**IN THE COURT OF COMMON PLEAS**
**FOR HAMILTON COUNTY, OHIO**

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| **PRETERM-CLEVELAND, *et al.*,** | : | |
| | : | **Case No. A 2203203** |
| *Plaintiffs*, | : | |
| | : | **Judge Christian A. Jenkins** |
| **v.** | : | |
| | : | |
| **DAVE YOST, *et al.*,** | : | |
| | : | |
| *Defendants.* | : | |
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# STATE DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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"Abortion contests of this sort are not going away." *Preterm-Cleveland v. McCloud*, 994 F.3d 512, 535 (6th Cir. 2021) (Sutton, J., concurring). That is because abortion is a morally contentious issue on which well-meaning citizens hold deeply felt, irreconcilable views. For some, abortion amounts to murder: the intentional termination of an innocent life. For others, abortion is a medical procedure key to preserving the liberty interests of women. For still others, abortion is something less absolute. "Complete elimination of the debate in one direction—that only the public, never the woman, has a say in the matter—shortchanges some interests. Complete elimination of the debate in the other direction—that only the woman, never the public, has a say in the matter—shortchanges other interests." *Id.* "A healthy society should have free rein to navigate between these poles." *Id.*

Ohio's Constitution allows for this sort of navigation. It says nothing about abortion; it neither protects nor prohibits abortion. It thus leaves the matter to the People of Ohio. They may



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address it directly through a constitutional amendment (which they would remain free, through future amendments, to rescind or modify). Or they may address it indirectly, through their elected representatives. But there is one institution that has no role to play: the judiciary. Courts are supposed to "say[] what the law is," *League of Women Voters of Ohio v. Ohio Redistricting Comm'n*, — Ohio St. 3d —, 2022-Ohio-65, ¶80 (quoting *Marbury v. Madison*, 5 U.S. 137, 177 (1803)), not what it *should be*. Because the Constitution is silent on abortion, the courts must leave the issue to be worked out in the democratic process—a process better suited than litigation to balancing the competing interests that are presented by morally fraught issues like abortion.

The General Assembly engaged in precisely that sort of balancing of interests when it passed Ohio's Heartbeat Act. *See* Sub. S.B. 23 (April 11, 2019). The Act protects unborn children and mothers alike. It protects unborn children by largely prohibiting doctors from ending the lives of those whose hearts have started to beat. It protects mothers by leaving doctors with leeway to perform medically necessary abortions. Specifically, it permits doctors to perform abortions when, in their reasonable medical judgment, the mother's pregnancy threatens "to directly or indirectly cause the substantial and irreversible impairment of a major bodily function." R.C. 2919.16(K); *see also* R.C. 2929.195(B); R.C. 2919.193(B).

The Act took effect on June 24 and remained in effect until September 14. During that time, the number of abortions performed in Ohio dropped. People whose lives would otherwise have been snuffed out in the womb will take their first breaths. They will celebrate birthdays. They will pursue personal and professional dreams. And they will make unknowable contributions to their families, their communities, and their country. At the same time, the Heartbeat Act guarantees mothers access to necessary medical care. R.C. 2929.195(B); R.C. 2919.193(B). A law that



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saves thousands of lives while costing none scores pretty well in cost-benefit terms.

But on September 14, this Court issued a temporary restraining order enjoining the defendants from enforcing the Heartbeat Act. The State respectfully suggests that the temporary restraining order was unwarranted and that a preliminary injunction would be improper. The State understands that materially indistinguishable standards govern the question whether to issue a temporary restraining order and the question whether to issue a preliminary injunction. *Coleman v. Wilkinson*, 147 Ohio App. 3d 357, 2002-Ohio-2021, ¶2 (10th Dist.) (*per curiam*); *Castillo-Sang v. Christ Hosp. Cardiovascular Assocs., LLC*, 1st Dist. Hamilton No. C-200072, 2020-Ohio-6865, ¶16 (citing *Procter & Gamble Co. v. Stoneham*, 140 Ohio App.3d 260, 267–68 (1st Dist. 2000)). Rather than rehashing every argument it raised already, the State will preserve (and incorporate by reference) its earlier arguments. And it will focus on responding to the specific justifications this Court advanced in support of its temporary restraining order. None of the Court's arguments justified the order, and none justify a preliminary injunction, either. Even if they did—*even if* the prohibition on performing abortions after detection of a fetal heartbeat were unconstitutional—the temporary restraining order was overbroad. The Court enjoined enforcement of the entire Heartbeat Act, rather than the specific provisions deemed unconstitutional. Thus, even if the Court again concludes that parts of the Heartbeat Act are unconstitutional, it must enjoin *only* the specific Revised Code provisions determined to violate the Ohio Constitution.

## ARGUMENT

Courts may issue preliminary injunctions only to plaintiffs who can show: (1) that they will likely prevail on the merits; (2) that they will suffer irreparable harm absent an injunction; (3) that "no third parties will be unjustifiably harmed if the injunction is granted"; and (4) that "the public interest will be served by an injunction." *Procter & Gamble Co. v. Stoneham*, 140 Ohio App. 3d 260,



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267 (1st Dist. 2000). The plaintiffs have not made any of these showings. Accordingly, they are not entitled to a preliminary injunction.

## I. The plaintiffs will not prevail on the merits.

The State previously argued, and the Court apparently agreed, that the question whether to enter an injunction turns on whether the plaintiffs will likely prevail on the merits. The plaintiffs will not prevail on the merits. That is because the Ohio Constitution confers no right to abortion. Further, even assuming it does, the plaintiffs lack third-party standing to sue.

### A. The Heartbeat Act comports with the Ohio Constitution.

The Court found that the Heartbeat Act likely violated three provisions in Ohio's Constitution: the Due Course of Law Clause, *see* art. I, §16; the Healthcare Freedom Amendment, *see* art. I, §21; and the Equal Protection and Benefit Clause, *see* art. I, §2. In fact, none of those provisions creates a right to abortion. And the Court's reasoning, if carried to its logical end, would compel a holding that the State must permit abortions *for all nine months* of every pregnancy—a position so extreme that even the plaintiffs have declined to urge it.

#### 1. Ohio's Due Course of Law Clause does not create a right to abortion.

***a.*** The Due Course of Law Clause provides:

> All courts shall be open, and every person, for an injury done him in his land, goods, person, or reputation, shall have remedy by due course of law, and shall have justice administered without denial or delay. Suits may be brought against the state, in such courts and in such manner, as may be provided by law.

Ohio Const., art. I, §16.

