EXHIBIT 3

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 PAUL A. ISAACSON, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, PAUL A. ISAACSON, M.D., pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am a Plaintiff in this lawsuit. I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of provisions of Arizona Senate Bill 1457 of 2021 ("the Act").

2. I am a physician licensed to practice medicine in Arizona and Nevada. I graduated from Tufts University School of Medicine in 1991. I am a board-certified obstetrician and gynecologist. I have provided reproductive health care, including performing abortions and delivering babies, to thousands of women in Arizona over more than 25 years.

3. I offer this declaration as a Plaintiff in this case. My statements herein are based on my personal knowledge as well as my experience providing obstetrical and gynecological care, including abortion care, to patients in Arizona.

I. Background

4. I am currently a physician at Reproductive Choice Arizona, PLC, doing business

as Family Planning Associates Medical Group ("FPA"). FPA is a private medical practice located in Phoenix, which I co-own along with another physician. It is licensed as an abortion clinic by the Arizona Department of Health Services.

5. At FPA, we provide a variety of services, including medication abortion to patients up to 10 weeks since their last menstrual period ("LMP") and surgical abortion prior to viability. FPA is one of only three medical practices in Arizona that regularly provides previability abortion care up to 23 weeks, 6 days LMP.

6. In my role as a physician at FPA, I provide the full range of services offered at the clinic, including performing medication abortions and pre-viability surgical abortions. I also oversee FPA's medical staff and ensure the clinic's policies, procedures, and protocols are in compliance with state law. Additionally, I lead one of the only two abortion-training programs available to Arizona's OB/GYN medical residents.

7. In order for FPA to remain in operation, the clinic charges a monetary fee for the medical services I provide to my patients, including patients for whom I provide abortion care after a fetal diagnosis.

II. Access to Abortion Care for Patients in Arizona with Fetal Diagnoses

8. I am familiar with other abortion providers in Arizona and the general availability of abortion care in Arizona.

9. FPA is the foremost medical practice in Arizona providing care to patients referred by other physicians and who are seeking abortion care because of medical indications, including following a diagnosis of a fetal condition. Some of my abortion patients are referred to FPA by other medical providers after receiving a fetal diagnosis from their obstetrician or a specialist in maternal-fetal medicine ("MFM") or high-risk pregnancies. They may also be referred by a genetic counselor or other therapist with whom they discussed the fetal diagnosis.

10. My patients who are referred to FPA after receiving a fetal diagnosis are more frequently among my patients who are further along in pregnancy. For example, many of the patients I have seen for an abortion who also had a fetal diagnosis were referred to me by another medical provider after an issue was detected during a full obstetric ultrasound, which usually occurs after a pregnancy is at or beyond 18 weeks LMP.

11. Very few Arizona providers offer abortion at the later stages of pregnancy when certain fetal conditions are likely to be detected. FPA's other physician owner and I are two of only a handful physicians in Arizona who provide abortion care beyond 16 weeks LMP. Medical providers accordingly refer patients with fetal diagnoses to us from across Arizona, as well as from other states.

12. Among my patients at FPA, some of the more common examples of fetal diagnoses are neural tube defects, including anencephaly (which causes lack of brain development), meinigomyeloceles (a condition in which the spinal canal and the backbone do not close before birth), and holoprosencephaly (a condition in which the brain does not properly divide into two hemispheres); chromosomal abnormalities such as trisomy 21, 18 and 13; diaphragmatic hernia (which impedes organ development); and fetal cardiac conditions. There is also a variety of referrals for other fetal diagnoses.

13. And as a physician who has provided abortion care to patients with fetal diagnoses for over two decades, I am familiar with patients' decision-making around abortion. Patients decide to have an abortion for many reasons, and often more than one reason at a time. But only the patient can ultimately know all of the reasons why they decided to have an abortion, or where there was a "sole" reason as opposed to several concurrent reasons. It is my practice to be supportive of patients' decision-making and personal autonomy; I do not attempt to steer a patient's decision toward or against abortion, and I do not press patients to elaborate on the basis

for their decisions.

