” S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 0:10:58 (May 9, 2023) (Rep. Thigpen)
- “six weeks is a total abortion ban.” *Id.* at 3:25:443 (Rep. Bamberg)
- S.C. House, Video of Floor Proceedings Part 1, at 0:59:15 (May 16, 2023) (Rep. Wetmore)
- “at six weeks most women don’t even know that they’re pregnant.” *Id.* at 3:22:40 (May 16, 2023) (Rep. Bamberg)
- “we’re doing the same exact thing on this bill” as the General Assembly did in the 2021 Act, and the Supreme Court has held “the six-week ban” is unconstitutional. *Id.* at 3:31:07 (Rep. Bamberg)
- “we’ve decided against our better judgment we’re going to stick with a six-week ban.” *Id.* at 7:13:17 (Rep. Bamberg)
- S. 474 “has the gestational age as six weeks.” *Id.* at 7:28:00 (Rep. Bernstein)
- *Id.* at 13:10:50 (Rep. Howard)
- “this essentially amounts to a total ban because it’s next to impossible for a woman to know she’s pregnant at six weeks.” S.C. House, Video of Floor Proceedings Part 2, at 2:16:50 (May 16, 2023) (Rep. Rose)
- S. 474 is a “total ban” because “very little people can actually know that they’re pregnant at six” weeks. *Id.* at 6:36:15 (Rep. Rose)

In addition to the statements by legislators as to their understanding of the law, a statement by Senators Massey, Campsen, and Grooms entered into the Senate Journal cites to the American Pregnancy Association in describing the time frame of when the Act would begin the ban. *See* Senate Journal, Gen. Assemb., 125th Session, February 9, 2023 (“According to the American Pregnancy Association the heartbeat of an unborn child can be detected between 6 ½ to 7 weeks

of pregnancy though it is possible, though much less likely, that a heartbeat can be detected a week earlier -- about 5 ½ weeks.”). In that same Senate Journal, Senator Senn, who opposed the measure, also described the Act as banning abortions at the six-week time frame. *Id.* (“S. 474 is another six-week ban on abortion Bill.” “Yet the same issues that were presented in the first six-week ban on abortion case will also need to be addressed in the second.” “The new six-week abortion ban is S. 474.”)

This Court can draw absolutely no other conclusion than that the General Assembly intended for the Act to begin at the six-week mark. To find that the General Assembly intended anything other than the six weeks would fly in the face of statutory interpretation and constitutional requirements. *State v. Pittman*, 373 S.C. 527, 561, 647 S.E.2d 144, 161 (2007) (“All rules of statutory construction are subservient to the maxim that legislative intent must prevail if it can be reasonably discovered in the language used.”).

ii. Court precedent

In *Planned Parenthood I*, the Supreme Court repeatedly and adamantly referred to the ban as a “six-week” limit throughout the opinion. While this case discussed the 2021 Act, it used the same definition of “fetal heartbeat” that is before this Court. *Compare* 2023 S.C. Acts No. 70, § 2 (S.C. Code Ann. § 44-41-610(6)), *with* 2021 S.C. Acts No. 1, § 3 (S.C. Code Ann. § 44-41-610(3) (repealed)). The Supreme Court used the phrase “six-week ban” in some form over 60 times. To highlight some examples:

- “In 2021, the General Assembly passed the Act, which prohibits an abortion after around six weeks gestation.” *Planned Parenthood I*, 438 S.C. 188, 195, 882 S.E.2d 770, 774 (2023).
- “...six weeks, precisely when the Act bans this medical procedure.” *Id.* at 214, 882 S.E.2d at 784.

- “Six weeks is, quite simply, not a reasonable period of time for these two things to occur, and therefore the Act violates our state Constitution's prohibition against unreasonable invasions of privacy.” *Id.* at 217, 882 S.E.2d at 786.
- “However, South Carolina's law is based on a factual premise—the existence of a fetal heartbeat as early as six weeks of gestation...” *Id.* at 221, 882 S.E.2d at 788.
- “In the instant case, the Act prohibits an abortion after a “fetal heartbeat” has been detected. S.C. Code Ann. § 44-41-680(A) (Supp. 2022). The Act defines a fetal heartbeat broadly, as any “cardiac activity.” *Id.* § 44-41-610(3). As discussed, this activity can be present as early as six weeks into a pregnancy.” *Id.* at 237, 882 S.E.2d at 797.
- “Banning abortions at the stage of detectable embryonic “cardiac activity,” presumably at the six-week gestation period...” *Id.* at 237-238, 882 S.E.2d at 797.
- “The six-week or detectable “cardiac activity” limitation...” *Id.* at 243, 882 S.E.2d at 800.
- “Petitioners note that when the Act became effective in February 2021, it banned most abortions upon the detection of embryonic “cardiac activity,” generally said to occur at approximately six weeks...” *Id.* at 246, 882 S.E.2d at 801.
- “‘Fetal Heartbeat Act’—also commonly referred to as the ‘six-week bill?’ ” *Id.* at 257, 882 S.E.2d at 807.
- “...our General Assembly specifically recognized in the six-week bill...” *Id.* at 269, 882 S.E.2d at 814.
- “The Fetal Heartbeat Act is referred to as the ‘six-week bill’ because cardiac activity ‘can be detected by transvaginal ultrasound by 6-7 weeks post [last menstrual period] or 4-5 weeks post-conception.’ (J.A. at 305 & n.6). The State contends this cardiac activity—the ‘fetal heartbeat’—can be detected at approximately six weeks. (Resp't Att'y General Br. 6). If the time period on which the common name ‘six-week bill’ is based were measured from conception—as is the name twenty-week bill—the common name would be the ‘four-week bill.’ This becomes important to my analysis in subsections V.B. and V.D. of this opinion.” *Id.* at 258, 882 S.E.2d at 808.

The reason that this Court finds the opinion of the Supreme Court so persuasive is not because it carries more weight than the legislative record, but rather as a trial court, this Court will always attempt to ascertain and follow the precedent as set out by the highest court in our state. More recently, an Order Granting a Preliminary Injunction by Judge Clifton Newman of the circuit court referred to the 2023 Act as the “Six-Week Ban.” Order, *Planned Parenthood South Atlantic v. State*, No. 2023-CP-40-002745 (S.C.Com.Pl. May 26, 2023).

After reviewing the legislative record and judicial precedent, this Court has no choice but to declare the clear intent of the General Assembly when it passed this Act: the legislature, **beyond any doubt**, intended the ban to start at the six-week mark and not another time. *Mitchell v. City of Greenville*, 411 S.C. 632, 634, 770 S.E.2d 391, 392 (2015) (“The cardinal rule of statutory interpretation is to ascertain and effectuate the legislative intent whenever possible.”); *I’On, L.L.C. v. Town of Mt. Pleasant*, 338 S.C. 406, 412, 526 S.E.2d 716, 719 (2000) (“A statute as a whole must receive a practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of the lawmakers.”); *State v. Baker*, 310 S.C. 510, 512, 427 S.E.2d 670, 671–72 (1993) (“Our primary function in interpreting a statute is to ascertain the intent of the Legislature.”); *Browning v. Hartvigsen*, 307 S.C. 122, 125, 414 S.E.2d 115, 117 (1992) (“The real purpose and intent of the lawmakers will prevail over the literal import of the words.”). Because this Court finds that the statute has only one meaning based on the intent of the General Assembly, this Court cannot apply an alternative interpretation. *State v. Pittman*, at 562, 647 S.E.2d at 162 (“Because we find that the statute has only one meaning, we cannot apply an alternate interpretation.”).

Even if this Court is presented with two susceptible definitions of “fetal heartbeat” – one at six weeks and the other at nine – this Court must adopt the definition that the legislature intended and not the one that “presents grave and doubtful constitutional questions.” *Edwards v. State*, 383 S.C. 82, 91–92, 678 S.E.2d 412, 417 (2009) (“Where a statute is susceptible of two constructions, one of which presents grave and doubtful constitutional questions, and the other of which avoids those questions, the Court’s duty is to adopt the latter.”); *State v. Pittman*, at 562, 647 S.E.2d at 162 (“This Court has held that where a statute is susceptible to *more than one construction*, the court should interpret the statute so as to avoid constitutional questions[.]”).

iii. Constitutional interpretation

The legal issue of defining “fetal heartbeat” has been positioned as a choice between two policy preferences: six or nine weeks. But this is not the case, and this Court does not believe that is what the Supreme Court referred to when it sent this case down to the trial arena. This Court believes that the issue that the Supreme Court was seeking to clarify was: Even though the General Assembly clearly intended the ban to begin at six weeks, did it properly write that definition into the Act?

After determining that the statute is not clear on its face, but the legislative intent is crystal clear, the next issue raised by Plaintiffs is the contention that the statute is too vague to survive constitutional muster. For Plaintiffs to succeed in challenging the statute for vagueness, they have a high burden to clear.

This Court has a limited scope of review in cases involving a constitutional challenge to a statute because all statutes are presumed constitutional and, if possible, will be construed to render them valid. *Davis v. County of Greenville*, 322 S.C. 73, 470 S.E.2d 94 (1996). “A possible constitutional construction must prevail over an unconstitutional interpretation.” *Westvaco Corp. v. South Carolina Dep't of Revenue*, 321 S.C. 59, 467 S.E.2d 739 (1995). Further, a legislative act will not be declared unconstitutional unless its repugnance to the Constitution is clear and beyond a reasonable doubt. *Id.* **Because Curtis does not establish an infringement of a constitutional right, the trial court was correct in holding he is not likely to succeed on the merits of the following constitutional challenges.**

Curtis v. State, 345 S.C. 557, 569–70, 549 S.E.2d 591, 597 (2001) (emphasis added). The constitutional issue at hand in this case is the right to procedural due process – which is violated by vague laws. The South Carolina Constitution’s Due Process Clause states that no person “shall . . . be deprived of life, liberty, or property without due process of law.” S.C. Const. art. I, § 3.

This Court is bound by the Constitution and Supreme Court precedent interpreting the Constitution which requires that courts to always seek to find statutes constitutional if permissible.

Davis v. Cnty. of Greenville, 322 S.C. 73, 77, 470 S.E.2d 94, 96 (1996) (“Accordingly, we construe the statutes so as to render them constitutional.”); *Last v. MSI Const. Co.*, 305 S.C. 349, 352, 409 S.E.2d 334, 336 (1991) (“All statutes are presumed constitutional and will, if possible, be construed so as to render them valid.”); *Mitchell v. Owens*, 304 S.C. 23, 24, 402 S.E.2d 888, 889 (1991) (“A statute enacted pursuant to legislative power is presumptively constitutional.”); *Bodman v. State*, 403 S.C. 60, 66, 742 S.E.2d 363, 365–66 (2013) (“We are reluctant to declare a statute unconstitutional. Hence, we will make every presumption in favor of finding it constitutional. Moreover, if possible, we must construe a statute so that it is valid. The party challenging the statute bears the heavy burden of proving that ‘its repugnance to the constitution is clear and beyond a reasonable doubt.’”).

i. Constitutional Avoidance

Plaintiffs ask this Court – if it finds the statutory language ambiguous – to construe the Act to avoid constitutional infirmity and interpret the definition consistent with the medical definition. Pls.’ Mem. in Supp. 16. But this Court has been presented with a medical definition from both experts. *See* Farris Decl.; Crockett Decl.; Skopp Decl. One states that the definition is consistent with a nine-week time frame and the other with the six-week. Both declarations go into great detail about this finding and how each conclusion is reached. While this might appear to balance the scales, they surely fall in favor of the State based on the record of legislative intent and that the General Assembly intended for the six-week mark to be the moment in time. *Planned Parenthood II*, at 475, 892 S.E.2d at 127 (“This deference is not diminished simply because there is medical support for ‘both sides’ of an issue.”).

Therefore, Plaintiffs are unlikely to succeed on the merits as to this constitutional issue because a court is required to construe a statute in alignment with the intent of the legislative body

that passed the law. Additionally, the South Carolina Supreme Court has already upheld the constitutionality of the Act in *Planned Parenthood II*.

ii. Vagueness

In *Planned Parenthood II*, the Supreme Court held for another day the as applied challenge to the definition of “fetal heartbeat.” *Planned Parenthood II*, at n. 4 (“We leave for another day (in an as-applied constitutional challenge) the meaning of ‘fetal heartbeat’ and whether the statutory definition—‘cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac’—refers to one period of time during a pregnancy or two separate periods of time.”). “The line between facial and as-applied relief is fluid one, and many constitutional challenges may occupy an intermediate position on the spectrum between purely as-applied relief and complete facial invalidation.” 16 C.J.S. Constitutional Law § 153. “Statutes are ordinarily challenged, and their constitutionality evaluated, ‘as applied’-that is, the plaintiff contends that application of the statute in the particular context in which he has acted, or in which he proposes to act, would be unconstitutional. The practical effect of holding a statute unconstitutional ‘as applied’ is to prevent its future application in a similar context, but not to render it utterly inoperative.” *Ada v. Guam Soc. of Obstetricians & Gynecologists*, 506 U.S. 1011, 113 S. Ct. 633, 121 L. Ed. 2d 564 (1992) (Scalia, J., Rehnquist, C.J., and White, J., dissenting). “Conversely, ‘[i]n an as-applied’ challenge, the party challenging the constitutionality of the statute claims that the ‘application of the statute in the particular context in which he has acted, or in which he proposes to act, would be unconstitutional.’” *State v. German*, 439 S.C. 449, 466, 887 S.E.2d 912, 921 (2023) (citation omitted).

That day is now upon us, and a decision must be made. Because this is a matter of first impression as to this specific definition in the Act, this Court will follow the mandate of the

Supreme Court and provide guidance as to its application based on the intent of the General Assembly and not based on any personal preference or policy choice. *Town of Mount Pleasant v. Chimento*, 401 S.C. 522, 534, 737 S.E.2d 830, 838 (2012) (“In deciding a void-for-vagueness challenge to a statute, the Court must look first to see whether the allegedly unconstitutional statute has been interpreted or limited by prior judicial decisions.”).

Even though the legislative intent is abundantly clear, the General Assembly still must actually write the law so that it is clear for the public to understand what it is. If the legislature fails at this, then the law will fail for vagueness. Our Supreme Court has made clear that the legislature must make laws clear enough to survive a due process challenge. *Curtis v. State*, at 571–72, 549 S.E.2d at 598 (“The constitutional standard for vagueness is the practical criterion of fair notice to those to whom the law applies.”); *State v. Albert*, 257 S.C. 131, 134, 184 S.E.2d 605, 606 (1971) (“The concept of vagueness or indefiniteness rests on the constitutional principle that procedural due process requires fair notice and proper standards for adjudication. The primary issues involved are whether the provisions of a penal statute are sufficiently definite to give reasonable notice of the prohibited conduct to those who wish to avoid its penalties and to apprise judge and jury of standards for the determination of guilt.”); *Toussaint v. State Bd. of Med. Examiners*, 303 S.C. 316, 320, 400 S.E.2d 488, 491 (1991) (“A law is unconstitutionally vague if it forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess as to its meaning and differ as to its application.”)

In addition, our Supreme Court and the United States Supreme Court have held that the standard for vagueness applies to those to whom the law is being applied. *Id.* (citations omitted) (“The constitutional standard for vagueness is the practical criterion of fair notice to those to whom the law applies. When the persons affected by the law constitute a select group with a specialized

understanding of the subject being regulated, the degree of definiteness required to satisfy due process is measured by the common understanding and knowledge of the group.”); *Huber v. S.C. State Bd. of Physical Therapy Examiners*, 316 S.C. 24, 26–27, 446 S.E.2d 433, 435 (1994) (“When the persons affected by the law constitute a select group with a specialized understanding of the subject being regulated, the degree of definiteness required to satisfy due process is measured by the common understanding and knowledge of the group.”)

Specifically, this Court will look to two lines of inquiry for a vagueness issue: is there fair notice to those affected by the law or does the law have the potential for arbitrary enforcement. *Johnson v. United States*, 576 U.S. 591, 595, 135 S. Ct. 2551, 2556, 192 L. Ed. 2d 569 (2015) (“Our cases establish that the Government violates this guarantee by taking away someone's life, liberty, or property under a criminal law so vague that it fails to give ordinary people fair notice of the conduct it punishes, or so standardless that it invites arbitrary enforcement.”); *State v. Lewis*, 434 S.C. 158, 167–68, 863 S.E.2d 1, 6 (2021) (citation omitted) (“Simply because a statute uses undefined terms or could have been drafted more precisely does not render it unconstitutionally vague. ...Instead, to satisfy due process concerns, a statute must be sufficiently definite to enable a person of common intelligence to not have to guess as to its meaning.”); *State v. Green*, 397 S.C. 268, 279, 724 S.E.2d 664, 669 (2012) (“A law is unconstitutionally vague if it forbids or requires the doing of an act in terms so vague that a person of common intelligence must necessarily guess as to its meaning and differ as to its application.”).

In the case at hand, this Court has already stated that the definition of “fetal heartbeat” is ambiguous, however the inquiry does not end there. The finding of ambiguity is merely a statutory interpretation, while the finding of vagueness is a much higher level of constitutional interpretation.

As discussed earlier, the term “fetal heartbeat” is defined as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” S.C. Code Ann. § 44-41-610. Additionally, the General Assembly made the following finding with the Act: “(2) Cardiac activity begins at a *biologically identifiable moment* in time, normally when the fetal heart is formed in the gestational sac.” South Carolina Fetal Heartbeat and Protection from Abortion Act, Act No. 70, 2023 S.C. Acts —, — § 1(2) (emphasis added); *Planned Parenthood II*, at 475, 892 S.E.2d at 127 (“As an initial matter, we recognize that legislative findings are entitled to deference and may be rejected only if determined to be arbitrary as a matter of law.”).

For three important reasons, this Court finds that the Plaintiffs have not met their burden in showing that the Act’s ban is void for vagueness. This Court received legal briefs, expert declarations, and oral arguments from both parties – which is what this Court decides the issue of vagueness on. First, counsel for Plaintiffs stated at oral argument that they were asking this Court to give a declaratory judgment as to whether the time frame was six weeks or nine weeks. This is important because it is a tacit admission that it is a choice between two definite time periods. Which leads to the second and most important point: a biological defining moment as intended by the General Assembly.

During oral arguments, both Plaintiffs and Defendants agreed that the six-week time frame was a biological identifiable moment. This is extremely important because Plaintiffs have not made the argument that Planned Parenthood was unable to determine when the six-week time “moment” was, but rather that they were not sure if the “moment” was the six-week mark or the nine-week mark. *See also* Pls.’ Mem. in Supp. 10 (“...[Plaintiffs] have had no choice but to stop providing abortions as soon as embryonic electrical activity can be detected via ultrasound – after approximately six weeks LMP (and sometimes sooner).”). This is imperative because it goes to

the key issue of a vagueness challenge which the Plaintiffs carry the burden. In addition to the legal arguments, Plaintiffs' expert states this point in her declaration and makes clear that they know when the six-week biological defining moment is, but that they disagree that it should be the starting point:

Due to the Act's severe criminal and civil penalties, when the Act was first passed in May of this year, I assumed it to prohibit abortion after the detection of embryonic electrical activity, which can be observed through ultrasound as early as six weeks as measured from the first day of a patient's last menstrual period ("LMP"). I thus understood the term "fetal heartbeat" to cover not just a "heartbeat" in the medical sense, but also early embryonic electrical activity present before development of any cardiovascular system. However, the South Carolina Supreme Court, at oral argument and in the majority decision, introduced the question of whether the statutory definition of "fetal heart" defines "cardiac activity" with the clause "or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac."⁴ In other words, the Court posed the question as to whether the Act prohibits abortion after embryonic electrical activity can be detected, as early as six weeks LMP, or after a heart has formed after approximately nine weeks LMP, before leaving this question unanswered.

Farris Decl. ¶ 7.

Accordingly, based on this ambiguity first raised by the South Carolina Supreme Court, I am unable to understand with confidence at what point(s) in pregnancy abortion is prohibited.

Id. ¶ 8. The declaration and statements by counsel indicate to this Court that Plaintiffs do not have to guess at when the ban begins – which is a crucial factor in a void for vagueness argument.

And third, and similarly to the second point, Planned Parenthood has stated that they have interpreted the ban at six weeks and used that as their time frame.

Because of the ambiguity about which point in pregnancy abortion is banned by the Act, on August 23, 2023, PPSAT stopped performing the vast majority of abortions—any with detectable embryonic electrical activity—that we performed before the Act went into effect. Because we face the threat of civil and criminal penalties for violating the Act, we must presume that a "fetal heartbeat" can be detected after approximately six weeks LMP—despite the fact that no heart has formed at that point and thus there is no heartbeat.

Id. ¶ 14. This again goes to the requirement of a vagueness argument that the Plaintiffs must guess as to the required conduct of the statute and that the law may be applied arbitrarily.

The South Carolina Supreme Court and the South Carolina Constitution require more than simply having an ambiguous statute or one that is subject to more than one interpretation. The vagueness doctrine is a far-reaching remedy and requires that the parties affected by the law suffer from guesswork, speculation, and arbitrariness. *Broadrick v. Oklahoma*, 413 U.S. 601, 608, 93 S. Ct. 2908, 2913, 37 L. Ed. 2d 830 (1973) (“Words inevitably contain germs of uncertainty...”); *State v. Lewis*, at 167, 863 S.E.2d at 6 (“Simply because a statute uses undefined terms or could have been drafted more precisely does not render it unconstitutionally vague.”). That is not the case here based on the evidence provided by Plaintiffs.

iii. Separation of Powers

The doctrine of separation of powers is at the forefront of this case because it involves the interpretation of a statute that is far reaching and consequential. But no matter the stakes, this Court will always follow its constitutional mandate. S.C. Const. art. I, § 8 (“In the government of this State, the legislative, executive, and judicial powers of the government shall be forever separate and distinct from each other, and no person or persons exercising the functions of one of said departments shall assume or discharge the duties of any other.”); *Edwards v. State*, at 90, 678 S.E.2d at 416 (“One of the prime reasons for separation of powers is the desirability of spreading out the authority for the operation of the government to prevent the concentration of power in the hands of too few and provide a system of checks and balances.”); *State ex rel. McLeod v. McInnis*, 278 S.C. 307, 312, 295 S.E.2d 633, 636 (1982) (“The legislative department makes the laws; the executive department carries the laws into effect; and the judicial department interprets and declares the laws.”).

If this Court were to cast aside the clear intent of the legislature when it wrote this law because of policy reasons, then this Court would be substituting its own judgment for that of the legislative body. That would be a clear violation of the separation of powers doctrine because the courts are not equipped with the constitutional authority or technical power to make policy decisions that legislators have been tasked with. *Abbeville Cnty. Sch. Dist. v. State*, 410 S.C. 619, 664-666, 767 S.E.2d 157, 180-182 (2014) (Kittredge, J., dissenting).

IV. Conclusion

In conclusion, this Court holds that it is clear beyond a shadow of a doubt that the General Assembly intended, and the public understood, that the time frame of the Act would begin around the six-week mark. The moral and ethical issues that this case presents are immense and this Court does not take that lightly. However, as Justice Kittredge noted in *Planned Parenthood II*, the courts must respect the separation of powers principles and the limited (non-policy) role it is enshrined with, and this Court must approach this case with one single commitment: to honor the rule of law. The South Carolina Supreme Court and the General Assembly have spoken. This Court must listen.

For the foregoing reasons, Plaintiffs' Motion for Injunctive and Declaratory Relief is **DENIED.**

AND IT IS SO ORDERED.

The Honorable Daniel McLeod Coble

May 16, 2024.

[ELECTRONIC SIGNATURE TO FOLLOW.]



Richland Common Pleas

Case Caption: Planned Parenthood South Atlantic , plaintiff, et al vs State Of South Carolina , defendant, et al
Case Number: 2024CP4000762
Type: Order/Other

So Ordered

s/ Daniel Coble, 2774

Electronically signed on 2024-05-16 16:11:39 page 31 of 31

**STATE OF SOUTH CAROLINA
RICHLAND COUNTY**

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients, and
its physicians and staff;

KATHERINE FARRIS, M.D., on behalf of
herself and her patients;

TAYLOR SHELTON.

Plaintiffs,

v.

SOUTH CAROLINA;

ALAN WILSON, in his official capacity as
Attorney General of South Carolina;

EDWARD SIMMER, in his official capacity as
Director of the South Carolina Department of
Health and Environmental Control;

ANNE G. COOK, in her official capacity as
President of the South Carolina Board of Medical
Examiners;

STEPHEN I. SCHABEL, in his official capacity
as Vice President of the South Carolina Board of
Medical Examiners;

GEORGE S. DILTS, in his official capacity as a
Member of the South Carolina Board of Medical
Examiners;

DION FRANGA, in his official capacity as a
Member of the South Carolina Board of Medical
Examiners;

RICHARD HOWELL, in his official capacity as
a Member of the South Carolina Board of
Medical Examiners;

**IN THE COURT OF COMMON
PLEAS FOR THE FIFTH
JUDICIAL CIRCUIT**

C/A No.: 2024-CP-[]-_____

SUMMONS

ROBERT KOSCIUSKO, in his official capacity as a Member of the South Carolina Board of Medical Examiners;

THERESA MILLS-FLOYD, in her official capacity as a Member of the South Carolina Board of Medical Examiners;

JENNIFER R. ROOT, in her official capacity as a Member of the South Carolina Board of Medical Examiners;

CHRISTOPHER C. WRIGHT, in his official capacity as a Member of the South Carolina Board of Medical Examiners;

SAMUEL H. McNUTT, in his official capacity as Chairperson of the South Carolina Board of Nursing;

SALLIE BETH TODD, in her official capacity as Vice Chairperson of the South Carolina Board of Nursing;

TAMARA DAY, in her official capacity as Secretary of the South Carolina Board of Nursing;

KELLI GARBER, in her official capacity as a Member of the South Carolina Board of Nursing;

LINDSEY K. MITCHAM, in her official capacity as a Member of the South Carolina Board of Nursing;

REBECCA MORRISON, in her official capacity as a Member of the South Carolina Board of Nursing;

KAY SWISHER, in her official capacity as a Member of the South Carolina Board of Nursing;

ROBERT J WOLFF, in his official capacity as a Member of the South Carolina Board of Nursing;

SCARLETT A. WILSON, in her official
capacity as Solicitor for South Carolina's Ninth
Judicial Circuit; and

BYRON E. GIPSON, in his official capacity as
Solicitor for South Carolina's Fifth Judicial
Circuit.

Defendants.

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, a copy of which is herewith served upon you, and to serve a copy of your Answer to the said Complaint upon the subscriber, Burnette Shutt & McDaniel, PA, 912 Lady Street (29201), Second Floor, P.O. Box 1929, Columbia, South Carolina 29202, within 30 days after service hereof, exclusive of the day of such service. If you fail to answer the Complaint within the aforesaid time, judgment by default will be rendered against you for the relief demanded in the Complaint.

/s/ M. Malissa Burnette
M. Malissa Burnette
Kathleen McDaniel
Grant Burnette LeFever
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Columbia, SC

February 5, 2024

**STATE OF SOUTH CAROLINA
RICHLAND COUNTY**

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients, and
its physicians and staff;

KATHERINE FARRIS, M.D., on behalf of
herself and her patients;

TAYLOR SHELTON.

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Examiners;

DION FRANGA, in his official capacity as a
Member of the South Carolina Board of Medical
Examiners;

RICHARD HOWELL, in his official capacity as
a Member of the South Carolina Board of
Medical Examiners;

**IN THE COURT OF COMMON
PLEAS FOR THE FIFTH
JUDICIAL CIRCUIT**

C/A No.: 2024-CP-[]-_____

**COMPLAINT FOR
DECLARATORY AND
INJUNCTIVE RELIEF**

ROBERT KOSCIUSKO, in his official capacity as a Member of the South Carolina Board of Medical Examiners;

THERESA MILLS-FLOYD, in her official capacity as a Member of the South Carolina Board of Medical Examiners;

JENNIFER R. ROOT, in her official capacity as a Member of the South Carolina Board of Medical Examiners;

CHRISTOPHER C. WRIGHT, in his official capacity as a Member of the South Carolina Board of Medical Examiners;

SAMUEL H. McNUTT, in his official capacity as Chairperson of the South Carolina Board of Nursing;

SALLIE BETH TODD, in her official capacity as Vice Chairperson of the South Carolina Board of Nursing;

TAMARA DAY, in her official capacity as Secretary of the South Carolina Board of Nursing;

KELLI GARBER, in her official capacity as a Member of the South Carolina Board of Nursing;

LINDSEY K. MITCHAM, in her official capacity as a Member of the South Carolina Board of Nursing;

REBECCA MORRISON, in her official capacity as a Member of the South Carolina Board of Nursing;

KAY SWISHER, in her official capacity as a Member of the South Carolina Board of Nursing;

ROBERT J WOLFF, in his official capacity as a Member of the South Carolina Board of Nursing;

SCARLETT A. WILSON, in her official

capacity as Solicitor for South Carolina's Ninth Judicial Circuit; and

BYRON E. GIPSON, in his official capacity as Solicitor for South Carolina's Fifth Judicial Circuit.

Defendants.

Planned Parenthood South Atlantic ("PPSAT"); Katherine Farris, M.D.; and Taylor Shelton (collectively, "Plaintiffs"), by and through their undersigned counsel and complaining of the State of South Carolina and Alan Wilson, Edward Simmer, Anne G. Cook, Stephen I. Schabel, George S. Dilts, Dion Franga, Richard Howell, Robert Kosciusko, Theresa Mills-Floyd, Jennifer R. Root, Christopher C. Wright, Samuel H. McNutt, Sallie Beth Todd, Tamara Day, Kelli Garber, Lindsey K. Mitcham, Rebecca Morrison, Kay Swisher, Robert J Wolff, Scarlett A. Wilson, and Byron E. Gipson, all in their official capacities (collectively, "Defendants"), allege as follows:

1. Plaintiffs bring this as-applied challenge to South Carolina's Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (hereinafter "S.B. 474" or the "Act") (attached as Exhibit A) to answer a narrow question of statutory interpretation. The Act bans abortion once a so-called "fetal heartbeat" can be detected and defines "[f]etal heartbeat" as "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac." *Id.* (amending S.C. Code Ann. § 44-41-610(6)). A violation of the Act carries felony criminal penalties, license revocation for a physician or other professionally licensed person, and civil liability, so clarity is of utmost importance.

2. Specifically, Plaintiffs seek clarification to the narrow question of at what point in pregnancy the Act bans abortion. *See* S.B. 474, § 2 (adding S.C. Code Ann. § 44-41-630(B)).

3. While PPSAT and Dr. Farris previously challenged the Act's constitutionality, the South Carolina Supreme Court held that it was constitutional, allowing the ban on abortion early in pregnancy to go into effect on August 23, 2023. *See generally Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 892 S.E.2d 121 (2023), *reh'g denied* (Aug. 29, 2023) ("*Planned Parenthood II*").

4. At oral argument in *Planned Parenthood II*, Justice Few asked whether "the steady and repetitive rhythmic contraction of the fetal heart" (the "Clause") was intended to define or supplement the term "cardiac activity" based on the commas surrounding the Clause. In upholding S.B. 474, the Supreme Court left this question "for another day," *Planned Parenthood II*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4. The Supreme Court declined to clarify the answer when it rejected PPSAT and Dr. Farris's petition for rehearing on August 29, 2023. On September 14, 2023, Plaintiffs filed a petition for original jurisdiction seeking to answer this question. The Supreme Court denied this petition on November 14, 2023.

5. As a result, there is remaining ambiguity about whether S.B. 474 prohibits abortion at the detection of the earliest embryonic electrical activity, after approximately six weeks of pregnancy as dated from a patient's last menstrual period ("LMP"),¹ or at the point when the heart forms, after approximately nine weeks of pregnancy LMP.

6. Faced with the threat of severe criminal and civil penalties imposed on anyone performing an abortion in violation of the Act, since the Supreme Court's ruling in *Planned Parenthood II*, PPSAT and Dr. Farris have had no choice but to stop providing abortion services to patients when any early embryonic electrical activity is visible on ultrasound, after

¹ It is standard medical practice to date pregnancy using "gestational age," or the number of weeks and days since the first day of the patient's last menstrual period. The LMP method of pregnancy dating can be accomplished by patient self-reporting and, when appropriate, confirmed via ultrasound.

approximately six weeks. Patients, like Plaintiff Taylor Shelton, have been unable to obtain abortions before six weeks LMP and have been denied care in South Carolina—and potentially altogether.

7. Plaintiffs seek a preliminary injunction, followed by declaratory and injunctive relief, construing the definition of “fetal heartbeat” to confirm that: (1) “cardiac activity” is modified by “the steady and repetitive rhythmic contraction of the fetal heart” such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed by the Act is the point when a heart has formed, which is after approximately nine weeks LMP, consistent with the medical consensus.

8. In the alternative, Plaintiffs seek a construction of the Act that cures any vagueness in the definition of “fetal heartbeat” such that the Act bans abortion after a heart has formed, after approximately nine weeks LMP. This relief is necessary to assuage provider confusion and safeguard the ability of PPSAT—and their physicians including Dr. Farris and staff—to provide medical care consistent with their medical judgment and protect their patients’ health and wellbeing and to protect the ability of South Carolinians, including Ms. Shelton, to access abortion at the earliest stages of pregnancy.

PARTIES

9. Plaintiff Planned Parenthood South Atlantic is a nonprofit corporation headquartered in North Carolina. It provides a range of family planning and reproductive health services and other preventive care in South Carolina, including well-person exams; contraception (including long-acting reversible contraception) and contraceptive counseling; gender-affirming hormone therapy as well as menopausal hormone replacement therapy; screening for breast and cervical cancers; screening and treatment for sexually transmitted infections; pregnancy testing

and counseling; physical exams; and abortion. PPSAT sues on its own behalf, on behalf of its patients whose pregnancies are between approximately six and nine weeks LMP, and on behalf of its physicians and staff.

10. PPSAT operates two of the only three abortion clinics in South Carolina, one in Columbia and the other in Charleston. Each of PPSAT's locations holds a state license to perform first-trimester abortions, *see* S.C. Code Ann. § 44-41-75(A), which corresponds to abortions up to fourteen weeks LMP, *id.* § 44-41-10;² *see also* S.C. Code Ann. Regs. 61-12.101(S)(4). At each of these facilities, physicians licensed to practice medicine in South Carolina provide abortions. Since S.B. 474 went into effect, PPSAT's physicians have been forced to deny patients abortions as soon as embryonic electrical activity can be detected, after approximately six weeks LMP. However, with the relief requested herein, PPSAT would provide abortions to patients until the point at which the major components of a heart have formed, after approximately nine weeks LMP.

11. Plaintiff Katherine Farris, M.D., is a physician licensed to practice medicine in South Carolina and serves as the Chief Medical Officer for Plaintiff PPSAT. She is a board-certified physician in family medicine, has been awarded the degree of Fellow of the American Academy of Family Physicians, and a member of the American College of Obstetricians and Gynecologists, the National Abortion Federation, Physicians for Reproductive Health, and the American Academy of Family Physicians. In her role as Chief Medical Officer, Dr. Farris provides oversight, supervision, and leadership on all medical services provided by

² Measuring the gestational age of a pregnancy following fertilization is different from measuring it from the date of a patient's last menstrual period. For a patient with regular monthly periods, fertilization typically occurs two weeks after their last menstrual period (two weeks LMP). Thus, while Section 44-41-10(i) refers to the first trimester as being through "twelve weeks of pregnancy commencing with conception," (the Act equates "[c]onception" with fertilization, *see id.* § 44-41-10(g)), this is the equivalent to fourteen weeks LMP.

PPSAT at its South Carolina health centers, including abortion. She also provides direct medical services at PPSAT's South Carolina health centers. Since S.B. 474 went into effect, Dr. Farris has been forced to deny patients abortions as soon as embryonic electrical activity can be detected, after approximately six weeks LMP. However, with the relief requested herein, Dr. Farris would provide abortions to patients until the point at which the major components of a heart have formed, after approximately nine weeks LMP. Dr. Farris brings this claim on behalf of herself and her patients whose pregnancies are between approximately six and nine weeks LMP.

12. Plaintiff Taylor Shelton is a resident of South Carolina. After S.B. 474 went into effect, Ms. Shelton learned that she had become pregnant, sought an abortion, but was unable to obtain one in South Carolina before six weeks LMP.

13. Defendant State of South Carolina is a government entity charged with enforcing the laws of the State.

14. Defendant Alan Wilson is the Attorney General for the State of South Carolina. He is responsible for, among other duties, enforcing the civil and criminal laws of the State. Defendant Wilson has criminal and civil enforcement authority for violations of the Act, pursuant to S.C. Code Ann. § 1-7-40; S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-680). Moreover, he has the "exclusive right, in his discretion, to assign" solicitors in the State to criminal matters outside their circuits "in case of the incapacity of the local solicitor or otherwise." S.C. Code Ann. § 1-7-350. He is sued in his official capacity.

15. Defendant Edward Simmer is the Director of the South Carolina Department of Health and Environmental Control ("DHEC"). He is responsible for directing all DHEC activities. DHEC is responsible for licensing abortion clinics, certifying that they are suitable for

the performance of abortions, and taking related enforcement action. *See id.* §§ 44-41-70(b), 44-41-460(D). He is sued in his official capacity.

16. Defendant Anne G. Cook is the President of the South Carolina Board of Medical Examiners (“BME”), which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

17. Defendant Stephen I. Schabel is Vice President of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

18. Defendant George S. Dilts is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

19. Defendant Dion Franga is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

20. Defendant Richard Howell is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann.

§ 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

21. Defendant Robert Kosciusko is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

22. Defendant Theresa Mills-Floyd is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

23. Defendant Jennifer R. Root is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

24. Defendant Christopher C. Wright is a Member of the BME, which is responsible for licensing and disciplining physicians who practice in South Carolina, pursuant to S.C. Code Ann. § 40-47-10. The Act mandates that, if a physician violates the Act, the BME revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

25. Defendant Samuel H. McNutt is the Chairperson of the South Carolina Board of Nursing ("BoN"), which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed

professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

26. Defendant Sallie Beth Todd is the Vice Chairperson of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

27. Defendant Tamara Day is the Secretary of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

28. Defendant Kelli Garber is a Member of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

29. Defendant Lindsey K. Mitcham is a Member of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

30. Defendant Rebecca Morrison is a Member of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

31. Defendant Kay Swisher is a Member of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). She is sued in her official capacity.

32. Defendant Robert J Wolff is a Member of the BoN, which is responsible for licensing and disciplining nurses who practice in South Carolina, pursuant to S.C. Code Ann. § 40-33-10. The Act mandates that, if a licensed professional violates the Act, the appropriate licensing board revoke their license. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690). He is sued in his official capacity.

33. Defendant Scarlett A. Wilson is the Solicitor for South Carolina's Ninth Judicial Circuit, which includes the City of Charleston, where PPSAT's Charleston health center is located. In cooperation with the Attorney General, she has criminal enforcement authority for violations of the Act, pursuant to S.C. Code Ann. § 1-7-320, as well as civil enforcement. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-680). She is sued in her official capacity.

34. Defendant Byron E. Gipson is the Solicitor for South Carolina's Fifth Judicial Circuit, which includes the portion of the City of Columbia where PPSAT's Columbia health center is located. In cooperation with the Attorney General, he has criminal enforcement

authority for violations of the Act, pursuant to S.C. Code Ann. § 1-7-320, as well as civil enforcement. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-680). He is sued in his official capacity.

JURISDICTION AND VENUE

35. This Court has jurisdiction and authority to adjudicate Plaintiffs' claims under South Carolina's Uniform Declaratory Judgments Act, S.C. Code Ann. § 15-53-20, and the Court's general legal and equitable powers, including its authority to enforce the South Carolina Constitution as against countervailing state law.

36. Venue is proper in this Court pursuant to S.C. Code Ann. § 15-7-20 because Defendant Byron E. Gipson initiates prosecutions in Richland County; the Board of Medical Examiners is headquartered in Richland County; PPSAT provides abortions prohibited by the challenged Act in Richland County; and many of PPSAT and Dr. Farris's patients in need of abortion reside in Richland County.

FACTUAL ALLEGATIONS

South Carolina Abortion Law

37. Plaintiff PPSAT operates two of the only three abortion clinics in South Carolina. PPSAT is not licensed to provide abortion beyond the first trimester of pregnancy (beyond fourteen weeks LMP).

38. Prior to 2021, abortion was legal in South Carolina until twenty-two weeks LMP.

39. However, in 2021, South Carolina enacted Senate Bill 1, 124th Gen. Assemb., Reg. Sess. (S.C. 2021) (hereinafter "S.B. 1"), which provided that "no person shall perform, induce, or attempt to perform or induce an abortion" where the "fetal heartbeat has been detected." *Id.*, § 3 (adding S.C. Code Ann. § 44-41-680(A)).

40. PPSAT and Dr. Farris³ challenged S.B. 1's constitutionality in federal court, and the U.S. District Court preliminarily enjoined its enforcement. *See generally Planned Parenthood S. Atl. v. Wilson*, 527 F.Supp.3d 801 (D.S.C. 2021), *aff'd*, 26 F.4th 600 (4th Cir. 2022). But after the U.S. Supreme Court's ruling in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), the District Court granted the Defendants' emergency motion to stay the preliminary injunction, allowing S.B. 1 to take effect. *See generally Planned Parenthood S. Atl. v. Wilson*, No. CV 3:21-00508-MGL, 2022 WL 2314508 (D.S.C. June 27, 2022). The federal court then granted PPSAT and Dr. Farris's motion to dismiss that case without prejudice under Federal Rule of Civil Procedure 41. *See generally Planned Parenthood S. Atl. v. Wilson*, No. CV 3:21-00508-MGL, 2022 WL 2905496 (D.S.C. July 22, 2022).

41. PPSAT and Dr. Farris then filed a new case in the Court of Common Pleas for the Fifth Judicial District against the Defendants in this case. The South Carolina Supreme Court then agreed to hear the case in its original jurisdiction and unanimously granted a temporary injunction against S.B. 1's enforcement on August 17, 2022, at which point S.B. 1 had been in effect for 51 days.

42. On January 5, 2023, the Supreme Court struck down S.B. 1, finding that it violated South Carolinians' right to privacy guaranteed by article I, section 10 of the State Constitution. *See generally Planned Parenthood South Atlantic v. State*, 438 S.C. 188, 882 S.E.2d 770 (2023), *reh'g denied* (Feb. 8, 2023) ("*Planned Parenthood I*").

43. After the Court struck down S.B. 1, a new so-called "heartbeat ban," S.B. 474, was introduced in the General Assembly.

³ In prior litigation related to both S.B. 1 and S.B. 474, Greenville Women's Clinic and Dr. Terry L. Buffkin, who are not parties in this case, were also plaintiffs.

44. The Act begins with three legislative findings: (1) “[a] fetal heartbeat is a key medical predictor that an unborn child will reach live birth,” S.B. 474, § 1(1); (2) “[c]ardiac activity begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac,” *id.*, § 1(2); and (3) “[t]he State of South Carolina has a compelling interest from the outset of a woman’s pregnancy in protecting the health of the woman and the life of the unborn child,” *id.*, § 1(3).

45. The Act imposes extreme limits on abortion access in South Carolina by banning abortion early in pregnancy. *Id.*, § 2 (adding S.C. Code Ann. § 44-41-630(B)). It provides that “no person shall perform or induce an abortion” where the “fetal heartbeat has been detected.” *Id.*⁴

46. The Act requires health care providers to determine whether the abortion ban applies by mandating the performance of an ultrasound. *Id.* (amending S.C. Code Ann. § 44-41-630(A)).

47. S.B. 474 defines “[f]etal heartbeat” as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” *Id.* (amending S.C. Code Ann. § 44-41-610(6)).

48. Both the physician who performs an abortion and the clinic in which the abortion is performed risk severe penalties for violating the abortion ban. Those penalties include a felony offense that carries a \$10,000 criminal fine and up to two years in prison. *Id.* (adding S.C. Code Ann. §§ 44-41-630(B), 44-41-640(B)); *see also* S.C. Code Ann. § 16-1-40 (accessory liability).

⁴ S.B. 474 contains only three narrow exceptions: (1) to save the life of the pregnant patient or to prevent certain types of irreversible bodily impairment to the patient (the “Death or Permanent Injury Exception”); (2) in cases of a fetal health condition that is “incompatible” with sustained life after birth (the “Fatal Fetal Anomaly Exception”), and (3) in narrow circumstances up to twelve weeks LMP where the pregnancy is the result of rape or incest (the “Reported Rape Exception”). S.B. 474, § 2 (amending S.C. Code Ann. §§ 44-41-610(9) (defining “[m]edical emergency”), 44-41-650, 44-41-660; adding S.C. Code Ann. 44-41-640(A)–(C)).

Moreover, any licensed professional who performs an abortion in violation of the Act will have their license revoked. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-690).