On its face, and as originally understood, this provision confers no *substantive* rights at all—it simply entitles injured parties to seek redress in court. *See State v. Aalim*, 150 Ohio St. 3d 489, 2017-Ohio-2956, ¶¶40, 45–48 (DeWine, J., concurring). But the Supreme Court of Ohio long ago



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abandoned the Clause's plain meaning. According to that court, the Due Course of Law Clause is "the equivalent of the 'due process of law' protections in the United States Constitution." *Arbino v. Johnson & Johnson*, 116 Ohio St. 3d 468, 2007-Ohio-6948, ¶48. The Due Process Clause in the Fourteenth Amendment has been interpreted to confer substantive rights. So the Due Course of Law Clause has been interpreted to do the same.

But the Clause confers *very few* substantive rights. It accords heightened protection only to "fundamental rights"—in other words, rights that are "objectively, deeply rooted in this Nation's history and tradition ... and implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed." *Aalim*, 150 Ohio St. 3d 489 at ¶16 (quotation omitted). "Government actions that infringe upon a fundamental right are subject to strict scrutiny, while those that do not need only be rationally related to a legitimate government interest." *Stolz v. J & B Steel Erectors*, 155 Ohio St. 3d 567, 2018-Ohio-5088, ¶14.

***b.*** The Due Course of Law Clause does not protect any right to abortion.

There is no "fundamental right" to abortion. That is because, as even the *Dobbs* dissenters conceded, the right to abortion is *not* deeply rooted in the nation's history. *See, e.g.*, *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228, 2323 (2022) (Breyer, Sotomayor, Kagan, JJ., dissenting); *accord id.* at 2249–54 (majority op.). It is not deeply rooted in Ohio's history, either. At all times between 1834 and the decision in *Roe v. Wade*, Ohio *prohibited* abortion. Indeed, shortly after the Clause's ratification, the Supreme Court of Ohio affirmed the conviction of a doctor prosecuted for performing abortions. *See Wilson v. State*, 2 Ohio St. 319, 320–22 (1853).

Because there is no "deeply rooted" right to abortion, it is not a "fundamental right." Laws restricting abortion are therefore subject to rational-basis review. *Stolz*, 155 Ohio St. 3d 567 at ¶14.



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And the Heartbeat Act survives rational-basis review, because it logically relates to the State's interest in protecting innocent life. Even the plaintiffs have never argued that the Heartbeat Act fails rational-basis review—they have instead argued that there *is* a "fundamental right" to abortion and that the Heartbeat Act cannot satisfy strict scrutiny. Because there is no fundamental right, strict scrutiny does not apply and that argument fails.

***c.*** The Court held otherwise, but it erred. As an initial matter, the Court relied significantly on a misreading of a non-binding opinion—namely, *Preterm-Cleveland v. Voinovich*, 89 Ohio. App.3d 684 (10th Dist. 1993). That case declared that, given "the broad scope of 'liberty'" *in Section 1, Article I* of Ohio's Constitution, "it would seem almost axiomatic that the right of a woman to choose whether to bear a child is a liberty within the constitutional protection." *Id.* at 691. The Court thought *Voinovich* supported the plaintiffs in this case. It does not, for at least three reasons.

*First*, the Tenth District located the purported right in Section 1 of Article I, *not* in the Due Course of Law Clause. *Id.* The former provision is irrelevant here, and not self-executing in any event. *State v. Williams*, 88 Ohio St. 3d 513, 523 (2000). (Notably, the Ohio Supreme Court confirmed Section 1's non-executing status in *Williams*, years *after* the Tenth District's decision *Voinovich.* To the extent *Voinovich* construed Section 1 to confer a self-executing right to abortion, *Williams* overruled it.)

*Second*, the Tenth District's discussion of the Ohio Constitution and abortion is not as significant as the Court seemed to think. The statement about the "broad scope of 'liberty'" makes the indisputable observation that laws restricting abortion restrict liberty. But the same is true of *all* laws that prohibit conduct in which people might wish to engage; literally every criminal law, for example, restricts liberty. But nearly all of those laws are subject to rational-basis review, not strict



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scrutiny, because they do not burden a "fundamental right." Nothing in *Voinovich* suggests that abortion laws are any different. To the contrary, the Tenth District expressly rejected a request to apply strict scrutiny, and left open the possibility that rational-basis review is the "appropriate" standard for assessing abortion restrictions under the Ohio Constitution. *Voinovich*, 89 Ohio. App.3d at 695 & n.10. The court applied the federal "undue burden" standard, which is a lesser standard than strict scrutiny, only because federal law required it. *Id.* That shows that *Voinovich* did not consider the right to an abortion to be a "fundamental right."

*Third*, the Court relied on *Voinovich* for the proposition that "the Ohio Constitution can and does in several contexts 'confer greater rights upon individuals (or greater restrictions upon the legislative power of the General Assembly) than are imposed by the United States Constitution.'" TRO at 11 n.8 (quoting *Voinovich*, 89 Ohio App.3d at 689). That is true, but does not get plaintiffs very far. For one thing, the Tenth District additionally recognized that the Ohio's Constitution may demand "*a lesser* ... standard" than that which applies under federal law. 89 Ohio App.3d at 692 n.5 (emphasis added). And, as just noted, the Tenth District suggested the Ohio Constitution could require rational-basis review—a standard *less* demanding of the State than the "undue burden" standard adopted by *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Further, while it is *generally* true that the Ohio Constitution can confer greater rights than the United States Constitution, that is not true with respect to the Due Course of Law Clause. That clause-specific distinction matters because, again, *Voinovich* dealt only with Article 1, Section 1, *not* the Due Course of Law clause. The Supreme Court of Ohio has said the Due Course of Law Clause confers protections "equivalent" to those conferred by the federal Due Process Clause. *Arbino*, 116 Ohio St. 3d 468 at ¶48. Neither this Court nor the plaintiffs have identified a single Supreme Court of Ohio



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case saying otherwise. Therefore, because the Due Process Clause confers no right to abortion, *see Dobbs*, 142 S. Ct. at 2243, neither does the Due Course of Law Clause.

In addition to improperly relying on *Voinovich*, the Court erroneously held that rights can be "fundamental" even if they are not deeply rooted in tradition and history. TRO at 18 n.15. It acknowledged that the Supreme Court of the United States adopted the "deeply rooted" standard in *Washington v. Glucksberg*, 521 U.S. 702 (1997). But it claimed the Supreme Court abandoned that test in *Obergefell v. Hodges*, 576 U.S. 644 (2015). That argument is both wrong and irrelevant. It is wrong because the Supreme Court still applies the "deeply rooted" standard. It employed that standard, and specifically relied on *Glucksberg*, when holding that the Constitution confers no right to abortion. *See Dobbs*, 142 S. Ct. at 2247–48. The argument is irrelevant because, even after *Obergefell*, the Supreme Court of Ohio has continued to hold that *Glucksberg*'s "deeply rooted" test governs the substantive-due-process analysis under Ohio's Due Course of Law Clause. *See Aalim*, 150 Ohio St. 3d at 494–97. (It held that *Glucksberg* continues to govern the federal due-process analysis, too. *Id.*) That holding binds this Court.