14. I am aware based on my experience providing care to patients with diagnosed fetal conditions that they come to FPA from across Arizona, and often rely on referrals and counselors to guide them toward an abortion provider who can meet their needs later in pregnancy.

III. My Abortion Practice and Patients

15. As a physician and co-owner of FPA, I am familiar with the manner in which my patients' appointments for abortion care are scheduled and conducted, and the process of obtaining informed consent, including pre-abortion consultation and counseling sessions.

16. FPA typically receives patients who either: (1) call the clinic and make appointments independently; or (2) are referred by other medical practices based on their existing medical circumstances.

17. Patients seeking abortion care at FPA without going through a referring physician typically first contact FPA over the phone and speak with a receptionist to schedule an appointment. These patients must visit FPA for at least two in-person appointments. The first appointment, which we refer to as the "consultation" appointment, must take place at least 24 hours before the second appointment, which is when the patient can receive the abortion (the "Day 2" appointment).

18. For patients who are referred to me by a genetic counselor, MFM, obstetrician, or other specialist, the referring provider will usually contact me or another FPA physician directly, speak with one of us about the patient and/or the fetal diagnosis at issue, and then usually send the patient's medical records to FPA so that I or one of FPA's other physicians can review the patient's medical history and any information regarding the fetal diagnosis before the patient's appointment.

19. While the vast majority of my patients with a fetal diagnosis are referred to FPA by specialists or other providers, patients who have received a fetal diagnosis will on occasion make

an appointment for themselves, without a referral and sometimes without directly disclosing the diagnosed fetal condition.

20. During the Day 1 consultation appointment, all patients seeking abortion care currently check in at the reception desk, where they are screened for COVID-19 and provided with paperwork to fill out. This paperwork includes a medical history form and other initial paperwork. After the patient completes the paperwork, a member of FPA's medical staff will take the patient for lab work and vitals, and then the same or another member of the medical staff will perform an ultrasound examination. The patient next schedules their second ("Day 2") appointment for the abortion procedure and then meets with me or one of FPA's other physicians for a pre-abortion consultation.

21. During the pre-abortion consultation, I go over the patient's medical history, other initial paperwork, and test results; tell the patient the name of the physician who will be providing the abortion (which would be me or another FPA physician); and provide all of the information patients are required by state law to receive at least 24 hours before an abortion (which I refer to as "State Mandated Information" or "SMI"). After the pre-abortion consultation concludes, the patient leaves the clinic.

22. My patients will usually next visit FPA at least 24 hours after their "consultation" appointment to receive their abortion (the "Day 2" appointment). During this appointment, my patients check in with an FPA receptionist who provides them with paperwork to complete, including consent forms for the abortion procedure or medication abortion, and forms seeking information about the patient and their pregnancy that I am legally required to report to the state.

23. Patients will then have a pre-abortion counseling session with a member of my medical staff who will review the patients' paperwork with them, including all consent forms and State-Mandated Information (which includes a form requesting the patient's reasons for having an

abortion). The medical staff member will also go over in detail the abortion procedure the patient has chosen and assess whether the patient is firm in their decision to have an abortion. The patient is given multiple opportunities to ask questions throughout this process.

24. The Day 2 appointment will then move forward based on the method of abortion the patient selected.

25. Once a patient receiving a medication abortion has confirmed they are certain in their decision to terminate their pregnancy, I will be brought into the counseling session. I will then give the patient an opportunity to ask me any additional questions, administer mifepristone to the patient (the first medication in the two-drug medication abortion regimen), and then either dispense or prescribe to the patient misoprostol (the second medication in the two-drug regimen, which the patient takes at home or another location). The patient then leaves the clinic with instructions for how to complete the medication abortion regimen.