49. Anyone performing an abortion in violation of the Act could also be subject to a civil suit brought by the person on whom the abortion was performed, their parent or guardian if they are either a minor at the time of the abortion or died as a result of the abortion, a solicitor or prosecuting attorney, or the Attorney General. *Id.* (amending S.C. Code Ann. § 44-41-680). In addition to actual damages, the person performing the abortion could be liable for punitive damages, statutory damages of \$10,000 for each violation of the Act's abortion ban, and attorney's fees and costs, all of which are not subject to the limitations of South Carolina's medical malpractice laws. *Id.*

50. The General Assembly adopted S.B. 474 on May 23, 2023, and it took immediate effect upon Governor Henry McMaster's signature on May 24, 2023. *See id.*, § 14 ("This act takes effect upon approval by the Governor.").

51. PPSAT and Dr. Farris immediately challenged the Act's constitutionality, and it was preliminarily enjoined by this Court on May 25, 2023. Order Granting Prelim. Inj., *Planned Parenthood S. Atl. v. State*, No. 2023-CP-40-002745, 2023 WL 3735109 (S.C. Com. Pls. May 26, 2023).

52. Defendants thereafter filed a petition for a writ of supersedeas and original jurisdiction petition to the South Carolina Supreme Court. Emergency Pet. for Writ of Supersedeas, *Planned Parenthood II* (May 26, 2023).

53. After the South Carolina Supreme Court accepted the case in its original jurisdiction, it ruled that the Act was constitutional and vacated the injunction, leading the Act to take effect on August 23, 2023. *See generally Planned Parenthood II.*

54. Due to the Act's severe criminal and civil penalties, since S.B. 474 went into effect, PPSAT and Dr. Farris have had to take the conservative approach of assuming that the Act's prohibitions apply once embryonic electrical activity can be detected—after approximately six weeks LMP (and sometimes sooner). PPSAT and Dr. Farris previously assumed that the term “fetal heartbeat” included not just a “heartbeat” once a heart has formed, but also embryonic electrical activity present before development of the cardiovascular system.

55. However, at oral argument in *Planned Parenthood II*, the Supreme Court identified a question of statutory interpretation—that “cardiac activity” may be defined by the clause “the steady and repetitive rhythmic contraction of the fetal heart,” based on the commas surrounding that clause. The Supreme Court expressly declined to address the issue in its ruling finding S.B. 474 constitutional. *Id.*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4 (“We leave for another day . . . the meaning of ‘fetal heartbeat’ and whether the statutory definition . . . refers to one period of time during a pregnancy or two separate periods of time.”); *id.*, 440 S.C. at 497, 892 S.E.2d at 139 (Beatty, C.J., dissenting) (“[The majority] does not resolve the anomaly appearing on the face of the legislation regarding the timing of the ‘fetal heartbeat’ ban.”).

56. Following the Supreme Court's ruling in *Planned Parenthood II*, PPSAT and Dr. Farris sought rehearing to clarify the point at which S.B. 474 bans abortion, but the Court denied the petition for rehearing. Order, *Planned Parenthood II* (Aug. 29, 2023) (denying rehearing). PPSAT and Dr. Farris then filed a petition for original jurisdiction with the South Carolina Supreme Court seeking an interpretation of S.B. 474 and requesting an emergency injunction blocking the enforcement of S.B. 474 before the point in pregnancy when a fetal heart has formed. The Supreme Court denied the petition and the injunction on November 14, 2023. Order,

Planned Parenthood II (Nov. 14, 2023) (denying petition for original jurisdiction and injunction).

Abortion in South Carolina

57. Legal abortion is one of the safest procedures in contemporary medical practice and is far safer than childbirth. A person's risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion,⁵ and every pregnancy-related complication is more common among people having live births than among those having abortions.⁶

58. Abortion is also very common: approximately one in four women in this country will have an abortion by age forty-five.

59. People seek abortion for a range of reasons. The majority of people who seek abortions are already parents, and they may already struggle with basic unmet needs for their families. Other people decide that they are not ready to become parents because they are too young or want to finish school before starting a family. Some people have health complications during pregnancy that lead them to conclude that abortion is the right choice for them; indeed, for some, abortion is medically indicated to protect their lives and their health, including their reproductive health. Some people receive fetal diagnoses incompatible with sustained life after birth and wish to terminate the pregnancy rather than continue to carry a non-viable pregnancy and expose themselves to the physical and psychological changes associated with pregnancy. In some cases, people are struggling with substance abuse and decide not to become parents or have

⁵ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012); *see also* Nat'l Acad. of Scis., Eng'g, & Med. ("Nat'l Acad."), *The Safety and Quality of Abortion Care in the United States*, at 75 tbl. 2–4 (2018), available at <http://nap.edu/24950> (finding the risk to be approximately twelve times higher).

⁶ Raymond & Grimes, *supra* note 5, at 216.

additional children during that time in their lives. Still others have an abusive partner or a partner with whom they do not wish to have children for other reasons.

60. Although patients generally obtain an abortion as soon as they are able, the vast majority of patients who obtained abortions in South Carolina, prior to the Act going into effect, were at least six weeks LMP by the time of the abortion.

61. Many patients do not know they are pregnant until at or after six weeks LMP, especially patients who have irregular menstrual cycles or who experience bleeding during early pregnancy, a common occurrence that is frequently and easily mistaken for a period. Other patients may not develop or recognize symptoms of early pregnancy. Other factors, including younger age and use of hormonal contraceptives, can also result in delayed recognition of symptoms of early pregnancy.

62. Prior to the adoption of S.B. 1 and S.B. 474, South Carolina did not require abortion providers to perform ultrasounds before an abortion, but PPSAT and Dr. Farris typically performed them when medically appropriate. For example, when patients are unsure of their last menstrual period, ultrasounds can be useful to pinpoint the gestational age of the pregnancy, which may affect, for example, whether medication abortion is available for the patient.

63. Ultrasounds may be transvaginal, meaning that a probe is inserted into the patient's vagina, or transabdominal, which involves placement of a probe onto the patient's bare abdomen.

The Menstrual Cycle, the Early Stages of Pregnancy, and Pregnancy Recognition

64. Menstruation is the shedding of the lining of the uterus, during which someone will experience bleeding for around two to seven days (commonly referred to as a "period").⁷

⁷ *How Do I Know if My Menstrual Cycle Is Normal?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/health-and-wellness/menstruation/how-do-i-know-if-my-menstrual-cycle-normal> (last visited Sept. 12, 2023).

While young people usually get their first period between the ages of ten and fifteen, some start menstruating earlier.⁸

65. For those who are actively menstruating, a menstrual cycle begins on the first day of the person's period and ends on the first day of their next period. Some may go six to eight weeks, or even longer, without experiencing a menstrual period.⁹ It is also very common for people to have irregular menstrual cycles that are difficult to predict because their menstrual cycle varies from month to month.¹⁰

66. During menstruation, the body prepares to release an egg cell from one of two ovaries. One of these eggs becomes mature each cycle, typically about one week after the start of a period. Halfway through the cycle, ovulation begins, releasing the egg from the ovary and through the fallopian tube towards the uterus.¹¹ While moving through the fallopian tube, the egg may join with a sperm cell through fertilization, at which point it would begin dividing into more cells as the egg moves down the fallopian tube toward the uterus. These cells (called a "blastocyst") typically get to the uterus about three to four days after fertilization.¹²

67. As a medical matter, implantation constitutes the beginning of pregnancy—if and when the cells attach to the lining of the uterus. Sometimes the cells do not implant in the uterine lining, and pregnancy does not result. If the cells do implant, it typically occurs about six days

⁸ *Getting Your Period: What Is a 'Normal' Menstrual Cycle for Teens and Preteens?*, UChicago Medicine, <https://www.uchicagomedicine.org/forefront/pediatrics-articles/getting-your-period-normal-menstrual-cycle-teens-preteens> (last visited Sept. 12, 2023); *see also Menstruation*, Planned Parenthood, <https://www.plannedparenthood.org/learn/health-and-wellness/menstruation> (last visited Sept. 12, 2023) ("Most people get their first period between ages 12 and 14, but some people get them earlier or later than that.").

⁹ *How Do I Know if My Menstrual Cycle Is Normal?*, *supra* note 7.

¹⁰ *Id.*

¹¹ *Menstruation*, *supra* note 8.

¹² *How Pregnancy Happens*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/how-pregnancy-happens> (last visited Sept. 12, 2023).

after fertilization and the process takes roughly three to four days to complete. Pregnancy hormones, including human chorionic gonadotropin (“hCG”), are triggered to release by implantation and prevent the lining of the uterus from shedding so no period occurs.¹³

68. In medical practice, the gestational age of a pregnancy is commonly measured starting from the first day of a person’s last menstrual period, rather than from implantation. Thus, this method of dating a pregnancy starts about two to three weeks before fertilization and about three to four weeks before implantation—the point at which someone is actually pregnant.¹⁴

69. A person with a highly regular, four-week cycle would already be four weeks LMP when they miss their period, leaving only two weeks to realize they have missed their period (rather than expecting a late period), learn they are pregnant, and then arrange for an abortion before an embryonic electrical impulse can be detected by a ultrasound.

70. For someone with a longer or irregular menstrual cycle, the gestational age could be even greater than four weeks LMP at the time of a missed period.

71. While for some people a missed period is the first sign of pregnancy, irregular menstrual cycles can also cause missed or late periods.¹⁵ Irregular cycles may result from hormonal contraceptive use, age, breastfeeding, a recent miscarriage, or other common medical conditions, like diabetes.¹⁶ Some pregnant people experience light bleeding that occurs upon implantation and mistake the bleeding for a menstrual period. Other early pregnancy symptoms, like fatigue, swollen or tender breasts, and nausea and/or vomiting, are not uniformly

¹³ *Pregnancy Tests*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-tests> (last visited Sept. 12, 2023).

¹⁴ *How Pregnancy Happens*, *supra* note 12.

¹⁵ *See How Do I Know if My Menstrual Cycle Is Normal?*, *supra* note 7 (“A missed period is one of the first signs of pregnancy, but it doesn’t always mean you’re pregnant.”).

¹⁶ *Id.*

experienced during early stages of pregnancy and may also occur as premenstrual symptoms that indicate a late period is coming.¹⁷

72. A missed period may prompt someone to take a pregnancy test. At-home pregnancy tests work by detecting the hormone hCG in urine. When used after a missed period, these tests are 99% effective.¹⁸

73. Many people do not learn they are pregnant as soon as they miss their periods. On average, people are unaware of their pregnancies until between five- and six-weeks LMP, but there are various individual characteristics that are associated with later pregnancy awareness.¹⁹ These characteristics include younger age, lower educational attainment, lower poverty-income ratios, and hormonal contraceptive use.²⁰ Moreover, those with longer or irregular menstrual cycles or who are breastfeeding may become aware of their pregnancies later.²¹

74. People may become pregnant despite the use of contraceptives, further risking delay in pregnancy awareness. Implants and IUDs are more than 99% effective at preventing pregnancy, meaning that fewer than one in 100 patients who use these methods will become pregnant within the first year of use.²² However, patients who become pregnant with an IUD in

¹⁷ *Pregnancy Symptoms*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-symptoms> (last visited Sept. 12, 2023) (“Many of these symptoms can also be signs of other conditions and don’t always mean that you’re pregnant.”).

¹⁸ *Id.*

¹⁹ Amy M. Branum & Katherine A. Ahrens, *Trends in Timing of Pregnancy Awareness Among US Women*, 21 *Maternal & Child Health J.* 715 (2017).

²⁰ Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *Contraception* 334, 338 (2006).

²¹ *Id.*

²² *How Effective Is the Birth Control Implant?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-implant-nexplanon/how-effective-is-the-birth-control-implant> (last visited Jan. 11, 2024); *How Effective are IUDs?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/iud/how-effective-are-iuds> (last visited Jan. 11, 2024).

place are more likely to have an ectopic pregnancy and face other related health risks.²³ IUD removal is recommended care for patients who become pregnant, as continuing a pregnancy with an IUD in place presents numerous risks to the pregnant patient's health.²⁴

75. The birth control shot is about 96% effective.²⁵ Hormonal birth control pills, the contraceptive patch, and a vaginal ring are each about 93% effective at preventing pregnancy.²⁶ Condoms and diaphragms are each about 87% effective at preventing pregnancy.²⁷ For patients who have never given birth, cervical caps and sponges are about 86% effective at preventing pregnancy.²⁸ For patients who have previously given birth, cervical caps are about 71% effective,

²³ Tiina Backman et al., *Pregnancy During the Use of Levonorgestrel Intrauterine System*, 190 Am. J. Obstetrics & Gynecology 50 (2004).

²⁴ *Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, Practice Bulletin No. 186, Am. Coll. Obstetricians & Gynecologists ("ACOG"), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices> (Nov. 2017).

²⁵ *How Effective Is the Birth Control Shot?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-shot/how-effective-is-the-birth-control-shot> (last visited Jan. 11, 2024).

²⁶ *How Effective Is the Birth Control Pill?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-effective-is-the-birth-control-pill> (last visited Jan. 11, 2024); *How Effective Is the Birth Control Patch?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-patch/how-effective-is-the-birth-control-patch> (last visited Jan. 11, 2024); *How Effective Is the Birth Control Ring?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-vaginal-ring-nuvaring/how-effective-birth-control-ring> (last visited Jan. 11, 2024).

²⁷ *How Effective Are Condoms?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/condom/how-effective-are-condoms> (last visited Jan. 11, 2024); *Vaginal Diaphragm*, Cleveland Clinic, <https://my.clevelandclinic.org/health/articles/23427-vaginal-diaphragm> (July 1, 2022).

²⁸ *How Effective Are Cervical Caps?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/cervical-cap/how-effective-are-cervical-caps> (last visited Jan. 11, 2024); *How Effective Is the Sponge?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-sponge/how-effective-sponge> (last visited Jan. 11, 2024).

and sponges are about 78% effective.²⁹ Spermicides are about 72% effective, and fertility awareness-based methods are about 76% effective at preventing pregnancy.³⁰

Embryonic and Fetal Development, Including of the Cardiovascular System

76. The developing organism in a uterus is referred to as an “embryo” in the field of medicine before approximately ten weeks of pregnancy. At the earliest stages of pregnancy, around five to six weeks LMP, an embryo is less than a fifth of an inch long.³¹

77. Cardiac development is a complex process that will advance throughout pregnancy and continue through birth. At minimum, the development of the four major components of a heart—the four chambers, the walls separating them, the valves connecting them, and the conduction system—cannot occur until after approximately nine weeks LMP.

78. At approximately three weeks LMP, no cardiovascular system exists. There is no heart nor circulatory system in the blastocyst.³²

79. At approximately five weeks LMP, the earliest primitive cells that will develop into a heart begin to form. These cells form a straight tube that will fold in on itself to build the chambers of a heart. At this point, the organ will begin to transmit electrical impulses that cause

²⁹ *Id.*

³⁰ *Effectiveness of Birth Control Methods*, ACOG, <https://www.acog.org/womens-health/infographics/effectiveness-of-birth-control-methods> (Apr. 2023).

³¹ *What Happens in the Second Month of Pregnancy?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-month-by-month/what-happens-second-month-pregnancy> (last visited Sept. 12, 2023).

³² See Richard Van Praagh, *Congenital Heart Disease* 14 (2022); Cheryl Mei Jun Tan & Adam James Lewandowski, *The Transitional Heart: From Early Embryonic and Fetal Development to Neonatal Life*, 47 *Fetal Diagnosis and Therapy* 373, 375–76 (2020).

cellular contractions.³³ The movement of the primitive cardiac cells caused by these early electrical impulses will not be visible on an ultrasound until approximately six weeks LMP.

80. By approximately six weeks LMP, the cells that develop into a heart are a tube-like organ. At this point, the heart's chambers begin to form.³⁴

81. After approximately six weeks LMP, an ultrasound will show a flicker within the embryo. The flicker is cardiac cells, or cardiomyocytes, which have special characteristics that promote the conduction and contraction of the cell tissue. This electrical impulse is detectable before the development of any of the four major components of a heart.³⁵

82. Furthermore, these cells are not organized into a coordinated and steady heartbeat until after the development of the natural pacemakers and conduction pathways within the heart.³⁶ In other words, the embryonic electrical activity that is visible as early as six weeks LMP is neither “steady” nor “rhythmic.”

83. Furthermore, at six weeks LMP, there is no detectable sound that can be heard by a medical provider or pregnant patient. Early in pregnancy, even with ultrasound, this activity would not be audible but would instead appear as a visual flicker. The “sound” audible at six weeks is the translated electrical impulses that the ultrasound machine itself converts into sound. *Planned Parenthood I*, 438 S.C. at 222, 882 S.E.2d at 788 (Beatty, J., concurring).

³³ See Praagh, *supra* note 32, at 16–27; Tan & Lewandowski, *supra* note 32, at 375–76; Preeta Dhanantwari et al., *Human Cardiac Development in the First Trimester: A High-Resolution Magnetic Resonance Imaging and Episcopic Fluorescence Image Capture Atlas*, 120 *Circulation* 343, 345–46 (2009).

³⁴ See Praagh, *supra* note 32 at 27–41; Tan & Lewandowski, *supra* note 32, at 375–76; Dhanantwari et al., *supra* note 33, at 346–47.

³⁵ Gary C. Schoenwolf et al., *Larsen's Human Embryology* 267–303 (6th ed. 2021).

³⁶ J. Boulin & J. M. Morgan, *The Development of Cardiac Rhythm*, 91 *Heart* 874, 874–75 (2005); Robert G. Gourdie, *Development of the Cardiac Pacemaking and Conduction System*, 69 *Birth Defects Res., Part C Embryo Today: Reviews* 46, 46–57 (2003).

84. Between approximately six and eight weeks LMP, the tube-like organ will begin to develop into four chambers.³⁷

85. Between approximately seven and ten weeks LMP, the valves will form.³⁸

86. At approximately ten weeks LMP, cardiac septation is completed, meaning that systemic and pulmonary circulation have completely separated and the four chambers of the heart have formed. It is at this point that the structure of the heart is sufficiently developed that it would have much of the same recognizable anatomic landmarks as a mature heart, but these details are not yet visible using the current resolution of ultrasound technology.³⁹

87. In the medical field, the developing organism present in the gestational sac during pregnancy is most accurately termed an “embryo” until at least ten weeks LMP; the term “fetus” is appropriately used after that time.

88. Thus, the Act’s reference to a “fetal heartbeat” obscures the fact that the Act could ban abortion so early in pregnancy that neither a “fetus” nor a “heart”—much less a heartbeat—exists yet as a matter of accurate medical terminology.

89. A full-term pregnancy typically lasts approximately forty weeks LMP, and the first trimester of pregnancy is usually considered to end after the thirteenth week of pregnancy.⁴⁰ Most pregnancy loss—otherwise known as miscarriage—occurs during the first trimester, as do the

³⁷ See also S.C. Dep’t of Health & Env’t Control, *Embryonic & Fetal Development*, <https://scdhec.gov/sites/default/files/Library/ML-017049.pdf> (last visited Sept. 12, 2023) (“The heart starts to form the normal four chambers” at 7–8 weeks LMP.).

³⁸ See Praagh, *supra* note 32, at 41–45; Tan, *supra* note 32, at 377; Dhanantwari, *supra* note 33, at 347–49.

³⁹ See also S.C. Dep’t of Health & Env’t Control, *supra* note 37 (noting that the heart has formed at 9–10 weeks LMP).

⁴⁰ *What Happens in the Fourth Month of Pregnancy?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-month-by-month/what-happens-fourth-month-pregnancy> (last visited Sept. 12, 2023).

vast majority of abortions.⁴¹ Roughly 15% of pregnancies end in miscarriage during the first trimester.⁴²

The Impact of the Act on PPSAT, Dr. Farris, and Their Patients, Including Taylor Shelton

90. As described above, because of the harsh penalties associated with violation of the Act, PPSAT and Dr. Farris have no choice but to assume that the Act prohibits nearly all abortions after approximately six weeks LMP. Yet prior to the Act taking effect, the vast majority of people in South Carolina who obtained abortion did so after six weeks LMP, while more than half were performed before approximately nine weeks LMP.⁴³

91. Without relief from this Court, PPSAT and its physicians, including Dr. Farris, and staff will continue to be forced to turn away the vast majority of patients seeking abortions, or risk substantial criminal penalties, professional sanctions, and/or civil liability. When patients with pregnancies that have detectable embryonic or fetal electrical activity seek abortions, PPSAT and Dr. Farris can provide care only where they can determine that one of the extremely narrow exceptions to the Act applies.

92. In nearly five months since S.B. 474 went into effect, it has severely limited access to abortions in South Carolina. While state data for 2023 is not yet available, in the month

⁴¹ *What Happens in the Third Month of Pregnancy?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-month-by-month/what-happens-third-month-pregnancy> (last visited Sept. 12, 2023).

⁴² *Id.*

⁴³ See S.C. Dep't of Health & Env't Control, *A Public Report Providing Statistics Compiled From All Abortions Reported to DHEC—2022*, at tbl. 1 (2023), available at https://scdhec.gov/sites/default/files/media/document/2022-Abortion_SC-Report.pdf. State reporting data tracks the post-fertilization age rather than as dated from the patient's last menstrual period. See *supra* note 2. Thus, the state reporting data shows that a little over half of abortions in South Carolina occur at or before eight weeks LMP, but an even smaller number occur before six weeks LMP.

after the Act went into effect, abortions decreased drastically: while there were 750 abortions statewide in August 2023, only 160 were performed in September 2023, a decrease of 79%.⁴⁴

93. From when the Act went into effect on August 23, 2023, until January 31, 2024, PPSAT provided only 303 abortions in South Carolina, despite the fact that 1,209 patients have presented to PPSAT's clinics seeking abortions. In other words, PPSAT turned away approximately 75% of people seeking abortions at their South Carolina clinics. Of those turned away, 778 (or about 86% of those unable to obtain abortions) had pregnancies that were nine weeks LMP or less. Many more did not schedule appointments because they were past six weeks LMP, and others likely did not even bother to call, having learned of South Carolina's new ban on abortion early in pregnancy.

94. By comparison, during the same period the prior year, from August 23, 2022 to January 31, 2023, PPSAT provided 1,819 abortions. Put differently, over the same period of time, PPSAT was able to provide less than 17% of the abortions it did before the Act went into effect, and the number of people making abortion appointments dropped substantially.

95. Taylor Shelton learned she was pregnant on September 7, 2023, shortly after the Act went into effect following the Supreme Court's ruling in *Planned Parenthood II*. Ms. Shelton was surprised she was pregnant because she had an IUD in place, and her gynecologist confirmed that it was still effective about one week before she found out she was pregnant. She has a regular menstrual cycle, which she tracks, so she quickly suspected she was pregnant and

⁴⁴ Kimya Forouzan, et al., *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Inst., (Dec. 7, 2023), https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care?utm_source=Guttmacher+Email+Alerts&utm_campaign=9096c1e61d-December+provision+study&utm_medium=email&utm_term=0_-b00c00d20f-%5BLIST_EMAIL_ID%5D.

took two home pregnancy tests approximately two days after her missed period (about 4 weeks, 2 days LMP), both of which confirmed that she was pregnant.

96. Ms. Shelton knew that she did not want to have a child and that she wanted to have an abortion as soon as possible.

97. The morning after Ms. Shelton found out she had become pregnant, she became aware that S.B. 474 was in effect. Ms. Shelton immediately understood the urgency required to obtain an abortion in South Carolina.

98. Despite recognizing her pregnancy very early, and making her decision very soon after, Ms. Shelton was unable to get an appointment with one of South Carolina's abortion providers before her pregnancy would have progressed to six weeks LMP.

99. Instead, Ms. Shelton made three trips to North Carolina, spending roughly twenty hours driving in total. North Carolina imposes a seventy-two-hour waiting period on patients seeking abortion⁴⁵ and requires at least two health center visits.⁴⁶ Ms. Shelton was first misled by an anti-abortion center in Charlotte (a four hour drive), where she thought she could get an ultrasound for her first visit. She next was able to complete her first visit and get an ultrasound at a PPSAT health center in Chapel Hill (another four hour drive) a week later. Ms. Shelton was then able to obtain an aspiration abortion at PPSAT's Wilmington health center (a two hour drive) on September 23, at which point she was roughly six weeks and four days pregnant.

100. By the time she obtained an abortion, Ms. Shelton was more than six weeks pregnant, roughly the point at which a so-called "fetal heartbeat" can be detected. Ms. Shelton used contraceptives and early pregnancy testing but was still unable to get an abortion before six weeks LMP. *Cf. Planned Parenthood II*, 440 S.C. at 477, 892 S.E.2d at 128 (identifying S.B.

⁴⁵ See N.C. Gen. Stat. Ann. § 90-21.82.

⁴⁶ See Senate Bill 20, 2023 Leg., 2023–24 Sess. (N.C. 2023).

474's emphasis on "contraceptives and early pregnancy testing" as a key change to the law as compared to S.B. 1); *Planned Parenthood II*, 440 S.C. at 495–96, 892 S.E.2d at 138 (Few, J., concurring) (similar). However, Ms. Shelton's pregnancy had not progressed to the point where the major components of the heart had formed.

South Carolinians Will Continue to Suffer Irreparable Harm from Forced Pregnancy.

101. The Act makes it exceedingly difficult to access abortion in South Carolina. Research shows that barriers to abortion delay, and in some cases altogether prevent, people from accessing that care. Not only does delay potentially increase the cost of the medical procedure, but it also increases the risk of complications (though pre-viability abortion remains incredibly safe and far safer than carrying a pregnancy to term). Those who are ultimately prevented from accessing care may choose to self-manage their abortion outside of the health care system, potentially increasing the risks to their health. Others will be forced to carry pregnancies to term against their will.

102. Pregnancy challenges a person's entire physiology. Individuals experience a dramatic increase in blood volume, a faster heart rate, increased production of clotting factors, breathing changes, digestive complications, and a growing uterus. These and other changes put pregnant patients at greater risk of blood clots, nausea, hypertensive disorders, and anemia, among other complications. Although many of these complications can be mild and resolve without medical intervention, some require evaluation and occasionally urgent or emergent care to preserve the patient's health or to save their life.

103. Pregnancy can also aggravate preexisting health conditions, including hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary disease. It can lead to the development of new and serious health

conditions as well, such as hyperemesis gravidarum, preeclampsia, deep-vein thrombosis, and gestational diabetes.

104. Pregnancy may also induce or exacerbate mental health conditions. A person with a history of mental illness may experience a recurrence of their illness during pregnancy. Pregnant patients regulating a mental health condition with medication that carries risk to the fetus may need to discontinue or modify their medication to avoid risking harm to the fetus, effectively increasing the likelihood that mental illness recurs both during and after pregnancy. These mental health risks can be higher for patients with unintended pregnancies, who may face physical and emotional changes and risks that they did not choose to take on. Some pregnant patients also face increased risk of intimate partner violence, with the severity sometimes escalating during or after pregnancy. Homicide is a leading cause of maternal mortality; the majority are committed by an intimate partner.

105. Separate from pregnancy, labor and childbirth are themselves significant medical events with many risks, far greater than those for legal pre-viability abortion.

106. The risks and complications associated with pregnancy go beyond mortality. In some cases, labor must be medically or physically induced (for example, by physically rupturing the membranes), and labor can last hours or sometimes days and be tremendously painful. Even a pregnancy with no comorbidities or previous complications can suddenly become life-threatening during labor and delivery.

107. Each of these consequences constitutes irreparable harm to PPSAT and Dr. Farris's patients.

The Act's Narrow Exceptions Will Continue to Harm South Carolinians.

108. The Act's narrow exceptions to the abortion ban do not cure these harms. Even patients who are able to qualify for one of the exceptions will have their decision to have an abortion—a deeply private decision—unnecessarily scrutinized. Pregnant people with rapidly worsening medical conditions—who, prior to the Act, could have obtained an abortion without explanation—may once again be forced to wait for care until their physician determines that their condition is deadly or threatens severe enough impairment so as to meet the Death or Permanent Injury Exception.

109. Under the Reported Rape Exception, health care professionals must disclose to the local sheriff the names and contact information of rape and incest survivors in order to provide abortions to these patients at or after approximately six weeks LMP. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-650). The Act's reporting requirement applies only if the patient decides to have an abortion after being told that the rape will be reported; if the patient decides not to go forward, the reporting requirement does not apply. *Id.* This requirement conditions access to health care on the disclosure of medical and other personal information, thereby discouraging patients from accessing abortion in South Carolina.

110. Conditioning abortion access on reporting sexual assault will deny care to survivors who do not want to involve law enforcement or do not want to talk about the circumstances of their pregnancies at all. In 2021, 78% of sexual assault incidents nationally were never reported to the police, a rate nearly two times higher than for other violent crimes.⁴⁷ This is due to many factors both fear-based and personal: some fear retaliation from their offenders, some are financially dependent on the offender, some believe there will not be any

⁴⁷ Alexandra Thompson & Susannah N. Tapp, U.S. Dep't of Just., *Criminal Victimization, 2021*, at 5 (Sept. 2022), available at <https://bjs.ojp.gov/content/pub/pdf/cv21.pdf>.

benefit to reporting abuse, and some require time to process their feelings after the assault—time they may not be able to spare under the Act.

111. The Fatal Fetal Anomaly Exception is likewise limited. Its narrow definition of a fatal fetal anomaly fails to account for the wide range of factors and fetal medical conditions that make an abortion medically necessary for PPSAT and Dr. Farris’s patients, including serious and devastating conditions that do not rise to the level of being “incompatible with sustaining life after birth.” S.B. 474, § 2 (amending S.C. Code Ann. §§ 44-41-660(A), 44-41-610(5)).

112. Plaintiffs have no adequate remedy at law.

CLAIMS FOR RELIEF

FIRST CAUSE OF ACTION

Declaratory Judgment

113. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

114. Under the Uniform Declaratory Judgments Act, “[c]ourts of record within their respective jurisdictions shall have the power to declare rights, status and other legal relations whether or not further relief is or could be claimed.” S.C. Code Ann. § 15-53-20. “Any person . . . whose rights, status, or other legal relations are affected by a statute[] . . . may have determined any question of construction or validity arising under the . . . statute.” *Id.* § 15-53-30.

115. Plaintiffs’ rights are affected by the Act, and thus they request the Court construe the definition of “fetal heartbeat” to confirm that: (1) “cardiac activity” is modified by “the steady and repetitive rhythmic contraction of the fetal heart” such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed by the Act is the

when a heart has formed, which is after approximately nine weeks LMP, consistent with medical consensus.

116. In the alternative, if the Court does not find that the Act's plain language and structure instruct that the Act applies only once a heart has formed (after approximately nine weeks LMP), the Act may infringe upon the constitutional right to privacy as guaranteed by article I, section 10 of the South Carolina Constitution as applied to Plaintiff Taylor Shelton and other similarly situated South Carolinians. Thus, to avoid this unconstitutional application, the Court should construe S.B. 474 such that the relevant point in time addressed by the Act is the point when a heart has formed.

SECOND CAUSE OF ACTION

Vagueness

117. Plaintiffs incorporate by reference the foregoing paragraphs of this Complaint as though fully set forth herein.

118. If the Court does not find that the Act's plain language and structure should be interpreted to apply only once a heart has formed (after approximately nine weeks LMP), in the alternative, Plaintiffs request that the Court construe the Act to cure the vagueness in the definition of "fetal heartbeat."

119. The South Carolina Constitution's Due Process Clause states that no person "shall . . . be deprived of life, liberty, or property without due process of law." S.C. Const. art. I, § 3.

120. The Due Process Clause is violated when a statute "either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application." *State v. Sullivan*, 362 S.C. 373, 376, 608 S.E.2d 422, 424 (2005) (citing *Connally v. Gen. Constr. Co.*, 269 U.S. 385, 391 (1926)).

121. The definition of “[f]etal heartbeat” is vague because it could be read as prohibiting abortion at two different points in pregnancy, allowing for arbitrary and discriminatory enforcement. PPSAT and Dr. Farris are subject to severe criminal penalties for performing an abortion that does not conform with the statute.

122. Because the Act carries the extreme consequence of the deprivation of PPSAT and Dr. Farris’s liberty if they were to provide abortions after six weeks LMP, the Act must be strictly construed against the State, and any ambiguity must be resolved in Plaintiffs’ favor. *State v. Miles*, 421 S.C. 154, 164, 805 S.E.2d 204, 210 (Ct. App. 2017).

123. By failing to set forth clear guidelines or criteria that would allow physicians of common intelligence to discern when the Act’s abortion ban does and does not apply, chilling their ability to provide abortions after six weeks LMP, PPSAT and Dr. Farris are subjected to criminal liability without “fair notice and proper standards for adjudication,” *Curtis v. State*, 345 S.C. 557, 571, 549 S.E.2d 591, 598 (2001) (citing *City of Beaufort v. Baker*, 315 S.C. 146, 152, 432 S.E.2d 470, 472 (1993)), in violation of their right to due process under article I, section 3 of the South Carolina Constitution.

124. “A possible constitutional construction must prevail over an unconstitutional interpretation,” *Curtis*, 345 S.C. at 569–70, 549 S.E.2d at 597 (quoting *Westvaco Corp. v. S.C. Dep’t of Revenue*, 321 S.C. 59, 467 S.E.2d 749 (1995)), and criminal statutes “should be strictly construed against the state and in favor of the defendant.” *State v. Jacobs*, 393 S.C. 584, 587, 713 S.E.2d 621, 623 (2011) (citing *State v. Blackmon*, 304 S.C. 270, 273, 403 S.E.2d 660, 662 (1991)). Plaintiffs thus seek an interpretation of the Act to clarify that S.B. 474’s prohibition on abortions only applies to one period of time: after approximately nine weeks LMP, the point in pregnancy after which a heart has been formed.

WHEREFORE, Plaintiffs having respectfully complained, pray for judgment against Defendants, with the following relief:

- A. That, pursuant to the South Carolina Uniform Declaratory Judgments Act, S.C. Code Ann. §§ 15-53-10–140, the Court declare that S.B. 474’s definition of “fetal heartbeat” means that: (1) “cardiac activity” is modified by “the steady and repetitive rhythmic contraction of the fetal heart” such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed by the Act is the point when a heart has formed, which is after approximately nine weeks LMP, consistent with medical consensus; or alternatively, that the Court declare that S.B. 474’s definition of “fetal heartbeat” is vague and construe it to cure the vagueness and clarify that the Act prohibits abortion after a heart has formed, after approximately nine weeks LMP.
- B. That the Court issue a preliminary injunction followed by a permanent injunction prohibiting Defendants and their officers, employees, servants, agents, appointees, or successors from administering, preparing for, enforcing, or giving effect to S.B. 474 and any other South Carolina statute or regulation that could be understood to give effect to S.B. 474, including through any future enforcement actions based on abortions performed during the pendency of an injunction, as they apply to pregnancies between approximately six and nine weeks LMP;
- C. That the Court waive any security requirement for any injunction issued under S.C. R. Civ. P. 65(c);

- D. That the Court retain jurisdiction of this action to render any further orders that this Court may deem appropriate;
- E. That the Court award Plaintiffs costs and expenses; and
- F. That the Court grant such other and further relief as the Court deems just and appropriate.

Respectfully submitted,

/s/ M. Malissa Burnette

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* Applications for admission *pro hac vice*
forthcoming

Dated: February 5, 2024

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients,
and physicians and staff, *et al.*,
Plaintiffs,

v.

SOUTH CAROLINA, *et al.*,
Defendants.

IN THE COURT OF COMMON
PLEAS FOR THE FIFTH
JUDICIAL CIRCUIT

C/A No.: 2024-CP-[]-_____

**PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION**

Pursuant to Rule 65 of the South Carolina Rules of Civil Procedure, Plaintiffs move the Court for a Preliminary Injunction to enjoin Defendants from enforcing South Carolina's Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (hereinafter "S.B. 474" or the "Act"), during the pendency of an injunction, as applied to abortions performed on patients whose pregnancies have detectable embryonic electrical activity but where a heart has not yet formed, or between approximately six and nine weeks LMP.

As explained in the accompanying memorandum in support, its attached affidavits and exhibits, and the complaint and its attached exhibit, injunctive relief is urgently necessary to prevent continued irreparable harm to Plaintiff Planned Parenthood South Atlantic and its physicians (including Plaintiff Dr. Katherine Farris), staff, and patients (including Plaintiff Taylor Shelton) from the continued application of S.B. 474 to pregnancies where electrical activity can be detected but where a heart has not yet formed. Absent an injunction, these patients will continue to be forced to travel out of state and wait days or weeks for an abortion, if they can obtain an abortion at all, and endure financial, physical, and emotional costs of forced pregnancy, for which they cannot be made whole after judgment.

While the South Carolina Supreme Court held that the Act is facially constitutional in August 2023, it left “for another day (in an as-applied constitutional challenge) the meaning of ‘fetal heartbeat’ and whether the statutory definition—‘cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac’—refers to one period of time during a pregnancy or two separate periods of time.” *Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 474 n.4, 892 S.E.2d 121, 126 n.4 (2023), *reh’g denied* (Aug. 29, 2023). The Court should now answer this question and issue a declaratory judgment finding that, consistent with the plain language of the Act: (1) “cardiac activity” is modified by “the steady and repetitive rhythmic contraction of the fetal heart” such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed by the Act is the point when a heart has formed, which is after approximately nine weeks LMP, consistent with the medical consensus. S.B. 474, § 2 (adding S.C. Code Ann. § 44-41-610(6)).

The Court should therefore block the Act’s enforcement immediately by granting Plaintiffs’ motion for a preliminary injunction and enjoin Defendants and their officers, employees, servants, agents, appointees, or successors from administering, preparing for, enforcing, or giving effect to S.B. 474 and any other South Carolina statute or regulation that could be understood to give effect to S.B. 474, including through any future enforcement actions during the pendency of an injunction, as applied to abortions performed on patients whose pregnancies have detectable embryonic electrical activity but where a heart has not yet formed.

A proposed order will be filed separately.

Respectfully submitted,

/s/ M. Malissa Burnette

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STATE OF SOUTH CAROLINA
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PLANNED PARENTHOOD SOUTH
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Plaintiffs,

v.

SOUTH CAROLINA, *et al.*,
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IN THE COURT OF COMMON
PLEAS FOR THE FIFTH
JUDICIAL CIRCUIT

C/A No.: 2024-CP-[]-_____

**PLAINTIFFS' MEMORANDUM IN
SUPPORT OF THEIR MOTION
FOR PRELIMINARY INJUNCTION**

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INTRODUCTION

Five months ago, the South Carolina Supreme Court ruled that Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (“S.B. 474” or the “Act”), a ban on abortion after the detection of so-called “fetal heartbeat,” does not violate the right to privacy guaranteed by article I, section 10 of the South Carolina Constitution. *See generally Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 892 S.E.2d 121 (2023), *reh’g denied* (Aug. 29, 2023) (“*Planned Parenthood II*”). In the present case, Plaintiffs raise only a narrow question of statutory interpretation left open by the Court in *Planned Parenthood II*: to what point in pregnancy does the statutory definition of “fetal heartbeat” refer? *Id.*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4.

The Act defines “[f]etal heartbeat” as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” S.B. 474, § 2 (adding S.C. Code Ann. § 44-41-610(6)). It also says that “[c]ardiac activity begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac.” *Id.*, § 1(2). While embryonic electrical activity is detectable after approximately six weeks of pregnancy as dated from a patient’s last menstrual period (“LMP”),¹ a heart does not form until later in pregnancy, after approximately nine weeks LMP.

While all parties treated S.B. 474 as a ban on embryonic electrical activity in past litigation, the Supreme Court recognized that the clause separated by commas—“or the steady and repetitive rhythmic contraction of the fetal heart” (the “Clause”)—may be meant to define “cardiac activity,” such that “[f]etal heartbeat” refers to a single point in pregnancy, after a heart has formed. Indeed, the Act’s plain language and rules of grammar indicate that the Clause defines “cardiac activity.” This is also consistent with the General Assembly’s finding that cardiac activity begins only once

¹ It is standard medical practice to date pregnancy using “gestational age,” or the number of weeks and days since the first day of the patient’s last menstrual period (“LMP”).

a heart has formed. *Id.* Despite this, because of the heavy penalties S.B. 474 imposes, including imprisonment and loss of licensure, PPSAT and Dr. Farris have no choice but to presume that the Act's abortion ban applies after approximately six weeks LMP rather than risk legal liability. As a result, since the Act went into effect, PPSAT and Dr. Farris have been forced to turn away the vast majority of patients seeking abortions in South Carolina, including those between approximately six and nine weeks LMP. Each person being denied an abortion is suffering irreparable harm, and collectively, this constitutes a public health crisis in South Carolina.

Plaintiffs thus bring this action on their own behalf, and PPSAT and Dr. Farris also bring this action on behalf of their patients seeking abortions whose pregnancies have detectable embryonic electrical activity but where a heart has not yet formed. In other words, Plaintiffs seek as-applied relief on behalf of South Carolinians who, like Taylor Shelton, whose pregnancies are between approximately six and nine weeks LMP. This Court should block S.B. 474's enforcement as to such patients immediately by granting Plaintiffs' motion for a preliminary injunction and enjoining Defendants and their officers, employees, servants, agents, appointees, or successors from administering, preparing for, enforcing, or giving effect to S.B. 474 as applied to pregnancies between approximately six and nine weeks LMP, including through any future enforcement actions based on abortions performed during the pendency of an injunction. Ultimately, Plaintiffs ask that the Court issue a declaratory judgment that, consistent with the plain language of the Act: (1) "cardiac activity" is modified by "the steady and repetitive rhythmic contraction of the fetal heart" such that the two phrases refer to one point in time during pregnancy, and (2) the relevant point in time addressed by the Act is the point when a heart has formed, which is after approximately nine weeks LMP, consistent with the medical consensus. *Id.*, § 2 (adding S.C. Code Ann. § 44-41-610(6)). In the alternative, because an interpretation of the Act applying it to

pregnancies where a heart has not yet formed but where there is detectable embryonic electrical activity may infringe on South Carolinians' privacy rights, the Court should construe it to apply to the later point; or the definition of "[f]etal heartbeat" is unconstitutionally vague, and the Court should construe it to refer to the point in pregnancy after which a heart has been formed.

STATEMENT OF FACTS

I. S.B. 474 Bans Abortion after a "Fetal Heartbeat" Is Detected.

The Act provides that, with extremely narrow exceptions for grave health threats, fatal fetal conditions, and cases of rape or incest that have been reported to law enforcement regardless of the survivor's wishes,² "no person shall perform or induce an abortion on a pregnant woman with the specific intent of causing or abetting an abortion if the unborn child's *fetal heartbeat* has been detected." S.B. 474, § 2 (adding S.C. Code § 44-41-630(B)) (emphasis added). The Act defines "[f]etal heartbeat" as "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac." *Id.* (adding S.C. Code § 44-41-610(6)). Furthermore, in enacting S.B. 474, the General Assembly found: "Cardiac activity begins at a biologically identifiable moment in time, normally *when the fetal heart* is formed in the gestational sac." *Id.*, § 1(2) (emphasis added).

Anyone who performs an abortion in violation of the Act is subject to severe criminal, civil, and licensure penalties. Those penalties include a felony offense that carries a \$10,000 criminal fine and up to two years in prison as well as revocation of professional licensure. *Id.*, § 2

² See S.B. 474, § 2 (adding S.C. Code Ann. § 44-41-640(A)–(C) ("It is not a violation of Section 44-41-630 if an abortion is performed or induced on a pregnant woman due to a medical emergency or is performed to prevent the death of the pregnant woman or to prevent the serious risk of a substantial and irreversible impairment of a major bodily function, not including psychological or emotional conditions, of the pregnant woman."); amending S.C. Code Ann. § 44-41-610(9) (defining "[m]edical emergency")); 44-41-650, 44-41-660; adding S.C. Code Ann. 44-41-640(A)–(C)).

(adding S.C. Code Ann. §§ 44-41-630(B), 44-41-640(B), 44-41-650(C), 44-41-660(C); amending S.C. Code Ann. § 44-41-690).

II. Relevant Legislative and Litigation History

S.B. 474 took immediate effect when Governor McMaster signed it into law on the morning of May 25, 2023. South Carolina abortion providers, including Planned Parenthood South Atlantic and Dr. Katherine Farris, filed suit in this Court the same day and were granted a preliminary injunction on May 26, 2023. Also on May 26, Defendants appealed the preliminary injunction order directly to the South Carolina Supreme Court. The Supreme Court accepted the case, denied Defendants' request to stay the preliminary injunction, and ordered an expedited briefing schedule.

At oral argument in *Planned Parenthood II*, Justice Few asked whether “the steady and repetitive rhythmic contraction of the fetal heart” was intended to define or supplement the term “cardiac activity” based on the commas surrounding the Clause. However, in its ruling upholding the constitutionality of S.B. 474, the Supreme Court did not answer that question definitively, instead leaving the question “for another day.” *Planned Parenthood II*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4; *see also id.*, 440 S.C. at 497, 892 S.E.2d at 139 (Beatty, C.J., dissenting) (“[I]t does not resolve the anomaly appearing on the face of the legislation regarding the timing of the ‘fetal heartbeat’ ban.”). While plaintiffs in that case sought rehearing to clarify the answer, the Court denied their petition for rehearing. Order, *Planned Parenthood II* (Aug. 29, 2023) (denying rehearing). The same abortion providers then filed a petition for original jurisdiction with the South Carolina Supreme Court on September 14, 2023, again seeking to answer the unresolved question of statutory interpretation. The Supreme Court again declined to clarify the question it first raised, denying the petition for original jurisdiction on November 14, 2023. Order, *Planned Parenthood II* (Nov. 14, 2023) (denying petition for original jurisdiction and injunction).

