EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Paul A. Isaacson, M.D., on behalf of himself and his patients, et al., Plaintiffs, v. Mark Brnovich, Attorney General of Arizona, in his official capacity; et al. Defendants.	Case No.

DECLARATION OF ERIC M. REUSS, M.D., M.P.H.,
IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

I, Eric M. Reuss, M.D., M.P.H., declare as follows:

1. I am an obstetrician and gynecologist ("OB/GYN") licensed in Arizona. I have maintained an independent OB/GYN practice, Scottsdale Obstetrics & Gynecology, P.C., since 2001. I participate as a plaintiff in this suit on behalf of myself, my staff, and my patients to enforce important constitutional protections and ensure that I can continue to provide high-quality care to patients without risking serious criminal and civil penalties.

2. I earned my medical degree and a Master's of Public Health degree from Tulane University in 1997. I completed my internship and residency training at the University of California San Diego from 1997 to 2001.

3. I am board certified in obstetrics and gynecology and a fellow of the American College of Obstetricians and Gynecologist ("ACOG").

4. I served as Chairman of the Department of Obstetrics & Gynecology at Scottsdale Healthcare Osborn Hospital from 2008 to 2014. I also have held leadership positions in the Arizona Section of ACOG. I am a member of the Arizona Medical Association.

5. During my two decades of practice, I have been named to numerous top doctor, patients' choice, and compassionate doctor lists.

6. This declaration is based on my education, training, practical experience, and personal knowledge as an OB/GYN; consultation and other interactions with fellow medical professionals; and review of professional practice guidelines and other medical literature.

7. I have reviewed the law recently enacted as Senate Bill 1457 ("SB 1457"), which amends and adds to Arizona's statutes governing abortion and introduces new rules of interpretation for all Arizona laws.

8. As detailed below, SB 1457's new ban on abortions sought after a pregnant patient learns of a possible fetal anomaly will significantly interfere with the health care that I provide to patients; is contrary to standard obstetrics care; and will seriously compromise the physician-patient relationship. It creates the risk of criminal and serious civil penalties for me—and for many other medical professionals, including genetic counselors and perinatologists/maternal-fetal medicine specialists—while depriving my patients of constitutionally-protected options. And this new ban on certain abortions is extremely unclear, internally contradictory, and subjective, leaving me and my pregnant patients without any discernible line that demarcates what is and what is not permitted.

9. In addition, the new law appears to create new "rights, privileges, and immunities" in "unborn children" in a manner that may expose a wide spectrum of physicians, others caring for pregnant patients, and those patients to potential criminal and other liability.

Again, however, this language that attempts to vest new rights in fertilized eggs, embryos, and fetuses is vague and highly uncertain in how it purportedly affects all Arizona laws and criminal or civil liability.

10. This declaration describes (a) my practice and my patients; (b) how fetal anomaly screening and diagnosis proceed during pregnancy; and (c) important context for understanding patients' abortion decision-making. I then discuss some of the specifics of SB 1457 and highlight some of the serious harms it threatens for me, other medical professionals, and patients.

Background on My Practice and My Patients

11. I have a broad solo OB/GYN practice. My practice includes gynecological care, gynecological surgery, prenatal care, labor and delivery, and abortion care. I provide contraceptives and counsel patients about basic fertility issues. When patients need more specialized testing, diagnosis, counseling, or treatment than I provide, I refer them to other appropriate resources, include perinatologists/maternal-fetal medicine specialists ("MFMs") and reproductive endocrinologists. I often consult with those specialists and other medical professionals about my patients.

12. I routinely provide pregnancy testing and then care for many pregnant patients. I deliver approximately 15-20 babies per month and have delivered thousands of babies over the course of my career.

13. I provide medication abortion and procedural abortions in my office during the first trimester for those patients that decide on that course. Later in pregnancy—the time period when abortions that follow a fetal anomaly indication often occur—I provide dilation and evacuation ("D&E") abortion procedures for my patients at HonorHealth Scottsdale Osborn Medical Center.

14. Many of my patients have been seeing me for years and for a range of needs. I have treated a number of patients from young adulthood through their reproductive years, often helping the same patient with multiple pregnancies. I aim to get to know each patient, and take pride in providing personalized, direct care. If my patients have an urgent need, for example, they can reach me directly on my cell phone; I do not use an after-hours answering service. Likewise, I personally perform all of my patients' deliveries so long as I am not traveling.