26. Once a patient having a surgical abortion confirms they are certain in their decision to terminate their pregnancy, a member of my medical staff will administer pre-procedure medications to the patient. The patient then waits for about 30 minutes before they are taken to the procedure room, where they will have another opportunity to meet with the physician and ask any final questions before the procedure begins.

27. Some patients who are further in pregnancy, starting at 16 weeks LMP, will have a surgical abortion procedure that takes place over two, three, or four days. However, all patients complete their pre-abortion counseling on Day 2. For example, a patient at 18 weeks LMP may need a two-day procedure where their Day 2 appointment would involve a procedure to prepare the cervix, and then the patient would return to the clinic the following day for the abortion procedure (which I refer to as a "Day 3" appointment). Altogether, that patient would visit the

clinic three times, but would nevertheless have the pre-abortion counseling session during the Day 2 appointment.

IV. If the Reason Ban Scheme Goes into Effect, I Will Be Forced to Turn Away Patients When There Is Any Inference of a Fetal Diagnosis

28. I have read the Act and am very concerned about its impact on my medical practice and my patients. In particular, I am concerned that if the "Reason Ban"[1] and its related reporting requirements,[2] which I will refer to together as the "Reason Ban Scheme," are permitted to go into effect, many pregnant people will be deprived of quality and compassionate medical care and either severely inhibited or fully deprived of their ability to access previability abortion care in Arizona.

29. I understand that violating the Reason Ban Scheme could result in me being subject to criminal prosecution, civil liability, and potentially losing my license to practice medicine.

30. For the reasons detailed below, coupled with these severe penalties, the Reason Ban Scheme would force me to turn away patients when there is any inference of a fetal diagnosis.

a. The Reason Ban does not make clear what previability abortion care it prohibits.

31. While I understand that the Reason Ban prohibits some previability abortions, it is not clear which actions it prohibits.

32. For example, I understand that if the Reason Ban goes into effect, a person who "[p]erforms an abortion knowing that the abortion is sought solely because of a genetic abnormality of the child" would be guilty of a felony punishable by up to two years in prison.[3] A person would commit another felony punishably by up to 8.75 years in prison if they accepted

[1] Act § 2, A.R.S. § 13-3603.2 (as amended); Act § 10, A.R.S. § 36-2157 (as amended).
[2] Act § 11, A.R.S. § 36-2158(A)(2)(d) (as amended); Act § 13, A.R.S. § 36-2161(A)(25) (as amended).
[3] Act § 2, A.R.S. § 13-3603.02(A)(2) (as amended).

money "to finance" an abortion that they know is sought "because of a genetic abnormality of the child."[4] And the Reason Ban similarly prohibits a person from performing an abortion unless they first sign an affidavit stating that they have "no knowledge" that the abortion is sought "because of a genetic abnormality of the child."[5] Because most of the Reason Ban (except for one provision) prohibits abortions when they are sought "*because of* a genetic abnormality of a child," regardless of whether it is the "sole" reason or one of several, the law appears to require that I abide by that arguably broader prohibition. In practice, however, and as discussed further below at paragraph 51, even if the qualifier of "solely" were taken into account, its application is so unclear in this context that it would make no practical difference.

33. I also understand that the term "genetic abnormality" is defined 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."[6] But there are many fetal diagnoses that may inform a specialist's decision to refer a patient to FPA that are not clearly within or outside of this definition. For example, a fetal condition such as a malformation could be the result of both a chromosomal condition and environmental factors, or the result of physical trauma to the fetus *in utero*.

34. I also understand that I will be required to report to the state "whether any genetic abnormality of the unborn child was detected at or before the time of the abortion by genetic testing . . . or by ultrasound, such as nuchal translucency screening, or by other forms of testing."[7] It is unclear to me what the term "detect" means in this context, or whether an abortion provider could

[4] Act § 2, A.R.S. § 13-3603.02(B)(2) (as amended).
[5] Act § 10, A.R.S. § 36-2157 (as amended).
[6] Act § 2, A.R.S. § 13-3603.02(G)(2) (as amended).
[7] Act § 13, at A.R.S. § 36-2161(A)(25) (as amended).

comply with the Reason Ban Scheme without determining with reasonably certainty whether an observed fetal condition is due to a "genetic abnormality."