Accordingly, Plaintiffs now ask this Court to address the statutory construction question identified by the Supreme Court.

III. Access to Abortion Under Prior South Carolina Law

Plaintiffs Planned Parenthood South Atlantic (“PPSAT”) and Dr. Katherine Farris are health care providers in South Carolina that offer a range of sexual and reproductive health services, including abortion. Decl. of Katherine Farris, M.D. in Supp. of Pls.’ Mot. for a Prelim. Inj. (“Farris Decl.”) ¶ 23. PPSAT operates health centers in Columbia and Charleston, Farris Decl. ¶ 22. PPSAT runs two of the only three clinics in the state that provide abortion services to the public, Farris Decl. ¶¶ 28–29,³ and previously provided abortions through the end of the first trimester, which corresponds to fourteen weeks of pregnancy as measured from the first day of the last menstrual period (“LMP”), S.C. Code Ann. § 44-41-10; S.C. Code Ann. Regs. 61-12.101(S)(4); Farris Decl. ¶¶ 25, 28–29.

Although patients generally obtain an abortion as soon as they are able, historically the vast majority of patients who seek abortions in South Carolina have been at least six weeks pregnant by the time they do so. Farris Decl. ¶¶ 46, 70. The difficulty of obtaining an abortion before six weeks LMP is especially pronounced for South Carolina’s marginalized communities, including those living in poverty and Black and Hispanic women. *Id.* ¶¶ 60–61. PPSAT and Dr. Farris’s patients seek abortions for a range of reasons, *id.* ¶ 32., and many do not know they are pregnant before six weeks LMP, *id.* ¶¶ 47–53. Even those who do may face logistical challenges in arranging an abortion appointment. *Id.* ¶¶ 57, 64. Many South Carolinians struggle to pay for an abortion, including because many forms of insurance do not cover abortion as well as the associated travel and childcare costs. *Id.* ¶¶ 61–62, 64, 78. Others are unable to take time off work. *Id.* ¶¶ 61.

³ The third is Greenville Women’s Clinic. *See* Greenville Women’s Clinic, <https://www.greenvillewomensclinic.com/> (last visited January 19, 2024).

Accordingly, since the Act went into effect, the vast majority of PPSAT and Dr. Farris's patients have been unable to access abortion in South Carolina. *Id.* ¶¶ 15, 75.

IV. Detection and Dating of Early Pregnancy and Development of the Cardiovascular System

Because the Act bans abortion at the early stages of pregnancy, it is important to understand the progression of a menstrual cycle and the beginning of pregnancy, in particular the timing of ovulation, fertilization, and implantation. Furthermore, because the Act identifies the formation of a heart and the presence of a "heartbeat" as its key developmental milestones, it is important to understand the medical consensus about the essential features of a human heart and how the cardiovascular system develops.

A. Detection and Dating of Early Pregnancy

A menstrual cycle begins on the first day of the menstruating person's period (that is, the shedding of the lining of the uterus) and ends on the first day of their next period. While menstrual cycles often last about four weeks, a normal cycle can be as shorter or longer, and some people may go six to eight weeks, or even longer, without experiencing a menstrual period. *Id.* ¶¶ 49–50. It is also very common for people to have irregular menstrual cycles that are difficult to predict because they last a different number of days from month to month. *Id.*

About two weeks after the start of a person's period, or halfway through their cycle, they will ovulate, releasing an egg from the ovary and through the fallopian tube towards the uterus. *Id.* ¶ 41. If the egg is fertilized by a sperm cell, it begins dividing into more cells as it moves toward the uterus. These cells (called a "blastocyst") typically get to the uterus about three to four days after fertilization. *Id.*

Pregnancy begins if and when the cells attach to the lining of the uterus—called implantation. Sometimes the cells do not implant in the uterine lining, and pregnancy does not

result. If implantation occurs, it usually happens about six days after fertilization and takes roughly three to four days to complete. Implantation triggers the release of pregnancy hormones including human chorionic gonadotropin (“hCG”), preventing the lining from shedding and stopping the person’s period. *Id.* ¶ 42.

While implantation constitutes the beginning of pregnancy, gestational age is commonly measured starting from the first day of a person’s last menstrual period (“LMP”). In other words, LMP dating counts the pregnancy as starting two to three weeks before fertilization occurs, and about three to four weeks before implantation—the point at which someone becomes pregnant. *Id.* ¶ 43. Thus, a person with a highly regular, four week cycle would already be four weeks LMP when they first could realize their period is late, leaving them with only *two weeks* to realize they have missed their period (rather than just having a late period) and are pregnant, decide they want to have an abortion, and arrange for an abortion before six weeks LMP. *Id.* ¶ 47. For someone with a longer or irregular menstrual cycle, the gestational age may be beyond four weeks LMP by the time they first realize they may have missed their period. *See id.* ¶¶ 49–50.

Many people do not learn they are pregnant as soon as they miss their periods. Many people do not notice a missed period until about a week after their period would normally start, at nearly five weeks LMP. *Id.* ¶ 48 On average, people are unaware of their pregnancies until between five and six weeks gestation. *Id.* ¶ 52. Characteristics associated with later pregnancy awareness include younger age, lower educational attainment, lower poverty-income ratios, and hormonal contraceptive use, as well as having longer or irregular menstrual cycles or breastfeeding. *Id.* Irregular cycles may result from contraceptive use, age, breastfeeding, a recent miscarriage, or other common medical conditions, like diabetes. *Id.* ¶ 50 For example, someone using hormonal contraceptives may stop menstruating altogether, but the contraceptive can nonetheless fail. *Id.* ¶¶

53–54. In addition, some pregnant people experience light bleeding upon implantation that is often mistaken for a menstrual period. *Id.* ¶ 51. Other early pregnancy symptoms can include fatigue, swollen or tender breasts, and nausea and/or vomiting. *Id.* But these same symptoms may also occur as premenstrual symptoms, so a person might mistake them for signs that a late period is actually coming, and not everyone experiences them in early stages of pregnancy. *Id.*

A missed period may prompt someone to take a pregnancy test. *See id.* ¶ 48. At-home pregnancy tests work by detecting the hormone hCG in urine, which is triggered by implantation and produced during pregnancy. *Id.* ¶¶ 42, 48. When used after a missed period, these tests are 99% effective. *Id.* ¶ 48. However, if a person does not have reason to suspect a pregnancy, they are unlikely to purchase or take an over-the-counter test. *Id.*

B. Development of the Cardiovascular System

The developing pregnancy is referred to as an “embryo” in the field of medicine before approximately ten weeks of pregnancy. *Id.* ¶ 11. At the earliest stages of pregnancy (five to six weeks LMP), an embryo is less than a fifth of an inch long. *Id.* ¶ 9. At this point, a cardiovascular system has yet to develop. *Id.* ¶ 10.

The human heart has four major components: four chambers, the walls separating them, the valves connecting them, and the conduction system. Decl. of Amy Crockett, M.D., in Supp. of Pls.’ Mot. for Prelim. Inj. (“Crockett Decl.”) ¶ 20. A heart is made of muscles, and electrical impulses cause the muscles to contract and send blood throughout the body. *Id.* ¶¶ 13–14. A heartbeat occurs when the heart muscles contract. *Id.* ¶ 17. The sound of a heartbeat is the valves—which are like doors between the heart’s chambers—closing during these contractions. *Id.* ¶ 16.

During pregnancy, the earliest primitive cells that will become the heart aggregate around two tubular structures around about five weeks LMP. At this point, the developing organ is a straight tube. *Id.* ¶ 27. The tube will begin to “loop,” or fold in on itself, which is the first step in

forming the chambers of a heart. *Id.* It is also around this time that the developing organ begins to transmit electrical impulses. *Id.* These electrical impulses are asynchronously contracting cardiac muscle cells and become visible as a “flicker” on ultrasound after approximately six weeks LMP. *Id.* ¶¶ 27, 31. These electrical impulses constitute early embryonic electrical activity and are sometimes even visible as early as partway through the fifth week LMP. Farris Decl. ¶ 27. At this time, however, the electrical activity is not organized into a coordinated heartbeat and will not be until after the development of the conduction system. Crockett Decl. ¶ 31. In other words, the embryonic electrical activity that is visible at this point is neither “steady” nor “rhythmic.” *See* S.B. 474, § 2 (adding S.C. Code § 44-41-610(6)). The term “heartbeat” is a misnomer because a cardiovascular system has yet to develop at this point. Farris Decl. ¶ 7. Furthermore, this early embryonic electrical activity cannot be heard as a heartbeat can. Instead, at this early gestational age, it is the ultrasound machine itself that converts these electrical impulses into sound. Crockett Decl. ¶ 27. From approximately six to nine weeks LMP, the chambers, walls, and valves of the developing organ will continue to form. *Id.* ¶¶ 28–30. It is after approximately nine weeks LMP that what physicians consider a “heart” has formed. *Id.* ¶¶ 11, 30, 32.⁴ The South Carolina Department of Health and Environmental Control agrees, stating that “[t]he heart starts to form the normal four chambers” at 7–8 weeks LMP and that the heart forms by 9–10 weeks LMP.⁵

⁴ Physicians and scientists may use different verbiage in talking about cardiac development at different stages of pregnancy. For example, some may use the term “heartbeat” to refer to early embryonic electrical activity. However, the medical consensus is that the four main components of a heart (four chambers, walls, valves, and conduction system) form after approximately nine weeks LMP. Crockett Decl. ¶ 32.

⁵ S.C. Dep’t of Health & Env’t Control, *Embryonic & Fetal Development*, <https://scdhec.gov/sites/default/files/Library/ML-017049.pdf> (last visited Jan. 31, 2024). An ultrasound will not be able to detect the essential features of a heart until later. Crockett Decl. ¶¶ 28, 30. Some highly sophisticated technology will be able to detect the four chambers of the heart as early as twelve weeks (typically performed for patients with high risk pregnancies), and an echocardiogram (also for patients with high risk pregnancies) performed at eighteen to twenty weeks LMP allows for an even more detailed visualization of the heart. *Id.* ¶ 35. Plaintiffs use the

After ten weeks LMP, “fetus” is the medically accurate term for the developing organism. Farris Decl. ¶ 11. A full-term pregnancy typically lasts approximately forty weeks LMP, *id.* ¶ 25, and the first trimester of pregnancy is usually considered to end after the thirteenth week of pregnancy. *Id.* ¶ 44. Most pregnancy loss—miscarriage—occurs during the first trimester, as do the vast majority of abortions. *Id.* ¶¶ 44, 46. Roughly 15% of pregnancies end in miscarriage during the first trimester. *Id.* ¶ 44.

V. Since Going into Effect, S.B. 474 Has Negatively Affected South Carolina Physicians and Public Health.

Since going into effect on August 23, 2023, the Act has negatively impacted PPSAT, their staff and physicians, including Dr. Farris, and patients, including Ms. Shelton. Because of the uncertainty surrounding the point at which S.B. 474’s abortion ban begins to apply and the harsh penalties it imposes, PPSAT and Dr. Farris have had no choice but to stop providing abortions as soon as embryonic electrical activity can be detected via ultrasound—after approximately six weeks LMP (and sometimes sooner).

As a result, PPSAT has been forced to turn away the vast majority of patients seeking abortions. From when the Act went into effect on August 23, 2023 until January 31, 2024, PPSAT has been able to provide only 303 abortions in South Carolina, out of 1,209 patients who have made abortion appointments at its South Carolina health centers. *Id.* ¶ 75. In other words, PPSAT turned away approximately 75% of patients seeking abortions at their South Carolina clinics. Of the 906 patients turned away, 778 (or about 86% of those unable to obtain abortions) had

term “after approximately nine weeks LMP” as a conservative estimate of when the heart has formed, acknowledging that heart development can continue to ten weeks LMP, consistent with the State’s materials. *See* Crockett Decl. ¶ 30 (noting that cardiac septation is completed at approximately ten weeks LMP). This is particularly true given that developmental processes can vary. *Cf., e.g., id.* ¶ 27 (noting range of dates for certain parts of cardiac development).

pregnancies that were nine weeks LMP or less. *Id.*⁶ By comparison, during the same period the prior year, from August 23, 2022 to January 31, 2023, PPSAT provided 1,819 abortions. *Id.* Put differently, over the same period of time, PPSAT was able to provide less than 17% of the abortions it did before the Act went into effect, and the number of people making abortion appointments dropped substantially. Many more South Carolinians likely did not schedule abortion appointments with PPSAT because they learned of South Carolina's ban on abortion early in pregnancy and concluded it was unlikely they would be able to access care in South Carolina before six weeks LMP. *Id.*

Among those who did not ultimately schedule an abortion appointment is Plaintiff Taylor Shelton. Ms. Shelton learned that she was pregnant on September 7, 2023, shortly after the Act went into effect. Decl. of Taylor Shelton in Supp. of Pls.' Mot. for Prelim. Inj. ("Shelton Decl.") ¶ 4. She was shocked she was pregnant because she had an IUD in place and had confirmed with her gynecologist about a week earlier that the contraceptive device was still effective. *Id.* ¶ 5. Ms. Shelton has regular menstrual cycles, which she tracks, so she noticed quickly that she had missed her period. *Id.* ¶ 4. Two days after her missed period, she took two home pregnancy tests, both of which confirmed her suspicion that she was pregnant. *Id.* Ms. Shelton was certain that she was not ready to have a child and that she wanted to have an abortion as soon as possible. *Id.* ¶ 6. Despite recognizing her pregnancy very early and quickly deciding that abortion was the right choice for

⁶ PPSAT's experience is consistent with a recent report from the Guttmacher Institute, which found that in the month after the Act went into effect, abortions decreased drastically: while there were 750 abortions statewide in August 2023, only 160 were performed in September 2023, a decrease of 79%. Kimya Forouzan, et al., *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Inst., https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care?utm_source=Guttmacher+Email+Alerts&utm_campaign=9096c1e61d-December+provision+study&utm_medium=email&utm_term=0_-b00c00d20f-%5BLIST_EMAIL_ID%5D (Dec. 7, 2023).

her, Ms. Shelton was unable to get an appointment with one of the abortion providers in South Carolina before her pregnancy would have reached six weeks. *Id.* ¶ 8. Instead, she was forced to travel out of state to get an abortion, ultimately making three trips to North Carolina—including one to a deceptive anti-abortion center⁷—driving a total of twenty hours. *Id.* ¶¶ 10–12, 15–16. Ms. Shelton had the support of her loved ones and the resources to travel out of state and pay for an abortion. *Id.* ¶ 17. Ms. Shelton ultimately got an aspiration abortion on September 23 at PPSAT’s Wilmington, North Carolina health center when she was roughly six weeks, four days LMP. *Id.* ¶ 16. If the Act were understood to apply only once the major components of a heart have formed, rather than at six weeks LMP, Ms. Shelton would have been able to access abortion in South Carolina.

Based on PPSAT’s experiences, if the Court construes the Act to apply only once a heart has formed (after approximately nine weeks LMP), many more South Carolinians seeking abortions will be able to obtain one in state. And for many South Carolinians who lack the support and resources to travel out of state, this will be the difference between being able to obtain an early, lawful abortion and being forced to continue a pregnancy against their will.

ARGUMENT

A preliminary injunction is warranted where (1) the plaintiff would suffer irreparable harm; (2) it has a likelihood of success on the merits; and (3) there is no adequate remedy at law. *Poynter Invs., Inc. v. Century Builders of Piedmont, Inc.*, 387 S.C. 583, 586–87, 694 S.E.2d 15, 17 (2010). A “plaintiff is not required to prove an absolute legal right when seeking a preliminary injunction.”

⁷ North Carolina imposes a seventy-two-hour waiting period on patients seeking abortion, *see* N.C. Gen. Stat. Ann. § 90-21.82, and requires at least two health center visits, *see* Senate Bill 20, 2023 Leg., 2023–24 Sess. (N.C. 2023).

AJG Holdings, LLC v. Dunn, 382 S.C. 43, 51, 674 S.E.2d 505, 509 (Ct. App. 2009). A “reasonable question as to the existence of such a right” is sufficient. *Id.*

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claims.

Plaintiffs are likely to succeed on the merits of their Declaratory Judgment Act and alternate vagueness claims because the grammatically correct and scientifically accurate way to interpret the definition of “[f]etal heartbeat” is that the Clause and “cardiac activity” refer to one point in time, which is when the heart has formed. In the alternative, if the Court finds that the statutory language is ambiguous, Plaintiffs are likely to succeed on the merits of the alternative vagueness claim because the Court should construe the definition consistently with the accepted medical understanding of when a heart has formed, and thus when a heartbeat exists.

II. The Clause and “[C]ardiac [A]ctivity” Refer to One Point in Time.

A. The Plain Meaning of the Statute Indicates That the Clause Defines “[C]ardiac [A]ctivity.”

When engaging in statutory interpretation, this Court “abide[s] by the plain meaning of the words of a statute.” *State v. Jacobs*, 393 S.C. 584, 587, 713 S.E.2d 621, 622 (2011). It must also “apply the ordinary rules of grammar and common usage to ascertain the meaning of a statute, and . . . should examine the grammatical structure of a clause or sentence that is at issue.” 82 C.J.S. *Statutes* § 410 (citations omitted); *see also* 73 Am. Jur. 2d *Statutes* § 123 (“It is presumed that the legislature in phrasing a statute knows the ordinary rules of grammar and that the grammatical reading of a statute gives its correct sense. An interpretation is to be avoided which is contrary to the grammatical construction of the statute.”) (footnotes omitted). While keeping these instructions in mind, the Court should also heed the “well-settled principle of statutory construction that penal statutes should be strictly construed against the state and in favor of the defendant.” *Jacobs*, 393

S.C. at 587, 713 S.E.2d at 623 (citing *State v. Blackmon*, 304 S.C. 270, 273, 403 S.E.2d 660, 662 (1991)).

It was the South Carolina Supreme Court itself that first raised, without resolving, “the anomaly appearing on the face of the legislation,” *Planned Parenthood II*, 440 S.C. at 497, 892 S.E.2d at 139 (Beatty, C.J., dissenting), and this Court should now ensure that the commas surrounding the Clause have meaning and are not rendered superfluous. *See State v. Sweat*, 386 S.C. 339, 351, 688 S.E.2d 569, 575 (2010) (“A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous.” (quoting *In re Decker*, 322 S.C. 215, 219, 471 S.E.2d 462, 463 (1995))); *Jackson v. S.C. Tax Comm’n*, 192 S.C. 350, 6 S.E.2d 745, 746 (1940) (“While punctuation in a statute is not controlling, it cannot be ignored where there is no patent ambiguity, and where the punctuation gives meaning and effect to the language used. Especially is this true where a disregard of the punctuation as found in the statute will have a material effect upon the construction thereof.” (citing *Caston v. Brock*, 14 S.C. 104 (1880))).

Indeed, the most natural reading is that the commas offset the Clause so as to explain the meaning of “cardiac activity.” “Commas are often used in statutes to set off expressions that provide additional but nonessential information about a noun or pronoun immediately preceding; such expressions serve to further identify or explain the word they refer to.” 82 C.J.S. *Statutes* § 413; cf. Catherine Traffis, *Appositives—What They Are and How to Use Them*, Grammarly, <https://www.grammarly.com/blog/appositive> (last visited Sept. 12, 2023). Here, offsetting the Clause by commas indicates that the Clause is additional information descriptive of “cardiac activity” and could be omitted.

While this definitional clause could be omitted, without such an explanation, the term “cardiac activity” would then be ambiguous because the Act does not follow the consensus in the medical community that a heart forms after approximately nine weeks LMP. *See* Crockett Decl. ¶¶ 24, 32. The Court should thus construe the Clause to define “cardiac activity” consistent with medical consensus, specifically looking to its inclusion of the term “fetal heart.” Medically, a heartbeat exists only after a heart containing the major components—four chambers, walls, valves, and conduction system—has formed. *Id.* ¶ 32. Furthermore, there is no “steady and repetitive rhythmic contraction” at the time embryonic electrical activity can first be detected. *See id.* ¶ 31 (noting that “cells are not organized into coordinated heartbeat” until later).

B. The Whole of S.B. 474 Confirms That “Cardiac Activity” Begins When a Heart Has Formed.

Moreover, the definition of “fetal heartbeat” should be read in conjunction with the whole of the Act. *See Town of Mount Pleasant v. Roberts*, 393 S.C. 332, 342, 713 S.E.2d 278, 283 (2011) (courts should consider “the language of the statute as a whole.” (quoting *Mid-State Auto Auction of Lexington, Inc. v. Altman*, 324 S.C. 65, 69, 476 S.E.2d 690, 692 (1996))). Here, the General Assembly found that “[c]ardiac activity begins at a biologically identifiable moment in time, normally when the *fetal heart is formed* in the gestational sac.” S.B. 474, § 1(2) (emphasis added). Thus, the Court should interpret the Act to give effect to the General Assembly’s finding that the definition applies to a singular point in time in pregnancy, which is when the heart has formed, after approximately nine weeks LMP. The General Assembly’s focus on the formation of a heart is consistent with the medical understanding that a heartbeat exists only once a heart does—when four chambers, walls, the major valves, and conduction system have formed. *See* Crockett Decl. ¶¶ 24, 30, 32. The State itself confirms this medical understanding in its materials on embryonic

and fetal development.⁸ The Court should therefore interpret the singular point in time to mean the period at which the chambers of the heart have formed and can be detected, rather than the time at which electrical impulses can be detected.⁹

This interpretation of “fetal heartbeat” is also consistent with the Act’s requirement that a provider inform the patient of their right to “hear the unborn child’s fetal heartbeat.” S.B. 474, § 10 (amending S.C. Code Ann. § 44-41-330(A)). When embryonic electrical activity can first be detected, this activity is not audible. Rather, a heartbeat itself cannot be heard until after approximately ten weeks LMP. Farris Decl. ¶ 9.

C. In the Alternative, if the Court Finds that “Fetal Heartbeat” is Ambiguous, It Should Construe the Definition Consistently with the Medical Definition.

In the alternative, if the Court finds that the statutory language is ambiguous, it should construe the Act to avoid constitutional infirmity or find that it is unconstitutionally vague. Because “[a] possible constitutional construction must prevail over an unconstitutional interpretation[.]” *Curtis v. State*, 345 S.C. 557, 569–70, 549 S.E.2d 591, 597 (2001) (quoting *Westvaco Corp. v. S.C. Dep’t of Revenue*, 321 S.C. 59, 467 S.E.2d 749 (1995)), the Court should interpret “fetal heartbeat” consistent with the medical definition.

⁸ S.C. Dep’t of Health & Env’t Control, *supra* note 5.

⁹ To the extent Defendants argue that the abortion ban applies after approximately six weeks based on legislative intent, their expressions of legislative intent related to S.B. 474 have shifted at various points. “The plain meaning of legislation should be conclusive, except in the ‘rare cases [in which] the literal application of a statute will produce a result *demonstrably at odds* with the intentions of its drafters.’” *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989) (quoting *Griffin v. Oceanic Contractors, Inc.*, 458 U.S. 564, 571 (1982) (alteration in original) (emphasis added)). And this plain meaning comports with the State’s assertion in *Planned Parenthood II* that “a fetal heartbeat may not be detected [until] as late as nine to ten weeks of pregnancy.” Br. of the Speaker of the House, the President of the Senate, the State, the Att’y Gen. and Solicitor Wilkins at 12, *Planned Parenthood II*.

D. If Construed as a Six-Week Ban, the Act Is Likely an Unreasonable Invasion of Privacy as Applied to Taylor Shelton and Other Patients Unable to Obtain an Abortion Prior to the Detection of Embryonic Electrical Activity.

It is black letter law that “[w]here a statute is susceptible of two constructions, one of which presents grave and doubtful constitutional questions, and the other of which avoids those questions, the Court’s duty is to adopt the latter.” *Edwards v. State*, 383 S.C. 82, 91–92, 678 S.E.2d 412, 417 (2009); accord *Henderson v. Evans*, 268 S.C. 127, 132, 232 S.E.2d 331, 333–34 (1977); *United Student Aid Funds, Inc. v. S.C. Dep’t of Health & Env’t Control*, 349 S.C. 162, 168, 561 S.E.2d 650, 653 (Ct. App. 2002), *aff’d*, 356 S.C. 266, 588 S.E.2d 599 (2003).

In *Planned Parenthood II*, the Supreme Court ruled that the Act, on its face, did not unreasonably infringe on South Carolinians’ right to privacy without resolving the question of when in pregnancy the Act bans abortion. Reading *Planned Parenthood II* in tandem with *Planned Parenthood I* and considering the intervening facts since the Supreme Court issued its opinion in *Planned Parenthood II*, as applied to Ms. Shelton’s experience, the Court should find that a ban on abortion at six weeks LMP likely violates Ms. Shelton’s privacy rights under the Privacy Clause of the South Carolina Constitution. Thus, because of the possible constitutional infirmity as applied to Ms. Shelton and other patients unable to obtain an abortion before embryonic electrical activity can be detected via ultrasound, the Court should interpret S.B. 474 to apply only once a heart has formed to avoid the “grave and doubtful constitutional question[]” of whether a ban on abortion after approximately six weeks LMP violates their right to privacy. *Edwards*, 383 S.C. at 91–92, 678 S.E.2d at 417.

In an earlier case evaluating the constitutionality of a so-called “fetal heartbeat” ban, the South Carolina Supreme Court assumed that Senate Bill 1, 124th Gen. Assemb., Spec. Sess. (S.C. 2021) (“S.B. 1”) banned abortion “after around six weeks gestation.” *Planned Parenthood S. Atl. v. State*, 438 S.C. 188, 195, 882 S.E.2d 770, 774 (2023) (“*Planned Parenthood I*”). With this

assumption in mind, Justice Few wrote in his concurrence that it is “obvious” that before six weeks “a substantial percentage of women cannot learn of their pregnancy in time to make and carry out a meaningful choice.” *Id.*, 438 S.C. at 286, 882 S.E.2d at 823 (Few, J., concurring in the judgment). The Court made no such assumption as to the gestational age at which S.B. 474 bans abortion in ruling it constitutional in *Planned Parenthood II*. *See Planned Parenthood II*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4. And because *Planned Parenthood II* merely found that S.B. 1 and S.B. 474 were distinguishable, rather than overturning *Planned Parenthood I*, *see id.*, 440 S.C. at 479, 892 S.E.2d at 129, the two cases should be read in conjunction with one another in this as-applied challenge.

Under the Supreme Court’s analysis in *Planned Parenthood II*, as in *Planned Parenthood I*, *unreasonable* invasions of privacy violate the South Carolina Constitution. *E.g., id.*, 440 S.C. at 482, 892 S.E.2d at 131. *Planned Parenthood II* focused its analysis on the changes made from S.B. 1 to S.B. 474, including the Act’s emphasis on contraceptives and home pregnancy tests. *See id.*, 440 S.C. at 477, 892 S.E.2d at 128 (identifying S.B. 474’s emphasis on “contraceptives and early pregnancy testing” as a key change to the law as compared to S.B. 1); *id.*, 440 S.C. at 492–94, 892 S.E.2d at 136–37 (Few, J., concurring). Justice Few called those alterations “designed to approach the idea of choice in terms of promoting active family planning” as “[t]he most impactful” differences distinguishing the two bans. *Id.*, 440 S.C. at 491, 892 S.E.2d at 135 (Few, J., concurring). In reviewing the legislative record, the Court recognized the possibility that a pregnant person would have “several weeks,” or an “‘ample’ period of weeks . . . ‘to make a decision about whether to terminate her pregnancy.’” *Id.*, 440 S.C. at 474–75, 892 S.E.2d at 127

(quoting S. 474, S. Journal No. 19, 125th Gen. Assemb. (S.C. Feb. 9, 2023) (“S. Journal”) (statement of Sens. Massey, Campsen, and Grooms)).¹⁰

Thus, *Planned Parenthood II*, like *Planned Parenthood I*, recognizes that any abortion ban “must be meaningful in that the time frames imposed must afford a woman sufficient time to determine she is pregnant and to take reasonable steps to terminate that pregnancy.” *Planned Parenthood I*, 438 S.C. at 217, 882 S.E.2d at 786 (Few, J., concurring in the judgment) (“Six weeks is, quite simply, not a reasonable period of time for these two things to occur.”). *Planned Parenthood II* only addressed the facial constitutionality of S.B. 474, *see Planned Parenthood II*, 440 S.C. at 476–77, 892 S.E.2d at 127–28, expressly deferring the question of statutory interpretation now before this Court, *id.*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4 (“We leave for another day (in an as-applied constitutional challenge)”). Accordingly, now is the time to determine the point during pregnancy at which the Act begins to ban abortion, as applied to Ms. Shelton and others whose pregnancies have detectable embryonic electrical activity but where a heart has not yet formed.

Considering the factors the Supreme Court identified in both *Planned Parenthood I* and *Planned Parenthood II*, a ban on abortion at six weeks LMP was likely an unreasonable invasion of Ms. Shelton’s privacy. Despite using contraceptives, tracking her period, testing for a pregnancy, and making her decision to get an abortion quickly, she was unable to carry out a “meaningful choice,” *see Planned Parenthood I*, 438 S.C. at 278, 882 S.E.2d at 818–19 (Few, J.,

¹⁰ The statement from Senators Massey, Campsen, and Grooms, cited by the Court also indicates that someone can learn they are pregnant at “two weeks after conception”—or approximately four weeks LMP—and then have “another 4 ½ to 5 weeks to make her decision and have an abortion.” S. Journal. It is difficult, however, to read the Senators’ statement with clarity given that it alternates between two methods of pregnancy dating: post-fertilization and LMP. *Compare* S. Journal (relying on Department of Health and Environmental Control Data (“DHEC”)) *with Planned Parenthood I*, 438 S.C. at 281, 882 S.E.2d at 820 (Few, J., concurring in the judgment) (explaining the same misinterpretation of the DHEC data).

concurring in the judgment), in South Carolina.¹¹ Ms. Shelton was not able to obtain an abortion in South Carolina before six weeks LMP, even with the early recognition of her pregnancy and the resources to travel and pay for an abortion. *See* Shelton Decl. ¶¶ 8, 16–17. She likely had her privacy unreasonably invaded under the Act as interpreted to ban abortion upon the detection of embryonic electrical activity by being forced to remain pregnant until she was able to obtain an abortion out of state despite that a heart had not yet formed.

The same is true for the hundreds (if not thousands) of other South Carolinians whose pregnancies were between six and nine weeks LMP, where a heart has not yet formed, and who have been denied abortions since the Act went into effect. Absent clarification from this Court, this will also likely be the case for thousands of South Carolinians in the future. S.B. 474 thus also likely violates the right to privacy as applied to these South Carolinians.

These likely unreasonable and thus unconstitutional invasions of privacy can be avoided. If the Act was interpreted to ban abortion only once a heart has formed, Ms. Shelton would have been able to access abortion in South Carolina, as would many other South Carolinians. To avoid this constitutional infirmity as applied to future patients who are unable to access abortion in South Carolina before an ultrasound can detect embryonic electrical activity, the Court should interpret S.B. 474 as a ban on abortion only once a heart has formed.¹²

¹¹ People using many forms of hormonal contraceptives may not get a period at all. Farris Decl. ¶ 53. Furthermore, because people often use contraceptives for the purpose of preventing pregnancy, they are less likely to assume they are pregnant if they have a late period. *Id.* Thus, contraceptive use is actually associated with *delayed* recognition of pregnancy. *Id.* That Ms. Shelton recognized she might be pregnant so shortly after her missed period makes her an outlier.

¹² This is particularly true given potential attacks by the General Assembly on contraceptive access. *See* Senate Bill 882, 125th Gen. Assemb., Spec. Sess. (S.C. 2024) (proposing that minors be required to obtain parental consent before getting a prescription, including hormonal birth control, without option for judicial bypass).

E. To the Extent that “Fetal Heartbeat” Is Unconstitutionally Vague, the Court Should Construe the Act to Apply at the Later Point in Pregnancy.

The South Carolina Constitution’s Due Process Clause states that no person “shall . . . be deprived of life, liberty, or property without due process of law.” S.C. Const. art. I, § 3. The due process guarantee requires “requires fair notice and proper standards for adjudication.” *City of Beaufort v. Baker*, 315 S.C. 146, 152, 432 S.E.2d 470, 473 (1993) (quoting *State v. Albert*, 257 S.C. 131, 134, 184 S.E.2d 605, 606 (1971)); *see also Curtis*, 345 S.C. at 571–72, 549 S.E.2d at 598 (“The constitutional standard for vagueness is the practical criterion of fair notice to those to whom the law applies.”). This notice requirement is embodied in the void-for-vagueness doctrine, which “requires that a penal statute define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement,” *S.C. Hum. Affs. Comm’n v. Zeyi Chen*, 430 S.C. 509, 529, 846 S.E.2d 861, 871 (2020) (citing *Kolender v. Lawson*, 461 U.S. 352, 357 (1983)). If people “of common intelligence must necessarily guess as to [a law’s] meaning and differ as to its application,” the law is unconstitutionally vague. *Toussaint v. State Bd. of Med. Exam’rs*, 303 S.C. 316, 320, 400 S.E.2d 488, 491 (1991); *see also, e.g., State v. Sullivan*, 362 S.C. 373, 376, 608 S.E.2d 422, 424 (2005).

The constitutional standard for vagueness is especially stringent when applied to criminal statutes because they carry the extreme consequence of the deprivation of an individual’s liberty. *See Planned Parenthood I*, 438 S.C. at 245–46, 882 S.E.2d at 801 (Beatty, C.J., concurring). For this reason, South Carolina courts have long recognized the rule of lenity—the principle that penal statutes are to be strictly construed against the State. *See, e.g., State v. Miles*, 421 S.C. 154, 164, 805 S.E.2d 204, 210 (Ct. App. 2017) (“This rule of lenity applies when a criminal statute is ambiguous, and requires any doubt about a statute’s scope be resolved in the defendant’s favor.”).

The Act's severe criminal penalties would result in a deprivation of liberty for anyone convicted. Violation of the prohibition is a felony, accompanied by a fine of ten thousand dollars, imprisonment up to two years, or both. S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-630(B)). But the Due Process Clause mandates that "no [one] shall be held criminally responsible for conduct which he could not reasonably understand to be proscribed." *Town of Mount Pleasant v. Chimento*, 401 S.C. 522, 541, 737 S.E.2d 830, 842 (2012) (quoting *United States v. Harriss*, 347 U.S. 612, 617 (1954)).

PPSAT's physicians, including Dr. Farris, under threat of civil and criminal penalties, cannot reasonably ascertain what conduct is prohibited if the meaning of "fetal heartbeat" can either "refer[] to one period of time during a pregnancy or two separate periods of time." *Planned Parenthood II*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4. If the South Carolina Supreme Court itself could not resolve the doubt about the scope of the law, the remaining ambiguity clearly violates PPSAT and Dr. Farris's right to fair notice. *Bouie v. City of Columbia*, 378 U.S. 347, 351 (1964) ("No one may be required at peril of life, liberty or property, to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the State commands or forbids.") (citation omitted)).

To find that the only operative term defining a "fetal heartbeat" is "cardiac activity" would be to walk "into a giant hole of ambiguity," as Justice Few noted at oral argument. While the most natural and grammatically correct way to read the definition of "[f]etal heartbeat" is that the Clause defines "cardiac activity," the Court pointed to multiple possible ways to interpret the definition. Consistent with the rule of lenity, this ambiguity should be resolved in favor of Plaintiffs, and the Court should construe to allow the broadest ability of PPSAT and Dr. Farris to provide care. In other words, it should interpret "fetal heartbeat" consistently with the accepted medical

understanding: that a heartbeat exists only once a heart has formed, after approximately nine weeks LMP. Crockett Decl. ¶¶ 24, 32.

Beyond providing “sufficient notice of the conduct prohibited,” to survive a vagueness challenge, a “statute must also not be written in such a manner as to permit or encourage arbitrary and discriminatory enforcement.” *Chimento*, 401 S.C. at 541, 737 S.E.2d at 842. “Where the legislature fails to provide such minimal guidelines, a criminal statute may permit a standardless sweep that allows policemen, prosecutors, and juries to pursue their personal predilections.” *Id.*, 401 S.C. at 542, 737 S.E.2d at 842–43 (quoting *Kolender*, 461 U.S. at 358) (cleaned up). S.B. 474 is also unconstitutionally vague to the extent that it provides insufficient guidance to entities seeking to enforce the law. For example, the Solicitor for the Ninth Judicial Circuit might interpret the Act to prohibit abortion after the detection of embryonic electrical activity but where a heart has not yet formed and thus bring charges related to an abortion performed at PPSAT’s Charleston health center, while the Solicitor for the Fifth Judicial Circuit might decline to bring charges for the same abortion if it had been performed at its Columbia clinic.

F. Unless the Act Is Construed to Apply Only Once a Heart Has Formed, Petitioners and Their Patients Will Continue to Suffer Irreparable Harm.

“[W]hether a wrong is irreparable” is a question that is “not decided by narrow and artificial rules,” but instead determined based on the facts of the case. *Kirk v. Clark*, 191 S.C. 205, 211, 4 S.E.2d 13, 16 (1939); *see also Peek v. Spartanburg Reg’l Healthcare Sys.*, 367 S.C. 450, 626 S.E.2d 34 (Ct. App. 2005). “The Courts proceed realistically if the threatened wrong involves actual damage; the mere uncertainty of fixing the measure of such damage to the injured party may itself be sufficient to justify the exercise of equitable jurisdiction.” *Kirk*, 191 S.C. at 211, 4 S.E.2d at 16.

III. The Act Is Irreparably Harming PPSAT's Physicians, Staff, and Patients.

PPSAT's physicians, including Dr. Farris, and staff are being irreparably injured by the lack of clarity of when the Act's prohibition applies. The Act interferes with the ability of PPSAT—and its physicians, including Dr. Farris, and staff—to provide medical care consistent with their medical judgment and in support of patient wellbeing. *See Joseph v. S.C. Dep't of Lab., Licensing & Regul.*, 417 S.C. 436, 452, 790 S.E.2d 763, 771 (2016) (recognizing physicians' "right to practice medicine in the best interests of their patients"). PPSAT, Dr. Farris, and staff will also face reputational harm and harm to their professional licenses from the threat of severe criminal and licensing penalties posed by the Act. These harms too are irreparable. *Peek*, 367 S.C. at 455, 626 S.E.2d at 37 (holding that a physician's "loss of professional practice and career" was an irreparable harm); *Levine v. Spartanburg Reg'l Servs. Dist., Inc.*, 367 S.C. 458, 465 n.3, 626 S.E.2d 38, 42 n3. (Ct. App. 2005).

Construing S.B. 474 to apply at six weeks LMP may violate South Carolinians' right to privacy. And to the extent that the Act's definition of "[f]etal heartbeat" is vague, PPSAT, Dr. Farris, and staff are also suffering irreparable harm because their constitutional due process rights are being obstructed. Generally, when a plaintiff has demonstrated a loss of a constitutional right, no further showing of irreparable injury is required. *E.g., B. P. J. v. W. Va. State Bd. of Educ.*, 550 F. Supp. 3d 347, 357 (S.D. W. Va. 2021) ("When a party has shown a likelihood of a constitutional violation, the party has shown an irreparable harm."); *Henry v. Greenville Airport Comm'n*, 284 F.2d 631, 633 (4th Cir. 1960) ("The District Court has no discretion to deny relief by preliminary injunction to a person who clearly establishes by undisputed evidence that he is being denied a constitutional right."); 11A Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 2948.1 (3d ed. 2022) (collecting cases).

A. The Act Is Irreparably Harming PPSAT's Staff, Physicians (Including Dr. Farris), and Patients (Including Taylor Shelton).

S.B. 474 is causing grave harm by forcing PPSAT and Dr. Farris to turn away the vast majority of South Carolinians seeking abortions. PPSAT and Dr. Farris expect to see many patients who are seeking abortion services during the coming weeks and months; most of these South Carolinians will have pregnancies with detectable embryonic electrical activity. While some of those will have pregnancies where a heart has formed, many will not. Those whose pregnancies, like Ms. Shelton's, fall between approximately six and nine weeks LMP are being turned away at great personal cost due to the legal limbo created by an Act that under the better reading would allow them to access care. They are being forced to carry their pregnancies to term against their will, with all of the physical, emotional, and financial costs that entails; self manage their abortions outside the health care system; or travel out of state to obtain care, often at great cost and delay. Each of these impacts constitutes irreparable harm to PPSAT and Dr. Farris's patients who are pregnant with detectable embryonic electrical activity but without a formed heart. *See, e.g., Planned Parenthood of Kan. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) ("A disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." (internal quotations omitted)); *Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (irreparable harm where individuals would experience complications and other adverse effects due to delayed medical treatment); *Banks v. Booth*, 468 F. Supp. 3d 101, 123 (D.D.C. 2020) (same).

If, in the absence of clarification, PPSAT and Dr. Farris must continue to construe the Act as a six week ban, S.B. 474 will continue to bar the vast majority of abortions in South Carolina. By contrast, over half of patients seeking abortions at PPSAT's health centers would likely be able to obtain abortions if S.B. 474 were determined to ban abortion after the point when a heart has

formed, after approximately nine weeks LMP. PPSAT has 110 patients scheduled for abortion-related appointments in the next week. Farris Decl. ¶ 15.

The Act threatens severe, actual, and irreparable damage to South Carolinians' lives and livelihood—harms that are more than sufficient to justify entry of injunctive relief. *See Kirk*, 191 S.C. at 211, 4 S.E.2d at 16.

B. Plaintiffs Do Not Have an Adequate Remedy at Law.

“Equitable relief is generally available only where there is no adequate remedy at law.” *Santee Cooper Resort, Inc. v. S.C. Pub. Serv. Comm’n*, 298 S.C. 179, 185, 379 S.E.2d 119, 123 (1989). “An ‘adequate remedy’ at law is one which is as certain, practical, complete and efficient to attain the ends of justice and its administration as the remedy in equity.” *Id.* (citing 27 Am. Jur. 2d *Equity* § 94 (1966)). No damages award could compensate Plaintiffs and PPSAT’s patients for the harms inflicted by S.B. 474. Nor could such a remedy compensate PPSAT, Dr. Farris, and staff for injury to their rights and interests under the threatened application of S.B. 474, a criminal law. *See De Treville v. Groover*, 219 S.C. 313, 328, 65 S.E.2d 232, 239 (1951); *see also Doe v. Bolton*, 410 U.S. 179, 188 (1973). In the absence of equitable relief from this Court, Plaintiffs do not have an adequate remedy at law to prevent Defendants from enforcing the Act prior to the formation of a heart.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that the Court issue a preliminary injunction, prohibiting all Defendants and their officers, employees, servants, agents, appointees, or successors from administering, preparing for, enforcing, or giving enforcing S.B. 474 and any other South Carolina statute or regulation that could be understood to give effect to S.B. 474, in a manner that would prohibit abortions before a heart has formed (after approximately nine weeks LMP), including through any future enforcement actions based on abortions performed during the

pendency of an injunction. Plaintiffs respectfully request that the Court waive any security under S.C. R. Civ. P. 65(c), in light of the constitutional interests at stake and PPSAT and Dr. Farris's critical role in providing medical services to South Carolinians who might otherwise not have access to these services.

Respectfully submitted,

/s/ M. Malissa Burnette

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Dated: February 5, 2024

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT

C/A No.: 2024-CP-[XX]-_____

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients,
and physicians and staff, *et al.*,
Plaintiffs,

v.

SOUTH CAROLINA, *et al.*,
Defendants.

**DECLARATION OF KATHERINE
FARRIS, M.D., IN SUPPORT OF
PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION**

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

1. I am a plaintiff in this case, and I serve as the Chief Medical Officer for Plaintiff Planned Parenthood South Atlantic ("PPSAT"). In this position, I provide oversight, supervision, and leadership on all medical services we provide, including abortion. As part of my role, I collaborate with other members of PPSAT senior management to develop policies and procedures to ensure that the medical services we provide follow evidence-based guidelines and comply with all relevant laws. I also provide direct medical services for PPSAT, including abortion services at PPSAT's South Carolina health centers.

2. The facts I state here and the opinions I offer are based on my education, my years of medical practice, my expertise as a doctor and specifically as an abortion provider, my personal knowledge, my review of PPSAT business records, information obtained through the course of my duties at PPSAT, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession.

3. A copy of my *curriculum vitae* is attached as **Exhibit A**.

4. I am a plaintiff in this case and submit this declaration in support of Petitioner's Motion for a Preliminary Injunction to enjoin enforcement of Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (hereinafter, the "Act" or "S.B. 474"), as applied to abortions where a pregnancy has detectable embryonic electrical activity (after approximately six weeks LMP) but where a fetal heart has not yet formed (which occurs after approximately nine weeks LMP).