Finally, the Court concluded that the Ohio Constitution confers a fundamental right to abortion through the Healthcare Freedom Amendment. That conclusion was wrong, and the State turns to it next.

**2. Ohio's Healthcare Freedom Amendment does not create a right to abortion.**

***a.*** The Healthcare Freedom Amendment provides, in relevant part:

> (A) No federal, state, or local law or rule shall compel, directly or indirectly, any person, employer, or health care provider to participate in a health care system.
>
> (B) No federal, state, or local law or rule shall prohibit the purchase or sale of health care or health insurance.



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> (C) No federal, state, or local law or rule shall impose a penalty or fine for the sale or purchase of health care or health insurance.
>
> (D) This section does not affect laws or rules in effect as of March 19, 2010; affect which services a health care provider or hospital is required to perform or provide; affect terms and conditions of government employment; or affect any laws calculated to deter fraud or punish wrongdoing in the health care industry.

Ohio Const., art. I, §21.

This provision creates no right to abortion. Indeed, it does not speak to abortion at all. Subsection (A) forbids laws compelling participation in healthcare markets—it forbids federal or state mandates to purchase healthcare. Subsection (B) guarantees a right to purchase healthcare; it entitles citizens to purchase healthcare themselves, and thus bars the State from adopting a single-payer system that would require citizens to obtain healthcare through the government instead of purchasing it independently. Subsection (C) forbids the government from punishing the sale or purchase of healthcare. And Subsection (D) expressly preserves the legislature's ability to regulate healthcare—in particular, its power to deter fraud and punish "wrongdoing."

At the hearing on the temporary restraining order, the plaintiffs expressly declined to argue that any of these provisions confers a right to abortion. Understandably so. The only provision that could even arguably be read to do so is Subsection (B), which bars laws that "prohibit the purchase or sale of health care or health insurance." If that language meant that people are free to buy and sell whatever type of healthcare they like, it would arguably confer a right to abortion. In fact, if that were what the provision meant, it would confer a right to an abortion for any reason under any circumstances *throughout all nine months* of every pregnancy. Indeed, on this reading of Subsection (B), the amendment would confer a right for *any* "treatment" that a patient and willing provider might self-define as "healthcare," whether amputation of a healthy body part or experimental surgery outside the accepted standard of care.



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But the Amendment is not susceptible of that reading. For one thing, Subsection (D) expressly preserves the General Assembly's right to "punish wrongdoing in the health care industry." That preserves the General Assembly's pre-existing power to *define* wrongdoing in the health care industry; after all, the General Assembly cannot bar wrongdoing without first defining what constitutes wrongdoing. Thus, the General Assembly can identify and prohibit medical procedures, like abortion, that it deems to constitute wrongdoing. What is more, Subsection (B) appears immediately after a provision (Subsection (A)) that prohibits the State or the federal government from *mandating* the purchase of health insurance or medical procedures. Subsection (B) is naturally read to work in tandem with that provision by barring the State from *prohibiting* the purchase of health insurance or health procedures. In other words, Subsection (B) ensures that citizens can purchase such procedures without regard to whether a private or public insurer is willing to pay. But that does not mean that citizens are free to purchase any medical procedure they can find a doctor willing to perform—it means they are free to purchase whatever medical procedures the State permits.

Add to all of this the absurd consequences that would follow from the alternative reading. Again, if Subsection (B) really meant that people were free to buy and sell whatever type of healthcare they like, the General Assembly would be barred from forbidding *any* medical procedures whatsoever—the General Assembly would be powerless to ban medical procedures *proven* to confer no medical benefits. There is no evidence the People of Ohio, when they ratified the Amendment, understood it to confer such a right.

***b.*** In concluding otherwise, the Court stressed that the Amendment "represents an express constitutional acknowledgment of the fundamental nature of the right to freedom and privacy in



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health care decision making." TRO at 14. But that argument is circular—it assumes its own conclusion. As just shown, the Amendment preserves a right to purchase (or refuse to purchase) whatever healthcare the General Assembly allows Ohio physicians to provide. It creates no freestanding right to purchase any medical procedure a consumer might want.

The Court seemed to acknowledge that Subsection (D) allows the General Assembly to define wrongdoing, which would include prohibiting certain medical procedures. But the Court insisted that abortion could not possibly be deemed "wrongdoing," since "abortion had been constitutionally protected as the law of the land for nearly 40 years." TRO at 14. That is a *non sequitur*. Subsection (D) imposes no limits on the types of procedures the General Assembly can prohibit; it allows the regulation of wrongdoing, which presupposes a power to identify acts that constitute "wrongdoing." The now-overruled federal decisions creating a right to abortion have no bearing on what "wrongdoing" means. As the Court observed, "wrongdoing" means "illegal or improper conduct." *Id.* (quotation omitted). Thus, Subsection (D) preserves *the General Assembly's* power to define conduct that is "illegal or improper." By declaring that abortion is never wrongdoing, the Court invaded the province of the General Assembly.

The Court also failed to acknowledge the consequences of its decision. If Subsection (B) confers a right to abortion, that right presumably extends through all nine months of every pregnancy. And on the Court's reading, Subsection (B) renders unconstitutional *all laws* prohibiting the performance of *any* medical procedure. The Court is correct that the Amendment's meaning does not turn on the drafters' intentions. *See* TRO at 13. But it *does* turn on "the common understanding of the people who framed and adopted it." *Pfeifer v. Graves*, 88 Ohio St. 473, 487 (1913). There is no evidence that the People of Ohio understood the Amendment to confer so extreme a



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right—or to confer any right to abortion at all.

### 3. Ohio's Equal Protection and Benefit Clause does not create a right to abortion.

***a.*** The Equal Protection and Benefit Clause states:

> All political power is inherent in the people. Government is instituted for their equal protection and benefit, and they have the right to alter, reform, or abolish the same, whenever they may deem it necessary; and no special privileges or immunities shall ever be granted, that may not be altered, revoked, or repealed by the General Assembly.

art. I, §2.

For two reasons, this Clause cannot be understood as conferring a right to abortion. *First*, the Supreme Court of Ohio has held that the equal-protection provisions in the state and federal constitution are co-extensive. *Am. Assn. of Univ. Professors, Cent. State Univ. Chapter v. Cent. State Univ.*, 87 Ohio St. 3d 55, 60 (1999). Because the federal Equal Protection Clause confers no right to abortion, *Dobbs*, 142 S. Ct. at 2245–46, neither does its state-law analogue.