15. In this relatively small private practice, my patients almost always have some health insurance that aids them in accessing health care; there are many others in Arizona, however, that unfortunately lack any insurance coverage at all. Even with some insurance coverage, however, many patients must pay significant out-of-pocket costs, including for abortion care. I know that many of my patients struggle financially, are physically and emotionally stressed caring for their current children or elderly parents, and/or face other significant challenges in their lives. Some of my patients are single parents. Some have recently lost their jobs—a phenomenon exacerbated by the COVID pandemic. Some of my patients have cancer or other serious illness.

16. My practice recognizes—consistent with all physicians' ethical obligations—that each patient is a unique individual with different preferences about patient care. I allow time with each patient, both in my office and in the exam/treatment room, to address any concerns or questions they might have. I emphasize to my patients that they should feel free to bring with them any information that they have read or received from others that they would like to discuss with me. The doctor-patient relationship is an active partnership that is dependent on trust and open communication. Only by my fully answering all questions and discussing all relevant

alternatives with patients can each patient make their own informed choices regarding healthcare.

Screening for and Diagnosis of Fetal Anomalies During Prenatal Care

17. I discuss genetic testing options with every patient for whom I am providing prenatal care. We discuss the genetic screening and diagnostic options that are available and that may or may not make sense for a particular patient during their pregnancy, and then proceed based on the patient's wishes.

18. Most of my patients opt to screen for common chromosomal conditions between 10 and 12 weeks, which is the earliest time in pregnancy when genetic screening tests can effectively occur. Additional or initial testing for fetal genetic conditions can also arise after an anatomy ultrasound, which is routinely performed between 18 and 20 weeks. As described below, a screening test or ultrasound is only the beginning of what is typically a multi-dimensional medical assessment that requires considerable time, and it is only the beginning of the patient's often-complex decision-making.

19. Offering genetic testing to each pregnant patient is standard medical practice. Likewise, an anatomy ultrasound screening for structural development issues in the fetus is standard pregnancy care.

20. ACOG is the preeminent national professional organization for OB/GYNs. Its practice bulletins spell out principles of current OB/GYN care to aid physicians in meeting professional standards and providing quality care. Similarly, the Society of Maternal-Fetal Medicine ("SMFM") is the leading professional organization for physicians and scientists focused on high risk maternal and/or fetal issues. As a recent joint ACOG and SMFM practice bulletin summarizes,

> Each pregnant patient should be counseled in each pregnancy about options for testing for fetal chromosomal abnormalities. It is important that obstetric care professionals be prepared to discuss not only the risk of fetal chromosomal abnormalities but also the relative benefits and limitations of the available screening and diagnostic tests. Testing for chromosomal abnormalities should be an informed patient choice based on provision of adequate and accurate information, the patient's clinical context, accessible health care resources, values, interests, and goals. All patients should be offered both screening and diagnostic tests, and all patients have the right to accept or decline testing after counseling.

ACOG and SMFM, Practice Bulletin No. 226, *Screening for Fetal Chromosomal Abnormalities*, available at https://www.smfm.org/publications/328-practice-bulletin-226-screening-for-chromosomal-abnormalities ("Screening Bulletin"); *see also* ACOG and SMFM, Practice Bulletin No. 162, *Prenatal Diagnostic Testing for Genetic Disorders*, available at https://www.smfm.org/publications/223-practice-bulletin-162-prenatal-diagnostic-testing-for-genetic-disorders ("Diagnostic Bulletin"). In medicine, the terms "abnormality" or "anomaly" are used to describe unusual or unexpected results or conditions; they are descriptive and embody no value judgment. I use the terms in that way, consistent with professional practice.

21. As these practice guidelines reflect, screening tests and diagnostic tests for fetal genetic abnormalities are distinct steps. Screening tests provide information about the likelihood or risk that an anomaly or anomalies may be present. Diagnostic tests—if available and pursued—aim to determine, with as much certainty as possible, whether a specific genetic anomaly or condition is present in the fetus. Each type of screening or diagnostic testing has limits and uncertainties.