5. I understand that the Act bans the provision of abortion in South Carolina as soon as a "fetal heartbeat" is detected, as that term is defined by the Act.¹

6. As I understand the Act, "fetal heartbeat" is defined as "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac."²

7. Due to the Act's severe criminal and civil penalties, when the Act was first passed in May of this year, I assumed it to prohibit abortion after the detection of embryonic electrical activity, which can be observed through ultrasound as early as six weeks as measured from the first day of a patient's last menstrual period ("LMP").³ I thus understood the term "fetal heartbeat" to cover not just a "heartbeat" in the medical sense, but also early embryonic electrical activity present before development of any cardiovascular system. However, the South Carolina Supreme Court, at oral argument and in the majority decision, introduced the question of whether the statutory definition of "fetal heart" defines "cardiac activity" with the clause "or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac."⁴ In other words, the Court posed the question as to whether the Act prohibits abortion after embryonic electrical

¹ S.B. 474, § 2 (adding S.C. Code Ann. § 44-41-630(B)).

² *Id.* (amending S.C. Code Ann. § 44-41-610(6)).

³ The LMP method of pregnancy dating can be accomplished by patient self-reporting and, when appropriate, confirmed via ultrasound.

⁴ *Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 474 n.4, 892 S.E.2d 121, 126 n.4 (2023), *reh'g denied* (Aug. 29, 2023).

activity can be detected, as early as six weeks LMP, or after a heart has formed after approximately nine weeks LMP, before leaving this question unanswered.

8. Accordingly, based on this ambiguity first raised by the South Carolina Supreme Court, I am unable to understand with confidence at what point(s) in pregnancy abortion is prohibited.

9. Based on my medical experience and expertise, embryonic electrical activity may be detected by ultrasound as early as six weeks of pregnancy LMP (and sometimes sooner). By that point in pregnancy, an ultrasound may reveal a ring, which represents the round sac within the uterus, and an electrical impulse that appears as a visual flicker on the edge of the sac and therefore, although this is not what one would think of as a “heartbeat,” the Act’s restrictions could begin to apply at this extremely early stage.⁵ This electrical activity cannot be made audible at that stage of pregnancy and only becomes audible after approximately ten weeks LMP.⁶ At these earliest stages of pregnancy, an embryo is less than a fifth of an inch long.⁷

10. The tissue producing these electrical impulses cannot be accurately described by the term “fetal heart”; it will not develop the four major components of a heart until later in pregnancy—after approximately nine weeks LMP.⁸ These components are the four chambers, the walls separating them, the valves connecting them, and the conduction system.

⁵ Panos Antsaklis et al., *Early Pregnancy Scanning: Step-by-Step Overview*, 13 Donald Sch. J. of Ultrasound in Obstetrics & Gynecology 236, 237 (2019).

⁶ Saeed Abdulrah Alnuaimi et al., *Fetal Cardiac Doppler Signal Processing Techniques: Challenges and Future Research Directions*, 5 Frontiers in Bioengineering & Biotechnology 3 (2017).

⁷ *What Happens in the Second Month of Pregnancy?*, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-month-by-month/what-happens-second-month-pregnancy> (last visited June 19, 2023).

⁸ See S.C. Dep’t of Health & Env’t Control, *Embryonic & Fetal Development*, <https://scdhec.gov/sites/default/files/Library/ML-017049.pdf> (last visited Sept. 12, 2023).

11. Additionally, in the field of medicine, the developing organism present in the gestational sac during pregnancy is most accurately termed an “embryo” before approximately ten weeks LMP. The term “fetus” is not used until after this time.

12. I understand that the Act’s ban on abortion after the detection of a so-called “fetal heartbeat” comes with heavy penalties. A physician’s violation of the Act is a felony, carrying up to a two-year prison sentence and a fine of \$10,000.⁹ A physician will also have their license revoked and may also be civilly liable if they are found to have violated the Act.

13. I understand that, to comply with this ban on abortion after detectable “fetal heartbeat,” the Act requires the abortion provider or a trained colleague to perform an ultrasound before every abortion to determine whether a “fetal heartbeat” can be detected and that it is a felony to perform the abortion without taking this step, except in a medical emergency.¹⁰

14. Because of the ambiguity about which point in pregnancy abortion is banned by the Act, on August 23, 2023, PPSAT stopped performing the vast majority of abortions—any with detectable embryonic electrical activity—that we performed before the Act went into effect. Because we face the threat of civil and criminal penalties for violating the Act, we must presume that a “fetal heartbeat” can be detected after approximately six weeks LMP—despite the fact that no heart has formed at that point and thus there is no heartbeat.

15. Since the Act went back into effect, PPSAT has been forced to turn away the vast majority of patients seeking abortion care in South Carolina. PPSAT has 110 patients scheduled for abortion-related appointments in the next week. In my clinical experience, the majority of these patients will be at least six weeks LMP and will not be able to obtain abortion care in the state of South Carolina, including at PPSAT’s clinics, absent an interpretation that the Act bans abortion

⁹ *Id.* (adding S.C. Code Ann. § 44-41-630(B)).

¹⁰ *Id.*

after approximately nine weeks LMP. Very few, if any, of the patients with pregnancies with detectable fetal or embryonic electrical activity will qualify for one of the Act's limited exceptions.

16. I anticipate that patients who can scrape together the resources will be forced to travel out of state for medical care, and many others who cannot do so will be forced to carry a pregnancy to term against their will or seek ways to end their pregnancies without medical supervision, some of which may be unsafe. I am gravely concerned about the effect that the Act has on South Carolinians' emotional, physical, and financial wellbeing and the wellbeing of their families.

My Background

17. I am licensed to practice medicine in South Carolina, North Carolina, Virginia, and West Virginia. I am board-certified in family medicine and have been awarded the degree of Fellow of the American Academy of Family Physicians. I am a member of the American College of Obstetricians and Gynecologists ("ACOG"), the National Abortion Federation, Physicians for Reproductive Health, and the American Academy of Family Physicians.

18. I obtained a bachelor's degree in molecular and cellular biology from Northwestern University in 1995 and a medical degree from Northwestern University Medical School in 2000. I completed an internship and residency in family medicine at Valley Medical Center in Renton, Washington. I served as Chief Resident from 2002 to 2003.

19. I have worked for PPSAT and a predecessor organization since 2009. Throughout that time, I have provided comprehensive family planning services, including medication abortion and abortion by procedure. I have also served in a range of leadership positions, including as Laboratory Director, Acting Vice President of Patient Services, and as an Interim Abortion Facility Administrator.

20. Before joining PPSAT, I provided full-spectrum family medicine in private practice and in a hospital setting in Massachusetts. That practice included comprehensive family planning and reproductive health care, as did my work in an earlier position with Planned Parenthood League of Massachusetts. I have provided medication abortion and abortion by procedure since 2003.

PPSAT and Its Services

21. PPSAT is a not-for-profit corporation that is headquartered in North Carolina.

22. PPSAT and its predecessor organizations have provided health care in South Carolina for more than four decades. We have two health centers in South Carolina—one in Columbia and the other in Charleston. I provide abortion services as needed for PPSAT in South Carolina, among other locations.

23. We offer our patients a range of family planning and reproductive health services and other preventive care at these centers. This care includes well-person exams; contraception (including long-acting reversible contraception) and contraceptive counseling; gender-affirming hormone therapy, as well as menopausal hormone replacement therapy; screening for breast and cervical cancers; screening and treatment for sexually transmitted infections; pregnancy testing and counseling; physical exams; and medication abortion and abortion by procedure.

24. Medication abortion involves the use of medication taken to safely and effectively end an early pregnancy in a process similar to a miscarriage. Abortion by procedure involves the use of gentle suction and/or the insertion of instruments through the vagina to empty the contents of a patient's uterus. Although sometimes known as "surgical abortion," abortion by procedure does not involve surgery in the conventional sense. It does not require an incision into the patient's skin or a sterile field.

25. At both the Columbia and Charleston health centers, PPSAT provides abortion only in the first trimester of pregnancy. Before the Act took effect, and other than when S.B. 1, 124th Gen. Assemb., Reg. Sess. (S.C. 2022) ("S.B. 1"), was in effect during the summer of 2022, PPSAT has generally provided medication abortion up to eleven weeks of pregnancy LMP and abortion by procedure up to fourteen weeks LMP. As a point of reference, a full-term pregnancy typically lasts approximately forty weeks LMP.

26. Prior to the Act taking effect, and other than when S.B. 1 was in effect last summer, on the day of a patient's abortion appointment, PPSAT staff would typically perform an ultrasound.

27. At four weeks LMP, an ultrasound might show the gestational sac as a ring within the uterus, but the yolk sac and embryo likely would not yet be visible. At five weeks LMP, the ultrasound might show the yolk sac as well as the gestational sac. By six weeks LMP, the ultrasound image would often include the gestational sac, the yolk sac, and the embryo, and the electrical impulse that constitutes embryonic electrical activity at this stage would usually be visible as a flicker within the embryo. Sometimes this flicker is visible as early as partway through the fifth week LMP (i.e., less than four weeks after conception and less than two weeks after a missed period if the patient has regular periods).

28. PPSAT's health centers are licensed as "abortion clinic[s]" under South Carolina law, a license that is required for any facility other than a hospital that performs five or more first-trimester abortions in a month or any second-trimester abortions.¹¹ PPSAT's physicians at the Columbia and Charleston health centers are licensed to practice medicine in South Carolina.

¹¹ S.C. Code Ann. § 44-41-75(A).

29. According to South Carolina's Department of Health and Environmental Control, there is only one abortion clinic in South Carolina other than PPSAT, Greenville Women's Clinic.¹²

Access to Abortion in South Carolina

30. Legal abortion is one of the safest procedures in contemporary medical practice and is far safer than childbirth.¹³ Less than 1% of women obtaining abortions experience a serious complication.¹⁴ The risk of a patient experiencing a complication that requires hospitalization is even lower, approximately 0.3%.¹⁵ A woman's risk of death associated with childbirth nationwide is approximately fourteen times higher than that associated with abortion,¹⁶ and every pregnancy-related complication is more common among women having live births than among those having abortions.¹⁷

31. Abortion is also very common: approximately one in four women in this country will have an abortion by age forty-five.¹⁸

32. Patients' decisions to have an abortion often involve multiple considerations.¹⁹ The majority—53% in 2023—of PPSAT's South Carolina patients who have an abortion are already

¹² *Find a Facility: Abortion Clinics*, S.C. Dep't of Health & Env't Control, Health Facilities & Servs., <https://sc-dhec.maps.arcgis.com/apps/webappviewer/index.html?id=e8b4eea83cab491bb3e3663093e14656> (last visited Apr. 26, 2023).

¹³ See, e.g., Nat'l Acads. of Scis., Eng'g, & Med. ("Nat'l Acads."), *The Safety and Quality of Abortion Care in the United States*, at 10, 59, 79 (2018), available at <http://nap.edu/24950>.

¹⁴ Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 175 (2015).

¹⁵ *Id.*

¹⁶ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012); see also Nat'l Acads., *supra* note 13, at 75 tbl. 2–4 (finding the risk to be approximately twelve times higher).

¹⁷ Raymond & Grimes, *supra* note 16, at 216.

¹⁸ Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 *Am. J. Pub. Health* 1904, 1907 (2017).

¹⁹ See, e.g., M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 *BMC Women's Health* 1 (2013).

parents. Our patients with children understand the obligations of parenting and decide to have an abortion based on what is best for them and their existing families, which may already struggle to make ends meet. Other patients decide that they are not ready to become parents because they are too young or want to finish school before starting a family. Some patients have health complications during pregnancy that lead them to conclude that abortion is the right choice for them. In some cases, patients are struggling with substance abuse and decide not to become parents or have additional children during that time in their lives. Still others have an abusive partner or a partner with whom they do not wish to have children for other reasons. In all of these cases, our patients decide that abortion is the best option for themselves and their families.

33. Regardless of the reasons that bring a patient to us, PPSAT is committed to providing high-quality, compassionate abortion services that honor each patient's dignity and autonomy. PPSAT trusts its patients to make the best decisions for themselves and their families.

The Act's Definition of "Fetal Heartbeat"

34. I understand that the Act defines "fetal heartbeat" as "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac."²⁰ Since the Supreme Court issued its ruling upholding S.B. 474 as constitutional, I have not understood at what point in pregnancy "fetal heartbeat," as defined by the Act, refers to, or if it refers to a singular point in pregnancy at all, given the ambiguity raised by the Court.

35. I know that the electrical impulses visible as a flicker on ultrasounds as early or earlier than six weeks LMP has been referred to by some as "cardiac activity," or even a "heartbeat," because the tissue that generates these flickers will eventually grow into the heart further along in embryonic development. However, it is only later in pregnancy that a "heart" has

²⁰ S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-610(6)).

actually formed and that that developing organ will contract in a steady and repetitive rhythmic contraction—typically after approximately nine weeks LMP. In other words, this presents two distinct points at which the Act could be construed to prohibit abortion.

36. Medically, the term “fetus” is not used until after ten weeks of pregnancy, and the tissue that can emit electrical impulses as early as partway through the fifth week does not develop characteristics of a heart, like four distinct chambers, until after approximately nine weeks LMP.²¹ Thus, if “or the steady and repetitive rhythmic contraction of the fetal heart” defines “cardiac activity,” I would be able to provide abortions until approximately nine weeks LMP rather than six weeks LMP.

37. On the other hand, “the steady and repetitive rhythmic contraction of the fetal heart” could be read to refer to a second point in pregnancy that is different from “cardiac activity.”

38. Due to the threat of prosecution and other penalties, I have in the past practiced under the interpretation that the earliest electrical impulses visible in five- to six-week embryos constitute “cardiac activity.” I would provide abortion care later than this point if the Act permitted—until a heart has formed after approximately nine weeks LMP— but the ambiguity raised in our previous challenge to the Act leaves us afraid of severe civil and criminal penalties.

39. In the absence of clarity, the harsh penalties imposed by the Act have forced PPSAT to stop providing abortion once embryonic electrical activity can be detected—prior to the point when a heart has formed. If we provide in good faith under an interpretation of the Act we find credible in our medical judgment, we fear that we could lose our licenses to practice, face civil liability, or even be criminally prosecuted.

²¹ Eleftheria Pervolaraki et al., *Antenatal Architecture and Activity of the Human Heart*, 3 Interface Focus 1, 3 (Apr. 2013) (“Distinct left and right chambers are visible by week 8, with ventricular septation completed by nine weeks [gestation].”).

The Menstrual Cycle and the Early Stages of Pregnancy

40. Menstruation is the shedding of the lining of the uterus, during which someone will experience bleeding for around two to seven days. While some start menstruating earlier, most young people usually get their first period between the ages of ten and fifteen.²²

41. A menstrual cycle begins on the first day of the person's period and ends on the first day of their next period. During menstruation, the body prepares to release an egg cell from one of two ovaries. One of these eggs becomes mature each cycle, typically about one week after the start of a period. Halfway through the cycle, ovulation begins, releasing the egg from the ovary and through the fallopian tube towards the uterus. While moving through the fallopian tube, the egg may join with a sperm cell through fertilization, at which point it would begin dividing into more cells as the egg moves down the fallopian tube toward the uterus. These cells (called a "blastocyst") typically get to the uterus about three to four days after fertilization.²³

42. Implantation constitutes the beginning of pregnancy—if and when the cells attach to the lining of the uterus. Sometimes the cells do not implant in the uterine lining, and pregnancy does not result. If the cells do implant in the uterus, it typically occurs about six days after fertilization and the process takes roughly three to four days to complete. Pregnancy hormones, including human chorionic gonadotropin ("hCG"), are triggered to release by implantation and prevent the lining of the uterus from shedding so no period occurs.²⁴

²² *Getting Your Period: What Is a 'Normal' Menstrual Cycle for Teens and Preteens?*, UChicago Medicine, <https://www.uchicagomedicine.org/forefront/pediatrics-articles/getting-your-period-normal-menstrual-cycle-teens-preteens> (last visited Sept. 12, 2023); see also *Menstruation*, Planned Parenthood, <https://www.plannedparenthood.org/learn/health-and-wellness/menstruation> (last visited Sept. 12, 2023) ("Most people get their first period between ages 12 and 14, but some people get them earlier or later than that.").

²³ *How Pregnancy Happens*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/how-pregnancy-happens> (last visited Sept. 12, 2023).

²⁴ *Pregnancy Tests*, Planned Parenthood, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-tests> (last visited Sept. 12, 2023).

43. The LMP method of dating a pregnancy starts about two to three weeks before fertilization and about three to four weeks before implantation—the point at which someone is actually pregnant.

44. Most early pregnancy loss (or “miscarriage”) occurs during the first trimester, which is usually considered to end after the thirteenth week of pregnancy. Roughly 15% of pregnancies end in miscarriage during the first trimester.²⁵

Timing of and Barriers to Abortion Services in South Carolina

45. For patients whose pregnancies are before the point at a heart has developed but after the point at which embryonic electrical activity is detected, the confusion created by the Act among providers deprives them of their ability to access lawful abortion in South Carolina.

46. Most patients obtain an abortion as soon as they are able, and the vast majority of abortions in the United States and in South Carolina take place in the first trimester of pregnancy.²⁶ According to data from the South Carolina Department of Health and Environmental Control from 2022, approximately 7,300 abortions were performed across the state in 2022, of which more than 99% occurred before approximately fifteen weeks LMP.²⁷ Furthermore, more than half (51.48%) of abortions in South Carolina were performed before approximately nine weeks LMP.²⁸

²⁵ *What Happens in the Third Month of Pregnancy?*, <https://www.plannedparenthood.org/learn/pregnancy/pregnancy-month-by-month/what-happens-third-month-pregnancy> (last visited June 19, 2023).

²⁶ Ctrs. for Disease Control & Prevention (“CDC”), *Reproductive Health: CDCs Abortion Surveillance System FAQs*, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (last reviewed November 22, 2021) (“Nearly all abortions in 2020 took place early in gestation: 93.1% of abortions were performed at ≤13 weeks’ gestation.”); S.C. Dep’t of Health & Env’t Control, *A Public Report Providing Statistics Compiled from All Abortions Reported to DHEC—2022* (2023), available at https://scdhec.gov/sites/default/files/media/document/2022-Abortion_SC-Report.pdf (providing data for abortions performed before thirteen weeks “postfertilization,” i.e., fifteen weeks LMP).

²⁷ S.C. Dep’t of Health & Env’t Control, *supra* note 26.

²⁸ *Id.*

47. Many patients do not learn they are pregnant before six weeks LMP, with many patients facing physiological limitations in pregnancy detection. Some people have fairly regular menstrual cycles; a four week cycle is common. For a person with a regular four week cycle, fertilization typically occurs at two weeks LMP. Thus, a person with a highly regular, four week cycle would already be four weeks LMP when they miss their period, and before that time, most over the counter pregnancy tests would not be sufficiently sensitive to detect her pregnancy.

48. After a missed period, home pregnancy tests are 99% effective. At-home pregnancy tests work by detecting the hormone hCG in urine. However, unless a person has reason to suspect they are pregnant, they are unlikely to buy and take an over-the-counter test. Even someone with a regular menstrual cycle may not notice they have missed their period until nearly five weeks LMP, roughly a week after they would expect their period. For those patients who are *not* trying to conceive, especially those who have never become pregnant previously, early pregnancy symptoms may not be noticed as an indication that they are pregnant.

49. People can also have regular cycles of different lengths. Some individuals can go six to eight weeks, or even more, without experiencing a menstrual period.

50. For those who menstruate, it is also extremely common to have irregular cycles for a variety of reasons, including certain common medical conditions, contraceptive use, breastfeeding, a recent miscarriage, and age. Breastfeeding can suppress menstruation for weeks or months, after which someone's menstrual cycle may return but be irregular for a period of time. Those who have had a miscarriage in the last six months may also have a higher likelihood of an irregular period contributing to delayed pregnancy detection.²⁹ Cycle irregularity is more common

²⁹ Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *Contraception* 334, 338 (2006).

among young women, Hispanic women, and women with common health conditions, such as diabetes and polycystic ovary syndrome.³⁰

51. Some pregnant patients experience light bleeding that occurs when a fertilized egg is implanted in the uterus. This implantation bleeding is often mistaken for a menstrual period. Some early pregnancy symptoms, like fatigue and swollen or tender breasts, may also occur as premenstrual symptoms, and a patient may thus interpret these symptoms to indicate their period is coming. Further, although some pregnant people experience nausea and vomiting early in pregnancy, many do not.

52. Also, pregnancy itself is not always easy to detect. On average, people are unaware of their pregnancies until between five and six weeks gestation.³¹ However, various individual characteristics during pregnancy, including younger age, lower educational attainment, and lower poverty-income ratios, are associated with later pregnancy awareness.³²

53. People may become pregnant despite the use of contraceptives, and use of hormonal contraceptives is also associated with delayed pregnancy awareness.³³ Because people often use contraceptives for the purpose of preventing pregnancy, they are less likely to assume they are pregnant if they have a late period. Furthermore, with some forms hormonal contraceptives, patients do not menstruate. Hormonal methods of contraception include implants, intrauterine devices (“IUDs”), injections, pills, vaginal rings, and skin patches. Implants are more than 99%

³⁰ Jenna Nobles et al., *Menstrual Irregularity as a Biological Limit to Early Pregnancy Awareness*, 119 Proc. of the Nat’l Acad. of Scis. 1 (2022).

³¹ Amy M. Branum & Katherine A. Ahrens, *Trends in Timing of Pregnancy Awareness Among US Women*, 21 Maternal & Child Health J. 715 (2017).

³² Finer et al., *supra* note 29 (finding that minors took a week longer than all other age groups to suspect they had become pregnant).

³³ Branum & Ahrens, *supra* note 31.

effective at preventing pregnancy and remain effective for up to five years.³⁴ IUDs are more than 99% effective at preventing pregnancy, meaning that fewer than one in 100 patients who use an IUD will get pregnant each year.³⁵ IUDs can protect from pregnancy for three to twelve years, depending on if it is a hormonal or copper IUD.

54. With typical use,³⁶ the birth control shot is about 96% effective, meaning about four out of every 100 shot users will get pregnant each year. Injections must be administered every twelve weeks.³⁷ Hormonal birth control pills are 93% effective with typical use—about seven out of 100 patients taking birth control pills will become pregnant in their first year of use.³⁸ With typical use, the transdermal contraceptive patch is about 93% effective. The patch must be replaced every week.³⁹ A vaginal ring can last from five weeks to a year, depending on type and is 93% effective with typical use.⁴⁰

³⁴ *How Effective Is the Birth Control Implant?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-implant-nexplanon/how-effective-is-the-birth-control-implant> (last visited Jan. 11, 2024).

³⁵ *How Effective Are IUDs?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/iud/how-effective-are-iuds> (last visited Jan. 11, 2024).

³⁶ Birth control efficacy is often described using the terms “typical use” and “perfect use.” Perfect use requires the user to use the method correctly all the time at the same time. Typical use is the closer measure for how effective a contraceptive is in reality given that it incorporates the variability in use seen in practice. *Progestin-Only Hormonal Birth Control: Pill and Injection*, Frequently Asked Questions, ACOG, <https://www.acog.org/womens-health/faqs/progestin-only-hormonal-birth-control-pill-and-injection> (Jan. 2023).

³⁷ *How Effective Is the Birth Control Shot?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-shot/how-effective-is-the-birth-control-shot> (last visited Jan. 11, 2024).

³⁸ *How Effective Is the Birth Control Pill?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-effective-is-the-birth-control-pill> (last visited Jan. 11, 2024).

³⁹ *How Effective Is the Birth Control Patch?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-patch/how-effective-is-the-birth-control-patch> (last visited Jan. 11, 2024).

⁴⁰ *How Effective Is the Birth Control Ring?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-vaginal-ring-nuvaring/how-effective-birth-control-ring> (last visited Jan. 11, 2024).

55. Additionally, patients who become pregnant with an IUD in place are more likely to have an ectopic pregnancy.⁴¹ Patients with an intrauterine pregnancy and an IUD in place also face increased health risks.⁴² IUD removal is recommended care for pregnant patients when the device can be removed safely from the cervical canal, as a pregnancy with an IUD in place increases risks of spontaneous abortion, septic abortion, chorioamnionitis, and preterm delivery.⁴³

56. Non-hormonal contraceptives⁴⁴ include condoms, copper IUDs, diaphragms, cervical caps, sponges, spermicides, and fertility awareness-based methods. With typical use, condoms are about 87% effective—about thirteen out of 100 patients who use condoms as their only birth control method will get pregnant each year.⁴⁵ With typical use, diaphragms are about 87% effective;⁴⁶ cervical caps are about 86% effective for patients who have never given birth and about 71% effective for those who have given birth;⁴⁷ sponges are about 86% effective for patients who have never given birth and about 78% effective for patients who have given birth.⁴⁸

⁴¹ Tiina Backman et al., *Pregnancy During the Use of Levonorgestrel Intrauterine System*, 190 Am. J. Obstetrics & Gynecology 50 (2004).

⁴² Kathryn M. Curtis et al., *U.S. Selected Practice Recommendations for Contraceptive Use, 2016*, 65 Morbidity & Mortality Wkly. Rep. 1 (2016).

⁴³ *Long-Acting Reversible Contraception: Implants and Intrauterine Devices*, Practice Bulletin No. 186, ACOG, <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/11/long-acting-reversible-contraception-implants-and-intrauterine-devices> (Nov. 2017).

⁴⁴ Non-hormonal contraceptives are sometimes referred to as “barrier” methods of birth control. Fertility awareness-based methods are not barrier methods.

⁴⁵ *How Effective Are Condoms?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/condom/how-effective-are-condoms> (last visited Jan. 11, 2024).

⁴⁶ *Vaginal Diaphragm*, Cleveland Clinic, <https://my.clevelandclinic.org/health/articles/23427-vaginal-diaphragm> (July 1, 2022).

⁴⁷ *How Effective Are Cervical Caps?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/cervical-cap/how-effective-are-cervical-caps> (last visited Jan. 11, 2024).

⁴⁸ *How Effective Is the Sponge?*, Planned Parenthood, <https://www.plannedparenthood.org/learn/birth-control/birth-control-sponge/how-effective-sponge> (last visited Jan. 11, 2024).

spermicides are about 72% effective;⁴⁹ and fertility awareness-based methods are about 76% effective.⁵⁰

57. Even after a patient learns that they are pregnant, arranging an appointment for an abortion may take some time as the logistical process presents its own delays. Logistical delays are often most pronounced for women with two or more children, minors, Black non-Hispanic women, and those living in poverty.⁵¹

58. There are only three abortion clinics in South Carolina. Due to provider availability and operational demands, each of PPSAT's health centers generally provides abortion only two days per week. As a result, even assuming that we have sufficient appointments to meet patient demand each week, patients generally cannot obtain an appointment immediately (even assuming they have met the requirements of South Carolina's twenty-four hour mandatory delay law, as discussed below).

59. For patients living in poverty or without insurance, travel-related financial barriers also help explain why the majority of our patients do not—and realistically could not—obtain abortions before detection of embryonic electrical activity.

60. South Carolina has the nation's tenth highest rate of poverty among women: nearly 14.1% of women in South Carolina live in poverty, exceeding the national average of 11.8%,⁵² and that rate rises to more than 22.1% among Black women, 19.4% among Latina women, and over 13.8% for Native women in South Carolina.⁵³ 37.2% of female-headed households in South

⁴⁹ *Effectiveness of Birth Control Methods*, ACOG, <https://www.acog.org/womens-health/infographics/effectiveness-of-birth-control-methods> (Apr. 2023).

⁵⁰ *Id.*

⁵¹ *Finer et al.*, *supra* note 29, at 339.

⁵² *South Carolina*, Nat'l Women's L. Ctr., <https://nwlc.org/state/south-carolina> (last visited Jan. 31, 2024).

⁵³ *Women in Poverty, State by State 2021*, Nat'l Women's L. Ctr. (Oct. 24, 2023), <https://nwlc.org/resource/women-in-poverty-state-by-state-2022/>.

Carolina live in poverty,⁵⁴ and South Carolina has the tenth highest rate of children living in poverty in the nation, at over 20%.⁵⁵

61. These patients face particularly high barriers to obtaining abortions, including, but not limited to, raising money for the abortion and associated travel and childcare costs and inability to take time off work.

62. The lack of comprehensive insurance coverage also poses a barrier to South Carolina women confirming they are pregnant and obtaining abortion coverage when they need it. Notably, South Carolina is one of just twelve states that have not expanded Medicaid,⁵⁶ and uninsured rates among South Carolina women of reproductive age (15.8%) are worse than the national average of 11.7%.⁵⁷ Unsurprisingly, more than 18% of women in South Carolina reported not receiving health care in the prior twelve months due to cost.⁵⁸ Even those patients who *do* have health insurance rarely have access to abortion coverage. With very narrow exceptions, South Carolina bars coverage of abortion in its Medicaid program, in health insurance plans offered to state employees, and it prohibits coverage of abortion in private insurance plans offered on the state's Affordable Care Act exchange,⁵⁹ an important source of health insurance for individuals

⁵⁴ *Id.*

⁵⁵ United Health Found., Am.'s Health Rankings, *2023 Health of Women and Children Report – State Summaries*, at 83 (2023), available at <https://assets.americashealthrankings.org/app/uploads/unitedstates-all-hwc2023.pdf>.

⁵⁶ *Status of State Medicaid Expansion Decisions: Interactive Map*, Kaiser Fam. Found. (Mar. 27, 2023), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

⁵⁷ Urb. Inst., *Insurance Coverage Among Women of Reproductive Age in South Carolina*, at 1 (2019), available at <https://www.urban.org/sites/default/files/2019/07/24/factsheet-uninsured-women-sc.pdf>.

⁵⁸ *South Carolina*, Nat'l Women's L. Ctr., *supra* note 52.

⁵⁹ Kaiser Fam. Found., *supra* note 56; *Regulating Insurance Coverage of Abortion*, Guttmacher Inst., <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion> (last updated Aug. 31, 2023); *see also* S.B. 474, § 3 (adding S.C. Code Ann. § 44-41-90(a)); S.C. Code Ann. §§ 1-1-1035, 38-71-238.

who do not have access to employer-sponsored health coverage and who do not qualify for Medicaid.

63. South Carolina's lack of investment in health care is reflected in health outcomes; it currently ranks 38th out of fifty in overall health outcomes.⁶⁰ Meanwhile, South Carolina has the tenth highest rate of mortality for women ages twenty to forty-four⁶¹ and the seventh highest rate of mortality for infants under age one,⁶² with a rate of 7.3 infant deaths per 1,000 live births among all women.⁶³ And even this unacceptably high rate of death conceals a stark racial disparity: while South Carolina's infant mortality rate is 5.2 infant deaths per 1,000 live births among white women, that rate rises to 12.7 infant deaths per 1000 live births among Black women.⁶⁴

64. Patients living in poverty and without insurance must often make difficult tradeoffs of other basic needs to pay for their abortions. Many patients must seek financial assistance from extended family and friends to pay for care as well—a process that takes time. Many patients, and especially patients who already have children, must navigate other logistics, such as inflexible or unpredictable job hours and childcare needs, that may delay the time when they are able to obtain an abortion.⁶⁵

⁶⁰ United Health Found., *Overall in South Carolina*, Am.'s Health Rankings, <https://www.americashealthrankings.org/explore/measures/Overall/SC> (last visited Jan. 31, 2024).

⁶¹ United Health Found., *Mortality Rate—Women in South Carolina*, Am.'s Health Rankings, https://www.americashealthrankings.org/explore/measures/mortality_women/SC (last visited Jan. 31, 2024).

⁶² United Health Found., *Infant Mortality in South Carolina*, Am.'s Health Rankings, https://www.americashealthrankings.org/explore/measures/IMR_MCH/SC (last visited Apr. 26, 2023).

⁶³ S.C. Dep't of Health & Env't Control, *Infant Mortality and Selected Birth Characteristics: 2021 South Carolina Residence Data* (Apr. 2023), available at <https://scdhec.gov/sites/default/files/Library/CR-012142-2021.pdf>.

⁶⁴ *Id.*

⁶⁵ *Finer et al., supra* note 29, at 343.

65. In addition to the medical and practical impediments to patients' obtaining an abortion—particularly before six weeks LMP—that I have just described, South Carolina has also enacted numerous medically unnecessary statutory and regulatory requirements that must be met before a patient may obtain an abortion. For example, South Carolina requires PPSAT to ensure that patients have available, at least twenty-four hours in advance of an abortion, certain state-mandated information designed to discourage them from having an abortion.⁶⁶ Patients who are unable to have the opportunity to review the State's counseling materials before coming to our offices must make two separate visits to the facility where they plan to get an abortion. Practically speaking, the effect of this twenty-four hour delay law lasts far longer than one day, which may push even patients who have discovered they are pregnant, decided to have an abortion, and scheduled an appointment prior to six weeks LMP past the six week point by the time they actually arrive at the health center for their abortion appointment.

66. Furthermore, South Carolina laws bars nurse practitioners and other qualified advanced practice clinicians from providing abortions, even though these clinicians are permitted to provide other health services of comparable complexity and risk and despite the fact that they fill critical gaps in medically underserved areas and can provide first-trimester medication and aspiration abortion as safely as physicians.

67. The impossibility of obtaining an abortion before detection of embryonic electrical activity is all the more clear for our minor patients who are under seventeen. Minor patients without a history of pregnancy may be less likely to recognize early symptoms of pregnancy than older patients who have been pregnant before. Furthermore, some of these patients cannot obtain written parental authorization for an abortion as required by state law and must obtain a court order

⁶⁶ S.C. Code Ann. § 44-41-330(C).

permitting them to receive care.⁶⁷ A court may take up to seventy-two hours to rule on a patient's petition to bypass the state's parental-consent law for abortions,⁶⁸ not including any time that may be necessary for a minor patient to appeal an unfavorable decision. That process cannot realistically happen before a patient's pregnancy reaches six weeks LMP, and many minors will still struggle to complete this process before nine weeks LMP.

68. South Carolina law also prohibits the use of telemedicine for the provision of medication abortion, closing off a safe and effective option for many patients to obtain an abortion.

69. For patients who would not qualify for the rape exception—either because they decided they do not want their assaults reported or they are experiencing interpersonal violence but have not become pregnant as the result of rape or incest—obtaining an abortion before six weeks LMP will be exceedingly difficult, if not impossible. For patients who qualify for the rape exception because they have become pregnant as a result of sexual assault or incest and they decide to have an abortion despite the mandatory reporting requirement, obtaining an abortion before twelve weeks LMP is still incredibly difficult. Since the Act went into effect, we have already had to turn away at least two patients who would otherwise qualify under the rape exception but were past twelve weeks LMP.

70. For all of these reasons, prior to S.B. 474 taking effect, the vast majority of PPSAT's abortion patients in South Carolina did not obtain an abortion until after six weeks LMP.

The Act Has Caused Immediate Harm to South Carolinians

71. The confusion and fear that this Act has created among PPSAT staff, physicians, and patients has led to the near elimination of abortions that would otherwise be performed after the detection of embryonic electrical activity.

⁶⁷ See *id.* §§ 44-41-31 to 33.

⁶⁸ See *id.* § 44-41-32(5).

72. Since the Supreme Court issued its opinion on August 23, 2023, PPSAT has ceased providing abortion after approximately six weeks LMP, subject to the Act's very narrow exceptions.

73. On the morning of August 23, patient appointments were scheduled as early as 8:10am, and we were able to provide abortions to two patients before the Supreme Court issued its opinion. A third patient had already received their ultrasound, discussed their care with a provider, and had medication ordered on their behalf but, due to South Carolina's mandatory one-hour delay between receipt of an ultrasound and abortion, they were still waiting to take the medication when the opinion was issued. That patient, whose pregnancy was past six weeks LMP, was ultimately turned away, along with dozens of others.

74. Shortly after the Act went into effect, patients left PPSAT's South Carolina health centers crying after being denied abortions; other patients tell us that they are running out of time and options to terminate their pregnancies. Most of our patients express distress about the challenges of traveling out of state to get care because even getting to a South Carolina health center had required time off work and caused expense.

75. From when the Act went into effect on August 23, 2023 until January 31, 2024 PPSAT has provided only 303 abortions, despite the fact that 1,209 patients have presented to PPSAT's clinic seeking abortions. Of those turned away, 7788 had pregnancies that were nine weeks LMP or less. Many more did not schedule appointments because they were past six weeks LMP, and others likely did not even bother to call, having learned of South Carolina's new ban on abortion early in pregnancy. By comparison, during the same period of time the previous year, from August 23, 2022 to January 15, 2023, PPSAT provided 1,819 abortions.

76. The Act's impact is harshest for our patients with low incomes, patients of color, and patients who live in rural areas. More than half of our abortion patients in our South Carolina health centers are Black, and in 2023, those health centers provided abortion services to patients residing in all but two South Carolina counties.

Out-of-State Travel and Related Burdens

77. If the Act bans abortion at approximately six weeks LMP, most South Carolinians will be forced to seek abortions in other states (if they are able to undertake the necessary travel at all), increasing their burdens and costs. Others are denied access to abortion care entirely. From PPSAT's Columbia health center, the nearest abortion providers outside of South Carolina are in Charlotte, North Carolina (the closest of which is about 98 miles away, one way); Asheville, North Carolina (about 160 miles away, one way); and Fayetteville, North Carolina (about 163 miles away, one way). From our Charleston health center, the nearest abortion providers outside of South Carolina are in Wilmington, North Carolina (about 177 miles away, one way) and Fayetteville, North Carolina (about 201 miles away, one way). Furthermore, North Carolina now bars abortion after twelve weeks LMP, which means some patients will have to travel even farther away.⁶⁹

78. The necessary travel caused by the Act will carry with it associated costs, such as lodging, gas, food, time off work, and childcare for the patient's other children. The logistics required for out-of-state travel may also force some patients to explain the reason for their travel, thus compromising the confidentiality of their decision to have an abortion in order to obtain transportation or childcare.

79. Given the logistical hurdles of traveling out of state, I expect that pregnant people able to obtain an abortion through another provider in a different state will do so later in pregnancy

⁶⁹ Senate Bill 20, 2023 Leg., 2023–24 Sess. (N.C. 2023).

than they would have had they had access to care in South Carolina. The likelihood of delay is particularly high given the fact that North Carolina imposes a seventy-two-hour waiting period on patients seeking abortion⁷⁰ and requires at least two health center visits.⁷¹ While S.B. 1 was in effect, I and other providers at PPSAT routinely witnessed patients struggle to overcome all of the barriers associated with out-of-state travel and have to delay their care by weeks or more in the process, and since the reimposition of S.B. 474, the same barriers have reemerged. Although abortion is very safe, the physical risks associated with abortion—as is true with pregnancy generally—do increase with gestational duration.⁷² Accordingly, even for patients able to travel to another state, the delays created by the Act will still increase those patients' risk of experiencing complications and prolong the period during which they must carry a pregnancy that they have decided to end. Because the cost of abortion services also increases with gestational duration,⁷³ delays in access to care caused by the Act may impose additional financial costs on patients related to the abortion service itself.

Forced Pregnancy and Parenthood

80. I also expect, as a result of the Act, many patients will be unable to travel out of state to obtain an abortion in light of the costs and coordination required and will be forced to carry pregnancies to term against their will.

81. Pregnancy affects an individual's health and social circumstances. The effects of pregnancy include a dramatic increase in blood volume, an increased heart rate, increased production of clotting factors, changes in breathing, digestive complications, substantial weight

⁷⁰ See N.C. Gen. Stat. Ann. § 90-21.82.

⁷¹ See Senate Bill 20, 2023 Leg., 2023–24 Sess. (N.C. 2023).

⁷² Nat'l Acads., *supra* note 13, at 77–78.

⁷³ R.K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 215 (2018).

gain, and a growing uterus. As a result of these and other changes, pregnant patients are at a greater risk of blood clots, nausea, hypertensive disorders, and anemia, among other complications. Some of these changes require evaluation and occasionally urgent or emergent care in order to preserve the patient's health or to save their life.

82. Many people seek emergency care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy), such as asthma, hypertension, or diabetes, are significantly more likely to do so.

83. Pregnancy can also aggravate preexisting health conditions, including hypertension and other cardiac disease, diabetes, kidney disease, autoimmune disorders, obesity, asthma, and other pulmonary diseases. New and serious health conditions can result, including preeclampsia, deep-vein thrombosis, hyperemesis gravidarum, and gestational diabetes. People who develop pregnancy-induced medical conditions are also at higher risk of developing the same condition in subsequent pregnancies.

84. Pregnancy may also induce or exacerbate mental health conditions. A person with a history of mental illness may experience a recurrence or worsening of their illness during pregnancy. These mental health risks can be higher for patients with unintended pregnancies. In South Carolina, 39% of pregnancies among women of reproductive age were unwanted or mistimed as of 2017.⁷⁴ For Black and Hispanic/Latino women, the rates of unintended pregnancy are likely to be even higher.⁷⁵

⁷⁴ Kathryn Kost et al., *Pregnancies and Pregnancy Desires at the State Level: Estimates for 2017 and Trends Since 2012*, Guttmacher Inst., at fig.2 (Sept. 2021), <https://www.guttmacher.org/report/pregnancy-desires-and-pregnancies-state-level-estimates-2017>.

⁷⁵ See, e.g., Charvonne N. Holliday et al., *Racial/Ethnic Differences in Women's Experiences of Reproductive Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 20 J. of Women's Health 828, 828 (2017) (finding higher incidence of unintended pregnancy among Black and multiracial women in California in 2009); Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008–2011*, 374 New Eng. J. of Med. 843, 850 fig.3

85. Some pregnant patients also face increased risk of intimate partner violence, and the severity of the risk can escalate during or after pregnancy. Homicides, the majority of which are caused by an intimate partner, are a leading cause of maternal mortality. Compared to women who are able to receive a wanted abortion, women denied wanted abortions are more likely to experience continued intimate partner violence from the man involved in the pregnancy.⁷⁶

86. Labor and childbirth are significant medical events that carry risks far greater than those for legal abortion. The abortion-related mortality rate for legal abortions is only 0.7 deaths per 100,000 procedures, as compared to the national mortality rate among individuals who carry their pregnancies to term, which is 8.8 deaths per 100,000 live births.⁷⁷ South Carolina's maternal mortality rate exceeds the national average: between 2015 and 2019, the maternal mortality rate in South Carolina was 26.2 deaths per 100,000 live births.⁷⁸ The maternal mortality rate in South Carolina was 2.4 times higher for Black and other women of color as compared to white women.⁷⁹

87. Other complications resulting from labor and childbirth occur at a rate of over 500 per 1,000 delivery hospital stays.⁸⁰ Hemorrhage is the leading cause of severe maternal morbidity.

(2016) (finding that Black and Hispanic women of reproductive age have higher unintended pregnancy rates than their white non-Hispanic peers); Guttmacher Inst., *Unintended Pregnancy in the United States*, at 1 (Jan. 2019), available at <https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf> (“At 79 per 1,000, the unintended pregnancy rate for non-Hispanic black women in 2011 was more than double that of non-Hispanic white women (33 per 1,000).”).

⁷⁶ Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Med. 1 (2014) (finding a statistically significant reduction in physical violence over time for women who received an abortion but no such decrease for those who were denied an abortion).

⁷⁷ Nat'l Acads., *supra* note 13, at 74, 75 tbl. 2–4.

⁷⁸ S.C. Maternal Morbidity & Mortality Rev. Comm., *Legislative Brief* (Mar. 2021), available at <https://scdhec.gov/sites/default/files/media/document/2021SCMMMRCLegislativeBrief.pdf>.

⁷⁹ *Id.*

⁸⁰ Anne Elixhauser & Lauren M. Wier, Stat. Br. No. 113, *Complicating Conditions of Pregnancy and Childbirth*, Healthcare Cost & Utilization Proj., at 2 tbl. 1, 5 tbl. 2 (May 2011), available at <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf>.

During labor, increased blood flow to the uterus places the patient at risk of hemorrhage and possibly death. Other unexpected adverse events include transfusion, ruptured uterus (the spontaneous tearing of the uterus) or liver, stroke, perineal laceration (the tearing of the tissue around the vagina and rectum), and unexpected hysterectomy (the surgical removal of the uterus). The most severe perineal tears involve tearing between the vagina through the anal sphincter and into the rectum and must be surgically repaired. These can lead to long-term urinary and fecal incontinence and sexual dysfunction. Vaginal delivery can also lead to long-term internal injuries, including injury to the bowel and the pelvic floor, causing urinary incontinence, fecal incontinence, and pelvic organ prolapse. Anesthesia or an epidural administered during labor can create additional risks, including infection, severe headaches, and nerve damage. Women who become pregnant during their teens or after age thirty-five are more likely to experience complications, placenta previa and preterm labor.

88. In South Carolina, 33.5% of live births in 2017 (approximately 19,000 births in all)⁸¹ were the result of a cesarean section, as compared to 31.7% for the national average.⁸² Because a cesarean section is an open abdominal surgery, patients must be hospitalized for at least a few days afterwards and the procedure carries significant risks of hemorrhage, infection, blood clots, and injury to internal organs. Cesarean sections also carry long-term risks, including an increased risk of placenta previa in later pregnancies (when the placenta covers the cervix, resulting in vaginal bleeding and requiring bed rest), increased risk of placenta accreta (when the

⁸¹ *S.C. Vital Records Data and Statistics, 2018 Birth Statistics*, S.C. Dep't of Health & Env't Control, <https://scdhec.gov/vital-records/parentage/sc-vital-records-data-and-statistics> (last visited May 24, 2023); Nat'l Ctr. for Health Stats., *Stats of the State of South Carolina, 2017*, CDC, <https://www.cdc.gov/nchs/pressroom/states/southcarolina/southcarolina.htm> (last visited Apr. 26, 2023) (together, calculating approximate number of cesarean sections based on 2018 birth statistics and 2017 cesarean rate).