*Second*, the Heartbeat Act does not deny equal protection or benefits to anyone. "As a general matter," the Equal Protection and Benefit Clause "requires that the government treat all similarly situated persons alike." *Sherman v. Ohio Pub. Emps. Ret. Sys.*, 163 Ohio St. 3d 258, 2020-Ohio-4960, ¶14. "When a claim involves a fundamental right or a suspect class, the government's action is subject to a higher level of scrutiny." *Id.* "But when no such right or class is involved, the government's action is subject to rational-basis review; it will be upheld if it is rationally related to a legitimate government interest." *Id.* (quotation omitted).

The Heartbeat Act does not burden a fundamental right—as laid out above, there is no fundamental right to abortion. Nor does the Heartbeat Act burden a "suspect class." *Id.* True enough, sex is a suspect classification. *State v. Thompson*, 95 Ohio St. 3d 264, 2002-Ohio-2124, ¶13.



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But the Act does not discriminate on the basis of sex. It prohibits anyone—regardless of sex—from performing an abortion. (The law does not regulate pregnant women directly.) No doubt, the law will have a disparate impact on women because only women can become pregnant. But the fact that a law will have a disparate impact on one sex does not require heightened scrutiny. If it did, then laws creating programs that benefit just one sex—for example, laws funding pap smears or prostate exams—would be subject to heightened scrutiny. That is not the law. The Equal Protection and Benefit Clause simply requires treating "all similarly situated persons alike." *Sherman*, 163 Ohio St. 3d 258 at ¶14. Laws that regulate a procedure available to only one sex *do* treat like individuals alike. Thus, even though a law that funds only pap smears can be used only by women, it is not subject to heightened scrutiny. (Presumably the plaintiffs would take no issue with a law funding abortions, even though only women can obtain abortions.) The Heartbeat Act works in precisely this way. "Abortion restrictions do not impose legal burdens on the basis of gender, but on the basis of the asserted presence and value of a human life in utero." Michael Stokes Paulsen, *The Worst Constitutional Decision of All Time*, 78 Notre Dame L. Rev. 995, 1009 n.35 (2003). Put differently, "an abortion restriction's target category—pregnancies (or some subset thereof)—embraces all relevant instances of the identified harm that the restriction seeks to prevent." *Id.* It thus treats like persons alike and comports with equal-protection principles.

***b.*** The Court's contrary decision rested entirely on its holding that Ohioans have a fundamental right to purchase any medical procedure they like. The Court explained that "it would be intellectually incoherent to recognize a fundamental right to privacy, bodily integrity and freedom of choice in health care decision making, but hold that a law that limits only pregnant women in the exercise of such rights ... does not discriminate against them." TRO at 17. Again, however, there



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is no fundamental right to obtain an abortion or to purchase any medical procedure an individual desires. Thus, the Court's analysis rests on a flawed premise. Because the Heartbeat Act does not burden a "fundamental right," it does not unequally deprive anyone of such a right.

Regardless, and as noted above, the Supreme Court of Ohio has held that the Equal Protection and Benefit Clause provides protections co-extensive with the federal Equal Protection Clause. Because the Equal Protection Clause does not create a right to abortion, *Dobbs*, 142 S. Ct. at 2245–46, this Court is barred by Ohio Supreme Court precedent from reading the Equal Protection and Benefit Clause to protect that right. The Court resisted this conclusion, claiming the "weight of recent authority recognizes that Ohio's Equal Protection and Benefit Clause confers broader protections than its federal analogue." TRO at 17. But of the three opinions the Court cited for this proposition, two failed to garner a majority. One is a concurring opinion. *League of Women Voters of Ohio*, 2022-Ohio-65 at ¶151 (Brunner, J., concurring). The other, *State v. Mole*, is a plurality opinion. *See* 149 Ohio St. 3d 215, 2016-Ohio-5124 ¶23 (plurality). (Justice Lanzinger, who supplied the dispositive fourth vote in *Mole*, issued a separate opinion that deemed the state provision dispositive and thus expressed no view on the federal Equal Protection Clause's application. *Id.* at ¶¶71–72 (Lanzinger, J., concurring in judgment only).) The remaining authority simply notes, in dicta, that "the Equal Protection Clause of the Ohio Constitution is coextensive with, or stronger than, that of the federal Constitution." *State v. Noling*, 149 Ohio St. 3d 327, 2016-Ohio-8252, ¶11. None of these decisions overrules the cases holding that "the federal and Ohio Equal Protection Clauses are to be construed identically and analyzed identically." *Am. Ass'n of Univ. Professors*, 87 Ohio St. 3d at 60 (quoted by *Noling*, 149 Ohio St. 3d 330 at ¶11). Those holdings bind this Court unless a majority of the Supreme Court of Ohio overrules them. *See State v. Fips*, 160 Ohio St. 3d



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348, 2020-Ohio-1449, ¶10.

*   *   *

One further point. This Court, in its temporary restraining order, took issue with the Heartbeat Act's exceptions permitting abortions where needed to save the life or health of the mother. *See* TRO at 16 (quoting R.C. 2919.195(B)). Those exceptions permit abortions that doctors determine, in their "reasonable medical judgment," are "necessary" to "prevent the death of the pregnant woman or to prevent a serious risk of the substantial and irreversible impairment of a major bodily function." *Id.* (quotation omitted). The Court suggested that the fear of being second-guessed with respect to "reasonable medical judgment" may prevent doctors from performing even legal abortions. *Id.* (quotation omitted).

Any such fear is unjustified. [redacted] What is more, doctors are subject to materially identical standards in numerous contexts. "The law imposes on physicians engaged in the practice of medicine a duty to employ that degree of skill, care and diligence that a physician or surgeon of the same medical specialty would employ in like circumstances." *Berdyck v. Shinde*, 66 Ohio St. 3d 573, 579 (1993). Thus, they can be found liable if they fail to make disclosures concerning risks that "a reasonably prudent physician would disclose." *Mahan v. Bethesda Hosp., Inc.*, 84 Ohio App. 3d 520, 526 (1st Dist. 1992) (*per curiam*). And they may be held liable under a medical-malpractice theory if they fail to provide "the care of a reasonably prudent physician." *Thamann v. Bartish*, 167 Ohio App. 3d 620, 2006-Ohio-3346, ¶46 (1st Dist. 2006). The Heartbeat Act imposes similar obligations. And while the affiants profess uncertainty surrounding the Act's meaning, they do not appear to have made much effort to familiarize themselves with the law. The Act



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*expressly defines* certain conditions—for example, "pre-eclampsia, inevitable abortion, and premature rupture of the membranes," R.C. 2919.16(K)—as presenting "a serious risk of the substantial and irreversible impairment of a major bodily function" sufficient to justify an abortion. R.C. 2919.193(B); *see also* R.C. 2919.16(K).