22. In addition, testing capabilities continue to evolve. Cell-free DNA testing has recently come into expanded use, for example, and that evolution contributed to the 2020 update of the ACOG/SMFM genetic screening guidance. I discuss my patients' use of cell-free DNA testing below.

23. Today, there are testing options to attempt to detect a wide range of clinically significant fetal conditions. Testing commonly occurs for (a) chromosomal anomalies, (b) single-gene disorders, and (c) isolated structural anomalies.

24. Chromosomal anomaly testing can occur for aneuploidy (extra or missing whole chromosomes), as well as for "copy number variants," which involve microdeletions and duplications of portions of a chromosome. Examples of aneuploidy include Trisomy 21 (Down syndrome), Trisomy 18 (Edward syndrome), Trisomy 13 (Patau syndrome), and the sex chromosome condition 47, XXY (Klinefelter syndrome). With copy number variants, because each chromosome consists of hundreds of functional genes, significant disruptions in a chromosome's genetic material can cause a wide range of potential outcomes, including a newborn with a life-limiting condition, failure to thrive, and structural and intellectual impacts.

25. Single-gene disorders include sickle cell anemia, cystic fibrosis, hemophilia, and Tay-Sachs Disease.

26. Isolated structural anomalies—such as congenital heart defects and neural tube defects, which include spina bifida—are as a category more common than the conditions describe in paragraphs 24 and 25. "Isolated" means that these structural differences usually are not associated with a known genetic syndrome or diagnosis. These structural traits, however, may be determined by multiple genes, infectious diseases, environmental factors, and/or other causes. As ACOG and SMFM noted in 2016, "[i]ncreasingly, it is recognized that" the distinctions between genetic causes and environmental or other disruptive factors "are not always clear." Diagnostic Bulletin. Because of their complex and uncertain origins, identification of isolated structural anomalies typically occurs through ultrasound and other imaging techniques, and specific DNA or chromosomal testing to confirm a particular diagnosis may not be available.

27. All prenatal imaging, screening, and diagnostic testing for fetal anomalies aims to provide additional information to physicians and their patients to guide pregnancy management: These components of prenatal care can indicate the presence of disorders for which prenatal treatment may provide benefit; help optimize maternal and neonatal outcomes by ensuring the appropriate location and personnel for delivery; and inform the patients' consideration of future steps, including termination (if that is something the patient is considering) or how best to manage the birth and continued care of a child with needs that may be significant and unexpected.. *See* ACOG and SMFM, Diagnostic Bulletin.

28. When any testing occurs, "[p]retest and posttest counseling is essential." AGOG and SMFM, Screening Bulletin. This counseling informs patient decision-making—including by answering their questions and discussing their concerns—but does not direct or otherwise attempt to determine those decisions. *See* ACOG and SMFM Screening Bulletin ("Counseling should be performed in a clear, objective, and nondirective fashion, allowing patients sufficient time to understand and make informed decisions regarding testing" and their pregnancy.); *see also* Diagnostic Bulletin. The nondirective approach to counseling is central to and used in many aspects of OB/GYN care and is one in which practitioners—including myself and the MFM specialists with whom I work—are well versed.

29. Pregnant patients may have misconceptions about fetal conditions or little information about them before considering and undergoing testing. Pre- and post-test counseling enables patients to base any decisions on available medical facts and case histories. Without that counseling, they may exaggerate the significance or likely consequences of a given condition, or confuse it with other genetic and/or structural manifestations. This counseling ensures that "patients realize there is a broad range of clinical presentations, or phenotypes, for many genetic

disorders and that the results of genetic testing cannot predict all outcomes." ACOG and SMFM, Diagnostic Bulletin.

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

31. The prognosis for fetal conditions that are or might be present is extremely varied, both among different conditions and within any one. Medical advances are making some fetal structural issues treatable in the fetal and neonatal periods, but there is a wide range of outcomes even with attempted treatment. Genetic conditions (and other structural issues that may be related to genetics) have a spectrum of expressivity; the term expressivity refers the degree or intensity that the condition manifests. Some fetal anomalies lead to the need for ongoing medical or other support interventions throughout life, and may manifest with serious and multiple physical as well as intellectual consequences. Some are less serious and may have more limited consequences. Some are invariably incompatible with sustained life, but even for those, there may be considerable uncertainty as to how long a child born with the anomaly may live.