35. Specifically, FPA's patients seeking abortion care receive an ultrasound examination during their consultation appointment; a physician must estimate the gestational age of the fetus based on this ultrasound.[8] In some cases, a physician can notice or detect a fetal condition on an ultrasound. This type of early detection does not reflect an actual diagnosis of a fetal condition, only a risk or likelihood of there being one. Further specialized testing would be necessary to diagnose a fetal condition observed on an ultrasound and determine whether it is due to an abnormal gene expression. FPA does not provide such testing and would have to refer a patient out to a specialist in order to know, with reasonable certainty, whether the fetal condition is due to a "genetic abnormality," as that term is defined in the Reason Ban Scheme.

36. I am concerned that if I observe a fetal condition on a pre-abortion ultrasound and the patient declines to undergo specialized testing to diagnose that fetal condition, and instead wishes to proceed with the abortion, I could be perceived as violating the Reason Ban by providing an abortion "with knowledge" it was being sought "because of" a genetic abnormality.

37. Further, I understand that the Reason Ban Scheme's definition of "genetic abnormality" excludes "lethal fetal conditions," which are defined as conditions that are "diagnosed before birth and that will result, with reasonable certainty, in the death of the unborn child within three months after birth."[9] This exclusion makes it difficult, if not impossible, for me to determine what actions could expose me to serious penalties for violating the Act.

38. Based on my experience treating pregnant patients with fetal diagnoses, medical

[8] A.R.S. § 36-449.03(D)(5).
[9] Act §§ 2, 11, at A.R.S. §13-3603.02(G)(2)(b) (as amended) (incorporating A.R.S. § 36-2158(G)(1)).

providers often disagree on the "reasonable certainty" of a fetal condition resulting in fetal death or a live birth, much less the likelihood of death occurring within three months after birth. The likelihood of survival can vary for a fetus with any fetal condition; such determinations are made on a case-by-case basis because each pregnancy is unique, and different physicians will inevitably reach varied conclusions.

39. In the case of a few types of fetal conditions, death is more certain. Fetuses with serious conditions—such as anencephaly, when the fetus has not developed a brain, and Potter Syndrome, when the fetus has not developed lungs—cannot survive outside of the womb. In other cases, it is important to consider potential medical interventions that are available, and whether such interventions will increase the likelihood of survivability. For example, a fetus with a severe cardiac condition may survive only a few hours or days after birth without medical intervention. On the other hand, while most fetuses with Trisomy 13 or 18 die *in utero* or within a few days or weeks after birth, some may survive beyond three months without medical intervention. For fetuses with Trisomy 13, providers are unlikely to pursue medical intervention after birth because newborns with Trisomy 13 often have complicating cardiac conditions that make medical intervention difficult and unlikely to succeed. However, in recent years, some physicians have become more willing to try medical interventions to increase the likelihood of survival for newborns with Trisomy 13.

40. But, medical interventions are not always possible and/or consistent with the standard of care. In general, the availability of medical interventions greatly depends on a number of factors such as the person's financial circumstances and the availability of physicians who specialize in these procedures in the state. And even if medical intervention is possible and accessible, its success is never guaranteed. For example, fetuses with cardiac anomalies present complications that continue to incite live discussions and disputes among physicians and

specialists about the success of medical interventions.

41. In my daily medical practice at FPA, I do not, and would not be able to, make approximations on a case-by-case basis as to whether and how long a fetus with a particular genetic condition or other severe diagnosis may survive after birth with or without medical interventions. Even given my long career as an OB/GYN and my expertise in providing abortion care to patients with fetal diagnoses, when faced with the need for making any such approximations I would refer the patient to a MFM or genetic specialist and it would largely be their opinion that I would rely upon if the patient were to return to FPA seeking abortion care.