Indeed, even with the Heartbeat Act enjoined, doctors can perform *post*-viability abortions only if, in their "reasonable medical judgment," the abortion is "necessary to prevent the death of the pregnant woman or a serious risk of ... substantial and irreversible impairment of a major bodily function." R.C. 2919.201(B)(1)(b). The plaintiffs do not contend that *this* exception to the prohibition on *post*-viability abortions creates unacceptable uncertainty. To the contrary, they specifically asked the Court to restore Ohio's pre-*Dobbs* regime, of which the just-quoted statute is a part. Further, for almost a half century between *Roe* and *Dobbs*, Ohio laws prohibiting post-viability abortions contained similar exceptions. *See, e.g.*, R.C. 2317.56(A) (1992); R.C. 2919.12 (1974); R.C. 2901.16 (1972); Parker Expert Report ¶9, Ex. I. Indeed, Ohio's abortion laws have contained similar exceptions since the 1830s. Loren G. Stern, *Abortion: Reform and the Law*, 59 J. Crim. L. & Criminology 84, 85 & n.20 (citing Ohio Gen. Stat. §§111(1), 112(2) at 252 (1834)); Liner



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[REDACTED]. Given that physicians presumably adhered to the limits of those exceptions, [REDACTED], they should be equally capable of complying with the exception in the Heartbeat Act.

**B. The plaintiffs lack standing to assert the rights of third parties.**

**1.** Doctors have no right to perform abortions. *See State v. Alfieri*, 132 Ohio App.3d 69, 79, (1st Dist. 1998); *see also Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908, 912 (6th Cir. 2019) (*en banc*). The plaintiffs—one doctor and several abortion clinics—do not claim otherwise. Instead, they are suing to vindicate the alleged rights of their patients; they say they have third-party standing to seek an injunction securing their prospective patients' right to an abortion.

As an initial matter, binding precedent forecloses any argument that the clinic-plaintiffs have standing to sue in their own right. *Preterm-Cleveland, Inc. v. Kasich*, 153 Ohio St. 3d 157, 2018-Ohio-441. *Preterm-Cleveland*—a case with the same lead plaintiff as this one—held that clinics lacked standing to challenge the Heartbeat Act's predecessor law. *Id.* at ¶26. The law in question prohibited doctors from performing abortions without first checking for, and informing the mother about, the presence of a fetal heartbeat. *Id.* at ¶6. In finding that the clinics lacked standing to challenge this law, the Court approvingly cited then-Judge Stewart's observation, in the decision below, that "[m]ost of what Preterm claims as injuries could only be suffered by potential patients and medical providers who perform abortions," not by clinics. *Id.* (quoting 2016-Ohio-4859, ¶35 (Stewart, J., dissenting)). The same logic applies here, and the plaintiff-clinics lack standing to sue in their own right. Because courts have no jurisdiction to enter relief for parties that lack standing to sue, *see Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 918 n.6 (9th Cir. 2004), *Preterm-Cleveland* bars the Court from awarding injunctive relief to the clinic-plaintiffs—unless the clinics have third-party standing to sue.



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Although the clinics and the plaintiff-doctor assert third-party standing to sue, none of the plaintiffs has third-party standing to sue. "Third-party standing is not looked favorably upon." *Util. Serv. Partners, Inc. v. Pub. Util. Comm.*, 124 Ohio St. 3d 284, 2009-Ohio-6764, ¶49 (quotation omitted). Courts will allow it only if the party "claimant (i) suffers its own injury in fact, (ii) possesses a sufficiently close relationship with the person who possesses the right, and (iii) shows some hindrance that stands in the way of the" right's holder "seeking relief." *Id.* (quotation omitted).

The State previously argued that the plaintiffs can satisfy neither the first nor the third factors. *See* State's TRO Br.27–29. What is more, the *clinic*-plaintiffs cannot satisfy the second factor. Even if doctors possess a sufficiently close relationship with patients in virtue of the patient-doctor relationship, clinics do not. While the State preserves all of those arguments, it wishes here to stress the plaintiffs' inability to meet the third prong: no hindrance prevents would-be patients from suing to vindicate their right to abortion. To the contrary, an aggrieved patient could file suit—as a *Jane Doe*, if necessary—seeking an injunction entitling her to an abortion. This Court's diligent handling of the request for a temporary restraining order proves that courts can act fast to provide relief when they think it is warranted. Women who desire an abortion prohibited by law are able to seek relief. Indeed, they have done so already. *Roe v. Wade* itself was brought by a woman asserting her own rights, not by a provider asserting her rights for her. And for decades, *even juveniles* have sought court orders entitling them to obtain abortions. *See, e.g.*, *In re Doe*, 7th Dist. Columbiana No. 11CO34, 2011-Ohio-6373, ¶1; *In re Doe*, 1st Dist. Hamilton No. C-110621, 2011-Ohio-5482, ¶1; *In re Jane Doe 01-01*, 141 Ohio App. 3d 20, 21 (8th Dist. 2001) (*per curiam*); *In re Complaint of Jane Doe*, 134 Ohio App. 3d 569, 570 (4th Dist. 1999) (*per curiam*); *In re Doe*, 2d Dist. Montgomery No. CA 0001, 1991 WL 96269, at *1 (May 30, 1991).



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**2.** This Court erred in holding otherwise. It claimed that "[d]ecades of precedent have confirmed ... that 'third party standing is available in circumstances like these.'" TRO at 10 (quoting *Planned Parenthood Southwest Ohio Region v. Ohio Dep't of Health*, Hamilton C.P. No. A 2101148 (Apr. 19, 2021) at 5 (alteration accepted)). But in support of that proposition, the Court cited a single, non-binding decision by a trial court. As just explained, Ohio case law does not justify holding that plaintiffs have standing.

In concluding otherwise, this Court asserted that, because women desiring abortions are "often under a great distress," it is "not surprising" that they decline to sue. TRO at 9–10. However unsurprising their reluctance to sue might be, binding law requires this Court to ask whether something is hindering individual women in exercising their own rights. Nothing is. No court has denied them the power to sue. *See, e.g.*, *E. Liverpool v. Columbiana Cty. Budget Comm.*, 114 Ohio St. 3d 133, 2007-Ohio-3759, ¶25. And, as noted already, individual plaintiffs have asserted their own alleged abortion rights for decades. They could do so here, too. Thus, "no hindrance ... stands in the way of" women asserting their own rights. *Util. Serv. Partners*, 124 Ohio St. 3d 284 at ¶49 (quotation omitted). Rather than being hindered in the exercise of their rights, individual women are choosing not to assert them. The plaintiffs cannot assert rights that the rights' holders are choosing not to enforce.

## II. The plaintiffs cannot satisfy the remaining preliminary-injunction factors.

The plaintiffs have not shown a likelihood of success on the merits. *See above* 4–19. The cannot satisfy any of the remaining preliminary-injunction factors, either.