32. For those patients whom I see for prenatal care during the first trimester, most decide after pre-test counseling to proceed with genetic screening and, in my practice today, that is most commonly cell-free DNA testing. This test screens fetal/placental DNA fragments that are present in maternal blood circulation. Because those fragments increase as gestation increases, cell-free DNA screening is most effective at 10 weeks and beyond. There are a number of other modalities for an initial genetic screen; all become available around this same point during pregnancy.

33. Cell-free DNA testing screens for all of the examples of aneuploidies described in paragraph 24 above. It can also screen for certain microdeletions, disorders that arise when small fragments of certain chromosomes are missing. While it is quite sensitive and specific in identifying the likelihood of the relatively more common aneuploidies, it nonetheless can produce false-positives and false-negatives and testing failures (that is, no or uninterpretable results).

34. Cell-free DNA is not the equivalent of diagnostic testing. Thus, especially when patients receive positive or uninterpretable screening results, I offer detailed information about the options for prenatal genetic diagnosis.

35. Diagnostic genetic testing requires the direct collection of placental or fetal cells through either Chorionic Villus Sampling ("CVS") or amniocentesis. I discuss with my patients the risks of these procedures, which include some small risk of pregnancy loss, and the diagnostic information they can potentially provide. Then patients may or may not decide to proceed with CVS or amniocentesis and diagnostic testing.

36. CVS is generally performed between 10 and 13 weeks; amniocentesis can be performed from 15 weeks gestation. After cells are collected through CVS or amniocentesis, they must be cultivated and analyzed in the laboratory and usually it at least a week before any diagnostic results might be available.

37. If my patients decide on CVS or amniocentesis, I refer them to an MFM for the procedure and the initial interpretation of the genetic testing results. The MFM sends me the results as well, though I often hear about the test results first from my patients by phone right after they have discussed those results with the MFM. My patients rely on me as a resource and

support throughout their pregnancies and stay in close contact with me. In every case, I would discuss the CVS or amniocentesis test results with the patient and provide post-test counseling.

38. In addition, it is standard practice to perform an ultrasound at approximately 18-20 weeks for all prenatal patients. At that time, the ultrasound may identify issues with fetal development, including structural abnormalities that have not been previously detected. I refer my patients to specialist practices (most often, MFM practices) for the ultrasound imaging, receive the results, and then talk with the patient about them.

39. When I discuss the results of the ultrasound exam with the patient, it may be appropriate for me to again offer information about testing for genetic anomalies. The ultrasound may indicate isolated structural anomalies and/or other conditions.

40. The specifics of the possible next screening and/or diagnostic steps depend on the findings of the ultrasound and whether there has been any earlier genetic screening: Certain structural anomalies or markers seen by ultrasound point to specific kinds of laboratory genetic testing. If that diagnostic testing follows the 18- to 20-week ultrasound, it will occur on cells obtained through amniocentesis.

41. MFM practices typically include perinatologists and genetic counselors. The doctors and genetic counselors at the MFM practice may be involved only in specific testing, assessment, and counseling, or may be a partner in the patient's care throughout their pregnancy.

42. In addition to the discussion of test results and counseling that I provide, there is often sophisticated test interpretation and other specialized counseling that these specialists can offer. For example, as the ACOG and SMFM guidelines describe, "[f]or many copy number variants identified by chromosomal microarray, interpretation requires consultation with a genetic counselor or specialist in prenatal genetic diagnosis." Diagnostic Bulletin.

43. Whenever diagnosis of a specific condition is made, or there is a likelihood of that condition, the patient receives detailed information, to the extent that information is available, about the condition, its expressive range, and potential support resources in the community. As described above, the patient receives non-directive counseling—either by me alone, or by both me and an MFM practice—that aims to address all of their concerns and answer all of the questions in a balanced way and that discusses any further options in which they are interested, including abortion.

44. When patients decide on an abortion after anomaly screening and counseling, I learn of that decision in a variety of ways. For some patients, a consulting MFM practice may report directly to me that the patient has expressed a decision to terminate. In other instances, the patient calls me or my office and directly indicates that they plan to proceed with an abortion after anomaly test results. Most patients see me in person after their MFM visit to discuss the findings with me and then, if abortion is their decision, move ahead to schedule it with me after our post-test counseling conversation. In other instances, as I describe further below, the patient's abortion decision emerges during a number of conversations that touch on a variety of considerations.