⁸² Michelle J.K. Osterman et al., *Births: Final Data for 2020*, 70 Nat'l Vital Stats. Reps. 1, 6 (2022), available at <https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-17.pdf>.

placenta grows into and possibly through the uterine wall, potentially necessitating complicated surgical interventions, massive blood transfusions, hysterectomy, and risk of maternal death), and bowel or bladder injury in future deliveries. Individuals with a history of cesarean delivery are also more likely to need cesarean delivery with subsequent births.

89. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum illness, which may go undiagnosed for months or even years.

90. In South Carolina, rates of pregnancy-related complications, including diabetes⁸³ and chronic hypertension,⁸⁴ postpartum depression,⁸⁵ and maternal mortality⁸⁶ are higher for Black and Hispanic/Latina women compared to non-Hispanic white women.

91. Due to structural barriers that limit access to contraceptives,⁸⁷ people with lower incomes experience disproportionately high rates of unintended pregnancies.⁸⁸ For people already facing an array of economic hardships, the cost of pregnancy can have especially long-term and severe impacts on their family's financial security. Many of the side-effects of pregnancy prevent patients from working the same number of hours that they had prior to pregnancy or working

⁸³ Cheryl P. Lynch et al., *Increasing Prevalence of Diabetes During Pregnancy in South Carolina*, 24 J. of Women's Health 316, 320 tbl.2 (2015).

⁸⁴ Sarah B. Laditka et al., *Racial and Ethnic Disparities in Potentially Avoidable Delivery Complications Among Pregnant Medicaid Beneficiaries in South Carolina*, 10 Maternal & Child Health J. 339, 343 (2006).

⁸⁵ Michael Smith et al., *Postpartum Depression Symptoms in South Carolina, 2004-2005*, S.C. Dep't of Health & Env't Control (Dec. 2007), https://dc.statelibrary.sc.gov/bitstream/handle/10827/39022/DHEC_PRAMS_Postpartum_Depression_2007-12.pdf?sequence=1&isAllowed=; CDC, *Prevalence of Self-Reported Postpartum Depressive Symptoms—17 States, 2004–2005*, 57 Morbidity & Mortality Weekly Rep. 361, 363 tbl.1 (2008).

⁸⁶ S.C. Maternal Morbidity & Mortality Rev. Comm., *supra* note 78, at 1.

⁸⁷ ACOG, *Comm. Op. No. 615: Access to Contraception* (Jan. 2015), available at <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf>; *see also* May Sudhinaraset et al., *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am. J. Preventive Med. 787, 788 (2020).

⁸⁸ Guttmacher Inst., *Unintended Pregnancy in the United States*, *supra* note 75, at 1.

altogether, and patients can lose their jobs as a result. For example, some patients with hyperemesis gravidarum must adjust work schedules because they vomit throughout the day. Patients with preeclampsia must severely limit activity for a significant amount of time. Even in the absence of pregnancy-related side effects, pregnancy-related discrimination can result in lower earnings both during pregnancy and over time.⁸⁹ South Carolina does not require private employers to provide paid family leave, meaning that for many pregnant South Carolinians, time taken to recover from pregnancy and childbirth or to care for a newborn is unpaid.⁹⁰ On average, a person in South Carolina who takes four weeks of unpaid leave loses more than \$2,800 in income.⁹¹

92. Aside from lost wages, pregnancy-related health care and childbirth are some of the costliest hospital-based health services, particularly for complicated or at-risk pregnancies. Many pregnant patients must pay for significant labor and delivery costs out of pocket, even with insurance coverage. In 2015, of the 98.2% of commercially-insured women who had out-of-pocket spending for their labor and delivery, the mean spending for all modes of delivery was \$4,569; the mean out-of-pocket spending for that same group of women for vaginal birth, specifically, was \$4,314; and for C-section, specifically, it was \$5,161.⁹² And the average proportion of delivery costs paid by patients has increased over time.⁹³ Many South Carolinians lack insurance to help

⁸⁹ See, e.g., Nat'l P'ship for Women & Fams., *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*, at 1–2 (Oct. 2016), available at <https://nationalpartnership.org/wp-content/uploads/2023/02/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf>; Jennifer Bennett Shinall, *The Pregnancy Penalty*, 103 Minn. L. Rev. 749, 787–89 (2018).

⁹⁰ Nat'l P'ship for Women & Fams., *Paid Leave Means a Stronger South Carolina*, at 1 (Feb. 2022), available at <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-leave-means-a-stronger-south-carolina.pdf>.

⁹¹ *May 2021 State Occupational Employment and Wage Estimates, South Carolina (Median Income, All Occupations)*, U.S. Bureau of Lab. Stat, https://www.bls.gov/oes/current/oes_sc.htm#00-0000 (last visited Apr. 26, 2023).

⁹² Michelle H. Moniz et al., *Out-of-Pocket Spending for Maternity Care Among Women With Employer-Based Insurance*, 2008, 39 Health Affrs. 18, 20 (2020).

⁹³ *Id.*

offset these costs at all—for example, four in ten Hispanic women of reproductive age in South Carolina report not having health insurance to pay for even prenatal care, nearly triple the national average.⁹⁴

93. Beyond childbirth, raising a child is expensive, both in terms of direct costs and due to lost wages. On average, women experience a large and persistent decline in earnings following the birth of a child, an economic loss that compounds the additional costs associated with raising a child.⁹⁵ In South Carolina, the average cost of infant care is more than \$7,000 per year, meaning it would take a minimum wage worker twenty-four weeks working full time to afford childcare for a single infant.⁹⁶ These costs can be particularly impactful for people who do not have partners or other support systems in place.⁹⁷

94. Most abortion patients do not consider adoption an equally acceptable substitute for abortion.⁹⁸ Placing a child for adoption can be very emotionally challenging for patients.⁹⁹ Adoption can also be also expensive, involving medical, legal, and counseling costs. Patients who

⁹⁴ Urb. Inst., *supra* note 57.

⁹⁵ Amanda Fins, Nat'l Women's L. Ctr., *Effects of COVID-19 Show Us Equal Pay Is Critical for Mothers* (May 2020), available at <https://nwlc.org/wp-content/uploads/2020/05/Moms-EPD-2020-v2.pdf> (analyzing the U.S. Census Bureau, 2018 Current Population Survey and determining that mothers in the U.S. are paid 71 cents for every \$1 fathers make, about \$16,000 a year in lost wages).

⁹⁶ *Child Care Costs in the United States, The Cost of Child Care in South Carolina*, Econ. Pol'y Inst., <https://www.epi.org/child-care-costs-in-the-united-states/#/SC> (last updated Oct. 2020).

⁹⁷ *Id.*

⁹⁸ Liza Fuentes et al., “Adoption Is Just Not for Me”: How Abortion Patients in Michigan and New Mexico Factor Adoption Into Their Pregnancy Outcome Decisions, 5 *Contraception*: X 1 (2023).

⁹⁹ Gretchen Sisson, “Choosing Life”: Birth Mothers on Abortion and Reproductive Choice, 25 *Women's Health Issues* 349, 351–52 (2015) (majority of forty study participants describing adoption experiences as “predominantly negative,” including those who “felt they had no options available to them other than adoption,” and finding “lack of employment” as an “enduring variable[] that led participants to consider adoption despite their desire to parent”); see also Gretchen Sisson, *Who Are the Women Who Relinquish Infants for Adoption? Domestic Adoption and Contemporary Birth Motherhood in the United States*, 54 *Persps. on Reprod. Health* 46, 50 (2022) (majority of birth mothers who chose adoption reported annual income under \$5,000).

choose to place their infant for adoption also face the physical risks of full-term pregnancy, labor, and delivery. In South Carolina, at least sixty children are currently waiting for adoption¹⁰⁰ and 3,473 children are in foster care.¹⁰¹ In fiscal year 2022, 504 children of any age were adopted.¹⁰²

95. Women who seek but who are denied an abortion are, when compared to those who are able to access abortion, more likely to moderate their future goals and less likely to be able to exit abusive relationships. Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increasing chance of living in poverty. Finally, as compared to women who received an abortion, women who are denied abortions are less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs.¹⁰³

Other Harmful Impacts

96. Even where it is possible for patients to have an abortion before embryonic electrical activity can be detected and in light of all the other legal and logistical barriers, the Act will also force patients to race to a health center for an abortion to avoid missing the narrow window when abortion is available to them—right now, up to approximately six weeks LMP at PPSAT's South Carolina health centers. Although patients who obtain abortions demonstrate a

¹⁰⁰ *Children Eligible for Adoption*, S.C. Dep't of Soc. Servs., <https://portal.dss.sc.gov/adoption/inquiry/Search.aspx> (last visited Jan. 12, 2024).

¹⁰¹ *Foster Care Services*, S.C. Dep't of Soc. Servs., <https://reports.dss.sc.gov/ReportServer/Pages/ReportViewer.aspx?/Foster+Care> (last visited Jan. 12, 2024).

¹⁰² S.C. Dep't of Soc. Servs., *Report 4—Number of Adoptions Finalized, “Legally Free” Determinations, and “All Parent TPRd/Relinquished” Rulings during Each State Fiscal Year (State Total, Finalized Adoptions, Previous SFY)* (Aug. 1, 2022), available at <https://dss.sc.gov/media/3847/completed-adoptions-and-tprs-sfy-2021-2022.pdf>.

¹⁰³ Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 409, 412–13 (2018).

strong level of certainty with respect to the decision, some patients take longer to make a decision than others. And patients in South Carolina are already required to have the opportunity to review state mandated information at least twenty-four hours before obtaining an abortion.¹⁰⁴

97. The Act will force some South Carolinians who cannot travel out of state for care to seek abortions outside the medical system using other methods that may in some instances be unsafe. People who seek abortion in these ways may also be at risk of criminal prosecution and incarceration. Women have already been prosecuted in a number of states, including in South Carolina, for self-managing an abortion based on offenses such as fetal homicide and failure to report a death to a coroner.¹⁰⁵

98. The Act's exception for certain sexual assault and incest survivors will be functionally inaccessible to most affected patients. That is because the Act requires the abortion provider, when counseling a patient, to notify the patient in advance of the abortion that if they have the abortion a report to law enforcement will be required. If they go through with the procedure, the physician will then have to report the sexual assault or incest allegation, along with the patient's name and contact information, to the county sheriff where the abortion occurred within twenty-four hours of the abortion. Under the Act, they can only receive an abortion until twelve weeks LMP.¹⁰⁶

99. I have cared for a sizeable number of patients who have been raped. I ask all of my patients if they have a history of violence, abuse, or coercion as a screener to see if they have other needs to attend to. Sometimes, in responding to that question, a patient will tell me that the

¹⁰⁴ S.C. Code Ann. § 44-41-330(C).

¹⁰⁵ Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 Guttmacher Pol. Rev. 70 (2015), available at https://www.guttmacher.org/sites/default/files/article_files/gpr1807015.pdf.

¹⁰⁶ S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-650).

pregnancy is a result of rape or incest. Sometimes I am the first person a patient has told. We already comply with mandatory reporting obligations in South Carolina for minors and certain vulnerable adults who have experienced sexual abuse, but those reporting requirements apply based on a health care provider's knowledge of the abuse, irrespective of whether someone ultimately receives health care from us.

100. The Act's reporting requirement will undermine patient safety because physician-patient confidentiality is critical to providing medical care. In addition, by conditioning the availability of abortion on reporting of sexual assault, the Act will deny needed care to survivors who do not wish to involve law enforcement or who do not wish to discuss the circumstances of their pregnancy as a mandatory condition of obtaining abortion. In the United States, 78% of rape cases in 2021 were never reported to the police, due to factors including trauma and fear of violent retaliation from the abuser.¹⁰⁷

101. Telling my patients who are survivors of sexual assault that they must file a police report in order for me to care for them goes against the standard of care, preventing me from providing medical care as soon as clinically appropriate, regardless of whether law enforcement is involved. In addition, the Act's mandatory ultrasound requirement will pose another barrier for patients who are survivors of rape or incest who may fear retraumatization by having an instrument placed in their vagina if transvaginal ultrasound is clinically indicated.

102. The Act's reporting requirement conflicts with guidelines from leading medical organizations, such as the American Medical Association, which recommends disclosure of patients' medical information without the patient's specific consent in emergent situations only to third parties "situated to mitigate the threat" and where there is a reasonable probability that the

¹⁰⁷ Alexandra Thompson & Susannah N. Tapp, U.S. Dep't of Just., *Criminal Victimization*, 2021, at 5 (Sept. 2022), available at <https://bjs.ojp.gov/content/pub/pdf/cv21.pdf>.

patient will seriously hurt herself or other identifiable people.¹⁰⁸ Similarly, the American College of Obstetricians and Gynecologists advises that physicians provide “trauma-informed care,” which focuses on maintaining trust and prioritizing patient autonomy.¹⁰⁹ When patients cannot rely on their doctors to keep medical information private, they may withhold medical information, and this can lead to negative health outcomes.

103. Based on my experience treating survivors of sexual violence, I know that many fear the involvement of law enforcement so much that they would choose to forgo the abortion rather than trigger a mandatory report to law enforcement, especially if the report will reveal their name, address, and the fact that they terminated a pregnancy. These patients, too, will be forced to carry to term the pregnancy resulting from their sexual abuse, to try and access care in another state, or to otherwise self-manage their abortions.

104. The Act’s exception for a medical emergency or to prevent death will also be functionally inaccessible to many patients with medical needs. The exception allows physicians to perform an abortion after the detection of a “fetal heartbeat” only where the procedure is necessary to prevent a pregnant person’s death or where there is a “serious risk of a substantial and irreversible physical impairment of a major bodily function . . . of the pregnant woman.”¹¹⁰

105. While the Act lists certain conditions that are “presumed” to meet this standard, it does not provide an explicit exception for them. It seems like I could still be second-guessed that the abortion was needed to prevent death or impairment even if the patient had one of those conditions. Moreover, pregnancy can pose a wide range of health problems that are not necessarily encapsulated by this exception. For example, pregnancy may exacerbate diabetes, hypertension,

¹⁰⁸ Am. Med. Ass’n., *Code of Med. Ethics Op. 3.2.1(e), Confidentiality*, available at <https://www.ama-assn.org/delivering-care/ethics/confidentiality> (last visited Apr. 26, 2023).

¹⁰⁹ ACOG, *Comm. Op. No. 777: Sexual Assault*, 133 *Obstetrics & Gynecology* e296, e298 (2019).

¹¹⁰ S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-640).

or multiple sclerosis, or cause an autoimmune disorder, such as Crohn's disease, to flare. Diabetic patients with depression or another underlying mental health condition can find their diabetes extremely challenging to manage during pregnancy.

106. Further, pregnant patients with rapidly worsening medical conditions—who, prior to the Act, could have obtained an abortion without explanation—may be forced to wait for care until a physician determines that their conditions become deadly or threaten substantial and irreversible impairment so as to meet the exception.

107. I also expect that the Act's exclusion of psychological or emotional conditions, including suicidal ideation, as those that would not qualify under the medical exception, will harm our patients.¹¹¹ For example, psychiatric disorders may emerge for the first time during pregnancy, especially among people who have had negative reactions to hormonal contraception in the past or due to psychosocial risk factors, such as youth, poverty, substance use, or a lack of family support. These psychiatric issues can range from worsening anxiety and mood disorders to active suicidal ideation with intentions to self-harm or psychotic symptoms, such as hallucinations or intrusive thoughts. Someone with a documented history of mental illness whose condition is stable before pregnancy may experience a worsening of mental illness as a result of the hormonal and neurochemical changes to their body and stress and anxiety relating to pregnancy. Moreover, patients regulating mental health conditions with medication that carries risk to the fetus may need to discontinue or modify their medication to avoid risking harm to the fetus, but this will significantly increase the likelihood that mental illness recurs. In these situations, the pregnant person faces an increased risk of mental illness both during and after pregnancy because it is more difficult to return to equilibrium after relapse than it is to maintain a stable condition. My

¹¹¹ *Id.*

understanding is that these patients would not qualify for abortion services under the Act's exception for certain medical conditions.

108. The Act also requires that if a patient does qualify for a medical exception, I still must "make reasonable medical efforts under the circumstances to preserve the life of the pregnant woman's unborn child, to the extent that it does not risk the death of the pregnant woman or the serious risk of a substantial and irreversible physical impairment of a major bodily function of the pregnant woman, not including psychological or emotional conditions and in a manner consistent with reasonable medical practices."¹¹² However, all abortions at PPSAT's South Carolina facilities are provided in the first trimester, prior to fetal viability (i.e., when there is a reasonable chance of survival). Yet, the Act seems to dictate the method of abortion used or the manner in which it is performed in ways that I do not understand but about which the physician could later be second-guessed.

109. As physicians, we work with patients to identify a medical plan that best addresses the patients' goals and risk tolerance, but we are not always able to predict when serious, potentially life-threatening complications will occur. When they do, we put the patients' health and safety at the center of our care. By excluding all conditions but the most severe physical ones from abortion eligibility and trying to dictate how we practice medicine, the Act would prevent physicians from providing treatment that is in our patients' health and safety interest and force us to go against our oath to first do no harm.

110. The Act will also add to the pain of patients and their families who receive fetal diagnoses later in pregnancy, nearly all of which would likely not meet the Act's narrow exception. There is no prenatal testing for fetal anomalies available at six weeks LMP or earlier, and there is

¹¹² *Id.*

limited testing available before nine weeks LMP. Indeed, some anomalies cannot be identified until eighteen to twenty weeks LMP. Often, these pregnancies are wanted throughout the first trimester of pregnancy and into the second. Patients facing devastating fetal diagnoses, and their physicians, will be forced to prove that the fetus “has a profound and irremediable congenital or chromosomal anomaly that, with or without the provision of life-preserving treatment, would be incompatible with sustaining life after birth.”¹¹³

111. Even those patients able to qualify for one of the Act’s narrow exceptions to the ban would be harmed. Instead of being able to make their own personal decision whether to have an abortion, based on their own needs, values, and goals, these patients will find that decision closely scrutinized.

* * *

112. For all of these reasons, I believe that the confusion and fear created by the definition of “fetal heartbeat” in the Act and harsh penalties that has forced PPSAT to stop providing abortions after the detection of embryonic electrical activity (after approximately six weeks LMP) will deprive PPSAT’s patients of access to critical health care and threaten their health, safety, and lives.

113. This Court’s intervention to bar enforcement of the Act as to pregnancies between six and approximately nine weeks LMP and prevent these grave harms is urgently needed. Most of these patients’ pregnancies are likely to be at or beyond six weeks LMP, such that these patients will be prohibited from obtaining abortions without clarification from this Court.

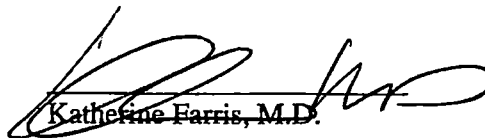
114. Even if S.B. 474 is later construed to apply after approximately nine weeks LMP, these patients would presently need to leave the state to obtain an abortion, assuming they could

¹¹³ *Id.* (amending S.C. Code Ann. § 44-41-610).

do so. Lacking clarity about when S.B. 474 prohibits abortion also imposes additional and substantial logistical, emotional, and financial burdens on patients. As discussed above, many of our patients must make advance preparations to have abortions, including by finding childcare, asking for time off work and missing out on earnings for that time, and potentially traveling long distances to reach our health centers. It is critically important that PPSAT be able to tell patients with upcoming appointments whether abortion services in South Carolina will resume after approximately six weeks LMP up to approximately nine weeks LMP.

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

Dated: February 5, 2024


Katherine Farris, M.D.

NOTARY PUBLIC

State of NC

County of Catawba

The foregoing instrument was acknowledged before me this February 5, 2024 (date) by Dr. Katherine Farris.


Valerie NOLF
Comm. exp: 10/28/2027



Exhibit A

Employment

Planned Parenthood South Atlantic

Winston-Salem/Raleigh, NC

Chief Medical Officer: April 2020 – present

Duties of Affiliate Medical Director with increased focus on strategic planning, oversight of new service lines including Primary Care and telehealth, and increased advocacy work in support of PPSAT mission.

Affiliate Medical Director: December 2014 – April 2020

Clinical, policy, and administrative oversight of all licensed staff and clinical services for 14 health centers located throughout NC, SC, VA, and WV, including developing and implementing medical protocols, ensuring regulatory compliance, and overseeing quality of care provided.

Laboratory Director: December 2014 – present

Oversight of non-waived laboratories WS, NC; AVL, NC; WILM, NC; CLT, NC; waived laboratory VIE, WV

Infection Control Professional: 2014-present

Serves as consultant and expert on any infection prevention concerns as per medical training.

Interim Abortion Facility Administrator: December 2019 – March 2020

Acting Vice President of Patient Services: March – June 2016; May – August 2017

Oversight of administrative and operational departmental functions including regulatory compliance and financial solvency for 14 health centers located throughout NC, SC, VA, and WV including direct and indirect supervision of management and non-licensed staff within the health centers.

Interim Affiliate Medical Director: July 2013 – December 2014

Reproductive Health Care: September 2009-present

Provision of comprehensive family planning services to women of all ages as well as STI counseling, testing and treatment to men and women.

PPFA Succession Planning Task Force, Member: April 2017 – March 2021

Task force was charged with addressing some of the systemic challenges of abortion provider training and recruitment at Planned Parenthood affiliates.

Medical Directors Council (MeDC), Mentor: 2015 – present

Serve as mentor to new Medical Directors/Chief Medical Officers at other PPFA Affiliates.

BetterHealth IT Board of Directors,

Member: September 2020 – present

Chair, Compliance Task Force: January 2023 – present

Board member for the organization responsible for providing revenue cycle services and supporting and rolling out Epic electronic medical records system across PPFA affiliates.

(Prior to merger and name change January 2015, organization was named Planned Parenthood Health Systems, Inc.)

Heywood Medical Group/Henry Heywood Hospital

Westminster/Gardner, MA

Family Practice/Obstetrics: August 2003 – May 2007

Meetinghouse Family Practice; 16 Wyman Rd.; Westminster, MA 01473

Provision of full-spectrum family medicine including comprehensive family planning and reproductive health care.

Planned Parenthood League of Massachusetts

Boston/Worcester, MA

Reproductive Health Care: August 2003 – May 2007

Provision of comprehensive family planning services to women of all ages.

Education

Valley Medical Center Family Practice Residency

Renton, WA

Chief Resident: 2002-2003

Residency: 2001-2003

Internship: 2000-2001
Northwestern University Medical School Chicago, IL
Degree: MD, 1995-2000
Northwestern University College of Arts and Sciences Evanston, IL
Degree: BA, 1991-1995
Major: Molecular and Cellular Biology Minor: Religion Studies

Certifications/Special Training

Physician for Reproductive Health, Leadership Training Academy Fellow 2018-2019
Basic Life Support/AED, Provider: renewed 11/2023
Title X Family Planning Program Training, Provider: 2015
CLIA Laboratory Director Training, Training for non-waived laboratory director: 2013
Single-rod Hormonal Implant Insertion Training, Provider: 2011, Certificate #30001820273

Professional Organizations / Positions

American Academy of Family Physicians (AAFP): 1995-present
North Carolina Academy of Family Physicians: 2007-present
National Abortion Federation (NAF): 2003-2005, 2018-present
Physicians for Reproductive Health: 2018-present
American College of Obstetricians and Gynecologists: 2020-present
Massachusetts Academy of Family Physicians: 2003-2007
Washington Academy of Family Physicians (WAFP): 2000-2003
American Medical Women's Association (AMWA): 1995-2000
Northwestern University Chapter President: 1997-1998
Vice-President: 1996-1997

Licenses

NC Physician License, active: 143375-2009
WV Physician License, active: 26126
VA Physician License, active: 0101265486
SC Physician License, active: MMD.84073 MD
American Board of Family Physicians, Board Diplomate, Fellow

Honors/Awards

Fellow of the American Academy of Family Physicians – Awarded December 2023

The Degree of Fellow recognizes AAFP members who have distinguished themselves among their colleagues, as well as in their communities, by their service to family medicine, by their advancement of health care to the American people, and by their professional development through medical education and research. Fellows of the AAFP are recognized as champions of family medicine. They are the physicians who make family medicine the premier specialty in service to their community and profession. From a personal perspective, being a Fellow signifies not only 'tenure' but additional work in your community, within organized medicine, within teaching, and a greater commitment to continuing professional development and/or research.

Sylvia Clark Award for Creativity in Clinical Services – Recipient 2023

Honors a clinical services provider team from a Planned Parenthood affiliate who, through their creativity in clinical services, have demonstrated special commitment and ingenuity in applying the PPFA mission to ensure access to reproductive and sexual health care for all.

Press Ganey Patient Experience Top Performing Provider 2020

Ranked in the top 10% of providers across the country for providing the highest level of patient experience.

2002 Roy Virak Memorial Family Practice Resident Scholarship Recipient

Awarded by the Washington Academy of Family Practice on the basis of academic achievement, excellence in patient care, and strong service to the community.

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients,
and physicians and staff, *et al.*,
Plaintiffs,

v.

SOUTH CAROLINA, *et al.*,
Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT

C/A No.: 2024-CP-[]-_____

**DECLARATION OF AMY
CROCKETT, M.D., IN SUPPORT OF
PLAINTIFFS' MOTION FOR A
PRELIMINARY INJUNCTION**

I, Amy Crockett, M.D., declare as follows:

1. I am a board-certified maternal-fetal medicine specialist ("MFM") and obstetrician-gynecologist ("OB/GYN"), licensed to practice medicine in South Carolina and North Carolina.

2. I received an undergraduate degree at Princeton University in 1996, my medical degree from the Ohio State University College of Medicine in 2000, and a master of science of public health from the University of North Carolina School ("UNC") of Public Health in 2006, where I specialized in maternal and child health. I completed an internship and residency in the OB/GYN department at Baylor College of Medicine in Houston, Texas in 2004. Because MFMs obtain three additional years of fellowship training, beyond the standard residency period for an OB/GYN, I completed a fellowship in the division of maternal-fetal medicine of the OB/GYN department at UNC School of Medicine in 2007.

3. Since completing my fellowship in 2007, I have been practicing as a full scope MFM in the upstate of South Carolina.

4. In this role, I provide medical care in both outpatient and hospital settings. I provide prenatal care, primarily for high risk patients. I perform prenatal diagnostic ultrasound, including fetal echocardiograms. In the hospital setting, I work on labor and delivery, provide antepartum services for patients with fetal or maternal complications that require hospitalization, and supervise residents and medical students.

5. I have also held academic appointments since completing my residency, including at UNC and the University of South Carolina School of Medicine – Greenville.

6. I have published research in many peer-reviewed professional journals, serve as a reviewer for several professional journals in my field, and have mentored the research of many graduate students and residents.

7. I am also a member of several professional organizations: the Society of Maternal Fetal Medicine, the American College of Obstetrics and Gynecology (“ACOG”), the American Institute of Ultrasound in Medicine, and the South Carolina Medical Association. I previously served as the chair, among other roles, of the South Carolina section of ACOG.

8. A curriculum vitae describing my education, experience, awards, memberships, and publications in more detail is attached as **Exhibit A**.

9. This declaration contains my expert opinions, based on my education, experience, training, and review of the medical literature, and I hold the opinions in this declaration to a reasonable degree of medical certainty. In this declaration, I do not speak on behalf of my employer or any institution or organization with which I am affiliated.

The Challenged Act and Summary of My Opinions

10. I understand that Plaintiffs in this case are challenging Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (hereinafter, the “Act” or “S.B. 474”), as applied to

abortions where a pregnancy has ultrasonographic evidence of movement in embryonic cardiac tissues (approximately 6 weeks gestational age by LMP dating) but where a heart has not yet fully formed (which occurs after approximately 9 weeks gestational age by LMP). The Act prohibits abortion, subject to narrow exceptions, once a so-called “fetal heartbeat” can be detected. I further understand that the Act defines “fetal heartbeat” as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.”¹ The Act also states that “[c]ardiac activity begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac.”²

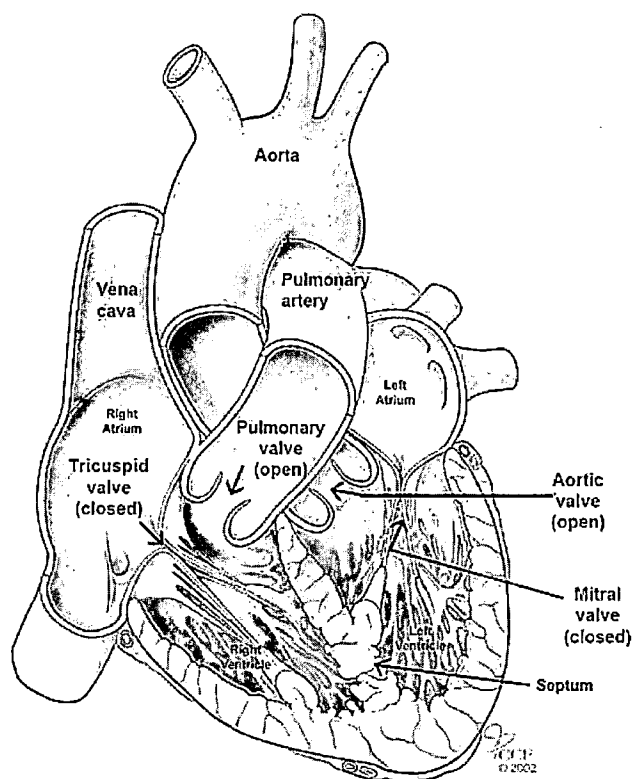
11. I submit this declaration to provide my opinions that: (1) the major components of the human heart are four chambers, walls, valves, and conduction system; (2) ultrasonographic evidence of movement in embryonic cardiac tissues may be detected as early as 5 weeks LMP; and (3) a heart containing the major components does not fully develop until after approximately 9 weeks LMP.

The Human Heart

12. The human heart is the primary organ of the circulatory system, serving to pump blood throughout the body. In discussing cardiac development during pregnancy, it is helpful to understand how a human heart works and what it looks like:

¹ S.B. 474, § 2 (amending S.C. Code Ann. § 44-41-610(6)).

² *Id.*, § 1(2).



3

13. The heart contains four chambers divided by walls and connected by valves. It is made of muscle and is powered by electrical impulses.

14. The walls of the heart are the muscles that contract to send blood throughout the body. The walls separate the chambers of the heart and keep oxygen-rich and oxygen-poor blood apart from each other.

15. The four chambers of the heart are the right atrium, the right ventricle, the left atrium, and the left ventricle. The atria are on top, and the ventricles are on the bottom.

16. Valves are like doors separating the heart chambers, opening and closing to allow blood through. They ensure blood moves in one direction through the heart. There are four valves: (1) the aortic valve, which allows blood to flow from the left ventricle to the aorta; (2)

³ *Heart*, Cleveland Clinic, <https://my.clevelandclinic.org/health/body/21704-heart> (last visited Sept. 12, 2023).

the mitral valve, which allows blood to flow from the lungs to the left atrium; (3) the pulmonary valve, which allows blood to flow from the right ventricle to the pulmonary artery, and (4) the tricuspid valve, which allows blood to flow from the right atrium to the right ventricle.

17. A heartbeat occurs when the chambers of the heart contract. It is initiated and controlled by electrical impulses, and results in the propulsion of blood to the lungs and the rest of the body. Scientists often describe a heartbeat as making a “lub-DUB sound.” The “lub” is the sound of the valves between the atria and the ventricles closing at the beginning of the ventricular contraction, and the “DUB” sound is the aortic and pulmonary valves closing as the ventricles begin to relax after pumping blood out of the heart.

18. Two large veins (the superior and inferior vena cava) bring oxygen-poor blood from the body into the right atrium. The right atrium contracts in the first part of the cardiac cycle and pumps blood into the right ventricle via the tricuspid valve. In the second part of the cardiac cycle, the right ventricle then pumps the oxygen-poor blood through the pulmonary valve and then the pulmonary artery to the lungs. The lungs reoxygenate the blood. After the lungs fill blood with oxygen, blood travels via the pulmonary vein to the left atrium. The left atrium (contracting simultaneously with the right atrium during the first part of the cardiac cycle) then pumps blood via the mitral valve to the left ventricle. The left ventricle (contracting simultaneously with the right ventricle during the second part of the cardiac cycle) then pumps oxygen-rich blood through the aortic valve and the aorta to the body.

19. Electric impulses travel through the conduction system of the heart and ensure coordination between the atria and ventricles during each heartbeat. They also ensure the heart maintains a normal rate and rhythm.

20. While there are additional components of the heart, there are four major components: the four chambers, the walls separating them, the valves connecting them, and the conduction system. I would consider a “heart” to be a developing organ that has all of four of these features.

Embryonic and Fetal Cardiac Development

21. Embryonic and fetal development is typically discussed in two ways: (1) from the date of a patient’s last menstrual period (“LMP”) or (2) from the point of fertilization, which typically occurs after approximately two weeks from the date of a patient’s last menstrual period. Accurate dating of pregnancy is essential to ensure appropriate timing and interpretation of many elements of prenatal care known to improve pregnancy outcomes.

22. The LMP method of dating a pregnancy relies on patient self-reporting and can be confirmed via ultrasound. Together, LMP and early ultrasound measurements of the embryonic crown-rump length are called the best obstetrical estimate of gestational age.⁴ The crown-rump length is typically visible on ultrasound between the 5th and 6th weeks of gestation, or 3rd to 4th weeks post-fertilization.

23. Throughout this declaration, because we are focusing so closely on fetal development, I will date a pregnancy and the developing organism based on the point of fertilization which is the convention commonly used in the embryology literature. When I say the 21st day of development, I am referring to a date which happens 3 weeks after fertilization or within the 5th week gestational age using LMP. A developmental milestone believed to happen at the 21st day of development would be expected to be appreciated within the window of 5 weeks, 0 days to 5 weeks, 6 days using LMP.

⁴ See Am. Coll. of Obstetricians & Gynecologists et al., *Committee Opinion No. 700, Methods for Estimating the Due Date* (May 2017), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/05/methods-for-estimating-the-due-date.pdf>.

24. Cardiac development is a complex process. Components of what will eventually become a functional adult heart develop throughout pregnancy and continue to develop through birth. But, at minimum, structures representing the functional elements of a heart are not present until after approximately 7 weeks developmental age (9 weeks LMP).

25. An ovum will be fertilized by a sperm cell at approximately two weeks LMP (day 0 of fertilization), and a developing organism, then called a blastocyst, will ordinarily implant after approximately 5–7 days after fertilization (3 weeks LMP). For families utilizing in vitro fertilization, embryos are typically transferred during the blastocyst stage.

26. At this point, during the third week LMP, no cardiovascular system exists.⁵ There is no heart nor circulatory system in the blastocyst.

27. By about the 21st or 22nd day of development, 5 weeks by LMP, the earliest primitive cells, which will become the heart, aggregate around two tubular structures. At this point, the developing organ is a straight tube. Between days 23–28 of development, the tube will begin to “loop,” or fold in on itself, which is the first step in forming the chambers of a heart. While it is a tube or as it is looping, the organ will begin to transmit electrical impulses which causes cellular contractions on approximately day 21 of development; blood begins to circulate in the embryo on days 24–25 of development (5 weeks LMP).⁶ Typically, however, the movement of the primitive cardiac cells caused by these early electrical impulses will not be visible on an ultrasound when it first begins since these few cells are below the resolution of current ultrasound technology. Even when movement first becomes visible though, the electrical

⁵ See Richard Van Praagh, *Congenital Heart Disease* 14 (2022); Cheryl Mei Jun Tan & Adam James Lewandowski, *The Transitional Heart: From Early Embryonic and Fetal Development to Neonatal Life*, 47 *Fetal Diagnosis and Therapy* 373, 375–76 (2020).

⁶ See Praagh, *supra* note 5, at 16–27; Tan & Lewandowski, *supra* note 5, at 375–76; Preeta Dhanantwari et al., *Human Cardiac Development in the First Trimester: A High-Resolution Magnetic Resonance Imaging and Episcopic Fluorescence Image Capture Atlas*, 120 *Circulation* 343, 345–46 (2009).

impulses cannot be heard in the way a mature heartbeat can be since in a mature heart those sounds are caused by the opening and closing of valves. Rather, technology in the ultrasound machine is used to measure the rate of flickering in the embryo and then this is used to estimate a “heart rate.” The visibility of this “flickering” is not associated with a particular developmental milestone. The timing of its appearance is arbitrary and is strongly influenced by the acoustic impedance of maternal tissues and the quality and age of the ultrasound machine and the ultrasound probe.

28. During the sixth week of pregnancy (6 weeks, 0 days to 6 weeks, 6 days LMP), the looping process will complete and the left and right ventricles will begin to separate. Major events for cardiac septation, which create a four-chamber heart, occur between days 28–37 developmental age (6–8 weeks gestational age by LMP). During this window, the cardiac structures transform from a tube into a more compact structure but still lack major connections with other embryonic structures like the lungs.⁷

29. The valves in the heart form during the 5th to 8th weeks developmental age (7–10 weeks LMP). At this point, the pulmonary artery, which will supply blood to the respiratory system and is connected to the right ventricle, and the aorta, which will supply blood to the rest of the body and is connected to the left ventricle, separate from one another. The mitral and tricuspid valves, which keep blood flowing in the correct direction, also separate from each other during this time, and the tricuspid valve will open into the right ventricle.⁸

30. Thus, at approximately 10 weeks LMP, cardiac septation is completed, meaning that systemic and pulmonary circulation have completely separated and the four chambers of the

⁷ See Praagh, *supra* note 5 at 27–41; Tan & Lewandowski, *supra* note 5, at 375–76; Dhanantwari et al., *supra* note 6, at 346–47.

⁸ See Praagh, *supra* note 5, at 41–45; Tan, *supra* note 5, at 377; Dhanantwari, *supra* note 6, at 347–49.

heart have formed. It is at this point that the structure of the heart is sufficiently developed that it would have much of the same recognizable anatomic landmarks as a mature heart, but these details are not yet visible using the current resolution of ultrasound technology.

31. The development of the pacemaker and conduction system in the heart, which are necessary in order to achieve a coordinated heartbeat, also follows a predictable developmental pathway. Cardiac muscle cells, or cardiomyocytes, have special characteristics which promote conduction and contraction. Cardiomyocytes that are removed from the primary heart tube of a developing embryo and grown in cell tissue culture will begin to beat in unison with one another even outside of the body, if they connect.⁹ In the primary heart tube, the cardiomyocytes begin contracting asynchronously and are visible as a “flicker” on ultrasound as early as 6 weeks LMP. These cells are not organized into coordinated heartbeat until after the development of the four chambers of the heart and the natural pacemakers and the conduction pathways within the heart are fully formed, which are believed to develop along with the branches of the coronary arteries.¹⁰

32. Physicians and scientists may use different verbiage in talking about cardiac development at different stages of pregnancy. For example, some may use the term “heartbeat” to refer to ultrasonographic evidence of movement in embryonic cardiac tissues. However, the medical consensus is that the four main components of a heart (four chambers, walls, valves, and conduction system) are formed after approximately 9 weeks LMP.

⁹ Gary C. Schoenwolf et al., *Larsen's Human Embryology* 267–303 (6th ed. 2021).

¹⁰ J. Boulin & J. M. Morgan, *The Development of Cardiac Rhythm*, 91 *Heart* 874, 874–75 (2005); Robert G. Gourdie, *Development of the Cardiac Pacemaking and Conduction System*, 69 *Birth Defects Res., Part C Embryo Today: Reviews* 46, 46–57 (2003).

33. Furthermore, the development of the sympathetic and parasympathetic nervous system which controls heart rate in response to external stimulation (like physical activity or hemorrhage) is not mature until the third trimester of pregnancy (26–30 weeks LMP).¹¹

34. For patients with high-risk pregnancies, MFM physicians will commonly do a detailed first trimester anatomy ultrasound between 12 weeks, 0 days and 13 weeks, 6 days LMP. This ultrasound study typically includes evaluation of the cardiac position within the fetal chest, the four chambers of the heart, the major outflow tracts (aorta and pulmonary artery) from the right and left sides of the heart, and flow across the tricuspid valve within the heart.¹² Still, many of the details of the heart are not visible on ultrasound at this point, particularly due to acoustic characteristics of maternal tissues and the quality of the ultrasound machine and probe.

35. Also, for patients with high risk pregnancies, an MFM or pediatric cardiologist might perform an echocardiogram between 18–20 weeks LMP. The echocardiogram performed at this later gestational age allows an even more detailed visualization of the heart. Many more cardiac features are visible at this gestational age, including the systemic and venous connections of the atria, pulmonary venous anatomy, right and left ventricular anatomy, all of the great arteries including the aorta, main and branch pulmonary arteries, transverse aortic arch and ductus arteriosus, atrioventricular valves, semilunar valves, and a heart rate and rhythm assessment.¹³

36. The heart continues to develop throughout the remainder of pregnancy (a full term pregnancy goes to approximately 40 weeks LMP) and even into the newborn period.

¹¹ Uwe Schneider et al., *Developmental Milestones of the Autonomic Nervous System Revealed via Longitudinal Monitoring of Fetal Heart Rate Variability*, 13 PLOS One 1, 2, 7 (2018).

¹² Am. Inst. of Ultrasound in Med., *AIUM Practice Parameter for the Performance of Detailed Diagnostic Obstetric Ultrasound Examinations Between 12 Weeks 0 Days and 13 Weeks 6 Days*, 40 J. of Ultrasound in Med. E1 (2020).

¹³ Am. Inst. of Ultrasound in Med., *AIUM Practice Parameter for the Performance of Fetal Echocardiogram*, 30 J. of Ultrasound in Med. E5 (2019).

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

Dated: February 5, 2024

Amy Crockett
Amy Crockett, M.D.

NOTARY PUBLIC

State of South Carolina

County of Greenville

The foregoing instrument was acknowledged before me this 2/5/2024 (date) by Dr. Amy Crockett.