As an initial matter, the plaintiffs face no prospect of irreparable injury. In arguing otherwise, the plaintiffs rely mostly on injuries they say their *patients* will sustain. Any argument that the patients will be harmed by the deprivation of their right to an abortion fails. For one thing, the



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patients *have no* right to abortion. Moreover, since the challenged laws allow doctors to perform abortions that they determine are reasonably necessary to protect a mother's life or health, *see* R.C. 2919.16(K); *see also* R.C. 2929.195(B); R.C. 2919.193(B), no patient may properly be denied needed care because of any provision in the Heartbeat Act. One plaintiff-clinic claims it will go out of business without an injunction. But that clinic has not carried its burden of proving this fact. The *only* witness to submit evidence on the matter claimed that he planned to close the clinic on September 15 if Indiana's abortion regulation took effect. *See* Haskell Decl., ¶11. But he

Moreover, the State has submitted three expert reports that undermine the plaintiffs' claims in this case. Dr. C. Brent Boles's expert reports notes that the Heartbeat Act's exceptions "allow for the intellectually honest physician to rationally and objectively assess the clinical



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situation and formulate a treatment plan." Boles Expert Report ¶12, Ex. G. In addition, Dr. Boles discusses the negative physical and mental-health impacts that abortion has on women. *See id.* ¶¶25-26. Dr. Dennis M. Sullivan's expert report explains the problem with the plaintiffs' assertions from a medical-ethics perspective. *See, e.g.*, Sullivan Expert Report ¶¶14-20, Ex. H. And Dr. Michael Parker, an Ohio physician with 30 years of experience in obstetrics, states that "the Heartbeat Act imposes appropriate requirements and can be easily understood by a competent physician," Parker Expert Report ¶6, Ex. I, and "an experienced and capable physician should be able to determine if these exceptions apply". *Id.* ¶9.

With respect to the third preliminary-injunction factor—harm to other parties—States always suffer irreparable harm when their constitutionally permissible laws are enjoined. *Thompson v. DeWine*, 959 F.3d 804, 812 (6th Cir. 2020) (*per curiam*). Enjoining the Heartbeat Act, which is constitutionally permissible, will thus harm the State. And it will inflict the most irreparable harm of all—death—on the unborn children whose lives are ended through procedures that the Heartbeat Act would have barred.

As for the fourth factor, "giving effect to the will of the people by enforcing the laws they and their representatives enact serves the public interest." *Id.*

## III. Even if the Heartbeat Act is unconstitutional in part, the Court should not enjoin the entre Act.

**A.** Any potential injunctive relief "must not be overly broad," but must instead "be narrowly tailored to prohibit only" enforcement of the provisions in the Heartbeat Act that are held unconstitutional. *Miami Twp. Bd. of Trustees v. Weinle*, 1st Dist. Hamilton No. C-200238, 2021-Ohio-2284, ¶50; *accord Eastwood Mall, Inc. v. Slanco*, 68 Ohio St. 3d 221, 224 (1994). "The injunction must also be specific enough to permit the defendant to comply without fear of committing an



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unwilling violation." *Miami Twp. Bd. of Trustees*, 2021-Ohio-2284 at ¶50.

These equitable rules have a jurisdictional component. "The Ohio Constitution expressly requires standing for cases filed in common pleas courts." *Preterm-Cleveland,* 153 Ohio St. 3d 157 at ¶20 (quotation omitted). For that reason, courts lack jurisdiction to award relief that no plaintiff has standing to seek. But "standing is not dispensed in gross." *Id.* at ¶30 (quotation omitted). "Rather, a plaintiff must demonstrate standing for each claim he seeks to press and *for each form of relief* that is sought." *Id.* (quotation omitted). Generally speaking, "to have standing to attack the constitutionality of a legislative enactment, the private litigant must ... show that [1] he or she has suffered or is threatened with direct and concrete injury in a manner or degree different from that suffered by the public in general, [2] that the law in question has caused the injury, and [3] that the relief requested will redress the injury." *Id.* at ¶21 (quoting *Ohio Trucking Assn. v. Charles*, 134 Ohio St. 3d 502, 2012-Ohio-5679, ¶5). "Thus, a party challenging multiple provisions in an enactment of the General Assembly ... must prove standing as to each provision the party seeks to have" held unconstitutional. *Id.* at ¶30.

Applied here, these principles permit the Court to identify only the *specific* provisions—statutes and subparts—that purportedly violate the Ohio Constitution and injure the plaintiffs (or the third parties they claim to represent). The Court cannot enjoin all of "Senate Bill 23," or the "Heartbeat Bill," unless the *entire law* is unconstitutional. Yet the Act includes provisions that are undoubtedly constitutional. For example, one provision creates a "joint legislative committee on adoption promotion and support." R.C. 2919.1910. Another creates a "foster care and adoption initiatives fund," R.C. 5103.11. So an order invalidating the Act *in toto* is off the table.

The Act's severability clause bolsters the point. Section 4 states:



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> If any provisions of a section as amended or enacted by this act, or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section or related sections which can be given effect without the invalid provision or application, and to this end the provisions are severable.

R.C. 1.50 also prohibits invalidating entire statutes when some sub-provisions are constitutional. Both Section 4 of the Heartbeat Act and R.C. 1.50 require courts to "respect the role of the legislature by" holding invalid *only* "unconstitutional portions of the statute in order to most effectively preserve the General Assembly's goal." *Noling*, 149 Ohio St. 3d 327 at ¶46.

**B.** In light of the foregoing, *even if* this Court finds a right to abortion, it should enjoin *only* R.C. 2919.195(A), which prohibits performing an abortion after finding a heartbeat. It should not enjoin any other statute or subsection. Enjoining that provision alone will give the plaintiffs all the relief they seek—an injunction of that provision will permit them to perform the abortions they aim to perform.

There is no need to enjoin any other provisions. For example, the provisions requiring that doctors check for and inform mothers about a fetal heartbeat, *see* R.C. 2919.192, are unproblematic even if there is a right to abortion, as they do not interfere with the right to obtain an abortion. Indeed, laws requiring doctors to inform patients about the consequences of the procedure, which can include terminating the life of an unborn child with a beating heart, were long considered to be permitted under cases recognizing the now-abrogated federal right to abortion. *See Casey*, 505 U.S. at 882–83 (plurality). And since 2013, Ohio has required doctors to check for, and to tell their patients about, the unborn child's heartbeat. *See* R.C. 2919.191 (2013) (renumbered and amended by Sub. S.B. 23) (as originally enacted by H.B. 59 (June 30, 2013)). So the provisions in R.C. 2919.192 requiring that doctors check and give information about the unborn child's heartbeat are unproblematic even under the plaintiffs' legal theory. The same is true of R.C. 2919.193(A), which



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simply prohibits doctors from performing an abortion without first checking for a fetal heartbeat. Even in the weeks after this Court issued its injunction, [REDACTED]

With respect to other provisions, the severability issue is even clearer. The provisions in the Heartbeat Act creating a committee and a fund relating to adoption and foster care have no bearing on the ability to obtain an abortion. R.C. 2919.1910; R.C. 5103.11. Similarly, recordkeeping duties do not violate even the broadest theory of abortion rights. R.C. 2919.195(B). The Department of Health has long collected statistical information regarding abortions, including the methods used, the weeks of gestation, and so on. Finding out how many abortions are occasioned by health threats is a valid public-health interest that the State may investigate without regard to the debate over abortion restrictions.