Patients' Abortion Decision-Making

45. Since establishing my practice in 2001, I have always offered abortions as an option for my patients who become pregnant and decide on that care. Throughout my internship, residency, and private practice, I have seen how vitally important access to abortion can be for myriad patients. I have also witnessed that the practical circumstances of pregnant patients' lives can be challenging in so many different ways, often in many ways at once.

46. When a pregnancy test comes back positive, my patients often quickly volunteer to me and my staff a reaction: Common reactions are joy; ambivalence and concern; or a desire for abortion. At that time, we meet our patients wherever they are in initially reacting to the pregnancy, listen to their perspective, and offer nondirective information and discussion that may assist them in deciding or confirming how to proceed. Patients may reference their own values, culture or religion, health history or concerns, and other personal information in reacting to and addressing news of a pregnancy.

47. In my experience, patients seek abortion for a wide range of personal reasons, including familial, medical, and financial, and often do not specifically delineate each one. Some patients have abortions because they conclude it is not the right time in their lives to have a child or to add to a family that already includes children. Or they may not want children at all. Some decide they need to prioritize education or greater economic or family stability.

48. Other patients seek abortions because continuing the pregnancy could pose a significant risk to their physical health, and still others struggle with addiction and do not wish to carry a pregnancy to term under those circumstances. Some decide on abortion in the context of intimate partner violence or after suffering a rape. Some decide that, at present, they do not have the emotional resources or mental health to carry a pregnancy to term and raise a child.

49. And some pregnant patients decide to have an abortion after an indication or diagnosis of a fetal medical condition, as touched on above. After screening and/or diagnosis, the patient may decide that they are not able to continue with the pregnancy. It may be the test results, the uncertainty even after testing, the likely or possible prognosis for the anomaly, and/or much else that contributes to that decision. Patients may take into account—for example—their familial situation; their physical or mental health; their economic security or insecurity; and their

capacity to care for a child with unique and potentially challenging needs (and simultaneously to provide for any children and other dependents they already have) given the other circumstances of their lives.

50. Some patients experience both a high-risk pregnancy, with elevated risks to their own health, and a fetal diagnosis or potential fetal condition. In my practice, these patients would likely be under the care of an MFM for their own health conditions as well as for the fetal indication. As described above, however, they would typically engage in ongoing consultation with me and return to me for the abortion procedure if they decide on that course.

51. As this summary reflects, patients' decision-making about abortion is always deeply personal, and sometimes occurs after extremely complex screening, diagnosis, and counseling related to fetal and maternal health conditions. In my experience, patients make these decisions through self-reflection; discussion with their health care providers, who offer nondirective information and counseling; and also, in many instances, discussion with a trusted family member, friend, therapist, or religious counselor.

52. After complying with all the pre-abortion steps now required under Arizona law, I provide pre-viability abortion care for my patients when they request it, including in instances where they have done screening or diagnostic steps for fetal genetic anomalies.

53. Neither my staff nor I provide any coercive counseling or any directive approach toward our patients who are making decisions about whether to undertake any genetic testing or whether to continue their pregnancy.

54. I respect my patient's autonomy and care greatly about their well-being. I put my patients' interests and health first, as I am required to do as a physician. I am participating in this suit to ensure that I am able to continue providing my patients with quality health care, that we

are able to communicate opening and freely within the physician-patient relationship, and that my patients retain their ability to access pre-viability abortion if they decide that is the right decision for them.

The Reason Ban Scheme and Its Threatened Harms

55. Section 2 of SB 1457, in its part A(2), amends Arizona law to provide that a person who "[p]erforms an abortion knowing that the abortion is sought solely because of a genetic abnormality of the child" is guilty of a class 6 felony.

56. In Section 2's part B(2), it provides that a person who knowingly "[s]olicits or accept monies to finance . . . an abortion because of a genetic abnormality of the child" is guilty of a class 3 felony, which I understand is an even more serious criminal offense than a class 6 felony.

57. The medical care that I provide my patients is, of course, paid for; I accept money from their insurance companies and the patients themselves to enable me to provide care, pay my employees, and otherwise operate my practice.