42. And even if I could make that determination, the diagnosis of fetal conditions is complex and subject to disagreement among medical professionals. I would fear that another physician looking at the same evidence and weighing the same factors could very easily disagree with my determination after the fact, and that could be used as a basis to prosecute me for violating the Reason Ban. This fear is particularly significant in Arizona because many members of the medical profession oppose abortion care in general.

43. I worry that because the penalties for violating the Reason Ban are so severe, and it is unclear which previability abortions are banned and which are allowed, I will be forced to err on the side of caution and deny abortion care to any of my patients whom I know have a fetal diagnosis, even if that diagnosis could arguably fall within one of the exceptions. Being prosecuted or losing my medical license would be too great a risk if I provided an abortion in such cases.

b. If the Reason Ban goes into effect, it will not be possible for me to avoid the inference that some of my patients are seeking abortions for the prohibited reason—*i.e.*, because it is apparent based on the patient's circumstances or medical chart.

44. I believe many pregnant people with fetal diagnoses who seek abortion care at FPA will ultimately disclose—either intentionally or unintentionally—their fetal diagnosis to me or to

a member of my staff. I believe this outcome is likely, both in cases that come to FPA through referrals and for patients who find FPA on their own. And I believe that it would be difficult, if not impossible, for me to avoid inferring that such patients are seeking abortion care because of the fetal diagnosis.

45. For example, medical professionals throughout Arizona's health care network currently work together to provide patients with fetal diagnoses with comprehensive medical care, information about their options, nondirective counseling, and abortion care for those who decide to end their pregnancies.

46. If the Reason Ban goes into effect, I would be concerned that officials enforcing it would interpret a patient's referral to FPA by an MFM or a genetic counselor as evidence that I knew the patient was seeking abortion care because of a fetal diagnosis they received from the referring provider. For this reason, along with the significant penalties for violating the Reason Ban, I would be afraid to provide abortion care to patients referred to me or to FPA by an MFM or genetic counselor, and would likely stop accepting such referrals.

47. If the Reason Ban goes into effect, it will not be possible for me to continue working with these providers to collaboratively and compassionately care for patients with fetal diagnoses, and to ensure they receive the medical care and information that enables them to make the best decision for their unique circumstances. This would undoubtedly result in some patients with fetal diagnoses being denied previability abortion care in Arizona altogether, and other patients being delayed in receiving that care or otherwise receiving less complete care than would have been available before the Reason Ban went into effect.

48. Even if I and FPA's other physicians stopped speaking directly with the network of medical providers we currently work with to provide care to patients with fetal diagnoses, patients who have been referred to FPA by another medical provider after a fetal diagnosis will often bring

up the referral and/or the fetal diagnosis during the pre-procedure consultation session or will include such information on the medical history form. When this occurs, it would typically be mentioned in the patient's FPA medical chart that the providing physician reviews prior to performing the abortion procedure or administering the drugs for a medication abortion. Most of the patients who are referred to me by MFMs, genetic counselors, or other specialists openly discuss their fetal diagnosis and decision to seek abortion care with me and my staff. Many of those patients clearly express that they very much wanted the pregnancy, are devastated by the fetal diagnosis, and are making a difficult decision to end the pregnancy.

49. Even less forthright patients will frequently talk about their fetal diagnosis with me and my staff in a manner that indicates they would have continued the pregnancy had they not received a fetal diagnosis. For example, patients with fetal diagnoses often ask me questions that are not relevant to the abortion procedure but are instead focused on how quickly the patient can try to get pregnant again after the abortion or the likelihood of getting a similar fetal diagnosis if they get pregnant again.