The problems with the broad relief the plaintiffs seek are jurisdictional, not just prudential. Again, courts can enjoin a particular provision *only if* some plaintiff has standing to challenge it. *Preterm-Cleveland*, 153 Ohio St. 3d 157 at ¶30. Even if the prohibition on *aborting* unborn children with heartbeats harms the plaintiffs or their patients, there is no evidence that any other provision injures patients. These provisions inflict no injury on the plaintiff-clinics at all. *See Preterm-Cleveland*, 153 Ohio St. 3d 157 at ¶¶26–27. And the sole plaintiff doctor has not shown injury relating to the requirement to check for a heartbeat—a requirement with which she has presumably been complying for years. As such, the plaintiffs lack standing to challenge any of these other provisions, and the Court lacks jurisdiction to enjoin them.



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* * *

"Equity requires that an injunction should be narrowly tailored to prohibit only the complained of activities." *Eastwood*, 68 Ohio St. 3d at 224. Here, even if plaintiffs persuade the Court that Ohio's Constitution contains a right to abortion, the Court should enjoin *only* R.C. 2919.195(A). An injunction any broader than that is broader than necessary, and thus improper.



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## CONCLUSION

This Court should deny the motion for a preliminary injunction.

Respectfully Submitted,

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## CERTIFICATE OF SERVICE

I certify the foregoing was served upon the following via electronic mail this 2nd day of October, 2022.

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**EXHIBITS**



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Exhibit A – Placeholder for Deposition of David Burkons, Filed with the Court for *In Camera* Review



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Exhibit B – Placeholder for Deposition of W.M. Martin Haskell, M.D., Filed with the Court for *In Camera* Review



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Exhibit C – Placeholder for Deposition of Dr. Sharon Liner, Filed with the Court for *In Camera* Review



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Exhibit D – Placeholder for Deposition of Allegra Pierce, Filed with the Court for *In Camera* Review



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Exhibit E – Placeholder for Deposition of Aeran Trick, Filed with the Court for *In Camera* Review



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Exhibit F – Placeholder for Deposition of Aeran Trick, Filed with the Court for *In Camera* Review



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Exhibit G – Expert Report of Dr. C. Brent Boles



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**IN THE COURT OF COMMON PLEAS**
**FOR HAMILTON COUNTY, OHIO**

| | | |
|---|---|---|
| **PRETERM-CLEVELAND, *et al.*,** | : | |
| | : | **Case No. A 2203203** |
| *Plaintiffs*, | : | |
| | : | **Judge Christian A. Jenkins** |
| v. | : | |
| | : | |
| **DAVE YOST, *et al.*,** | : | |
| | : | |
| *Defendants*. | : | |
| | : | |
| | : | |

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**EXPERT REPORT OF DR. C. BRENT BOLES, M.D.**

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I, Charles Brent Boles, state as follows:

1. I am a medical doctor who has been retained by the Office of the Attorney General of the State of Ohio to assist in the defense of The Human Rights and Heartbeat Protection Act. I am currently being compensated at an hourly rate of $375.00 for my work in preparing my expert report in this case.

2. I graduated from Murray State University in 1988 with a bachelor's degree in biology, and attended the University of Louisville School of Medicine, graduating from there in 1992 with the degree of Medical Doctor. I completed my residency in Obstetrics and Gynecology in 1996 at the University of Louisville School of Medicine in the Department of Obstetrics and Gynecology, serving as Chief Administrative Resident in the final year. I completed the certification process with the American Board of Obstetrics and Gynecology in 1998, and have participated in the annual Maintenance of Certification since that time.



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3. I was licensed to practice medicine in the State of Kentucky, where I was a partner in a single specialty OB/GYN group practice for nine years. I then practiced OB/GYN in Tennessee for 15 and a half years, with all but the first six months being in solo practice serving the full range of OB/GYN needs of my patients. I am also licensed to practice in Florida where I currently work as an OB/GYN hospitalist in addition to occasional travel for Locum Tenens assignments.
4. During my time in Tennessee, I served as Vice Chief and then Chief of the Department of OB/GYN at Saint Thomas Rutherford Hospital, then known as Middle Tennessee Medical Center. During that time, I also held three different academic appointments. I was the assistant residency director for the Meharry College of Medicine Department of Obstetrics and Gynecology and was responsible for supervising and teaching OB/GYN residents in the second and third years of residency as they rotated in our community hospital. I was also a clinical instructor for the University of Tennessee Physician Assistant Program. The third appointment was as a clinical professor with the University of Tennessee School of Medicine Department of Emergency Medicine, and I had the responsibility of providing lectures to Emergency Medicine interns and residents on the field of women's health issues they would encounter in an Emergency Department. I also had direct responsibility for clinical instruction and training during the month each intern spent on the OB/GYN service.
5. I also served as the Medical Director for a Pregnancy Resource Center (PRC) in Tennessee for 13 years. In addition to the non-medical services provided there, clients were able to obtain pregnancy tests and ultrasounds, as well as STD testing. I was responsible for supervising this care which was provided to patients, and for reviewing and interpreting all the ultrasound images.



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6. I also currently serve as the Medical Director for Abortion Pill Reversal Services for Heartbeat International, the world's largest organization for PRCs.
7. I have served as a legislative consultant for members of the Tennessee General Assembly in both the House of Representatives and in the Senate on issues related to abortion, and have testified before different committees on three different occasions.
8. I have also served as an expert witness for the Tennessee Attorney General and for the Indiana Attorney General on issues related to abortion and abortion informed consent, and have had my status as an expert in this area accepted by federal judges in both Tennessee and Indiana. Those cases were: *Planned Parenthood of Tennessee and North Mississippi et al. v. Slatery et al.*, Case No. 3:20-cv-00740 (M.D. Tenn.); and *All-Options, Inc. et al. v. Attorney General of Indiana et al.*, Case No. 1:21-cv-1231-JPH-MJD (S.D. Ind.). I have also served as an expert for the plaintiff in *National Institute of Family and Life Advocates et al. v. Rauner et al.*, Case No. 3:16-cv-50310 (N.D. Ill.).
9. I submit this expert report as an expert in the field of obstetrics and gynecology in opposition to the plaintiffs' motion for an injunction against the Heartbeat Act.
10. The legislation in dispute has been enacted because the duly elected members of the Ohio General Assembly chose to recognize the scientific reality that the presence, in a pregnancy, of a living member of the human species can be determined using widely available and easily utilized ultrasound technology. They have recognized that the overwhelming majority of pregnancies having the presence of embryonic or fetal cardiac activity progress to deliver living human infants. The Ohio General Assembly has determined that the State has an interest in protecting the lives of these living but not yet born human beings.
11. The General Assembly has also appropriately recognized that there are rare instances when continuing a pregnancy endangers a woman's life, or can result in permanent impairment of a



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major physical function of her body, and that in those rare cases the pregnancy must end in order to preserve her life and her physical health. Also recognized within the law is the fact that ectopic pregnancies must be treated, as they pose an imminent risk to the life of the mother.