58. Section 2's part A(2) is the only provision of the new law where the "solely because of" phrasing appears. In all of the other related provisions of SB 1457, the new law references "abortion because of a genetic abnormality."

59. For example, there is another prohibition in SB 1457, Section 10, that forbids any abortion unless and until the physician performing it swears in an affidavit that the physician "has no knowledge that the child to be aborted is being aborted … because of a genetic abnormality of the child." That provision requires that the physician "shall not" "perform or induce" any abortion before swearing to that affidavit.

60. Section 2 and Section 10 spell out the strict, onerous terms of SB 1457's "Reason Ban." Those terms include that "any "physician, physician's assistant, nurse, counsellor or other medical or mental health professional" must report "known violations" of the Reason Ban to Arizona law enforcement authorities or be subject to a civil fine of up to $10,000.

61. I understand that "knowledge" under Arizona law may be established by circumstances and need not be proven directly.

62. This new law defines "genetic abnormality" as "the presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression," but excludes a "lethal fetal condition."

63. "Lethal fetal condition" is defined as "a fetal condition that is diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth."

64. In addition, SB 1457 requires that the reporting that either I or the hospital where I practice must provide with respect to each abortion requires reporting of "[w]hether any genetic abnormality of the unborn child was detected at or before the time of the abortion by genetic testing, such as maternal serum tests, or by ultrasound, such as nuchal translucency screening, or by other forms of testing."

65. Under this Reason Ban scheme, I would risk felony criminal prosecution if I continued to provide pre-viability abortions at the request of my pregnant patients when I am aware of any testing the patient has received that indicates a possible fetal genetic anomaly, or I am otherwise aware in any way that a patient may be seeking an abortion "because of" such an anomaly.

66. In order to protect my ability to care for all of my OB/GYN patients and maintain my practice, I would have to avoid any, even circumstantial indication that I may be violating the Reason Ban. I would thus have to stop offering pre-viability abortions whenever a possible fetal anomaly may factor into the patient's decision.

67. If allowed to take effect, the Reason Ban scheme will severely distort, limit, and damage the physician-patient relationship in addition to erecting an explicit ban on many abortions. It will force me to depart from full, standard non-directive counseling with my patients because I must deprive my patients of an option for their pregnancies that many have found critical in the past.

68. The Reason Ban's harmful impact is further exacerbated by its indeterminate, inconsistent, and subjective nature. As described above, this new scheme variously refers to any detection of a fetal anomaly, abortion "because of" an anomaly, and—in one provision alone—abortion "solely because of" an anomaly. All of those phrases introduce confusion and uncertainty in this context: Does detection mean any positive screening test, a high likelihood assessment, a formal diagnosis, or something else? Is an abortion "because of" an anomaly or "solely because of" an anomaly if the practical challenges associated with the anomaly are part of the patients' thinking? These are just some of the questions that will leave me and other physicians subject to the Reason Ban unable to understand its rules.

69. The exception for lethal fetal anomalies does not create any objective safe harbor. Who decides whether there is a "reasonable certainty" that the child would die within three months? How much certainty is reasonable? Is that considered with or without every conceivable medical intervention?

70. The Reason Ban scheme does not account for the fact that its interlocking set of required but unclear determinations would have to be made on a patient-by-patient basis—with many factors and unknowns potentially influencing, e.g., outcome after birth—under considerable time pressure because of the gestational age limit for abortion. Assessments of "because of" and "lethal fetal condition" would have to occur in a context that would make it very easy to be later second-guessed and targeted by enforcement authorities. Similarly, what is the standard for a "morphological malformation occurring as the result of abnormal gene expression"? If a structural anomaly *may* be caused by abnormal gene expression, does that fit within the ban? Or can I provide the abortion unless I have some basis for concluding that it is "the result of abnormal gene expression" and not environment or other factors? What basis does the law contemplate for determining a genetic origin?

71. Under this Reason Ban scheme, how would I need to satisfy myself and later enforcement authorities that I have "no knowledge" that an abortion is occurring because of the "presence or presumed presence of an abnormal gene expression"? Because SB 1457 newly requires my reporting of any detection of an anomaly through any type of testing, would I need to probe my patient's reasoning in every instance when even a small likelihood of anomaly risk was detected through screening or ultrasound before abortion? That would be contrary to medical ethics and, like many other parts of this scheme, would harm the physician-patient relationship and inappropriately prevent medical care.