50. Even when a patient was not referred to FPA by an outside specialist or counselor, I or a member of my staff usually learn about the fetal diagnosis when the patient includes it on their medical history form or brings it up during the pre-abortion consultation. For example, I am required by law to determine at least 24 hours before providing an abortion whether a patient is seeking an abortion for a "lethal" or "nonlethal" fetal condition and, if so, to provide them with state-mandated information about, *e.g.*, the availability of perinatal hospice services if the fetus survives the birthing process.[10] FPA complies with this requirement by providing all patients with this state-mandated information during the Day 1 pre-abortion consultation appointment. My staff

[10] A.R.S. § 36-2158(A).

and I are also required under existing law to ask our patients why they are seeking an abortion and to report their response(s) to the Department of Health Services. FPA complies with this law by providing patients with a pre-printed form to fill out during their Day 2 appointment that includes a list of reasons the state requires us to report, if given by the patient. That list of reasons currently includes, among other things, whether the abortion is "elective," and whether the abortion is due to "fetal health considerations," including a fetal diagnosis of a lethal condition, a central nervous system condition, Trisomy 18 or 21, Triploidy, or "other" condition.[11]

51. Even if patients with a fetal diagnosis note other or additional reasons for seeking an abortion, that would often not be sufficient for me to determine that they are not seeking an abortion "because of" or "solely because of" the fetal diagnosis. At times, patients for whom I have provided an abortion after a fetal diagnosis have expressed other reasons for seeking abortion care, in addition to learning of a fetal diagnosis, which appear to be inextricably intertwined with the diagnosis itself. For example, some patients have told me that they lack sufficient financial, emotional, family, or community support to raise a child with special needs. For those patients, it is not clear how I would determine whether the fetal diagnosis is the reason for the patient's decision to terminate the pregnancy or not.

52. If the Reason Ban Scheme goes into effect, I expect pregnant people will continue to seek abortion care at FPA after receiving a fetal diagnosis, even if we stop accepting referrals.

53. Due to the nature of existing reporting requirements, my medical practice, and the reality of patients' circumstances, it would be highly unlikely, if not impossible, for me to avoid inferring that a patient is seeking abortion care due to a fetal diagnosis. Under the Reason Ban Scheme, I would likely be forced to turn those patients away.

[11] A.R.S. § 36-2161(A)(12)(c)(i)-(vi).

c. If the Reason Ban Scheme goes into effect, patients are unlikely to conceal a fetal diagnosis to the extent necessary to secure an abortion.

54. If the Reason Ban Scheme goes into effect, I expect that pregnant people in Arizona will continue to seek abortion care at FPA after receiving a fetal diagnosis, but some will be discouraged from engaging in open and honest communications with me and my staff about their medical diagnoses and options, lest by doing so they are unable to receive an abortion.

55. However, I believe it would be extremely difficult for me or my medical staff to avoid discovering that some patients have fetal diagnoses and inferring that those patients are seeking an abortion due to a fetal diagnosis.

56. For example, as I explained above, I am required by law to determine the gestational age of each patient for whom I provide an abortion based on that patient's ultrasound examination.[12] In some cases, I am able to notice or detect a fetal condition on an ultrasound. If I am able to see a fetal condition on a patient's ultrasound, and that patient has not disclosed a fetal diagnosis to me, I would fear proceeding with providing abortion care to that patient for fear such an action could be interpreted as violating the Reason Ban.

57. Similarly, the Reason Ban Scheme will require me to report to the state "whether any genetic abnormality of the unborn child was detected at or before the time of the abortion by genetic testing . . . or by ultrasound . . . ."[13] It is unclear to me what the term "detect" means in this context, or whether I would be punished for violating the Reason Ban Scheme if I did not report a fetal condition that I observed on an ultrasound and suspected to be caused by a "genetic abnormality," but could not confirm a diagnosis through testing.

[12] A.R.S. § 36-449.03(D)(5).
[13] Act § 13, at A.R.S. § 36-2161(A)(25) (as amended).