Anne M. Edland
NOTARY PUBLIC
State of South Carolina
My Commission Expires
March 25, 2032

Exhibit A

Curriculum Vitae
Amy Hairston Crockett, MD, MSPH

Personal Information

Previous name Amy Hayden Hairston (prior to 2004)
 Previous name Amy Hairston Picklesimer (2004 – 2016)

Prisma Health/University of South Carolina School of Medicine-Greenville
 Department of Obstetrics and Gynecology
 Division of Maternal-Fetal Medicine
 [REDACTED]
 [REDACTED]

Phone: [REDACTED]
 Email: [REDACTED]

Home address: [REDACTED]
 [REDACTED]

Education and Medical Training

Undergraduate	AB, Department of History, <i>cum laude</i> Princeton University, Princeton NJ	1992-1996
Medical School	MD, The Ohio State University College of Medicine Columbus OH	1996-2000
Residency	Department of Obstetrics and Gynecology Baylor College of Medicine, Houston TX	2000-2004
Public Health	MSPH, Department of Maternal and Child Health University of North Carolina School of Public Health Chapel Hill NC	2005-2006
Fellowship	Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology University of North Carolina School of Medicine Chapel Hill NC	2004-2007

Academic Appointments

Fellow and Clinical Instructor Division of Maternal Fetal Medicine Department of Obstetrics and Gynecology University of North Carolina School of Medicine, Chapel Hill NC	2004-2007
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Assistant Professor	2007-2014
Division of Maternal Fetal Medicine	
Department of Obstetrics and Gynecology	
University of South Carolina School of Medicine – Greenville	
Greenville SC	

Associate Professor	2014-2019
Division of Maternal Fetal Medicine	
Department of Obstetrics and Gynecology	
University of South Carolina School of Medicine – Greenville	
Greenville SC	

Adjunct Professor	2015-present
College of Health, Education and Human Development	
School of Nursing, Clemson University	
Clemson SC	

Professor	2019-present
Division of Maternal Fetal Medicine	
Department of Obstetrics and Gynecology	
University of South Carolina School of Medicine – Greenville	
Greenville SC	

Certification

ABOG Maternal-Fetal Medicine Board Certification	2010-present
ABOG Obstetrics and Gynecology Board Certification	2008-present
United States Medical Licensing Exam, Steps 1-3	1998-2002

Licensure

South Carolina Medical License	2007-present
North Carolina Medical License	2004-present
Texas State Medical License	2002-2004

Professional Society Memberships

Society of Maternal Fetal Medicine, fellow
 American College of Obstetrics and Gynecology, fellow
 American Institute of Ultrasound in Medicine, member
 South Carolina Medical Association, member

Administrative/Service

Chair, Program Committee	American College of Obstetrics and Gynecologists District IV	2022-2024
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Chair	American College of Obstetrics and Gynecologists District IV, South Carolina Section	2019-2022
Vice-Chair	American College of Obstetrics and Gynecologists District IV, South Carolina Section	2016-2019
President	South Carolina Obstetrical and Gynecologic Society District IV, South Carolina Section	2019-2020
Clinical Lead	South Carolina Birth Outcomes Initiative This is the SC Perinatal Quality Collaborative, which includes representation from multiple stakeholders.	2012-present
Committee Member	SC Department of Health and Human Services Medical Care Advisory Committee	2012-present
Committee Member	SC Department of Health and Environmental Control Obstetric Task Force	2010-present
Medical Director	Greenville County Nurse Family Partnership NFP is an evidence-based nurse home-visitation program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Initial funding came from a 7-year \$2.8 million grant from the Duke Endowment, written in collaboration with SC First Steps to School Readiness. The program now receives support from federal funding through the Affordable Care Act and the Maternal, Infant, and Early Childhood Home Visiting Program, and is now eligible for reimbursement through the SC Medicaid.	2008-present
Medical Director	Greenville Health System OB Center	2008-2018
Committee Member	SC Department of Health and Environmental Control Midwifery Advisory Council	2010-2016
Member	American Association of Birth Centers Board of Directors	2014-2016
Member	SC PASOs Advisory Council PASOs serves the Latino community of SC by providing culturally responsive education on family health, early childhood and positive parenting skills; individual guidance for participants in need of resources; and partnership with health care and social service providers.	2010-2015

Honors and Awards

- 2009 American College of Obstetricians and Gynecologists and the Council on Resident Education in Obstetrics and Gynecology National Faculty Award. Greenville Hospital System Academic Medical Center, Obstetrics and Gynecology Residency Program.
- 2010 South Carolina March of Dimes "Heroes in the Field" Award for significant contribution in reducing the incidence of infant mortality.
- 2010 Greenville Hospital System University Medical Center Outstanding Faculty Research Award for Patient Characteristics Associated with Attendance at the Post-partum Visit in a Medicaid Population.
- 2011 Liberty Fellowship Class of 2013. Two-year leadership development program for young leaders in South Carolina who have demonstrated the potential to make an impact on the future of the State. Competitive application process.
- 2011 Scholar, Greenville Hospital System Institution for Advancement of Healthcare. Selected from a competitive applicant pool to pursue comparative effectiveness research projects in collaboration with other scholars nominated at the University of South Carolina.
- 2012 Golden Apple Award. Awarded by medical students at the University of South Carolina in recognition of residents and attending physicians demonstrating excellence in teaching.
- 2012 Greenville Hospital System University Medical Center Outstanding Faculty Research Award for The impact of Centering Pregnancy group prenatal care on pre term birth in a low- income population.
- 2013 WellCare CommUnity Hero Award. WellCare is a national provider of Medicaid and Medicare managed care. This award recognizes health care providers utilizing maternal care best practices aimed at reducing pre-term births and improving maternal health. The GHS Centering Pregnancy clinical and research program was recognized with this national award.
- 2016 University of South Carolina School of Medicine Greenville Outstanding Scholar Award for productive scholarly activity that makes important contributions to one's field, the reputation of the shared Academic Health System, and the quality of healthcare provided by the Greenville Health System
- 2016 John P. McNulty Prize. The McNulty Prize recognizes the spirit of innovation and excellence of leaders from around the world who use entrepreneurship to address important global social issues. The Prize is given annually to honor the visionary work of a Fellow of the Aspen Institute, and is selected by an international panel of judges.
- 2017 Society for Maternal Fetal Medicine Award of Research Excellence, Poster Session IV, Abstract 728. Awarded at 37th Annual Meeting in Las Vegas, NV for "The South Carolina Centering Pregnancy Expansion Project: Improving racial disparities in preterm birth" in January 2017

2018 Women's Rights Empowerment Network Trailblazers Award, given in recognition of women in South Carolina who are paving the way for a better South Carolina. This award was given for the work with CenteringPregnancy and the positive impact on reducing preterm birth in South Carolina.

Abstracts, Oral and Poster Presentations (Peer Reviewed)

1. Doherty E, Heo M, **Crockett A**, Chen L, Heberlein E, Zhang L, Britt J. Associations of adverse childhood experiences with substance use and depression: the role of prenatal support. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
2. Britt J, Heo M, Keenan-Devlin L, Borders A, Chen L, **Crockett A**. The impact of maternal ACEs on obstetric outcomes and psychosocial wellbeing during pregnancy. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
3. Suresh S, Freedman A, Keenan-Devlin L, Miller G, **Crockett A**, Borders A, Ernst L. Association between physical activity level and chronic inflammatory and vascular pathology in the placenta. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
4. Keenan-Devlin L, Singh L, Miller G, Ernst L, Britt J, Smart B, Freedman A, **Crockett A**, Borders A. The association of group prenatal care and pregnancy outcomes among high stress pregnant individuals. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
5. Suresh S, Freedman A, Keenan-Devlin L, Miller G, **Crockett A**, Borders A, Ernst L. Placental histology of term and preterm birth in a prospectively collected sample. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
6. Keenan-Devlin L, Ernst L, Miller G, Britt J, Freedman A, Smart B, Singh L, **Crockett A**, Borders A. The association of group prenatal care and inflammation among pregnant individuals reporting high stress. Poster presentation. Society for Maternal Fetal Medicine 43rd Annual Meeting. San Francisco, CA. February 2023.
7. **Crockett A**, Chen L, Heberlein E, Covington-Kolb S, Britt J, Sun X, Witrick B, Zhang L, Miller G, Borders A, Keenan-Devlin L, Heo M. Randomized clinical trial comparing group vs. traditional prenatal care for improving equity in birth outcomes. Oral presentation. Society for Maternal Fetal Medicine 42nd Annual Meeting. Virtual Meeting. February 2022.
8. Borders A, Keenan-Devlin L, Smart B, Freeman A, Singh L, Britt J, Ernst L, Miller G, **Crockett A**. Comparing systemic inflammation in pregnancy for patients participating in group versus individual prenatal care. Poster presentation. Society for Maternal Fetal Medicine 42nd Annual Meeting. Virtual Meeting. February 2022.

9. Chen Y, **Crockett A**, Zhang L, Britt J, Sun X, Heo M, Chen L. The effect of CenteringPregnancy group prenatal care on Gestational Diabetes Mellitus – Cradle Study. Poster presentation. Society for Maternal Fetal Medicine 42nd Annual Meeting. Virtual Meeting. February 2022.
10. Pratt K, **Crockett A**, Britt J, Doherty E, Heo M, Chen L, Sun X, Witrick B, Zhang L. Rates if hypertensive disorders of pregnancy in group versus individual prenatal care: CRADLE secondary analysis. Poster presentation. Society for Maternal Fetal Medicine 42nd Annual Meeting. Virtual Meeting. February 2022.
11. Deighan T, Self S, Huang R, **Crockett A**. Induction of labor versus planned cesarean section for women with body mass index ≥ 45 . Poster Presentation, Society for Maternal Fetal Medicine 41st Annual Meeting. Virtual Meeting. January, 2021.
12. Boland J, Ewing A, **Crockett A**. Risk-based screening vs universal screening for Hepatitis C in pregnancy: A retrospective cohort study. Poster Presentation, Society for Maternal Fetal Medicine 41st Annual Meeting. Virtual Meeting. January, 2021.
13. Harris S, Boland J, Harris S, Grzejdziak M, Heberlein E, **Crockett A**. Food and housing insecurity: The effects of the COVID-19 pandemic in the obstetric population. Poster Presentation, Society for Maternal Fetal Medicine 41st Annual Meeting. Virtual Meeting. January, 2021.
14. Markenson G, Saade G, Laurent L, Heyborne K, Coonrod D, Schoen C, Baxter J, Haas D, Longo S, Grobman W, Sullivan S, Major C, Wheeler S, Pereira L, Boggess K, Su E, Hawk A, **Crockett A**, Fox A, Burchard J, Kearney P, Fleischer T, Critchfield G, Boniface J, Lam G. Treetop Study. Performance of a proteomic preterm delivery predictor in a large independent prospective cohort. Poster Presentation, Society for Maternal Fetal Medicine Annual Meeting in Gaylord, TX. February 2020.
15. Saade G, Markenson G, Laurent L, Heyborne K, Coonrod D, Schoen C, Baxter J, Haas D, Longo S, Grobman W, Sullivan S, Major C, Wheeler S, Pereira L, Boggess K, Su E, Hawk A, **Crockett A**, Fox A, Burchard J, Polpitiya A, Fleischer T, Critchfield G, Boniface J, Lam G. Treetop Study. Enhanced preterm delivery predictors: verification in a large independent prospective cohort. Poster Presentation, Society for Maternal Fetal Medicine Annual Meeting in Gaylord, TX. February 2020.
16. Heberlein, EC, Smith, J, **Crockett, AH**, Ozluk, P, Willis, C, Covington-Kolb, S. Postpartum Visit Attendance for Medicaid-enrolled Women Receiving CenteringPregnancy Compared to Individual Prenatal Care. 2018 CityMatCH Leadership and MCH Epidemiology Conference in Portland, Oregon. September 2018.
17. Smith J, Heberlein E, Willis C, **Crockett A**, Covington-Kolb S. Impacts of Group Care on Birth Outcomes: Evidence from South Carolina's Centering Pregnancy Expansion. Oral Presentation. American Society of Health Economists Conference Annual Meeting in Atlanta, GA. June 2018.
18. McDowell M, Abshire C, Fleischer N, **Crockett A**. The impact of CenteringPregnancy group prenatal care on preterm birth. Poster Presentation, Society for Maternal Fetal Medicine Annual Meeting in Dallas, TX. February 2018.

19. Chambers C, Mills B, Van Deman J, Heberlein E, **Crockett A**. Increased Utilization of Immediate Postpartum Etonorgestrel Contraceptive Implant in Adolescents after Novel Medicaid Policy Change. Oral Presentation. North American Society for Pediatric and Adolescent Gynecology 31st Annual Meeting in Chicago, IL. April 2017.
20. **Crockett A**, Covington-Kolb S, Zhang L, Chen L. The South Carolina Centering Pregnancy Expansion Project: Improving racial disparities in preterm birth. Poster Presentation, Society for Maternal Fetal Medicine 37th Annual Meeting in Las Vegas, NV. January 2017. Received the Award of Research Excellence for the poster session.
21. Mills B, VanDeman J, Heberlein E, **Crockett AH**. Utilization of Immediate Postpartum Etonorgestrel Oral Presentation. American Society for Reproductive Medicine. Salt Lake City, UT. October, 2016.
22. Heberlein E, Covington-Kolb S, **Crockett A**, Glasscock L, Shea K, Khan I. CenteringPregnancy Reduces Newborn Hospitalization Costs. Poster Presentation. CityMatCH Annual Urban MCH Leadership Conference, Philadelphia, PA. September 2016.
23. Chen, L, Heberlein E, Covington-Kolb S, **Picklesimer A**. South Carolina Centering Pregnancy Expansion Project: Improving racial disparities in birth outcomes for a low-income population." Poster Presentation. 143rd American Public Health Association Annual Meeting, Chicago IL. November, 2015.
24. Van De Griend K, Billings D, Covington-Kolb S, Marsh N, Kelley S, **Picklesimer A**. Scaling up CenteringPregnancy across South Carolina." Oral Presentation. CityMatCH Annual Urban MCH Leadership Conference, Salt Lake City, UT. September, 2015.
25. Chen L, Heberlein E, Covington-Kolb S, **Picklesimer A**. The impact of group compared to individual prenatal care on gestational Diabetes Mellitus: The South Carolina Centering Pregnancy Expansion Project. Poster Presentation. American Diabetes Association 75th Scientific Sessions, Boston MA. June, 2015.
26. Chen L, Heberlein E, Covington-Kolb S, **Picklesimer A**. Group and individual prenatal care on Gestational Diabetes Mellitus: the South Carolina CenteringPregnancy expansion project. Poster Presentation. Society of Epidemiologic Research 48th Annual Meeting. Denver, CO. June 2015.
27. **Picklesimer AH**, Heberlein E. CenteringPregnancy group prenatal care does not change biomarkers or self-reported stress measures. Poster Presentation, Society for Maternal Fetal Medicine Annual Annual Meeting in San Diego, CA February 2015.
28. Heberlein E, Covington-Kolb S, **Picklesimer AH**. The impact of group prenatal care on breastfeeding decisions. Poster Presentation. Association of Maternal and Child Health Programs Annual Conference. Washington DC, January 2015.
29. Leutenbacher M, Dietrich M, Narrigan D, **Picklesimer AH**. A comparison of maternal and neonatal health outcomes: Women enrolled and not enrolled in a Nurse Family Partnership

Program. Oral Presentation, American Society for Public Health 141st Annual Meeting and Exposition in Boston, MA November 2013.

30. Heberlein E, Billings D, **Picklesimer A**, Covington-Kolb S. Narrowing the gap: Does Centering Pregnancy reduce the racial disparity in preterm birth? Poster Presentation, CityMatCH Urban Maternal and Child Health Leadership Conference. Savannah, GA. September 2013.
31. **Picklesimer AH**. Effect of Centering Pregnancy on inpatient cost at the time of delivery. Oral presentation. Centering Healthcare Institute 4th National Conference. Washington DC. October, 2013.
32. Hale N, **Picklesimer AH**, Billings D. "The effect of Centering Pregnancy group prenatal care on enrollment in the post-partum family planning Medicaid waiver program." Poster Presentation, Society for Maternal-Fetal Medicine Annual 33rd Annual Meeting in San Francisco, CA February 2013.
33. Thompson C, **Picklesimer AH**. Pregnancy outcomes and economic analysis for Centering Pregnancy group prenatal care. Oral presentation. Annual South Carolina OB-GYN Society Meeting. Asheville, NC August, 2012.
34. **Picklesimer AH**, Blackhurst D, Covington-Kolb S, Hale N, Billings D. The impact of Centering Pregnancy group prenatal care on preterm birth in a low-income population. Poster Presentation, Society for Maternal-Fetal Medicine Annual 32nd Annual Meeting in Dallas, TX February 2012.
35. Patel B, Amsden S, White K, **Picklesimer AH**. Barriers to desired post-partum sterilization in a diverse population. Poster Presentation, Society for Maternal-Fetal Medicine Annual 32nd Annual Meeting in Dallas, TX 2012.
36. Lee J, Wilt A, Clark R, **Picklesimer AH**. The risk of adverse neonatal outcomes for growth restricted extremely low gestational age newborns with absent or reverse Doppler flow in the umbilical artery. Poster Presentation, Society for Maternal-Fetal Medicine Annual 32nd Annual Meeting in Dallas, TX 2012.
37. White KS, Patel BG, **Picklesimer AH**. Improving attendance at the post-partum visit in a Medicaid population. Poster Presentation, American Congress of Obstetricians and Gynecologists Annual Clinical Meeting in Washington, DC 2011.
38. White KS, Patel BG, **Picklesimer AH**. Characteristics associated with utilization of post-partum tubal sterilization in a racially diverse population. Poster Presentation, American Congress of Obstetricians and Gynecologists ss" Annual Clinical Meeting in Washington, DC 2011.
39. Marshall A, White KS, **Picklesimer AH**. "The impact of Centering Pregnancy on preterm birth." Poster Presentation, American Congress of Obstetricians and Gynecologists Annual Clinical Meeting in Washington, DC 2011. Also presented as a poster presentation at the North and South Carolina Perinatal Association Annual Perinatal Partnership Conference. Charlotte, NC.

2011. Also presented as an oral presentation at the 2nd Annual Centering Health Institute Healthcare Research Consortium. Chicago, IL 2011.

40. Keane MK, Billings D, Higdon HL, **Picklesimer AH**. Barriers to prenatal care for women with limited English proficiency (LEP): a pilot study. Poster Presentation, American Society for Public Health 138th Annual Meeting and Exposition in Denver, CO 2010.
41. **Picklesimer AH**, Covington-Kolb S, Riopelle S. Centering Pregnancy: Improving the standard of care with an innovative, evidence-based model." Poster Presentation, North and South Carolina Perinatal Association Annual Perinatal Partnership Conference. Myrtle Beach, SC 2010.
42. Davis E, **Picklesimer AH**, Rodgers CM. Familial campomelic dysplasia caused by a missense mutation in the DNA binding domain. Poster Presentation, American College of Medical Genetics Annual Clinical Genetics Meeting in Albuquerque, NM 2010.
43. **Picklesimer AH**, Moss K, Offenbacher S, Beck J, Boggess K. Black women demonstrate higher levels of systemic inflammation in pregnancy as measured by serum C-reactive protein. Oral Presentation, Society for Gynecologic Investigation 54th Annual Meeting in Reno, NV 2007.
44. **Picklesimer, AH**. Chancellor J, DeMaria N, Wolfe H. Congenital cystic adenomatoid malformation: prenatal sonographic findings and the prediction of postnatal outcome. Poster Presentation, Society for Gynecologic Investigation 54th Annual Meeting in Reno, NV 2007.
45. **Picklesimer AH**, Moise KJ, Wolfe H. Performance of the "genetic" sonogram in the second and third trimester. Poster Presentation, Society for Maternal Fetal Medicine Annual Meeting in Reno, NV 2005.
46. **Hairston A**, Goetzl L. "Term hemoglobin A 1 C > 6.3%: A potentially useful predictor of birth injury in diabetic gravidas" Poster Presentation, Society for Gynecologic Investigation 51st Annual Meeting in Houston, TX. 2004.

Publications: Peer Review

My Bibliography/NIH:

https://www.ncbi.nlm.nih.gov/myncbi/18c_BPe1MAsl6v/bibliography/public/

1. Smith, J, Heberlein E, Domingue A, LaBoy A, Britt J and Crockett A. Randomized Controlled Trial on the Effect of Group Versus Individual Prenatal Care on Psychosocial Outcomes. Journal of Obstetric, Gynecologic and Neonatal Nursing. Published online August 2023.
2. Chen, Zhang, Bianogo, Britt, Chen, Crockett. Effect of group versus traditional prenatal care on gestational diabetes mellitus: a secondary analysis of a randomized controlled trial. JAMA Network Open. July, 2023. After your article is deposited, you may obtain your PMCID on the PMC site at <https://www.ncbi.nlm.nih.gov/pmc/pmctopmid/>.

3. Caballero, Crockett. Supporting sexual and reproductive health for immigrant families across the lifespan. *Academic Pediatrics*. June 2023.
4. Burchard J, Markenson GR, Saade GR, Laurent LC, Heyborne KD, Coonrod DV, Schoen CN, Baxter JK, Haas DM, Longo SA, Sullivan SA, Wheeler SM, Pereira LM, Boggess KA, Hawk AF, **Crockett AH**, Treacy R, Fox AC, Polpitiya AD, Fleischer TC, Garite TJ, Jay Boniface J, Zupancic JAF, Critchfield GC, Kearney PE. Clinical and economic evaluation of a proteomic biomarker preterm birth risk predictor: Cost-effectiveness modeling of prenatal interventions applied to predicted higher-risk pregnancies within a large and diverse cohort. *J Med Econ*. 2022 Nov 15:1-51. doi: 10.1080/13696998.2022.2147771. Epub ahead of print. PMID: 36377363.
5. Heberlein E, Smith J, Marton J, Otekunrin A, LaBoy A, Britt J, **Crockett A**. Well child visit attendance for group prenatal care participants. *Acad Pediatr*. 2022, Oct 8; S1876-2859(22). Online ahead of print. PMID: 36220619
6. **Crockett A**, Chen L, Heberlein E, Britt J, Covington-Kolb S, Witrick B, Doherty E, Zhang L, Borders A, Keenan-Devlin L, Smart B, Heo M. Group versus traditional prenatal care for improving racial equity in preterm birth and low birthweight: the Cradle randomized clinical trial study. *American Journal of Obstetrics and Gynecology*. 2022. Sep 13:S0002-9378(22)00734-7. Online ahead of print. PMID: 36113576
7. Heberlein, EC, Smith, JC, LaBoy, A, Britt, J, **Crockett, AH**. (2021). Birth outcomes for medically high-risk pregnancies: Comparing group to individual prenatal care. *American Journal of Perinatology*. 2021 Oct 28. PMID 34710941
8. Marton, J, Smith, J, Heberlein, EC, Laboy, A, Britt, J, **Crockett, AH**. (2021). Group prenatal care and emergency room utilization. *Medical Care Research and Review*. 2022 Oct;79(5):687-700. Epub 2021 Dec 9. PMID: 34881657
9. Burchard J, Markenson G, Saade G, Laurent C, Heyborne K, Coonrod D, Schoen C, Baxter J, Haas D, Longo S, Sullivan S, Major C, Wheeler S, Pereira L, Su E, Boggess K, Hawk A, **Crockett A**, Garite T, Boniface J, Fleischer T, Fox A, Polpitiya A, Critchfield G, Kearney P. "Clinical and Economic Utility of a Preterm Birth Predictor Derived from an Analysis of a Large and Diverse Pregnancy Cohort." *Journal of Perinatology*. 2021. In press (preprint posted Sept 14, 2021). doi: <https://doi.org/10.1101/2021.09.08.21262940>
10. Place JM, Van de Griend K, Zhang M, Schreiner M, Khubchandani J, Munroe T, **Crockett A**. National assessment of obstetrics and gynecology and family medicine residents' experiences with CenteringPregnancy group prenatal care. 2022. Submitted
11. Markenson GR, Saade GR, Laurent LC, Heyborne KD, Coonrod DV, Schoen CN, Baxter JK, Haas DM, Longo S, Grobman WA, Sullivan SA, Major CA, Wheeler SM, Pereira LM, Su EJ, Boggess KA, Hawk AF, **Crockett AH**, Fox AC, Polpitiya A, Fleischer TC, Critchfield GC, Burchard J, Boniface JJ, Lam GK. "Performance of a Proteomic Preterm Delivery Predictor in a Large Independent Prospective Cohort." *Am J Obstet Gynecol MFM* 2020 Aug;2(3):100140. PMID 33345877

12. Heberlein E, Smith J, Willis C, Hall W, Covington-Kolb S, **Crockett A**. "The Effects of CenteringPregnancy Group Prenatal Care on Postpartum Visit Attendance and Contraception Use." *Contraception*. 2020 Jul;102(1):46-51. PMID: 32114005
13. Van De Griend K, Covington-Kolb S, Billings D, Messias D, **Crockett A**, Frongillo E. "Core Strategies, Social Processes and Contextual Influences of Early Phase Implementation and Statewide Scale-up of Group Prenatal Care in South Carolina." *Evaluation and Program Planning*. 2019 Nov 22; 79: 101760. PMID 31835150
14. **Crockett AH**, Heberlein EC, Smith JC, Ozluk P, Covington-Kolb S, Willis C. Effects of a Multi-site Expansion of Group Prenatal Care on Birth Outcomes. *Maternal and Child Health Journal*. 2019 Oct; 23(10):1424-1433. PMID 31230168
15. Francis E, Johnstone MB, Covington-Kolb S, Witrick B, Griffin S, Sun X, **Crockett A**, Chen L. "Group Prenatal Care Attendance and Women's Characteristic Associated with Low Attendance: Results from Centering and Racial Disparities (Cradle Study)." *Maternal Child Health Journal*. 2019. PMID: 31236826
16. Abshire C, McDowell M, Crockett A, Fleishcer N. "The Impact of CenteringPregnancy Group Prenatal Care on Spontaneous Preterm Birth." *Journal of Women's Health*. 2019 Jul; 28(7):919-928. PMID: 31259671.
17. Miller G, Borders A, **Crockett A**, Ross K, Qadir S, Keenan-Devlin L, Leigh A, Ham P, Ma J, Arevalo J, Ernst L, Cole S. "Maternal Socioeconomic Disadvantage is Associated with Transcriptional Indications of Greater Immune Activation and Slower Tissue Maturation in Placental Biopsies and Newborn Cord Blood." *Brain, Behavior and Immunity*. 2017 Aug;64:276-284. Epub 2017 Apr 21. PMID: 28434870
18. Chen L, **Crockett A**, Covington-Kolb S, Heberlein E, Zhang L, Sun X. Centering and Racial Disparities (CRADLE Study): Rationale and Design of a Randomized Controlled Trial of Centering Pregnancy and Birth Outcomes. *BMC Pregnancy and Childbirth*. 2017 Apr 13;17(1):118. PMID: 28403832
19. Keenan-Devlin L, Ernst L, Ross K, Qadir S, Grobman W, Holl J, **Crockett A**, Miller G, Borders A. "Maternal Income during Pregnancy is Associated with Chronic Placental Inflammation at Birth." *American Journal of Perinatology*. 2017 Aug;34(10):1003-1010, Epub 2017 Apr 6. PMID: 28384838
20. Kominiarek, M, **Crockett A**, Grobman W. Association of Group Prenatal Care with Gestational Weight Gain," *Obstetrics and Gynecology*. 2017 Apr;129(4):663-670. PMID: 28277365
21. **Crockett AH**, Heberlein EC, Glasslock L, Covington-Kolb S, Khan I, Shea K. "Investing in Centering Pregnancy Group Prenatal Care Reduces Newborn Hospitalization Costs." *Women's Health Issues*, 2017 Jan-Feb;27(1):60-66. PMID: 27838034
22. **Crockett AH**, Pickell LB, Heberlein EC, Billings DL, Mills B. "Six- and Twelve- Month Documented Removal Rates among Women Electing Postpartum Inpatient Compared to Delayed or Interval

- Contraceptive Implant Insertions after Medicaid Payment Reform." *Contraception*. 2017 Jan;95(1):71-76. PMID 27400823.
23. Gareau S, Lopez-De Fede A, Loudermilk BL, Hardin JW, **Picklesimer AH**, Crouch E, Covington-Kolb S. "Group Prenatal Care Results in Medicaid Savings with Better Outcomes: A Propensity Score Analysis of Centering Pregnancy Participation in South Carolina." *Maternal and Child Health Journal*. 2016 Jul;20(7):1384-93. PMID: 26979611
 24. Heberlein E, **Picklesimer A**, Covington-Kolb S, Billings, D, Covington-Kolb S, Farber, N, Frongillo E. "Effects of Group Prenatal Care on Food Insecurity during Late Pregnancy and Early Postpartum." *Maternal and Child Health Journal*. 2016; 20: 1014-1024. PMID: 26662280
 25. Heberlein E, **Picklesimer A**, Covington-Kolb S, Billings, D, Covington-Kolb S, Farber, N, Frongillo E. "The Comparative Effects of Group Prenatal Care on Psychosocial Outcomes," *Archives of Women's Mental Health*. 2016 Apr; 19 (2): 259-269. Epub 11 August 2015. PMID:26260037
 26. Heberlein E, **Picklesimer A**, Covington-Kolb S, Farber N, Billings D, Frongillo E. "Qualitative Comparison of Women's Perspectives on the Functions and Benefits of Group and Individual Prenatal Care." *Journal of Midwifery and Women's Health. J Midwifery Womens Health* 2016;Feb 15. [Epub ahead of Print] PMID: 26878599
 27. Walker MW, **Picklesimer AH**, Clark RH, Spitzer AR, Garite TJ. "Impact of duration of rupture of membranes on outcomes of premature infants." *Journal Perinatology*. 2014 Sept;34(9):669-72. PMID: 24762412
 28. Hale N, **Picklesimer AH**, Billings D, Covington-Kolb S. "The Impact of Centering Pregnancy Group Prenatal Care on Post-partum Family Planning." *American Journal of Obstetrics and Gynecology* 2014 Jan; 210(1):50.e1-7. PMID: 24018309
 29. Kolb K, **Picklesimer A**, Covington-Kolb S, Hines L. "Centering Pregnancy Electives A Case Study in the Shift toward Student-Centered Learning in Medical Education." *Journal of the South Carolina Medical Association* 2012, August; 108(4): 103-105. PMID: 23270104
 30. **Picklesimer AH**, Billings D, Hale N, Blackhurst D, Covington-Kolb S. "The Effect of Centering Pregnancy Group Prenatal Care on Preterm Birth in a Low-income Population." *American Journal of Obstetrics and Gynecology* 2012, May; 206(5):415.e1-7. PMID: 22542115
 31. **Picklesimer AH**, Jared H, Moss K, Offenbacher S, Beck J, Boggess K. "Racial Differences in C-Reactive Protein during Normal Pregnancy." *American Journal of Obstetrics and Gynecology* 2008, Nov; 199: 523. e1-6. Epub 2008 Jun 9. PMID: 18539258
 32. **Picklesimer AH**, Oepkes D, Moise KJ, Kush ML, Weiner CP, Harmon CR, Baschat AA. "Determinants of the Middle Cerebral Artery Peak Systolic Velocity in the Human Fetus." *American Journal of Obstetrics and Gynecology* 2007 Nov; 197:526.e1-4. PMID: 17980196

33. **Picklesimer A**, Zanagnolo V, Niemann TH, Eaton LA, Copeland L. "Case Report: Malignant Peritoneal Mesothelioma in Two Siblings." *Gynecologic Oncology* 2005 Nov;99(2):512-6. Epub 2005 Ju126. PMID: 16051325
34. **Picklesimer A**, Moise K, Wolfe H. "The Impact of Gestational Age on the Sonographic Detection of Aneuploidy." *American Journal of Obstetrics and Gynecology* 2005 Sep; 193(3 Pt 2):1243-7. PMID: 16157145
35. **Hairston A**. "The Debate Over Twilight Sleep: Women Influencing Their Medicine" *Journal of Women's Health*. 1996; 5: 489-499.

Publications: Invited Articles

1. **Picklesimer A**, Heberlein E, Covington-Kolb S. "Group Prenatal Care Has Its Time Come?" *Clinical Obstetrics and Gynecology*. 2015 Jun;58(2)380-91. PMID: 25775438.

Publications: Invited Book Chapters

1. **Picklesimer A**, Dorman K. Maternal Obesity: Effects on Pregnancy. In: Troiano N, Harvey C, Chez B, eds. *High Risk and Critical Care Obstetrics*. Philadelphia: Lippincott Williams & Wilkins, 2012: 357-370.
2. **Picklesimer A**, Clarke-Pearson D. Deep Venous Thrombosis and Pulmonary Embolus. In: Hillard, P ed. *The 5-Minute Obstetrics and Gynecology Consult*. , Philadelphia: Lippincott Williams & Wilkins, 2008: 374-375.

Invited Lectures

"This ain't medical school or residency! Preparing an academic CV and promotion packet" in collaboration with Dr. Robert Best. Prisma Health/University of South Carolina Residency2Practice Lecture Series. October, 2022

"South Carolina Birth Outcomes Initiative: Improving Maternal Health by Reducing Low-Risk Cesarean Delivery." In collaboration with Dr. Ana Lopez-Defede. Center for Medicaid and CHIP Services Low-Risk Cesarean Deliveries Webinar Series hosted by Mathematica. June 10, 2022.

"Moving Toward Racial Equity in Birth Outcomes: The Cradle Study." University of Mississippi Department of Obstetrics and Gynecology Grand Rounds. May 4, 2022

*** COVID-19 PANDEMIC ***

"Isoimmunization" AnMed Family Medicine Residency noon conference. Anderson, SC. Oct 1, 2019.

"Severe hypertension: an introduction to patient safety bundles," "Using teamwork to improve patient outcomes: postpartum hemorrhage bundle," and "Leveling the playing field: maternal mortality and

racial equity." American College of Nurse Midwives 4th Annual Tristate Conference sponsored by the South Carolina Affiliate. Hilton Head, SC. September, 2019.

"Obstetric Care Redesign – 'One Size Does Not Fit All'" American College of Obstetrics and Gynecology Annual Clinical and Scientific Meeting. The ABOG Educational Foundation Lectureship on Patient Safety. Colloquia Panel Discussion. Nashville, TN. May, 2019.

"CenteringPregnancy: Changing the Standard of Care." NorthShore University Grand Rounds. Chicago, IL. August 22, 2018.

"The South Carolina Inpatient LARC experience." Illinois Perinatal Quality Collaborative Annual Conference. Chicago, IL. January, 2018.

"Breaking Barriers in the Workforce." Discussion Panel Member. Women's Rights and Empowerment Network 2017 Summit. Columbia, SC. April, 2017.

"Update on Zika Virus and the South Carolina Experience." Annual South Carolina OB-GYN Society Meeting. Charleston, SC. September, 2016.

"South Carolina Birth Outcomes Initiative." Annual South Carolina OB-GYN Society Meeting. Charleston, SC. September, 2016.

"Better together; expanding group prenatal care in South Carolina" with Sarah Covington. CityMatCH Annual Urban MCH Leadership Conference, Philadelphia, PA. September 2016

"CenteringPregnancy Model" with Sarah Covington. South Carolina Campaign to Prevent Teen Pregnancy Summer Institute 2016. Greenville, SC. June, 2016.

"Integrating Help Me Grow with CenteringPregnancy and Centering Parenting" with Sarah Covington and John Craine. Help Me Grow National Forum. Greenville, SC. May, 2016.

"South Carolina Birth Outcomes Initiative." South Atlantic Association of Obstetricians and Gynecologists Annual Meeting. Charleston, SC. February, 2016.

"Update on the South Carolina Birth Outcomes Initiative," in collaboration with Melanie Giese. South Carolina Hospital Association Annual Meeting. Columbia, SC. January, 2016.

"Group Prenatal Care: Financing a Proven Preterm Birth Prevention." Panel presentation. March of Dimes Prematurity Prevention Conference. Washington, DC, November 2015.

"The South Carolina CenteringPregnancy Story." 4th Annual Northeastern Centering Symposium presented by the New England Chapter of the March of Dimes. Boston, MA. November, 2015

"The South Carolina CenteringPregnancy Expansion Project." 4th Annual South Carolina Birth Outcomes Initiative Symposium. Columbia, SC. November, 2015

"The South Carolina CenteringPregnancy Story," in collaboration with Dr. Judy Burgis. South Carolina Perinatal Association 22nd Annual Perinatal Partnership Conference. Concord, NC. September, 2015.

"Strategies for inpatient LARC placement," in collaboration with Dr. Judy Burgis. Annual South Carolina OB-GYN Society Meeting. Hilton Head, SC. September, 2015.

"South Carolina Birth Outcomes Initiative." Annual South Carolina OB-GYN Society Meeting. Hilton Head, SC. September, 2015.

"Out of Hospital Birth in South Carolina." Greenville Health System Department of Obstetrics and Gynecology Grand Rounds Series. March 25, 2015

"Out of Hospital Birth in South Carolina." University of South Carolina Department of Obstetrics and Gynecology Grand Rounds Series. February 24, 2015

"Insertion of LARC in the immediate post-partum period." Association of State and Territorial Health Officers Webinar. February 19, 2015.

"Strategies for inpatient LARC placement." South Carolina Campaign to Prevent Teen Pregnancy Contraceptive Care Leadership Summit. November 21, 2014.

"The South Carolina Centering Pregnancy Story." Missouri Birth Outcomes Initiative. Columbia, MO. November 14, 2014.

"The South Carolina Centering Pregnancy Story." Brown University Group Prenatal Care. Providence, RI. November 9, 2014.

"Strategies for inpatient LARC placement," in collaboration with Dr. Judy Burgis. South Carolina Birth Outcomes Initiative 3rd Annual Conference. Columbia, SC. November 6, 2014.

"Centering Pregnancy: A New Model for Prenatal Care." South Carolina Children's Trust Home Visitation Summit. Columbia, SC. September 29, 2014.

"South Carolina Birth Outcomes Initiative." Annual South Carolina OB-GYN Society Meeting. Asheville, NC August, 2014.

"Out of Hospital Birth." Annual South Carolina OB-GYN Society Meeting. Asheville, NC August, 2014.

"Strategies to Prevent the Second Teen Birth." South Carolina Campaign to Prevent Teen Pregnancy Summer Institute 2013. Breakout session. Columbia, SC. June 14, 2013.

"Obstetric Adverse Events." Annual South Carolina Patient Safety Symposium sponsored by the South Carolina Hospital Association. Panel speaker. Columbia, SC. April 18, 2013.

"Update on Gestational Diabetes." 4th Annual Perinatal Conference sponsored by the Spartanburg Regional Healthcare System. Spartanburg, SC. April 18, 2013.

"Group Prenatal Care: Has Its Time Come?" Grand Rounds. Medical University of South Carolina Department of Obstetrics and Gynecology. Charleston, SC. April 16, 2013

"Group Prenatal Care: Has Its Time Come?" Luncheon Roundtable Session. Society for Maternal-Fetal Medicine 33rd Annual Meeting in San Francisco, CA. February 14, 2013.

"Update on Gestational Diabetes." Upper Piedmont Association of Diabetic Educators Annual Conference. Greenville, SC. November 1, 2012.

"Update on Gestational Diabetes." American Association of Birth Centers s" Annual Birth Institute. St. Pete Beach, FL. October 5, 2012.

"CenteringPregnancy: Improving the Standard of Care with an Innovative, Evidence-Based Approach." North Carolina and South Carolina Perinatal Association is" Annual Perinatal Partnership Conference. Myrtle, Beach SC. October 1, 2012.

"CenteringPregnancy: Improving the Standard of Care with an Innovative, Evidence-Based Approach. 66th Annual South Carolina OB-GYN Society Meeting. Asheville, NC August, 2012.

"Centering Pregnancy: What We Know, and What We Don't." Annual South Carolina OB-GYN Society Meeting. Asheville, NC August, 2012

"Update on Gestational Diabetes." Greenville Hospital System University Medical Center Diabetes Day; part of South Carolina Upstate Area Health Education Center lecture series. Greenville, SC November 10, 2011.

"Greenville Hospital System Centering Research Program." Centering Healthcare Institute National Research Symposium. Chicago, IL April 2011.

"Preterm birth and the primigravid patient" and "Social determinants of preterm birth." Guilford County Nurse-Family Partnership 1 O-year Anniversary Celebration. Greensboro, NC November 2010.

"Update on Gestational Diabetes." Women's Health and Pharmacology Conference sponsored by the Georgia, South Carolina and North Carolina Chapters of the American College of Nurse Midwives. Lake Lure, NC September 2010.

"The Tip of the Iceberg: Maternal Mortality and the Impact of Racial Disparities on Health Outcomes." The University of South Carolina Department of Obstetrics and Gynecology Ground Rounds Lecture Series. Columbia, SC September 2010.

"Start at the Beginning: An Obstetrician's Role in Building Healthy Families." Greenville Hospital System Department of Pediatrics Grand Rounds Lecture Series. Greenville, SC January 2010.

"Racial Disparities in Maternal Mortality." Issues in Medicine Undergraduate Seminar. Clemson University. Fall Semester, 2007. Fall Semester, 2008.

"The Role of Obstetricians in Public Health" Greenville Hospital System Department of Obstetrics and Gynecology Easley Symposium. Greenville, SC. August 2007.

Extramural Teaching Roles

Course lecturer, Maternal Fetal Medicine, America's OB/GYN Board Review Course. Greenville, SC November 2011-2019

South Carolina Birth Outcomes Initiative "SimCoach" Obstetric Emergencies Simulation Course 2015 – 2020. Taught at various hospitals in Upstate South Carolina during that time.

Sponsored Programs: Current

Funder: NIH/Maternal Health Research Centers of Excellence

Principal Investigator: Constance Guille

My role: Co-Investigator

Project Title: "Center of Maternal Behavioral Health and Technology (COMBAT)"

Award: \$18,145,818

Institution: Medical University of South Carolina

Project Period: 2023 - 2029

Funder: Duke Endowment

Principal investigator: Amy Crockett

Project Title: "Implementation and Evaluation of Two Group Prenatal Care Models"

Award: \$67,450

Institution: Prisma Health

Project Period: July 2022 – June 2025 (delayed by COVID-19 Pandemic)

Funder: NICHD/NIH: 1 R01 HD092446-01A1

Principal Investigators: co-PI Ann Borders; co-PI Amy Crockett

Project Title: Psychosocial Intervention, Maternal Inflammation, and Birth Outcomes: Centering vs. Routine Prenatal Care (PIINC) Study

Institution: NorthShore University HealthSystem

Project Period: April 2018 - 2023

Sponsored Programs: Completed

Funder: NICHD/NIH (R01: 1R01HD082311)

Principal Investigator: Moonseong Heo, Amy Crockett

Project Title: Reducing Disparities in Birth Outcomes: A Randomized Controlled Trial on Centering Pregnancy

Award: \$2,674,467

Institution: Clemson University

Project Period: August 2015 - April 2022

Funder: South Carolina Department of Health and Human Services

Principal Investigator: Amy Crockett

Project Title: South Carolina Centering Pregnancy Expansion Program

Award: \$1,059,985

Project Period: January 2019- December 2021

Funder: South Carolina Chapter of the March of Dimes

Principal Investigator: Amy Crockett

Project Title: Reducing Racial Disparities in Preterm Birth with Centering Pregnancy

Award: \$368,475 SC

Project Period: February 2015 - December 2017

Funder: South Carolina Department of Health and Human Services
 Principal Investigator: Amy Crockett
 Project Title: South Carolina Centering Pregnancy Expansion Project
 Award: \$2,337,364
 Project Period: January 2012 – December 2018

Funder: The Duke Endowment, Greenville County First Steps to School Readiness and other community agencies, including the Holligsworth Foundation, Greenville Women's Giving and the Greenville County United Way
 Medical Director, Greenville County (site): Amy Crockett
 Project Title: Nurse-Family Partnership Implementation
 Award: \$2.8 million (approximate, site)
 Project Period (initial): 2009 – 2014

Funder: South Carolina Chapter of the March of Dimes
 Principal Investigator: Amy Crockett
 Project Title: Centering Pregnancy: Improving the Standard of Care with an Innovative, Evidence-Based Program
 Award: \$411,271
 Project Period: 2009-2014

Funder: Various
 Medical Director, Greenville County (site): Amy Crockett
 Project Title: PASOs Project Implementation
 Award: \$151,000 USC Public Health Institute and Duke Endowment
 \$45,000 GHS Office of Philanthropy, Department of Pediatrics
 \$14,000 Greenville Community Foundation
 Project Period: May 2009 – April 2013

Research: Industry Sponsored

1. Agency: Sera Prognostics, Inc
 Principal Investigator (site): Amy Crockett
 Project Title: TREETOP: A Multi-Center Assessment of a Spontaneous Preterm Birth Risk Predictor
 Project Period: August 2018 – February 2020
2. Agency: Lutipold Pharmaceuticals, Inc.
 Principal Investigator (site): Amy Crockett
 Project Title: A Multi-Center, Randomized, Controlled Study to Investigate the Safety and Tolerability of Intravenous Ferric Carboxymaltose vs. Standard Medical Care in Treating Iron Deficiency Anemia in Heavy Uterine Bleeding and Postpartum Patients
 Project Period: August 2008 – December 2008

Formal Teaching Responsibilities

1. Fellows research and QI curriculum starting 2022
2. Fellowship Director, Maternal-Fetal Medicine. Department of Obstetrics and Gynecology. I was responsible for developing the application to the Accreditation Council of Graduate Medical Education, including all clinical, didactic and research curriculum for the three-year fellowship which received initial accreditation in February, 2018.
3. Course Director, Centering Pregnancy group prenatal care University of South Carolina - Greenville 4th year Medical Student Elective. 2010- 2020.
Approved by the University in 2010, this was the first longitudinal elective approved in the Medical School. We hold a day-long training workshop in July, and then students are assigned to Centering Pregnancy prenatal care groups which include 8-10 women due to deliver in the same month. Students are expected to attend 10 group sessions over 6 months, and then are "on call" for the deliveries for these women. Groups disbanded with the COVID-19 pandemic in 2020.
4. Course Director, Family Medicine Residency. Centering Pregnancy Prenatal care. 2011–2018. I provided clinical and administrative oversight for the longitudinal outpatient obstetric training of the Greenville Hospital System Academic Medical Center 3rd year Family Medicine Residents. In 2011, the Family Medicine Residency Program Director and I worked together to incorporate the Family Medicine Residents into the Centering Pregnancy groups for their continuity obstetric experience. I am responsible for training these residents in the group care model, assigning them to groups, and evaluating their performance.

Research: Resident and Graduate Student Mentor

Title: Mixed methods study of group prenatal care attendance
 Student: Emily Doherty, Doctoral Candidate
 Institution: Clemson University, Department of Public Health
 I served as a member of her dissertation committee
 Dates: 2021-2023
 Outcomes: Publications

Title: Breastfeeding in NICU babies: the impact of group prenatal care
 Resident: Solita Harris, MD
 Institution: Prisma Health/University of South Carolina School of Medicine Greenville MFM Fellowship Program
 Dates: 2019 - 2021
 Outcome: Ongoing

Title: Risk-based vs universal screening for Hepatitis C in pregnancy: A retrospective cohort study
 Resident: Jill Boland, MD
 Institution: Prisma Health/University of South Carolina School of Medicine Greenville MFM Fellowship Program
 Dates: 2018 - 2021

Outcome: Boland J, Crockett A, Ewing A. Risk-based vs universal screening for Hepatitis C in pregnancy: A retrospective cohort study. Poster Presentation. Society for Maternal Fetal Medicine 41st Annual Meeting held virtually 2021.

Title: Induction of labor versus planned cesarean section for women with body mass index ≥ 45 .

Resident: Trace Dieghan, MD

Institution: Prisma Health/University of South Carolina School of Medicine Greenville Ob/Gyn Residency Program

Dates: 2019 - 2021

Outcome: Dieghan T, Self S, Huang R, Crockett A. Induction of labor versus planned cesarean section for women with body mass index ≥ 45 . Poster Presentation. Society for Maternal Fetal Medicine 41st Annual Meeting held virtually 2021.