72. The Reason Ban scheme upends the highly personal but standard medical care it intrudes upon. The care that I and other OB/GYNs provide to our patients—when they are experiencing pregnancy, possible fetal anomalies, and/or considering abortion—generates and requires frank physician-patient conversations.

73. Thus, I know whether a given patient is excited about a pregnancy and preparing for welcoming a new child into their family. They may have struggled with infertility or other conditions that interfere with pregnancy under my care. If a patient who previously expressed joy at pregnancy desires an abortion right after receiving genetic testing indications, it will be apparent those played some role. The Reason Ban scheme is riddled with lack of clarity, but its harsh terms would harmfully force me to deny my patient that care in order to preserve my ability to continue my medical practice for all patients and to avoid criminal consequences.

The Unclear "Rights, Privileges and Immunities" Beginning at Conception

74. There is another very troubling part of this new legislation. Section 1 of SB 1457 directs a new interpretation and construction of all of the laws of Arizona "to acknowledge, on behalf of an unborn child at every stage of development, all rights, privileges and immunities available to other persons" subject "only to the Constitution of the United States" and the U.S. Supreme Court's interpretation of that constitution.

75. As stated, Section 1 applies to the construction of all Arizona laws, whether criminal or civil.

76. "Unborn child" is defined as "the offspring of human beings from conception until birth." Under Arizona law's existing definition of "conception," that term means "the fusion of a human spermatozoon with a human ovum."

77. Section 1 carves out just two exceptions: It states that it does not create a cause of action against "a person who performs in vitro fertilization procedures as authorized under the laws of this state" or against "a woman for indirectly harming her unborn child by failing to properly care for herself or by failing to follow any particular program of prenatal care."

78. The inclusive stated scope of Section 1 and these very narrow exceptions together indicate that medical care and maternal decisions would—beyond the narrow exceptions—trigger rights and protections in the "unborn child." As a physician who cares for pregnant patients, I am left with serious questions and fears about what Section 1 might mean, and how the "unborn child" rights will affect medical practice and my patients.

79. For example, does Section 1 create new liability for physicians who provide maternal medical care that, when undertaken by the patient, might negatively affect fertilized eggs, embryos, or fetuses? I think of examples such as prescription drugs for a wide variety of illnesses and conditions, cancer care, and other interventions to treat the often-serious medical issues of pregnant patients where those interventions may create risks for the developing pregnancy. The pregnancy itself may cause or exacerbate maternal medical issues for which I prescribe drugs or other treatment.

80. Currently, when a patient is taking or considering medication to treat a serious condition (such as epilepsy or a cardiac condition) that may have effects on their pregnancy, we have a conversation about the potential risks to the developing pregnancy and assess those against the patient's health needs. But now, Section 1 adds new embryo and fetal rights and immunities to Arizona law that may create liability for these types of decisions. Section 1 seems to create potential new criminal and civil liability issues for both me and my patients.

81. Section 1's narrow carve-out for certain indirect harms begs the question of what might be considered direct harms or what other indirect harms could trigger a cause of action against a patient. Might a patient be subject to liability for, in consultation with me or another physician, continuing prescription medications to treat her own health conditions?

82. Section 1's language purports to alter all Arizona law. Its narrow exceptions highlight that it somehow covers medical care. But I am left wholly unclear as to its meaning, its effects, and how I must act to conform my medical practice to it and avoid legal liability for me and/or my patients.

Conclusion

83. If SB 1457 were allowed to take effect, the Reason Ban scheme would immediately harm my patients, deprive them of medically-appropriate counseling, restrict physician-patient communication, and ban pre-viability abortions after emergence of fetal anomaly indications. The Reason Ban and Section 1 would subject me and other physicians to criminal liability and other serious penalties without discernible standards for our conduct and without protection against arbitrary enforcement. I ask the Court to protect both my patients' and my own constitutional rights by issuing a preliminary injunction to prevent grave medical care disruptions from occurring while this case proceeds.

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 14, 2021.

Eric M. Reuss, M.D. M.P.H.