58. Further, under current protocols due to COVID-19, most patients are not permitted to have a spouse, partner, friend, or other person accompany them during the consultation appointment. But prior to the pandemic patients were permitted to bring a trusted support person, such as a spouse, partner, or other family member—into their abortion consultation after all State Mandated Information had been provided to the patient and the patient had an opportunity to have a private discussion with the physician. While we would grant any patient seeking abortion care this courtesy, in my experience patients who have had a fetal diagnosis most frequently request to have a spouse, partner, or other trusted person join the pre-abortion consultation. I expect FPA to resume that policy once the pandemic has subsided. Even if a patient was trying to conceal a fetal diagnosis, a support person accompanying the patient may inadvertently bring it up to me or my medical staff.

59. It is my understanding that under the Reason Ban Scheme, I would also be required to sign an affidavit certifying that I am not providing the abortion "because of" a fetus's "genetic abnormality" and have "no knowledge" that the pregnant person decided to receive an abortion "because of" a "genetic abnormality" of the fetus.[14] I will also have to report "whether any genetic abnormality of the [fetus] was detected at or before the time of the abortion."[15] Because sometimes only my patients know this information, it is not clear what I am obligated to do to meet these requirements. Can I proceed with providing an abortion without first asking the patient these questions? If that is not the case, I believe patients would feel obligated to provide honest answers in response.

60. Additionally, before providing any medical information to a patient, I must first get their informed consent to the procedure. While Arizona has many laws titled or referred to as

[14] A.R.S. § 36-2157(A)(1).
[15] A.R.S. § 36-2161(A)(25).

"informed consent," very few of those laws reflect the informed consent process recognized by the medical profession and required by physicians' medical ethics. That is an ongoing process during which a physician must ensure that the patient understands what will happen during a medical procedure; the risks associated with the procedure; and the available alternatives. I am ethically bound to use my best medical judgment to deliver this information in a manner that recognizes each patient as an autonomous and capable decision-maker, and to act with the intent of benefiting the patient and to *avoid harming the patient*.

61. Another important aspect of obtaining informed consent from each of my abortion patients is to ensure that each one wants to have an abortion. If a patient expresses doubts, or appears uncertain, I advise them not to go ahead with the abortion. I tell such patients that they can always come back if and when they are certain of their decision. My staff and I begin the process of obtaining the patient's informed consent, as recognized by the medical profession and required by medical ethics, during the pre-abortion consultation. Members of the FPA staff also meet with the patient as part of the informed consent process, which continues during the Day 2 counseling session and includes an assessment of the patient's decisional certainty. Occasionally, a patient may also have questions about the consent form or another matter which the physician may address prior to initiating the abortion procedure.

62. Based on the realities of my medical practice and treating pregnant patients who have received fetal diagnoses, I believe it would be difficult for many of those patients to go through the informed consent process at FPA over the course of at least two, if not more, appointments without either revealing information that would cause me to infer they were seeking an abortion due to their fetal diagnosis or causing me to question whether they were certain in their decision to end their pregnancy.

63. For example, it is currently my practice to always speak with patients who were referred to FPA by MFM or other specialists about their fetal diagnosis during the pre-abortion consultation and/or the Day 2 counseling session. Many of these patients express difficult and complex emotions about terminating a pregnancy that was wanted, even though they are firm in their decision to have an abortion. Patients with fetal diagnoses often want to distinguish themselves from patients seeking abortion care for reasons that, *e.g.*, do not reflect the patient's personal beliefs or values. They also often ask me questions that are not relevant to the abortion procedure but are instead focused on future pregnancies, such as asking how quickly they can try to get pregnant again after the abortion or the likelihood of getting a similar fetal diagnosis if they get pregnant again. If the Reason Ban goes into effect and I observed a patient expressing similar emotions or asking similar questions, it would be difficult, if not impossible, for me to avoid inferring that the patient was seeking an abortion because of a fetal diagnosis.

Pursuant to 28 U.S.C. § 1746, I hereby declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated this 13th day of August, 2021.

Paul A. Isaacson, M.D.