Title: Utilization of immediate postpartum etonorgestrel implant

Resident: John Van Deman, III, MD

Institution: Greenville Health System Ob/Gyn Residency Program

Dates: 2014 – 2016

Outcome: Mills B, VanDeman J, Heberlein E, Crockett AH. Utilization of Immediate Postpartum Etonorgestrel Oral Presentation. American Society for Reproductive Medicine. Salt Lake City, UT. October, 2016.
Chambers C, Mills B, Van Deman J, Heberlein E, Crockett A. Increased Utilization of Immediate Postpartum Etonorgestrel Contraceptive Implant in Adolescents after Novel Medicaid Policy Change." Oral Presentation. North American Society for Pediatric and Adolescent Gynecology 31st Annual Meeting in Chicago, IL. April 2017.

Title: Indications for preterm delivery in women receiving Centering Pregnancy group prenatal care, compared with women receiving traditional prenatal care.

Resident: Misty McDowell, MD

Institution: Greenville Health System OB/GYN Residency Program

Dates: 2014 – 2016

Outcome: Poster Presentation, Society for Maternal-Fetal Medicine 38th Annual Meeting in Dallas, TX 2018
Abshire C, McDowell M, Crockett A, Fleishcer N. "The Impact of Centering Pregnancy Group Prenatal Care on Spontaneous Preterm Birth." Journal of Women's Health. 2019 Jul; 28(7):919-928. PMID: 31259671.

Title: Placental Inflammation and Prenatal Care (PINC) Study

Resident: William Perez, MD

Institution: Greenville Health System OB/GYN Residency Program

Dates: 2013 – 2015

Outcome: Miller G, Borders A, **Crockett A**, Ross K, Qadir S, Keenan-Devlin L, Leigh A, Ham P, Ma J, Arevalo J, Ernst L, Cole S. "Maternal Socioeconomic Disadvantage is Associated with Transcriptional Indications of Greater Immune Activation and Slower Tissue Maturation in Placental Biopsies and Newborn Cord Blood." Brain, Behavior and Immunity. 2017 Aug;64:276-284. Epub 2017 Apr 21. PMID: 28434870

Title: The risk for adverse neonatal outcomes for growth restricted extremely low gestational age newborns with absent or reverse Doppler flow in the umbilical artery
 Resident: Jill Lee, MD and Andrew Lane, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2011 – 2015
 Outcome: Poster Presentation, Society for Maternal-Fetal Medicine Annual 32nd Annual Meeting in Dallas, TX 2012.

Title: Removal rates for immediate post-partum inpatient vs. routine outpatient placement of Nexplanon
 Resident: Leslie Bundon Pickell, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2013 – 2015
 Outcome: Crockett AH, Pickell LB, Heberlein EC, Billings DL, Mills B. "Six- and Twelve- Month Documented Removal Rates among Women Electing Postpartum Inpatient Compared to Delayed or Interval Contraceptive Implant Insertions after Medicaid Payment Reform." Contraception. 2017 Jan;95(1):71-76. PMID 27400823.

Title: Centering pregnancy group prenatal care does not change inflammatory biomarkers
 Resident: Jully Aguirre, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2012 – 2014
 Outcome: Poster Presentation, Society for Maternal-Fetal Medicine Annual 35nd Annual Meeting in San Diego, CA. 2015.

Title: Group Outcomes, Pregnancy and Stress (GROUPS) Study
 Student: Emily Heberlein, Doctoral Candidate
 Institution: University of South Carolina, Arnold School of Public Health, Department of Health Promotion, Education and Behavior
 I served as a member of her dissertation committee
 Dates: 2012 – present
 Outcomes: Publications
 1. Heberlein E, **Picklesimer A**, Covington-Kolb S, Billings, D, Covington-Kolb S, Farber, N, Frongillo E. "Effects of Group Prenatal Care on Food Insecurity during Late Pregnancy and Early Postpartum." Maternal and Child Health Journal. 2016; 20: 1014-1024. PMID: 26662280
 2. Heberlein E, **Picklesimer A**, Covington-Kolb S, Billings, D, Covington-Kolb S, Farber, N, Frongillo E. "The Comparative Effects of Group Prenatal Care on Psychosocial Outcomes," Archives of Women's Mental Health. 2016 Apr; 19 (2): 259-269. Epub 11 August 2015. PMID: 26260037
 3. Heberlein E, **Picklesimer A**, Covington-Kolb S, Farber N, Billings D, Frongillo E. "Qualitative Comparison of Women's Perspectives on the Functions and Benefits of Group and Individual Prenatal Care." Journal of Midwifery and Women's Health. J Midwifery Womens Health 2016;Feb 15. [Epub ahead of Print] PMID: 26878599

Title: Indications for preterm delivery in women receiving Centering Pregnancy group prenatal care, compared with women receiving traditional prenatal care.

Resident: Jennifer Simpson, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2011 – 2013

Title: Two-year follow-up of women who did not receive desired post-partum sterilization at the time of delivery
 Resident: Tressa Levinson, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2011 – 2013

Title: Evaluation of inpatient costs for CenteringPregnancy group prenatal care compared with traditional prenatal care
 Resident: Cara Thompson, DO
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2010 – 2012
 Outcome: “Best Resident Research Presentation” Award from the Greenville Hospital System University Medical Center Department of Obstetrics and Gynecology, 2012.
 Oral Presentation, South Carolina Obstetrical and Gynecologic Society 66th Annual Meeting in Asheville, NC 2012.

Title: The impact of CenteringPregnancy on preterm birth
 Student: Allison Marshall
 Institution: University of South Carolina School of Medicine summer research internship with Greenville Hospital System University Medical Center
 Dates: Summer 2010
 Outcome : Poster Presentation, American College of Obstetricians and Gynecologists 59th Annual Clinical Meeting in Washington, DC 2011.

Title: Can participation in CenteringPregnancy improve breast-feeding self-efficacy?
 Student: Sara Malarik, MPH
 Institution: The University of South Carolina School of Public Health semester long internship with Greenville Hospital System University Medical Center
 Dates: Spring Semester 2010

Title: Barriers to desired post-partum sterilization in a diverse population
 Resident: Bonnie Patel, MD
 Institution: Greenville Hospital System OB/GYN Residency Program
 Dates: 2009 – 2010
 Outcome : Poster Presentation, Society for Maternal-Fetal Medicine Annual 32nd Annual Meeting in Dallas, TX 2012.

Title: Barriers to prenatal care for women with Limited English Proficiency
 Student: Mary Kathryn Keane
 Institution: University of South Carolina School of Medicine summer research internship with Greenville Hospital System University Medical Center
 Dates: Summer 2009

Outcome: Poster Presentation, American Society for Public Health 138th Annual Meeting and Exposition in Denver, CO 2010.

Title: Compliance with post-partum visit for resident teaching service patients

Resident: Krystal White, MD

Institution: Greenville Hospital System OB/GYN Residency Program

Dates: 2008 - 2010

Outcome: Poster Presentation, American College of Obstetricians and Gynecologists 59th Annual Clinical Meeting in Washington, DC 2011.

Ad hoc Reviewer for Peer Reviewed Journals

American Journal of Obstetrics and Gynecology
American Journal of Obstetrics and Gynecology - MFM
American Journal of Perinatology
British Journal of Obstetrics and Gynecology

STATE OF SOUTH CAROLINA
RICHLAND COUNTY

PLANNED PARENTHOOD SOUTH
ATLANTIC, on behalf of itself, its patients,
and physicians and staff, *et al.*,
Plaintiffs,

v.

SOUTH CAROLINA, *et al.*,
Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT

C/A No.: 2024-CP-[]-_____

**DECLARATION OF TAYLOR
SHELTON IN SUPPORT OF
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION**

I, Taylor Shelton, declare as follows:

1. I am a plaintiff in this case and make this declaration in support of Plaintiffs' motion for a preliminary injunction.
2. I understand that Senate Bill 474, 125th Gen. Assemb., Spec. Sess. (S.C. 2023) (hereinafter, the "Act" or "S.B. 474"), went into effect on August 23, 2023 following the South Carolina Supreme Court's ruling that the Act is constitutional. I further understand that, because of the heavy criminal and civil penalties the Act imposes, South Carolina's only abortion providers have been treating it as a ban on abortion after approximately six weeks of pregnancy.
3. I am a resident of South Carolina and have been for almost ten years.
4. I have regular menstrual cycles (27–28 days) and track my period, so I quickly noticed that my period was unusually late in September of last year. I took two home pregnancy tests approximately two days after my missed period, which confirmed that I was pregnant. I learned that I was pregnant on the night of September 7, 2023.
5. I was shocked to learn that I was pregnant because I had an intrauterine device ("IUD") in place at the time. I had the IUD inserted in May of 2017. About a week before I

learned I was pregnant, I had a routine appointment with my gynecologist who told me that my IUD was still effective. I originally chose an IUD because it is marketed as one of the most effective forms of birth control.

6. I knew that I was not ready to have a child and that I wanted to abort my pregnancy as soon as possible. If I had felt I was ready to have a child, then I would have made a conscious decision to get my IUD removed to do so. This is especially true for me because I am type 1 diabetic and know that strict blood sugar control is necessary for a healthy pregnancy.

7. The morning after finding out that I was pregnant, I began exploring how to get an abortion and learned that S.B. 474 was in effect. I was four and a half weeks pregnant at this time and understood that I had limited time to access care in South Carolina.

8. Despite the fact that I recognized my pregnancy very early and quickly decided that abortion was the right choice for me, I was unable to get an appointment with one of the abortion providers in South Carolina before my pregnancy would have reached six weeks.

9. I then called my gynecologist's office to see if they could give me a referral to another abortion provider in South Carolina or otherwise provide me with resources. The person I spoke to was dismissive and made no attempt to help me. At this point, I knew I would have to cross state lines to access the care I needed.

10. From researching online where I might be able to get abortion in another state, I learned that the closest option was to travel to North Carolina, but that North Carolina law requires two separate trips to the health center (one for the ultrasound and counseling and one for the abortion) at least 72 hours apart.

11. I was able to get an appointment at a pregnancy center in Charlotte, North Carolina a few days later. When making the appointment, I made sure the receptionist knew that

I had an IUD and that I wanted to terminate my pregnancy. I understood that they did not provide abortions, but I was under the impression that they could provide me with an ultrasound, and thus, a referral.

12. The drive to Charlotte was four hours long, and as soon as I stepped foot in the pregnancy center, I knew something was off. After taking a pregnancy test, a woman began to counsel me. Although I made my position clear when speaking to the receptionist on the phone before making the appointment, the “counselor” was unaware that I wanted an abortion. Once she knew this information, she claimed that they could no longer help me. Further, the “counselor” was unaware of my IUD, and upon learning this information, she claimed that I needed to go to the hospital because my “baby” was in danger due to the possibility of an ectopic pregnancy. I later learned that this establishment was an anti-abortion center. Upon leaving abruptly, I felt I had been both misled and mistreated, and even more frustrated than I was before.

13. On my way home from Charlotte, I called my gynecologist’s office to inquire about the possibility of an ectopic pregnancy. The nurse I was speaking to over the phone asked if I had been experiencing any unusual pain, which I had been. I initially thought the pain was due to the onset of my period, but once I learned I was pregnant, I unknowingly thought it was normal to have some accompanying pain. I went down to Charleston the next day to see my gynecologist. She performed an ultrasound, confirmed that I did not have an ectopic pregnancy, and said that she could remove the IUD because keeping it in while pregnant could potentially cause infertility. The doctor removed the IUD successfully, which happened to be misshaped. I learned that my body was trying to protect the pregnancy by attempting to expel the IUD, causing it to bend. This explains the sharp pain I was experiencing.

14. While my gynecologist said she understood that I probably did not want to be pregnant based on the fact that I had an IUD, she did not provide me with a referral or any information about how I might obtain an abortion despite the fact that I was still under six weeks of pregnancy at that point.

15. I was able to get a first appointment at Planned Parenthood in Chapel Hill, North Carolina the following week on September 19. While the appointment was relatively quick and easy, I had to drive another four hours to get there.

16. I was then able to get an abortion appointment at Planned Parenthood in Wilmington, North Carolina (another two hour drive to get there) on September 23. I had an aspiration abortion that day. I was roughly six weeks and four days pregnant at that point.

17. I feel fortunate to have been able to get an abortion, though I had to cross state lines to do so. I had the time to be able to make three trips to North Carolina, a car, and the means to pay for travel and abortion fees. I also had the undying support of my loved ones.

18. While I had all the support I could possibly ask for from my family and friends, I felt completely unsupported and disoriented by the medical system throughout the roughly two weeks between when I found out I was pregnant and had an abortion. I felt uneasy, confused, and scared throughout the process and like I did not have the resources to ask the right questions. I also felt like I was doing something against the law, even though I know that I learned I was pregnant before the legal limit in South Carolina and even though I know it is legal to travel to get an abortion out of state. Even though I made the decision to get an abortion quickly and confidently, I was still faced with total apprehension. I feel that I was neglected by our healthcare system and that I endured unnecessary and unfair hardship.

19. I know that I found out I was pregnant fairly early on compared to when most other women find out. I also recognize that many women seeking an abortion do not have the resources to travel for care like I had.

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

Dated: February 02, 2024

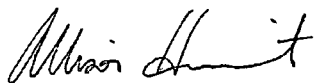

Taylor Shelton

NOTARY PUBLIC

State of South Carolina

County of Charleston

The foregoing instrument was acknowledged before me this 2/2/2024 (date) by Taylor Shelton.





STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
Civil Action No. 2024-CP-40-00762

PLANNED PARENTHOOD SOUTH ATLANTIC, on behalf of itself, its patients, and its physicians and staff; KATHERINE FARRIS, M.D., on behalf of herself and her patients; and TAYLOR SHELTON,

Plaintiffs,

v.

SOUTH CAROLINA; ALAN WILSON, in his official capacity as Attorney General of South Carolina; EDWARD SIMMER, in his official capacity as Director of the South Carolina Department of Health and Environmental Control; ANNE G. COOK, in her official capacity as President of the South Carolina Board of Medical Examiners; STEPHEN I. SCHABEL, in his official capacity as Vice President of the South Carolina Board of Medical Examiners; GEORGE S. DILTS, in his official capacity as a Member of the South Carolina Board of Medical Examiners; DION FRANGA, in his official capacity as a Member of the South Carolina Board of Medical Examiners; RICHARD HOWELL, in his official capacity as a Member of the South Carolina Board of Medical Examiners; ROBERT KOSCIUSKO, in his official capacity as a Member of the South Carolina Board of Medical Examiners; THERESA MILLS-FLOYD, in her official capacity as a Member of the South Carolina Board of Medical Examiners; JENNIFER R. ROOT, in her official capacity as a Member of the South Carolina Board of Medical Examiners; CHRISTOPHER C. WRIGHT, in his official capacity as a Member of the South Carolina Board of Medical Examiners; SAMUEL H. MCNUTT, in his official capacity as Chairperson of the South Carolina Board of Nursing; SALLIE BETH TODD, in her official capacity as Vice Chairperson of the South

GOVERNOR MCMASTER'S
UNOPPOSED MOTION TO INTERVENE

Carolina Board of Nursing; TAMARA DAY, in her official capacity as a Member of the South Carolina Board of Nursing; KELLI GARBER, in her official capacity as a Member of the South Carolina Board of Nursing; LINDSEY K. MITCHAM, in her official capacity as a Member of the South Carolina Board of Nursing; REBECCA MORRISON, in her official capacity as a Member of the South Carolina Board of Nursing; KAY SWISHER, in her official capacity as a Member of the South Carolina Board of Nursing; ROBERT J. WOLFF, in his official capacity as a Member of the South Carolina Board of Nursing; SCARLETT A. WILSON, in her official capacity as Solicitor for South Carolina's Ninth Judicial Circuit; and BYRON E. GIPSON, in his official capacity as Solicitor for South Carolina's Fifth Judicial Circuit,

Defendants.

Under Rule 24 of the South Carolina Rules of Civil Procedure, Henry McMaster, in his official capacity as Governor of the State of South Carolina ("Governor McMaster" or "Governor"), moves to intervene in this case to defend Plaintiffs' challenge to South Carolina law. The Governor requests expedited consideration of this Motion to facilitate his participation in any hearing or further proceedings in this litigation. In accordance with Rule 11(a), SCRCPP, the undersigned has conferred with opposing counsel, who confirmed that Plaintiffs do not oppose the Governor's intervention in this matter.

INTRODUCTION

Once again, Planned Parenthood South Atlantic ("PPSA") has sued to challenge a law regulating abortion in South Carolina. In every previous instance, the courts have authorized Governor McMaster to intervene to defend state law. The Court should do so again now, particularly in view of Plaintiffs' lack of opposition to the Governor's intervention.

In May 2023, Governor McMaster signed into law the Fetal Heartbeat and Protection from Abortion Act of 2023, Act 70, S. 474, R-88 (“2023 Act”). Much like they did with Act 1 of 2021 (“2021 Act”), PPSA and its allies immediately challenged the new law. In that pre-*Dobbs* setting, they sued in federal court. When Governor McMaster moved to intervene, the district court granted him permission to intervene. *See* Mem. Op. and Order Granting Mots. to Intervene, *Planned Parenthood S. Atl. v. Wilson*, No. 3:21-cv-508 (D.S.C. Mar. 9, 2021), ECF No. 62. After *Dobbs* rightly returned the issue of abortion to the States, those plaintiffs ran to state court and sued there. Once again, the Governor sought to intervene, and the circuit court granted his intervention motion, both as a matter of right under Rule 24(a) and with permission under Rule 24(b). *See* Order Granting Mot. to Intervene, *Planned Parenthood S. Atl. v. State*, No. 2022-CP-40-03569 (S.C. Comm. Pls. July 28, 2022).

As it relates to the intervention question, this case is nearly identical to the previous ones. The Governor signed into law legislation regulating abortion in this State. Plaintiffs challenged it. And the Governor seeks to intervene. The previous court orders faithfully applied the relevant rules and principles governing intervention, and the same authorities command the same (unopposed) result here: The Court should grant the Governor’s request to intervene and defend the 2023 Act.

BACKGROUND

Following the South Carolina Supreme Court’s decision in *Planned Parenthood South Atlantic v. State*, 438 S.C. 188, 882 S.E.2d 770 (2023), the General Assembly enacted the 2023 Act. Subject to certain exceptions for rape, incest, maternal life or health, and fatal fetal anomalies, the 2023 Act generally prohibits abortion after a fetal heartbeat is detected. It also makes other changes to state law, such as repealing the prior codification of the *Roe* trimester framework,

explicitly stating that women on whom an abortion is performed cannot be prosecuted, and imposing child-support obligations on fathers from conception.

Within minutes of the Governor signing the 2023 Act, Plaintiffs sued. The South Carolina Supreme Court ultimately took that case in its original jurisdiction and rejected the facial claims against the 2023 Act. *See Planned Parenthood S. Atl. v. State*, 440 S.C. 465, 892 S.E.2d 121 (2023) (“*PPSA II*”).

Some of Plaintiffs who were parties in *PPSA II* then sought to have the Supreme Court take a case in its original jurisdiction about the meaning of “fetal heartbeat,” but the Supreme Court declined to do so. *See Order, Planned Parenthood S. Atl. v. State*, No. 2023-001449 (Nov. 14, 2023). Plaintiffs now bring their claims about the meaning of “fetal heartbeat” in this Court.

LEGAL STANDARD

Rule 24 allows a party to intervene either as a matter of right or by permission. To intervene as of right pursuant to Rule 24(a), an intervenor must (1) seek to intervene timely, (2) have an interest in the subject of the action, (3) have that interest be impaired if the case is decided without him, and (4) demonstrate that his interest is not sufficiently represented by the other litigants. *Ex parte Builders Mut. Ins. Co.*, 431 S.C. 93, 99, 847 S.E.2d 87, 90 (2020); *see* Rule 24(a), SCRCF. Under Rule 24(b), to intervene by permission, an intervenor must (1) seek to intervene timely, (2) assert a claim or defense that has a question of law or fact in common with the underlying action, and (3) prove his intervention will not delay or prejudice the original parties. *Ex parte Builders Mut. Ins. Co.*, 431 S.C. at 101, 847 S.E.2d at 91; *see* Rule 24(b), SCRCF. It is axiomatic that the rules of intervention should be liberally construed. *E.g., Cooper v. S.C. Dep’t of Soc. Servs.*, 428 S.C. 402, 411, 835 S.E.2d 516, 520 (2019); *Berkeley Elec. Co-op., Inc. v. Town of Mt. Pleasant*, 302 S.C. 186, 189, 394 S.E.2d 712, 714 (1990). The decision to grant intervention “is wholly

discretionary with the trial court and will be reversed only for abuse of discretion.” *Sauner v. Pub. Serv. Auth. of S.C.*, 354 S.C. 397, 411, 581 S.E.2d 161, 168–69 (2003).

ARGUMENT

I. The Governor has a right to intervene under Rule 24(a).

A. The Governor’s Motion is timely.

Plaintiffs filed their Complaint on February 5, 2024. Governor McMaster now moves to intervene, just two days later.

The South Carolina Supreme Court has explained that intervention is timely when a “motion [is] filed only days after [the] complaint was filed.” *Berkeley Elec. Co-op., Inc.*, 302 S.C. at 189, 394 S.E.2d at 714. In the same vein, the District of South Carolina has routinely found such prompt motions to intervene timely. *See, e.g., S.C. Coastal Conservation League v. Ross*, No. 2:18-CV-03326-RMG, 2019 WL 5872423, at *2 (D.S.C. Feb. 8, 2019) (ten days); *S.C. Coastal Conservation League v. Pruitt*, No. 18-CV-330-DCN, 2018 WL 2184395, at *8 (D.S.C. May 11, 2018) (22 days); *cf. Middleton v. Andino*, 481 F. Supp. 3d 563, 568 (D.S.C. 2020) (concluding even three months is timely). Notably, the Governor’s prompt filing of this Motion closely, but even more quickly, tracks his motion to intervene in the prior federal court action. *See Planned Parenthood S. Atl.*, 2021 WL 878791, at *3 (noting, where the Governor moved to intervene four days, and two business days, after the plaintiffs filed their complaint that “the filings by the Proposed Intervenors several days after Plaintiffs filed their motion for a TRO and PI lead the Court to conclude them timely filed”). Just as the Governor’s motions to intervene to defend the facial challenges to the 2021 Act and 2023 Acts were timely when it was filed within two days of the complaint, so too is his Motion timely now. The Governor therefore satisfies this element.

B. The Governor has significant interests in this action.

The Governor has multiple interests here. *First*, acting pursuant to his constitutional obligation to “be presented” with “[e]very bill or joint resolution which shall have passed the General Assembly” “before it becomes a law” and either “approv[e]” or “return” it, the Governor signed into law the 2023 Act that Plaintiffs challenge here. *See* S.C. Const. art. IV, § 21. These constitutional duties give Governor McMaster a “direct,” “significantly protectable interest” in the litigation. *Thomas v. Andino*, 335 F.R.D. 364, 370 (D.S.C. 2020) (internal quotation marks omitted). Moreover, Governor McMaster, “through the democratic process,” naturally had the opportunity to “gai[n] familiarity with the matters of public concern that le[d] to the statute’s passage in the first place.” *Stuart v. Huff*, 706 F.3d 345, 351 (4th Cir. 2013); *see Hearon v. Calus*, 178 S.C. 381, 183 S.E. 13, 26 (1935) (“There is no doubt that His Excellency, the Governor, is familiar with this law. He set it in motion.”).

Second, the Governor is the State’s “Chief Magistrate” and “supreme executive authority.” S.C. Const. art. IV, § 1. As such, Governor McMaster is constitutionally charged with the duty to “take care that the laws be faithfully executed.” *Id.* art. IV, § 15; *see Edwards v. State*, 383 S.C. 82, 91, 678 S.E.2d 412, 417 (2009) (“The Governor is charged with executing the law.”). The U.S. Supreme Court has called this obligation a “Chief Executive’s most important constitutional duty.” *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 577 (1992). Thus, this State’s governors have repeatedly been allowed to intervene to defend challenges to state law. *See, e.g.,* Order Granting Mot. to Intervene, *Planned Parenthood S. Atl. v. State*, No. 2022-CP-40-03569 (S.C. Comm. Pls. July 28, 2022) (2021 Fetal Heartbeat Act); Order, *Owens v. Stirling*, No. 2021-CP-40-2306 (Richland Cnty. Ct. Comm. Pls. May 25, 2021) (Act 43 adding the firing squad as a method of execution); *Planned*

Parenthood S. Atl., 2021 WL 878791 (the 2021 Act); *Williams v. Morris*, 320 S.C. 196, 464 S.E.2d 97 (1995) (appropriations act).

Third, not only has the Governor been a longtime proponent of protecting the right to life, but he also actively defended the 2021 Act in federal court for nearly a year and a half before the litigation moved to state court, where he defended the 2021 Act for the entirety of that litigation. Even Plaintiffs themselves acknowledged the Governor's leading role in the federal court litigation over the 2021 Act. *See* Pls.' Reply in Supp. of Mot. to Dismiss 2, *Planned Parenthood S. Atl. v. Wilson*, No. 3:21-cv-00508-MGL (D.S.C. June 28, 2022), ECF No. 150 ("most, if not all, of this work [about expert witnesses to defend the Act] was apparently conducted on behalf of Intervenor-Defendant Governor McMaster"). And even before the Governor intervened in the earlier litigation, Plaintiffs were pointing to the Governor's statements in explaining their basis for challenging the 2021 Act in federal court. *See* Compl. ¶¶ 1, 37 & n.2, *Planned Parenthood S. Atl. v. Wilson*, No. 3:21-cv-00508-MGL (D.S.C. Feb. 18, 2021), ECF No. 1. The Governor likewise intervened to defend the 2023 Act against facial challenges. *See PPSA II*, 440 S.C. at 465, 892 S.E.2d at 121. Thus, it will come as no surprise to Plaintiffs that the Governor seeks to defend the 2023 Act in this Court.

Given the significant constitutional duties and discretionary authority entrusted to the Governor, it is imperative that he be allowed to intervene and defend the 2023 Act and his prerogative powers under South Carolina law. As the popularly elected head of the Executive Branch of the State, the Governor is uniquely positioned to represent the people when their law is challenged. *See Stuart*, 706 F.3d at 351. Indeed, as the Fourth Circuit has explained, "the need for government to exercise its representative function is perhaps at its apex where, as here, a duly

enacted statute faces a constitutional challenge.” *Id.* Accordingly, Governor McMaster satisfies the second factor.

C. The Governor’s interests and authority would be impaired absent intervention.

On the third element, “a party need not prove that it would be bound in a res judicata sense by the judgment, only that it would have difficulty adequately protecting its interests if not allowed to intervene.” *Berkeley Elec. Co-op., Inc.*, 302 S.C. at 190, 394 S.E.2d at 715. If the Governor is not a party to this case and the Court were to enjoin the 2023 Act (whether on a temporary or permanent basis) such that the Executive Branch cannot carry out the General Assembly’s clear directives, the Governor would not have access to the proper forum to defend the 2023 Act’s constitutionality and demonstrate why it should be faithfully executed as enacted by the people’s representatives. *Cf. Gibson v. City of Vancouver*, No. 3:20-cv-06162-BHS, 2020 WL 7641202, at *1 (W.D. Wash. Dec. 23, 2020) (“The Court also permitted the Governor and the Attorney General to intervene to defend the constitutionality of the COVID-19 Guidance.”). To that end, absent intervention, Governor McMaster could not “make motions or to appeal the final judgment in the case,” so “the ‘practical impairment’ requirement for intervention is satisfied.” *Feller v. Brock*, 802 F.2d 722, 730 (4th Cir. 1986).

Denying intervention would thus impair Governor McMaster’s ability to assert and protect his interests and “supreme executive authority.” S.C. Const. art. IV, § 1. It would impede his constitutional interests in ensuring that legislation he recently signed into law is “faithfully executed.” *Id.* art. IV, § 15. Therefore, the Governor’s requested intervention satisfies this element.

D. The Governor must represent his unique interests and authority.

A proposed intervenor must meet only a “minimal” burden to demonstrate that his interest is not sufficiently represented by the other litigants. *Berkeley Elec. Co-op., Inc.*, 302 S.C. at 191,

394 S.E.2d at 715. The Supreme Court has noted that in considering whether this low threshold is met in a particular case involves addressing “(1) whether the existing parties will undoubtedly make all of the intervenor’s arguments; (2) whether the existing parties are capable and willing to make such arguments; and (3) whether the intervenor offers different knowledge, experience, or perspective on the proceedings that would otherwise be absent.” *Id.*

Although some of the named Defendants may have similar goals to the Governor—that is, implementing and defending the 2023 Act as passed by the General Assembly—the existing Defendants do not share the same legal interests and authority and, thus, are unlikely to make the same arguments as the Governor.¹ Defendants do not have the same constitutional authority and duties as the Governor. *See, e.g., Berger v. N.C. State Conf. of the NAACP*, 597 U.S. 179, 186 (2022) (“Like the Governor, the attorney general is an independently elected official.”); *Cameron v. EMW Women’s Surgical Ctr., P.S.C.*, 142 S. Ct. 1002, 1011 (2022) (“The way in which Kentucky divides executive authority . . . should not obscure the important constitutional consideration at stake.”); *State ex rel. Condon v. Hodges*, 349 S.C. 232, 240, 242, 562 S.E.2d 623, 627, 628 (2002) (discussing the “dual role” and “other duties” of the Attorney General); *Williams*, 320 S.C. at 206, 464 S.E.2d at 102 (emphasizing the Governor’s constitutional role related to, and participation in, the legislative process). In light of these differences, no one can say at this stage that the existing Defendants will “undoubtedly” make all of the arguments the Governor will make, whether in this Court or in any appeal.

¹ Some Defendants, in fact, might not even participate in defending the 2023 Act. *See, e.g., Stipulations for Non-Enforcement Pending Final Resolution, Attorney’s Fees and Costs, Planned Parenthood S. Atl. v. Wilson*, No. 3:21-cv-00508-MGL (D.S.C.), ECF Nos. 42, 43, 72, 74 (stipulations by Solicitor Gipson, members of the Board of Medical Examiners, Director Simmer, and Solicitor Wilson “not to participate in litigating the above-styled and numbered case unless required by the Court to do so”).

Similarly, while the State of South Carolina was not a named defendant in the federal court action challenging the 2021 Act, *see Ex parte Young*, 209 U.S. 123, 150 (1908), the addition of the State as a Defendant here does not alter the analysis or subvert the Governor's distinct interests and authority. Indeed, Plaintiffs do not endeavor to demonstrate that the State of South Carolina, as a sovereign, is either a necessary or proper party or that it could be subject to injunctive relief prohibiting its officials from enforcing the 2023 Act. *See Charleston Cnty. Sch. Dist. v. S.C. State Dairy Comm'n*, 274 S.C. 250, 252, 262 S.E.2d 901, 902 (1980); *Walker v. Harris*, 170 S.C. 242, 170 S.E. 270, 271 (1933); *see, e.g., Harbor Island Owner's Ass'n v. State*, C/A No. 2018-CP-07-02331, at 3 (Beaufort Cnty. Ct. Comm. Pls. Apr. 19, 2019) ("To require an action such as removal [of structures] or a directive requiring others to act necessitates an official with such duties and authority or at least an agency with such responsibilities. Plaintiff has named none. Therefore, the State is not a proper defendant to this action and is dismissed.").

Although the Governor is authorized to bring suit as a relator on behalf of the State in raising constitutional questions, *see State ex rel. Riley v. Pechilis*, 273 S.C. 628, 629, 258 S.E.2d 433, 433 (1979); *State ex rel. Edwards v. Abrams*, 270 S.C. 87, 89, 240 S.E.2d 643, 644 (1978), that does not make the State a substitute for Governor McMaster so as to preclude the his involvement or undercut his authority to intervene. Rather, the presence of the State of South Carolina as a named Defendant actually underscores that the Governor's intervention and involvement will further the State's interests. As the U.S. Supreme Court recently noted in the context of intervention under Rule 24 of the Federal Rules of Civil Procedure, "federal courts should rarely question that a State's interests will be practically impaired or impeded if its duly authorized representatives are excluded from participating in federal litigation challenging state law." *Berger*, 597 U.S. 191. "To hold otherwise," the Court explained, would "evinces disrespect

for a State's chosen means of diffusing its sovereign powers among various branches and officials" and "risk turning a deaf federal ear to voices the State has deemed crucial to understanding the full range of its interests." *Id.*; *see also id.* at 2203 ("[A] full consideration of the State's practical interests may require the involvement of different voices with different perspectives. To hold otherwise would risk allowing a private plaintiff to pick its preferred defendants and potentially silence those whom the State deems essential to a fair understanding of its interests."); *Cameron*, 142 S. Ct. at 1011 ("Respect for state sovereignty must also take into account the authority of a State to structure its executive branch in a way that empowers multiple officials to defend its sovereign interests in federal court."). As in *Berger*, authorizing the Governor to intervene in this matter will facilitate "a full and fair adversarial testing of the State's interests and arguments." *Id.*

At bottom, Governor McMaster's distinct duties and different perspective as the State's supreme executive authority and Chief Magistrate satisfy this final element and further support his intervention as a matter of right.

* * *

Governor McMaster therefore satisfies all four elements for intervention as a matter of right. The Court should authorize the Governor to intervene under Rule 24(a).

II. The Court should alternatively permit the Governor to intervene under Rule 24(b).

In the alternative, the Court should permit Governor McMaster to intervene under Rule 24(b), SCRCF. As explained in Part I.A., the Governor's Motion to Intervene is timely. Thus, this Part focuses on the two other elements of permissive intervention: (1) that the Governor is asserting a claim or defense that shares a common question of law or fact and (2) that his intervention will not delay or prejudice the existing parties. *See Ex parte Builders Mut. Ins. Co.*, 431 S.C. at 101, 847 S.E.2d at 91; *see* Rule 24(b), SCRCF.

A. The Governor seeks to defend the 2023 Act.

Plaintiffs challenge the definition of “fetal heartbeat” the 2023 Act. The Governor seeks to defend the constitutionality of that law. Accordingly, there is no question that Governor McMaster’s proposed intervention involves the very same question of law Plaintiffs have already put before this Court. *See Middleton*, 481 F. Supp. 3d at 571 (“The Proposed Intervenors’ interests in the constitutionality of the Challenged Provisions present questions of law or fact common to Plaintiffs’ Complaint.”). Additionally, Rule 24(b) provides that “[w]hen a party to an action relies for ground of claim or defense upon any statute or executive order administered by a federal or state governmental officer or agency or upon any regulation, order, requirement or agreement issued or made pursuant to the statute or executive order, the officer or agency upon timely application may be permitted to intervene in the action.” Rule 24(b), SCRCF. Once again, Plaintiffs are attacking statutes, as enacted or amended by the 2023 Act, that the Governor has the obligation to faithfully execute in accordance with the South Carolina Constitution. Therefore, under Rule 24(b), permissive intervention is both warranted and appropriate.

B. The Governor’s intervention will not prejudice any existing party.

Plaintiffs will not be prejudiced by Governor McMaster’s intervention. This case is in its earliest stages. The existing Defendants have not yet appeared or responded to Plaintiffs’ Complaint or their Motion for Preliminary Injunction, and the record reflects that the Court has not taken any formal action to date. The deadlines imposed by the South Carolina Rule of Civil Procedure can remain in place. *See Planned Parenthood S. Atl.*, 2021 WL 878791, at *4 (“Here, as to the potential for delay, the Court agrees with the Proposed Intervenors that their involvement at this early stage of the litigation fails to delay this matter. The Court will enforce all existing deadlines upon the Proposed Intervenors.”). Governor McMaster is prepared to respond to

Plaintiffs' Motion for Preliminary Injunction and to file a dispositive motion under Rule 12(b), SCRCP, on any expedited schedule directed by the Court. At most, the Governor's intervention at this stage might mean more briefing for Plaintiffs, but courts have repeatedly rejected the idea that "some additional work" is a reason to deny intervention. *Id.* ("Regarding prejudice to the Plaintiffs, the Court concludes briefing by the Proposed Intervenors fails to amount to a finding of prejudice, even if it creates some additional work for the Plaintiffs and the Court. Hence, the Court concludes the Proposed Intervenors' intervention fails to prejudice Plaintiffs."); *see also Middleton*, 481 F. Supp. 3d at 568 ("[T]he court finds briefing by the Proposed Intervenors would not amount to prejudicial delay, even if it creates some additional work for Plaintiffs (and the court)."). Further, no other party has ever objected to the Governor's intervention in any of the previous abortion-related litigation. Accordingly, permitting Governor McMaster to intervene under Rule 24(b) would not and will not prejudice Plaintiffs and is otherwise warranted under the circumstances.²

CONCLUSION

For the foregoing reasons, the Court should grant this unopposed Motion and authorize him to intervene in the instant action as a matter of right under Rule 24(a), SCRCP. In the alternative, Governor McMaster requests that the Court permit him to intervene in this action in

² Given this timing and the imminent preliminary injunction briefing, an accompanying pleading under Rule 24(c) is unnecessary. As explained by the Fourth Circuit, "a motion to intervene that clearly spells out the intervenor's position satisfies Rule 24(c), as it provides notice to the Court and the parties of the intervenor's interest in the litigation." *Veasey v. Wilkins*, No. 5:14-cv-369-BO, 2015 WL 7776557, at *2 (E.D.N.C. Dec. 2, 2015) (citing *Spring Constr. Co. v. Harris*, 614 F.2d 374, 376–77 (4th Cir. 1980)). Because this Motion "provides the appropriate parties with notice" of the Governor's intention to defend the 2023 Act (and because at least some Plaintiffs have already seen the Governor's substantive briefing on the substantially similar claims they raised in their failed petition for original jurisdiction after *PPSA II*), Rule 24 is satisfied. *Id.*; *see, e.g., S.C. Elec. & Gas Co. v. Whitfield*, No. 3:18-cv-01795-JMC, 2018 WL 3470660, at *2 n.4 (D.S.C. July 18, 2018) (applying this rule) ("The court finds that President Leatherman's Motion to Intervene is proper as it provides notice to the court and the parties of his intention in the case." (internal citation omitted)).

accordance with Rule 24(b), SCRCF. Finally, Governor McMaster respectfully requests expedited consideration of this Motion to facilitate the Governor's prompt defense of the 2023 Act and participation in any hearing and briefing on Plaintiffs' pending motion. In accordance with Rule 11(a), SCRCF, the undersigned conferred with counsel for Plaintiffs, who do not oppose the Governor's request to intervene.

Respectfully submitted,

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February 7, 2024
Columbia, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

IN THE COURT OF COMMON PLEAS
FIFTH JUDICIAL CIRCUIT
Civil Action No. 2024-CP-40-00762

PLANNED PARENTHOOD SOUTH ATLANTIC, on behalf of itself, its patients, and its physicians and staff; KATHERINE FARRIS, M.D., on behalf of herself and her patients; and TAYLOR SHELTON,

Plaintiffs,

v.

SOUTH CAROLINA; ALAN WILSON, in his official capacity as Attorney General of South Carolina; EDWARD SIMMER, in his official capacity as Director of the South Carolina Department of Health and Environmental Control; ANNE G. COOK, in her official capacity as President of the South Carolina Board of Medical Examiners; STEPHEN I. SCHABEL, in his official capacity as Vice President of the South Carolina Board of Medical Examiners; GEORGE S. DILTS, in his official capacity as a Member of the South Carolina Board of Medical Examiners; DION FRANGA, in his official capacity as a Member of the South Carolina Board of Medical Examiners; RICHARD HOWELL, in his official capacity as a Member of the South Carolina Board of Medical Examiners; ROBERT KOSCIUSKO, in his official capacity as a Member of the South Carolina Board of Medical Examiners; THERESA MILLS-FLOYD, in her official capacity as a Member of the South Carolina Board of Medical Examiners; JENNIFER R. ROOT, in her official capacity as a Member of the South Carolina Board of Medical Examiners; CHRISTOPHER C. WRIGHT, in his official capacity as a Member of the South Carolina Board of Medical Examiners; SAMUEL H. McNUTT, in his official capacity as Chairperson of the South Carolina Board of Nursing; SALLIE BETH TODD, in her official capacity as Vice Chairperson of the South

GOVERNOR MCMASTER'S
MOTION TO DISMISS
AND RESPONSE IN OPPOSITION TO
PLAINTIFFS' MOTION FOR
PRELIMINARY INJUNCTION

Carolina Board of Nursing; TAMARA DAY, in her official capacity as a Member of the South Carolina Board of Nursing; KELLI GARBER, in her official capacity as a Member of the South Carolina Board of Nursing; LINDSEY K. MITCHAM, in her official capacity as a Member of the South Carolina Board of Nursing; REBECCA MORRISON, in her official capacity as a Member of the South Carolina Board of Nursing; KAY SWISHER, in her official capacity as a Member of the South Carolina Board of Nursing; ROBERT J. WOLFF, in his official capacity as a Member of the South Carolina Board of Nursing; SCARLETT A. WILSON, in her official capacity as Solicitor for South Carolina's Ninth Judicial Circuit; and BYRON E. GIPSON, in his official capacity as Solicitor for South Carolina's Fifth Judicial Circuit,

Defendants,

and

HENRY MCMASTER, in his official capacity as Governor of the State of South Carolina,

Intervenor-Defendant.

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The Governor moves to dismiss the Complaint under Rule 12(b)(6), SCRCF, and responds to Plaintiffs' Motion for Preliminary Injunction.

INTRODUCTION

Perhaps no rule is more entrenched in South Carolina law than the one that “[t]he cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature.” *Hodges v. Rainey*, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000). Our courts have consistently invoked this rule for at least two centuries. *See, e.g., USAA Cas. Ins. Co. v. Rafferty*, 439 S.C. 130, 132, 886 S.E.2d 222, 223 (2023) (quoting *Rainey*); *Kecheley v. Cheer*, 15 S.C.L. 397, 399 (S.C. App. L. & Eq. 1827) (“the great leading rule” is “that the intention of the legislature must be preserved”). Yet this rule appears nowhere in the Motion for Preliminary Injunction. Plaintiffs relegate legislative intent to a single footnote—a telling sign that their argument is incompatible with this touchstone of statutory interpretation. *See* Pls.’ Mem. 16 n.9.

It is not difficult to discern why Plaintiffs want to hide from legislative intent. The 2023 Fetal Heartbeat Act defines “fetal heartbeat” as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” 2023 S.C. Acts No. 70, § 2 (S.C. Code Ann. § 44-41-610(6)). The legislative record associated with the 2023 Act and the Supreme Court’s decision in *Planned Parenthood I* confirm that this definition is intended to protect unborn life as soon as cardiac activity can be detected by an ultrasound, often at roughly six weeks of pregnancy.

In fact, Plaintiffs themselves have—at least until *Planned Parenthood II* was decided—expressed this same understanding of the 2023 Act. Although they now contend the challenged language begins restricting abortions beginning at approximately nine weeks, over the course of challenging both the 2021 Act and the 2023 Act, they insisted that this same language imposed a

“six-week ban” more than 300 times in their court filings. It’s implausible (to put it mildly) that the “plain meaning,” Pls.’ Mem. 13, of “fetal heartbeat” escaped them (as well as everyone else) for so long.

Ultimately, it seems clear why Plaintiffs are pushing this new nine-week theory: It would let them perform more abortions. *See* Compl. ¶ 93. PPSA candidly admits that it has had to turn away about 75% of women seeking abortions since the Supreme Court’s decision in *Planned Parenthood II*, as PPSA followed the General Assembly’s intent regarding the meaning of “fetal heartbeat.” *See id.* But if PPSA had been permitted to use its new nine-week rule, PPSA says it would have been able to abort about 87% of those unborn children whose lives were saved by the 2023 Act. *See id.*

There is no basis for permitting those additional abortions. Everyone understood exactly what the General Assembly intended in the 2023 Act. Plaintiffs can change their argument, but they cannot change by judicial fiat what the 2023 Act established through the constitutional process of bicameralism and presentment. Any change to the State’s abortion laws must come from the General Assembly, which enjoys “plenary” “authority to legislate,” so long as the legislation is consistent with the state and federal Constitutions. *Planned Parenthood S. Atl. v. State* (“*Planned Parenthood II*”), 440 S.C. 465, 475, 892 S.E.2d 121, 127 (2023). The 2023 Act remains entirely consistent with both Constitutions. “[T]here is no fundamental constitutional right to abortion under article I, section 10,” *id.* at 481, 892 S.E.2d at 130, and the federal “Constitution makes no reference to abortion, and no such right is implicitly protected by any constitutional provision,” *Dobbs v. Jackson Women’s Health Org.*, 142 S. Ct. 2228, 2242 (2022). Nor is there any right to perform abortions, and Plaintiffs do not contend there is.

Because the General Assembly’s intent here is evident, Plaintiffs are *unlikely* to prevail on

the merits, so they are not entitled to any injunctive relief. *See Compton v. S.C. Dep't of Corr.*, 392 S.C. 361, 366, 709 S.E.2d 639, 642 (2011) (“a likelihood of success on the merits” is a required element of injunctive relief). In fact, their claims fail as a matter of law, so they should be dismissed now. *See* Rule 12(b)(6), SCRPC.

BACKGROUND

A. The 2023 Act

Planned Parenthood II rejected a facial challenge to the 2023 Act. This new lawsuit features a more focused argument, involving only the definition of “fetal heartbeat”—even if the scope of relief requested is similarly expansive in scope to *Planned Parenthood II*.

The 2023 Act defines “fetal heartbeat” as “cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac.” 2023 Act, § 2 (S.C. Code Ann. § 44-41-610(6)). The Act recognizes that a “fetal heartbeat is a key medical predictor that an unborn child will reach live birth.” *Id.* § 1(1).

Before any abortion may be performed, the provider must give the pregnant woman the ability to view the ultrasound and inform her of a fetal heartbeat, if one exists. *Id.* § 10 (S.C. Code Ann. § 44-41-330(A)). If that heartbeat does exist, “no person shall perform or induce an abortion” unless one of the Act’s exceptions for rape, incest, fatal fetal anomaly, or maternal health applies. *Id.* § 2 (S.C. Code Ann. § 44-41-630(B)).

B. *Planned Parenthood II*, its impact, and this new lawsuit

In their facial challenge to the 2023 Act, the plaintiffs there never questioned the meaning of “fetal heartbeat.” In fact, their brief in that case labeled the prohibition on abortions “where a ‘fetal heartbeat has been detected,’ or roughly *six weeks* LMP,” as the “Six-Week Ban,” Br. of Resp’ts 5, *Planned Parenthood II*, No. 2023-000896 (S.C. June 20, 2023) (emphasis added)

(quoting 2023 Act, § 2 (S.C. Code Ann. § 44-41-630(B)), and their brief proceeded to use that term 22 more times, *see generally* Br. of Resp'ts, *Planned Parenthood II*, No. 2023-000896 (S.C. June 20, 2023).

At oral argument, Justice Few, after reciting the definition of “fetal heartbeat,” posed this inquiry to counsel for the Attorney General:

Those commas may or may not have great significance. Do you think that the phrase that is within the commas, the parenthetical within the commas, is actually a phrase that the legislature intended to define the term “cardiac activity” or to supplement the term “cardiac activity”? In other words, the question that I’m asking you is simply is “fetal heartbeat” defined simply as “any cardiac activity” or is it defined as “the steady and repetitive rhythmic contraction of the fetal heart”?

Oral Argument Video 0:07:10–0:08:10, *Planned Parenthood II*, No. 2023-000896 (S.C.) (Few, J.).

Then, in the opinion, the Court “[le]ft for another day (in an as-applied constitutional challenge) the meaning of ‘fetal heartbeat’ and whether the statutory definition—‘cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac’—refers to one period of time during a pregnancy or two separate periods of time.” *Planned Parenthood II*, 440 S.C. at 474 n.4, 892 S.E.2d at 126 n.4. The dissent made much of this footnote, doubting that a fetal heartbeat exists at six weeks and demanding clarity on the law. *See id.* at 497–98, 892 S.E.2d at 139–40 (Beatty, C.J., dissenting). The Chief Justice later suggested that those plaintiffs file a new lawsuit on this question. *See Order 3, Planned Parenthood II*, No. 2023-000896 (S.C. Aug. 29, 2023) (Beatty, C.J., dissenting from denial of rehearing).

Plaintiffs have taken these statements as their cue to challenge the meaning of “fetal

heartbeat.”* Some of Plaintiffs were among the petitioners who have already asked the Supreme Court to take a case in its original jurisdiction about the meaning of “fetal heartbeat,” but the Supreme Court declined to do so. *See Order, Planned Parenthood S. Atl. v. State*, No. 2023-001449 (Nov. 14, 2023). Now, Plaintiffs ask this Court to declare that the 2023 Act’s use of “fetal heartbeat” “is the point when the heart is formed, which is approximately after nine weeks LMP,” either because the plain language, they contend, requires as much or because they suddenly believe the statute is ambiguous and should be construed against the State. Compl. ¶¶ 115, 121–22. They seek a preliminary injunction to prevent state officials from enforcing the law “as applied to abortions performed on patients whose pregnancies have detectable embryonic activity but where a heart has not formed yet.” Mot for Prelim. Inj. 2.

LEGAL STANDARD

A motion to dismiss should be granted whenever a complaint “fail[s] to state facts sufficient to constitute a cause of action.” Rule 12(b)(6), SCRCP. Thus, even taking the allegations in the light most favorable to the plaintiffs, if the plaintiffs are not entitled to relief under any theory, the complaint should be dismissed. *See Doe v. Marion*, 373 S.C. 390, 395, 645 S.E.2d 245, 247–48 (2007). When “the dispute is not as to the underlying facts but as to the interpretation of the law, and development of the record will not aid in the resolution of the issues, it is proper to decide even novel issues on a motion to dismiss.” *Unisys Corp. v. S.C. Budget & Control Bd. Div. of Gen. Servs. Info. Tech. Mgmt. Off.*, 346 S.C. 158, 165, 551 S.E.2d 263, 267 (2001).

* To the extent Plaintiffs implicitly blame the Supreme Court for not addressing their current confusion in *Planned Parenthood II*, such criticism is easily dismissed. The petitioners there never challenged the definition of “fetal heartbeat,” and an appellate court must “decline” “to rule on issues not presented to” it. *State v. Harrison*, 432 S.C. 448, 464, 854 S.E.2d 468, 476 (2021) (cleaned up).

“The remedy of an injunction is a drastic one and ought to be applied with caution.” *Strategic Res. Co. v. BCS Life Ins. Co.*, 367 S.C. 540, 544, 627 S.E.2d 687, 689 (2006). “An applicant for a preliminary injunction must allege sufficient facts to state a cause of action for injunction and demonstrate that this relief is reasonably necessary to preserve the rights of the parties during the litigation.” *Allegro, Inc. v. Scully*, 400 S.C. 33, 45, 733 S.E.2d 114, 121 (Ct. App. 2012). A plaintiff “must establish three elements” to obtain a preliminary injunction: (1) irreparable harm, (2) likelihood of success on the merits, and (3) no adequate remedy at law. *Compton*, 392 S.C. at 366, 709 S.E.2d at 642. Whether to grant a preliminary injunction is in a trial court’s discretion. *Id.*

ARGUMENT

Plaintiffs have failed to state a viable claim because the General Assembly’s intent in the 2023 Act is clear. Their claims should therefore be dismissed under Rule 12(b)(6). And because their claims fail as a matter of law, they are not likely to prevail on the merits, so they are not entitled to a preliminary injunction.

I. The 2023 Act protects unborn life from approximately six weeks of pregnancy.

Every act of the General Assembly receives a “weighty” presumption of constitutionality. *Planned Parenthood II*, 440 S.C. at 476, 892 S.E.2d at 127. Courts will hold an act unconstitutional only if a plaintiff carries “the heavy burden,” *Bodman v. State*, 403 S.C. 60, 66, 742 S.E.2d 363, 366 (2013), to prove the act’s “repugnance to the Constitution is clear and beyond a reasonable doubt,” *Curtis v. State*, 345 S.C. 557, 570, 549 S.E.2d 591, 597 (2001).

There is no way for Plaintiffs to carry this burden on their challenge to the 2023 Act. The General Assembly debated the 2023 Act over dozens of hours. At no point in that long debate did anyone ever suggest that “fetal heartbeat” in this Act was intended to begin prohibiting abortions

at approximately nine weeks of pregnancy when, Plaintiffs now claim, “a heart has formed.” *E.g.*, Pls.’ Mem. 1. Rather, all legislators—both those for and against S. 474—consistently described the legislation as protecting life from approximately six weeks of pregnancy, when an ultrasound can first detect cardiac activity in an unborn child. To credit Plaintiffs’ revisionist arguments to the contrary would require ignoring this legislative record and rewriting the 2023 Act.

A. The General Assembly’s intent is clear.

There are scores of rules of statutory interpretation. *See generally* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* (2012) (identifying 57 canons of interpretation). Whatever canons exist, the “cardinal rule of statutory construction” in South Carolina is legislative intent. *Rainey*, 341 S.C. at 85, 533 S.E.2d at 581. Giving effect to the General Assembly’s intent is the “ultimate goal,” *City of Rock Hill v. Harris*, 391 S.C. 149, 153, 705 S.E.2d 53, 55 (2011), the “great leading rule,” *Kecheley*, 15 S.C.L. at 399, and the “primary function,” *State v. Baker*, 310 S.C. 510, 512, 427 S.E.2d 670, 671 (1993), of interpreting statutes.

With this North Star in mind, the legislative record here leaves no doubt as to what the General Assembly intended to protect with the definition of “fetal heartbeat.” During the committee hearings and the floor debates, legislators—both those supporting and opposing the bill—understood S. 474 as drawing a line at approximately six weeks. For example, during the first debate on the Senate floor, Senator Massey (one of the four sponsors of S. 474), citing the American Pregnancy Association, explained that “a heartbeat can be detected between six and seven weeks.” S.C. Senate, Video of Floor Proceedings, at 1:31:00 (Feb. 7, 2023) (Sen. Massey). Arguing against S. 474, Senator Senn insisted that a “six-week ban, as the Court actually started calling it and as most people call it,” “was already held unconstitutional one time” in *Planned Parenthood I*. S.C. Senate, Video of Floor Proceedings, at 3:45:10 (Feb. 9, 2023) (Sen. Senn).

Particularly damning for Plaintiffs in the Senate floor debate is an exchange between Senator Matthews and Senator Senn, both of whom opposed S. 474. Senator Matthews asked about signs of pregnancy. Senator Senn stated that only after a second missed period do some women realize they are pregnant.

Senator Matthews interjected, “How many weeks are you in at that point?”

“Eight,” Senator Senn replied.

“Eight weeks,” Senator Matthews echoed.

“Eight,” Senator Senn repeated once more.

S.C. Senate, Video of Floor Proceedings, at 4:50:00–4:51:40 (Feb. 8, 2023) (Sens. Matthews and Senn).

This exchange is telling. Both Senators Matthews and Senn understood S. 474 as protecting unborn life at approximately six weeks. That’s why “eight” weeks prompted a reaction from both Senators. If they had thought S. 474’s definition of “fetal heartbeat” was aimed at approximately nine weeks, neither Senator would have had such a reaction to eight weeks.

Turning to the House of Representatives, the story is the same. To be sure, supporters of the bill described it as a “six”-week law. *See, e.g.*, S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 1:40:34 (May 9, 2023) (Rep. Brittain). But more telling in the House are the repeated statements from the opponents of S. 474. As one example, consider Representative Wheeler’s comments and proposed amendment in committee. He called S. 474 essentially the same as the 2021 Act, claiming that “six weeks is six weeks. It’s the heartbeat bill.” S.C. House Judiciary Comm, Constitutional Laws Subcomm., Video of Comm. Hearing, at 46:08 (May 9, 2023) (Rep. Wheeler). He later proposed an amendment to permit abortions up to eight weeks—a proposal that would not have made sense if S. 474 wasn’t intended to protect life at approximately

six weeks. *See* S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 3:16:40–3:21:20 (May 9, 2023) (Rep. Wheeler). The Judiciary Committee rejected that amendment to extend the line to eight weeks. *Id.* at 3:38:30.

Many other opponents expressed a similar understanding of S. 474. At one point in the floor debate, Representative Bamberg declared that “the very crux of this piece of legislation surrounds time” and “it’s a six-week ban.” S.C. House, Video of Floor Proceedings Part 1, at 8:49:44 (May 16, 2023) (Rep. Bamberg). Representative Bauer stated that in the 2021 Act, “the General Assembly passed the act which prohibits an abortion after around the sixth week of gestation, which we are here discussing again” with S. 474. *Id.* at 12:28:54 (Rep. Bauer). Representative Dillard claimed the General Assembly was “now cutting off abortion—or the access to abortion—at six weeks.” *Id.* at 2:35:15 (Rep. Dillard).

These were far from isolated statements. *See, e.g.*, S.C. House Judiciary Comm., Video of Comm. Hearing Part 1, at 0:13:30 (May 9, 2023) (Rep. Bernstein) (S. 474 “still ha[s] the six weeks”); S.C. House Judiciary Comm., Video of Comm. Hearing Part 2, at 0:10:58 (May 9, 2023) (Rep. Thigpen) (S. 474 prohibits abortion at “six weeks”); *id.* at 3:25:443 (Rep. Bamberg) (“six weeks is a total abortion ban”); S.C. House, Video of Floor Proceedings Part 1, at 0:59:15 (May 16, 2023) (Rep. Wetmore) (noting the general rule of “six weeks” before discussing extending the exceptions for minors); *id.* at 3:22:40 (May 16, 2023) (Rep. Bamberg) (“at six weeks most women don’t even know that they’re pregnant”); *id.* at 3:31:07 (Rep. Bamberg) (“we’re doing the same exact thing on this bill” as the General Assembly did in the 2021 Act, and the Supreme Court has held “the six-week ban” is unconstitutional); *id.* at 7:13:17 (Rep. Bamberg) (“we’ve decided against our better judgment we’re going to stick with a six-week ban”); *id.* at 7:28:00 (Rep. Bernstein) (S. 474 “has the gestational age as six weeks”); *id.* at 13:10:50 (Rep. Howard)

(proposing an amendment to fund out-of-state abortions because of the “six-week ban”); S.C. House, Video of Floor Proceedings Part 2, at 2:16:50 (May 16, 2023) (Rep. Rose) (“this essentially amounts to a total ban because it’s next to impossible for a woman to know she’s pregnant at six weeks”); *id.* at 6:36:15 (Rep. Rose) (S. 474 is a “total ban” because “very little people can actually know that they’re pregnant at six” weeks).

That all of these legislators referred to S. 474 as a “six-week” law is not surprising. The definition of “fetal heartbeat” in the 2023 Act is the same as the definition of the 2021 Act. *Compare* 2023 S.C. Acts No. 70, § 2 (S.C. Code Ann. § 44-41-610(6)), *with* 2021 S.C. Acts No. 1, § 3 (S.C. Code Ann. § 44-41-610(3) (repealed)). The Supreme Court has already recognized that abortion regulations based on this definition come into play at approximately six weeks of pregnancy. Justice Hearn called the 2021 Act a “six-week ban.” *Planned Parenthood S. Atl. v. State* (“*Planned Parenthood I*”), 438 S.C. 188, 216, 882 S.E.2d 770, 785 (2023). Chief Justice Beatty talked about it as a “six-week restriction.” *Id.* at 238, 882 S.E.2d at 797 (Beatty, C.J., concurring). Justice Few observed that the 2021 Act was “commonly referred to as the ‘six-week bill,’” *id.* at 257, 882 S.E.2d at 807 (Few, J., concurring in the judgment), and called that act the “six-week bill” throughout his analysis, *id.* at 272–83, 882 S.E.2d at 815–21. Justice Few even cited legislative history discussing the 2021 Act as a six-week law. *Id.* at 258 n.42, 882 S.E.2d at 808 n.42. And in dissent, Justice Kittredge noted that the 2021 Act “dr[e]w[] a line at the approximate six- to eight-week mark.” *Id.* at 236, 882 S.E.2d at 844 (Kittredge, J., dissenting).

A final observation about the 2023 Act’s use of “fetal heartbeat”: Until now, PPSA and Dr. Farris themselves never doubted that the 2023 Act protected unborn life from approximately six weeks. In their *Planned Parenthood II* briefing, they termed that Act a “Six-Week Ban” and used that phrase 22 more times. *See generally* Br. of Resp’ts, *Planned Parenthood II*, No. 2023-000896.

(S.C. June 20, 2023). They used that same phrase 31 times in circuit court before *Planned Parenthood II* was transferred to the Supreme Court's docket. They used it more than 100 times in *Planned Parenthood I* between circuit court and the Supreme Court. And they used it 150 times while in federal court challenging the 2021 Act.

Lest that phrase be thought of as some lawyerly creation, the plaintiffs' own affidavits in *Planned Parenthood II* took the same view of the 2023 Act. Dr. Farris averred that "as [she] understand[s] the Act, it prohibits abortion any time after identification of embryonic or fetal cardiac activity," and that "[b]ased on [her] medical experience and expertise, that activity may be detected by vaginal ultrasound as early as *six weeks of pregnancy* (LMP)." App. 105, *Planned Parenthood II*, No. 2023-000896 (S.C. June 14, 2023) (emphasis added). Dr. Buffkin (a plaintiff in earlier cases who performs abortions in Greenville) expressed an identical understanding, testifying in his affidavit that he "understand[s] that the Act bans the provision of abortion care in South Carolina upon detection of any embryonic or fetal cardiac activity, which in [his] experience occurs very early in pregnancy, potentially as early as *6 weeks* LMP." *Id.* at 143 (emphasis added). And until their most recent press releases that accompanied their latest lawsuits about the meaning of "fetal heartbeat," even Plaintiffs' public statements called the 2023 Act a "six-week ban." Compare *Planned Parenthood, South Carolinian Challenges State's Abortion Ban in Court* (Feb. 5, 2024), <http://tinyurl.com/8bpmtph5> (plaintiffs "fil[ed] a lawsuit challenging the scope of the ban"); *Planned Parenthood, Abortion Providers File New Case Challenging South Carolina Abortion Ban* (Sept. 14, 2023), <https://tinyurl.com/2nsdbxey> (claiming there was "uncertainty of the definition of 'fetal heartbeat'"), with *Planned Parenthood, South Carolina Supreme Court Allows Six-Week Abortion Ban to Go into Effect* (Aug. 24, 2023), <https://tinyurl.com/mr3wrrfy>; *Planned Parenthood, South Carolina Abortion Providers File New State Court Challenge to Six-*

Week Abortion Ban (May 25, 2023), <https://tinyurl.com/2dmmdmwm>.

In the face of this voluminous record, Plaintiffs cannot point to any instance in which any legislator described S. 474 as permitting abortion until nine weeks. Not a single one. Instead, Plaintiffs offer a solitary footnote about legislative intent. *See* Pls.' Mem. 16 n.9. In that footnote, they strain to cherry pick part of a sentence from the Attorney General's brief in *Planned Parenthood II* and impute it to the General Assembly so as to suggest that the legislative intent in the 2023 Act was to protect unborn life from approximately nine weeks. As a threshold matter, South Carolina courts have repeatedly rejected efforts to point to "the opinions of legislators or others concerned in the enactment of the law—*expressed subsequent to enactment*—to ascertain the intent of the legislature." *Creswick v. Univ. of S.C.*, 434 S.C. 77, 83, 862 S.E.2d 706, 709 (2021) (emphasis added); *see also, e.g., Greenville Baseball v. Bearden*, 200 S.C. 363, 371, 20 S.E.2d 813, 817 (1942).

Aside from the fact that the Attorney General is not involved in the enactment of the law, even if the Court were to consider this statement, read in context, it's clear that the Attorney General's brief was not making some claim about the number of weeks at which the General Assembly intended to begin regulating abortion. Rather, the brief was insisting that the key feature of the 2023 Act was that unborn life was protected not from a particular number of weeks but instead from the presence of a fetal heartbeat, which in some instances might be "as late as" nine or ten weeks, suggesting that a heartbeat will in many cases be detected before then. Br. of Att'y Gen. 12, *Planned Parenthood II*, No. 2023-000896 (S.C. June 14, 2023). After all, "[c]ardiac activity begins at a biologically identifiable moment in time." 2023 Act, § 1(2).

B. Plaintiffs' grammatical and statutory arguments are not compelling and cannot overcome the obvious legislative intent.

Seemingly recognizing the weakness of any argument that they could put forward on

legislative intent, Plaintiffs open their merits argument by focusing on the commas in the definition of “fetal heartbeat,” insisting this appositive “further identif[ies] or explain[s]” “fetal heartbeat,” which they define as not existing until nine weeks. Pls.’ Mot. 13–14. To try to bolster this after-the-fact argument and support their sudden claims of confusion, they also point to the rule against superfluity and the rule of lenity. *See* Pls.’ Mot. 14, 21–22.

Even if Plaintiffs were somehow correct that a fetal heartbeat does not exist until nine weeks (and they are not correct), what Plaintiffs’ grammatical argument misses is the “great wealth of authority to the effect that punctuation is not a part of a statute, and may be disregarded in order to effect the intention of the Legislature.” *Bruner v. Smith*, 188 S.C. 75, 82, 198 S.E. 184, 188 (1938). Indeed, our Supreme Court has repeatedly recognized that punctuation cannot be used to thwart legislative intent. *See, e.g., Comm’rs of Pub. Works of the City of Laurens v. City of Fountain Inn*, 428 S.C. 209, 219, 833 S.E.2d 834, 839 (2019) (“In most circumstances, the presence or absence of a comma is not determinative of whether the writing is ambiguous.”); *Bruner*, 188 S.C. at 82, 198 S.E. at 188 (“Punctuation is a minor, and not a controlling, element in interpretation, and Courts will disregard the punctuation of a statute, or repunctuate it, if need be, to give effect to what otherwise appears to be its purpose and true meaning.”); *Kitchen v. S. Ry.*, 68 S.C. 554, 567, 48 S.E. 4, 8 (1904) (“The punctuation of a statute cannot be permitted to control the construction that is required by other and more weighty considerations.”); *Caston v. Brock*, 14 S.C. 104, 107 (1880) (“Punctuation is the least reliable guide to the sense of a statute, but cannot properly be said to be without any force. In itself it is ordinarily insufficient to fix the sense of a statute where that is disputable, especially where the question is one of the force of a comma . . .”). In the face of the unambiguous legislative record from both supporters and opponents of the bill that became the 2023 Act, two commas in one definitional subsection cannot

change the entire thrust of the legislation—a thrust that even Plaintiffs have admitted is the “hallmark feature” of the Act. Br. of Resp’ts 42 n.50, *Planned Parenthood II*, 2023-000896 (S.C. June 20, 2023).

What this argument ultimately asks the Court to do is “concentrate on [this] isolated phrase[] within the statute.” *CFRE, LLC*, 395 S.C. at 74, 716 S.E.2d at 881. But the Court “should not” do that. *Id.* Instead, the Court must read the statute “as a whole,” *id.*, so that “the purpose of an enactment will prevail over the literal import of the statute,” *Rainey*, 341 S.C. at 87, 533 S.E.2d at 582. Put another way, the Court must “reject a statutory interpretation which would lead to a result so plainly absurd that it could not have been intended by the Legislature or would defeat the plain legislative intention.” *State v. Sweat*, 386 S.C. 339, 351, 688 S.E.2d 569, 575 (2010). Whatever the rule against superfluidity may require in other contexts, that rule is “subservient” to the mandate to give effect to the General Assembly’s intent. *State v. Pittman*, 373 S.C. 527, 561, 647 S.E.2d 144, 161 (2007).

Plaintiffs fare no better with the rule of lenity. That rule applies only when “a genuine ambiguity exists” *after* a court has exhausted the usual tools of statutory construction. *Bryant v. State*, 384 S.C. 525, 533, 683 S.E.2d 280, 284 (2009) (emphasis omitted). In other words, the tie goes to the proverbial runner (or, in this circumstance, hypothetical criminal defendant who performed an abortion prohibited by the 2023 Act). The rule of lenity does not, however, preclude a court from discerning the statutory meaning by using the tools of statutory construction. *See State v. Dawkins*, 352 S.C. 162, 166, 573 S.E.2d 783, 785 (2002) (“even though penal statutes are to be strictly construed, the canons of construction certainly allow the court to consider the statute as a whole and to interpret its words in light of the context” (cleaned up)). As discussed at length, *see supra* Part I.A., the legislative intent here is clear, and the Court can therefore declare the 2023

Act's meaning such that no ambiguity could possibly exist. With this declaration, no one—including Plaintiffs—can claim not to know what “fetal heartbeat” means, which resolves any ambiguity concerns Plaintiffs might have recently developed and ensures that enforcement of the law involves clear standards. *See* Pls.’ Mot. 21–22.

Nor do Plaintiffs gain any traction with their related vagueness argument. *See* Pls.’ Mot. 21. Plaintiffs actually appear to confuse vagueness and ambiguity. Ambiguity is when a statute has two potential meanings, while vagueness is when a statute is simply unclear. *See* Scalia & Garner, *supra*, at 31–33. Here, state officials have consistently interpreted the 2023 Act as regulating abortion from approximately six weeks, while Plaintiffs belatedly offer an alternative reading of nine weeks. Indeed, Plaintiffs even admit that the language here involves “ambiguity.” Pls.’ Mot. 22. Even if the Court were not to reject Plaintiffs’ new-found reading out of hand, the Court can still compare two proffered readings of a statute and conclude that one reading of the statute is “plainly” correct. *State v. Hercheck*, 403 S.C. 597, 603, 743 S.E.2d 798, 801 (2013) (holding that the State’s plain-meaning argument was correct, despite the Court of Appeals holding the statute meant “the exact opposite” of the State’s position).

C. Plaintiffs’ appeal to a “medical consensus” is unavailing.

Underlying (and undermining) Plaintiffs’ entire case is their recently adopted position that “fetal heartbeat” points to “approximately nine weeks” because the “medical consensus” is that “a heart does not form until” then. Pls.’ Mot. 1–2. For at least two reasons, this assertion carries no weight and provides no basis to rewrite the 2023 Act.

The first reason is that Plaintiffs’ about-face regarding the meaning of “fetal heartbeat” represents a break with the claims of other medical “experts” in *Planned Parenthood II*. Take the amicus brief from the American College of Obstetricians and Gynecologists in that case. There,

ACOG (which called itself “the nation’s leading group of physicians providing health care to women”) declared that “[a]s a matter of medical science, a true fetal heartbeat exists only after the chambers of the heart have been developed and can be detected via ultrasound, which typically occurs around 17–20 weeks’ gestation.” Amicus Br. of ACOG 1, 10, *Planned Parenthood II*, 2023-000896 (S.C. June 20, 2023).

Plaintiffs never try to explain their sudden break with ACOG. Instead, they ignore it completely, pointing only to their new expert, Dr. Crockett, to say the heart fully develops between nine and ten weeks. *See* Pls.’ Mot. 9–10 n.5. Still, they concede that “an ultrasound will not be able to detect the essential features of the heart until later.” Pls.’ Mot. 9 n.5. The earliest the heart can be detected, with “highly sophisticated technology,” is 12 weeks, Plaintiffs say. *Id.*

But this only creates other problems for Plaintiffs. For one, their new nine-week theory attempts to draw that line based on when the heart “forms.” *E.g.*, Pls.’ Mot. 15. But the 2023 Act’s line is when the “fetal heartbeat has been *detected*,” 2023 Act, § 2 (S.C. Code Ann. § 44-41-630(B)) (emphasis added), not when that heartbeat is formed (or begins to exist).

For another, Plaintiffs face a related textual problem. The 2023 Act protects unborn life once “the unborn child’s fetal *heartbeat* has been detected.” *Id.* (emphasis added). Nowhere do Plaintiffs state when that *heartbeat*—rather than the heart itself—can be detected. Or even when that heartbeat begins to exist.

For a third, even if the Court were to assume that detecting the “fetal heartbeat” for purposes of the 2023 Act necessarily means there is a fully formed heart and to accept that the “highly sophisticated technology” necessary to detect the heart at 12 weeks is common enough that the General Assembly would have legislated based on that technology, Plaintiffs admit that 12 weeks is the earliest the fetal heart can be detected. *See* Pls.’ Mot. 9 n.5. Yet they never

acknowledge, much less grapple with, the fact that the General Assembly specifically rejected attempts to draw the line in the 2023 Act at 12 weeks. *See, e.g.*, S. Journal No. 18, 125th Sess. (Feb. 8, 2023) (Amendment No. 3 by Sen. Senn: subject to certain exceptions, “no person shall perform, induce, or attempt to perform or induce an abortion on a pregnant woman when the probable gestational age of the unborn child is more than twelve weeks”); *see also* S.C. Senate, Video of Floor Proceedings, at 4:13:05 (Feb. 8, 2023) (Sen. Senn) (the “underlying bill” to Amendment No. 3 is “six weeks”). From a legislative-intent perspective, that’s an insurmountable hurdle for Plaintiffs’ argument here.

Also troubling for Plaintiffs is that this new claim of nine weeks even conflicts with Planned Parenthood’s previous assertions outside of litigation in this State. Until recently, Planned Parenthood’s website explained that “during week 5–6,” “[a] very basic beating heart and circulatory system develop.” WebArchive, Planned Parenthood, *What happens in the second month of pregnancy?* (July 25, 2022), <https://tinyurl.com/2jvsvh34>. That statement aligns with the experience of countless parents who have heard their new child’s heartbeat at an early ultrasound.

Now, however, Planned Parenthood has changed that language to read that, at this point in pregnancy, a “part of the embryo starts to show cardiac activity” that “sounds like a heartbeat on an ultrasound, but it’s not a fully-formed heart—it’s the earliest stages of the heart developing.” Planned Parenthood, *What happens in the second month of pregnancy?* (last visited Feb. 8, 2024), <https://tinyurl.com/53axutaf>. In addition to Planned Parenthood’s earlier admission about a “basic” heart forming at six weeks, the 2023 Act never says a “fully formed” heart is what’s required for an unborn child to be protected, and even Planned Parenthood still admits that what exists at five to six weeks is a heart, even if in its “earliest” form. This shift seems obvious enough: Planned Parenthood conveniently claimed confusion and quietly changed its vocabulary as a litigation

tactic to challenge fetal heartbeat laws like the 2023 Act.

Ultimately, what Plaintiffs seem to be taking issue with is how the General Assembly used “fetal heartbeat” in the 2023 Act, as compared to what Plaintiffs think that term should mean. This leads directly to the second reason that that Plaintiffs’ appeal to medical consensus is unpersuasive. Even if some medical consensus did exist about the meaning of “fetal heartbeat,” the General Assembly was still free to define “fetal heartbeat” as it wanted to define that term. Or, as some courts have more colorfully put it, the legislature “can be its own lexicographer.” *Tesla Inc. v. Del. Div. of Motor Vehicles*, 297 A.3d 625, 632 (Del. 2023); *see also Iowa v. Thomas*, 275 N.W.2d 422, 423 (Iowa 1979); *Theophelis v. Lansing Gen. Hosp.*, 424 N.W.2d 478, 495 (Mich. 1988). That’s why “courts have looked to the usual dictionary meaning to supply its meaning” only when “a word is not defined in a statute.” *Berkeley Cnty. Sch. Dist. v. S.C. Dep’t of Revenue*, 383 S.C. 334, 345, 679 S.E.2d 913, 919 (2009); *cf. Planned Parenthood II*, 440 S.C. at 475, 892 S.E.2d at 127 (“This deference [due to the General Assembly’s decision] is not diminished simply because there is medical support for ‘both sides’ of an issue.”).

In addition to the robust legislative record and Plaintiffs’ own arguments in *Planned Parenthood II*, *see supra* Part I.A., the petitioners’ amici in *Planned Parenthood II* also recognized how the General Assembly used “fetal heartbeat” in the 2023 Act. ACOG stated that, based on the definition of that term and the legislative findings, “South Carolina believes its definition of ‘fetal heartbeat’ includes the embryonic cardiac activity that occurs as a result of electrical flickering of a portion of the embryonic tissue, which is typically detectable at approximately six weeks’ gestation.” Amicus Br. of ACOG 10, *Planned Parenthood II*, 2023-000896 (S.C. June 20, 2023). Similarly, the Women’s Rights and Empowerment Network noted that the legislative definition of “fetal heartbeat” was “the electrical activity of a tube of cells in an embryo that will eventually

form into a heart.” Amicus Br. of WREN 6 n.3, *Planned Parenthood II*, 2023-000896 (S.C. June 20, 2023).

Plaintiffs effectively admit that the General Assembly could have defined “fetal heartbeat” this way. They acknowledge that “[p]hysicians and scientists may use differed verbiage in talking about cardiac development” and that “some may use the term ‘heartbeat’ to refer to early embryonic electrical activity.” Pls.’ Mot. 9 n.4. That’s precisely how the General Assembly used the term “heartbeat” in the 2023 Act, to use Plaintiffs’ verbiage. And it is, of course, the General Assembly’s intended use of the term that matters, not how Plaintiffs or others have used that term. *See Rainey*, 341 S.C. at 85, 533 S.E.2d at 581 (“The cardinal rule of statutory construction is to ascertain and effectuate the intent of the legislature.”).

The General Assembly’s use of “fetal heartbeat” is thus entirely consistent with the rest of the 2023 Act. *Cf.* Pls.’ Mot. 15–16. The first detection of this heartbeat (or of “embryonic electrical activity,” to use Plaintiffs’ term for it, *id.* at 15) exists at an identifiable moment. *See* 2023 Act, § 1(2). It’s just not the moment that Plaintiffs want it to be. Similarly, a pregnant woman can hear this “fetal heartbeat” through an ultrasound, just as the 2023 Act gives her the opportunity to do.

D. Plaintiffs cannot rely on *Planned Parenthood I* to narrow the scope of the 2023 Act.

Plaintiffs treat Justice Few’s controlling opinion in *Planned Parenthood I* as still the definitive word on “meaningful choice.” *See* Pls.’ Mot. 18. But what they ignore is Justice Few’s discussion of the statutory change from the 2021 Act to the 2023 Act, which removed the legislative finding about such a choice. *See Planned Parenthood II*, 440 S.C. at 490, 892 S.E.2d at 135 (Few, J., concurring) (calling this “[t]he most obvious change” in the 2023 Act). Justice Few explained later in his *Planned Parenthood II* opinion that “[t]he elimination of the interest of ‘informed choice’ from the 2021 Act leaves this interest in life—which includes the life and health

of the mother—as the sole purpose of the 2023 Act.” *Id.* at 495, 892 S.E.2d at 138. “With this purpose stated more clearly and without the countervailing statutory interest of informed choice,” Justice Few continued, “the correlation between reaching the threshold of a fetal heartbeat and the likelihood of a live, healthy birth stands out more clearly as a reasonable standard by which to regulate most abortion.” *Id.* Thus, Plaintiffs’ continued focus on “meaningful choice” and citations to *Planned Parenthood I* are unavailing. *See, e.g.,* Pls.’ Mot. 19.

But there’s an even more fundamental flaw in Plaintiffs’ reliance on *Planned Parenthood I*. The Supreme Court in *Planned Parenthood II* expressly rejected the contention that *Planned Parenthood I* “control[led] [the Court’s] decision.” 440 S.C. at 477, 892 S.E.2d at 128 (majority opinion). That was because “the 2023 Act is materially different from the 2021 Act.” *Id.* In other words, whatever *Planned Parenthood I* had to say about the 2021 Act, that has little relevance to interpreting the 2023 Act—at least where those two acts are different. The 2023 Act reflects “that the State has a compelling interest in protecting the lives of unborn children.” *Id.* at 485, 892 S.E.2d at 132. It would be illogical, given that interest, to conclude that the 2023 Act actually protects less than 20% of the children who PPSA had been aborting before the 2023 Act was enacted. *Cf.* Compl. ¶ 93. Given the intense debates over this law and the contentious litigation, surely the Act sweeps more broadly and protects more children than that.

In any event, even if *Planned Parenthood I* could have some relevance here or “meaningful choice” were a governing standard despite not appearing in the majority opinion in *Planned Parenthood II* other than a parenthetical quoting Justice Few in *Planned Parenthood I*, the facts here confirm that a woman can know that she is pregnant in time to obtain an abortion under the 2023 Act. Shelton says she learned of her pregnancy at four-and-a-half weeks. Shelton Decl. ¶ 7. Yet she submits she was “unable to get an appointment with one of the abortion providers in South

Carolina before [her] pregnancy would have reached six weeks,” *id.* ¶ 8, but that isn’t the fault of the 2023 Act. Instead, any blame lies with the abortion providers, who apparently did not have sufficient staff to see Shelton in the time frame she requested despite performing fewer abortions in light of the 2023 Act. But even under *Planned Parenthood I*, there is no doubt that a “woman can know of her pregnancy” before the 2023 Act begins to protect unborn life because Shelton knew of her pregnancy at four-and-a-half weeks. *Planned Parenthood I*, 438 S.C. at 278, 882 S.E.2d at 819.

II. Plaintiffs will not suffer irreparable harm without an injunction.

Beyond their insurmountable challenge with proving that they are likely to prevail on the merits, Plaintiffs’ request for a preliminary injunction faces additional hurdles they cannot clear. One such hurdle is proving irreparable harm. Our Supreme Court has made clear that “for a preliminary injunction to be granted, the plaintiff must establish that . . . *he* would suffer irreparable harm if the injunction is not granted.” *Greenville Bistro, LLC v. Greenville Cnty.*, 435 S.C. 146, 160, 866 S.E.2d 562, 569–70 (2021) (emphasis added). A plaintiff cannot rely on harm to others. *Cf. State v. McKnight*, 352 S.C. 635, 651, 576 S.E.2d 168, 176 (2003) (“one cannot obtain a decision as to the invalidity of an act on the ground that it impairs the rights of others”); *Stone v. Salley*, 244 S.C. 531, 537, 137 S.E.2d 788, 790 (1964) (holding that a plaintiff “cannot obtain a decision as to the invalidity of [an] Act on the ground that it impairs the rights of others”).

Given this black-letter law, PPSA and Dr. Farris cannot obtain injunctive relief based on having “to turn away the vast majority of South Carolinians seeking abortions.” Pls.’ Mem. 25. That supposed harm (if it really is actually a harm) is suffered by the women they are turning away—not by PPSA or Dr. Farris. *See* Compl. ¶¶ 10–11, 91, 93. Thus, it cannot be the basis for injunctive relief. And they do not have, nor have they claimed, a constitutional right to perform

abortions. *Cf. Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908, 910 (6th Cir. 2019) (en banc) (doctors “do not have a due process right to perform abortions”).

Nor can PPSA and Dr. Farris insist that the number of abortions they are no longer legally allowed to perform somehow threatens their practice sufficiently to justify enjoining enforcement of the 2023 Act. To the extent South Carolina courts have recognized that type of loss as an irreparable harm, it has generally only been when it threatens the plaintiff’s business as a whole. *See Peek v. Spartanburg Reg’l Healthcare Sys.*, 367 S.C. 450, 455–56, 626 S.E.2d 34, 37 (Ct. App. 2005) (“the complete loss of a professional practice can be an irreparable harm”). But Planned Parenthood itself has claimed that “Abortion Services” constituted only 4% of its business, so the reduction in the abortions PPSA performs cannot threaten its entire practice. *See Planned Parenthood, 2021–22 Annual Report*, at 28–29, <http://tinyurl.com/44dze3db>. That little loss of revenue is not an irreparable harm. *See, e.g., Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017) (“money” is not an irreparable harm).

Notably, Plaintiffs spend virtually no time focusing on Shelton specifically when discussing irreparable harm. Whatever their reason for doing so, it makes good sense because there is no way that one individual plaintiff can justify a sweeping injunction that applies statewide, as Plaintiffs seek. That is because “[e]quitable remedies, like remedies in general, are meant to redress the injuries sustained by a particular plaintiff in a particular lawsuit.” *Dep’t of Homeland Sec. v. New York*, 140 S. Ct. 599, 600 (2020) (Gorsuch, J., concurring in the grant of stay). Thus, “[w]hen a [trial] court orders the government not to enforce a rule against the plaintiffs in the case before it, the court redresses the injury that gives rise to its jurisdiction in the first place.” *Id.* “But when a court goes further than that, ordering the government to take (or not take) some action with respect to those who are strangers to the suit, it is hard to see how the court could still be acting in

the judicial role of resolving cases and controversies.” *Id.*; *see also Trump v. Hawaii*, 138 S. Ct. 2392, 2424–29 (2018) (Thomas, J., concurring) (reviewing the history of and explaining the unconstitutionality of nationwide injunctions). At most, therefore, Shelton could obtain injunctive relief specific to her. But Plaintiffs have not asked for that (nor could they prevail if they had asked, given that she has shown she can know she is pregnant in sufficient time to obtain an abortion under the 2023 Act, if PPSA is willing to schedule her an appointment more quickly). In fact, Plaintiffs admit that nonlitigants here would be harmed without an injunction, *see* Pls.’ Mot. 12, but courts don’t grant relief to nonparties.

One final point on irreparable harm: “A preliminary injunction should issue only if necessary to preserve the status quo ante.” *Poynter Invs., Inc. v. Century Builders of Piedmont, Inc.*, 387 S.C. 583, 586, 694 S.E.2d 15, 17 (2010). Here, the status quo is (by Plaintiffs’ own admission) that the 2023 Act governs Plaintiffs’ conduct. Even if some state officials temporarily could not enforce the Act against them, *see Planned Parenthood II*, 440 S.C. at 471, 892 S.E.2d at 125 (noting the circuit court preliminarily enjoined the 2023 Act), “the status quo is that which the People have wrought, not that which unaccountable federal [or in this case, state] judges impose upon them,” *Planned Parenthood of Blue Ridge v. Camblos*, 116 F.3d 707, 721 (4th Cir. 1997) (Luttig, J.). Thus, enjoining the 2023 Act would upset the status quo, so there should not be any preliminary injunction here.

III. The public interest and equities favor leaving the 2023 Act in effect.

A. An injunction against public officials should take the equities and public interest into account.

Enjoining public officials from carrying out their legislatively imposed duties is, no doubt, a significant exercise of judicial power. It is, in effect, the unelected (by the People, at least) branch of government overruling the People’s representatives. Before taking such a drastic step, a court

must take into account the equities and public interest, so as to ensure that the public at large will not be harmed by an injunction.

Nothing about this contention should be controversial. Federal courts have long factored such considerations into the injunction analysis. *See, e.g., Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Indeed, at least in federal court, “when the Government is the opposing party,” considerations of harm to the government and the public interest “merge” into a single analysis. *Nken v. Holder*, 556 U.S. 418, 435 (2009).

More fundamentally, an injunction is an “equitable” remedy. *Lambries v. Saluda Cnty. Council*, 409 S.C. 1, 7, 760 S.E.2d 785, 788 (2014). It makes no sense for an equitable remedy not to consider the equities. Plus, not doing so unnecessarily lowers the bar for obtaining what has long been recognized to be a “drastic” remedy that “ought to be applied with caution.” *Strategic Res. Co.*, 367 S.C. at 544, 627 S.E.2d at 689.

B. The equities and public interest cut against an injunction.

For at least two reasons, the equities and public interest do not support an injunction. *First*, enjoining the 2023 Act would mean that Plaintiffs may perform abortions of unborn children with heartbeats that are prohibited by the Act. The public interest favors life. It favors protecting these unborn children who cannot yet speak for themselves as a reasonable regulation of the medical profession. *See Sloan v. S.C. Bd. of Physical Therapy Examiners*, 370 S.C. 452, 477, 636 S.E.2d 598, 611 (2006) (“It is axiomatic that the Legislature has broad authority, within constitutional limits, to regulate the medical and other professions through the enactment of statutes and regulations.”), *overruled on other grounds by Joseph v. S.C. Dep’t of Lab., Licensing & Regul.*, 417 S.C. 436, 790 S.E.2d 763 (2016); *cf. Dobbs*, 597 U.S. at 301 (“These legitimate interests include respect for and preservation of prenatal life at all stages of development; the protection of

maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.” (internal citation omitted)).

Second, our democratic process counsels against an injunction here. The State has a profound interest in seeing its law—passed by overwhelming majorities of the People’s representatives and signed by the Governor—respected and enforced. *See Planned Parenthood II*, 440 S.C. at 476, 892 S.E.2d at 127 (laws are presumed constitutional); *Planned Parenthood Minnesota, N.D, S.D. v. Rounds*, 530 F.3d 724, 732 (8th Cir. 2008) (en banc) (“[G]overnmental policies implemented through legislation or regulations developed through presumptively reasoned democratic processes are entitled to a higher degree of deference and should not be enjoined lightly.” (internal quotation marks omitted)); *accord Maryland v. King*, 567 U.S. 1301, 1303 (2012) (Roberts, C.J., in chambers) (“Any time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.” (cleaned up)). To be sure, the courts play a vital role in our system of government; courts must “say what the law is.” *Abbeville Cnty. Sch. Dist. v. State*, 410 S.C. 619, 632, 767 S.E.2d 157, 163 (2014) (quoting *Marbury v. Madison*, 5 U.S. 137, 138 (1803)). But they do not write the law or invent rights, and courts must be wary of exercising the judicial power to enjoin enforcement of a law that has been approved by the People’s representatives after vigorous debate.

C. Plaintiffs’ delay in filing this case precludes equitable relief.

“If there has been unreasonable delay in asserting a claim, or if, knowing his rights, a party does not seasonably seek to avail himself of the means at hand for their enforcement,” “then equity will ordinarily refuse to enforce those rights, especially if an injunction is asked.” *Rabon v. Mali*,

289 S.C. 37, 40, 344 S.E.2d 608, 610 (1986). Here, the Supreme Court upheld the 2023 Act against a facial challenge in *Planned Parenthood II* in August 2023. Some of these very Plaintiffs, within three weeks of that decision, sought to have the Supreme Court take up the question of the definition of “fetal heartbeat.” But the Supreme Court declined to do so on November 14, 2023. Plaintiffs then waited almost three months to bring this case—despite the fact that it’s *very* similar to their filings in that failed original jurisdiction action. That unreasonable delay precludes them from extraordinary injunctive relief here.

CONCLUSION

The Court should grant Governor McMaster’s Motion to Dismiss and deny Plaintiffs’ Motion for Preliminary Injunction. If the Court does grant the Motion for Preliminary Injunction, the Governor moves the Court to stay the injunction pending appeal under Rule 241(d)(1), SCACR, and Rule 62, SCRPC.

Respectfully submitted,

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