12. The exceptions set forth in Ohio Revised Code section 2919.195 clearly allow for abortions in the rare cases in which a doctor concludes that, without an abortion, a woman faces possible death or "a serious risk of the substantial and irreversible impairment of a major bodily function." R.C. 2919.195(B). The exceptions allow for the intellectually honest physician to rationally and objectively assess the clinical situation and formulate a treatment plan. Such a plan, when outlined in compliance with Ohio Revised Code sections 2919.195 and 2919.196, can proceed to the legal termination of a pregnancy when the assertion that the life or preservation of bodily function is appropriate and defensible in accordance with these statutory provisions, and incidentally, also with standards for medical documentation of any condition and proposed treatment plan. Since such documentation is a standard across all fields of legitimate medicine when any treatment plan or intervention is proposed to a patient, such documentation is not inconsistent with currently existing standards for any proposed treatment for any condition.

13. In the document titled Verified Complaint for Declaratory and Injunctive Relief, the plaintiffs in this action promote multiple false assertions in their attempt to maintain the current abortion client volume of approximately 20,000 women annually in Ohio.[1] They make the claim that a lack of abortion access is "inflicting serious, irreparable harm to their physical, psychological, and emotional well-being, as well as that of their families." Compl. ¶ 1. In the plaintiffs'

[1] *See* https://odh.ohio.gov/explore-data-and-stats/published-reports/data-and-stats-abortion-reports.



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Motion for a Temporary Restraining Order, the document opens by stating that a lack of abortion access has "devastating consequences," and that there would be ongoing irreparable harm if the Heartbeat Act were to be in effect. TRO Mot. at p. 1.

14. The plaintiffs rely on assertions commonly made by the abortion industry and its supporters that ignore the harm that abortion can cause for the women who seek abortion services, and do not address the status of the living but not yet born human life at stake in each abortion decision. They allege that abortion is safe care, that complications are rare, and that having a pregnancy termination is 13 times safer than childbirth. Compl. ¶¶ 32-33. They repeatedly allege that carrying an unwanted pregnancy will result in devastating and irreparable harm to women, without acknowledging to the Court that the 20,000 women in Ohio who obtain abortion services each year are also at risk for serious and even devastating and irreparable harm, and without acknowledging that 20,000 living but not yet born human beings whom the State has chosen to protect will suffer the ultimate harm possible—the loss of life and all the liberties that come with life.

15. The first assertion I will address is the fallacy that "abortion is 13 times safer than childbirth." This data comes from a report published by Dr. Raymond and Dr. Grimes.[2] This paper has become an industry standard of sorts when supporters of abortion wish to say that abortion is so safe that it is less dangerous than childbirth. There are problems with this paper that those who use it to support their position have not been able to address. First, the paper claims to use comprehensive data on deaths resulting from abortion in all 50 states. It compares that data to maternal mortality rates as derived from reports of death as a result of childbirth that have been submitted to the Centers for Disease Control and Prevention (CDC). However,

[2] Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States.* Obstetrics & Gynecology, Vol. 119, NO. 2, Part 1, February 2012.



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there is no such data set that comprehensively reports deaths from abortion in all 50 states. That data set does not exist in the United States of America.

16. A review of abortion complication reporting requirements easily accessed on the website of the Guttmacher Institute clearly shows that status of abortion reporting in America. Four states report nothing on the status of abortion in their state to the CDC. Eighteen other states report some information, mostly demographic in nature, but do not report the numbers or types of abortion complications or the number of abortion-related deaths. This minority of 22 states which do not report complications and deaths to the CDC account for an almost 60% majority of the nation's abortion clinics and abortions performed annually.

17. The other 28 states do have statutory requirements for the reporting of complications and mortality, but enforcement mechanisms are lacking, and I have been able to find no examples of any investigation or auditing of any abortion facility as it relates to reporting compliance. A CDC physician has publicly stated that abortion mortality rates and maternal mortality ratios are two separate statistical measures and are used for different purposes. It is inappropriate to claim to have used a data set that includes reliable data from all 50 states on abortion mortality when no such data set exists. It is also inappropriate to compare abortion mortality rates and maternal mortality ratios when the two measures are not comparable, as stated in 2004 by then director of the CDC, Dr. Julie Louise Gerberding. She stated that the two "are conceptually different and are used by CDC for different public health purposes."[3] Dr. Raymond and Dr. Grimes would have us believe that the two measures are equivalent when they are not.

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[3] Julie Louise Gerberding, M.D., to Walter Weber, American Center for Law & Justice, July 20, 2004, http://afterabortion.org/pdf/CDCResponsetoWeberReAbortionStats-Gerberding%20Reply.pdf, responding to Weber's April 30, 2004, letter to Tommy G. Thompson, U.S. Department of Health and Human Services, requesting a reassessment of pertinent statistical measures of mortality rates associated with pregnancy outcome, http://afterabortion.org/pdf/WeberLettertoThompson&CDCReAbortionStats.pdf.



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18. Furthermore, Dr. Raymond and Dr. Grimes claim to have completed a thorough review of all data relevant to this topic available in the PubMed database.[4] They selectively chose to omit relevant data that contradicted their desired conclusion when they set the time frame to exclude a review of 173,249 low-income women in California, and to also exclude at least six studies done in Finland. Each of these selectively excluded studies employed what can be considered "record-linkage" to assess the comparative risk of death related to childbirth and death related to induced abortion. The data sets evaluated death certificates for reproductive age women in the populations, and analyzed for any care for pregnancy, childbirth or induced abortion or other types of care, and compared the risks of mortality. This is the only manner in which a true "apples to apples" comparison can be accomplished. The data from California showed that post-abortive women had an elevated relative risk of death 1.62 times higher than those having childbirth, a 2.54 higher relative risk of death from suicide, and that these elevations in risk persisted over a prolonged period of time following the abortion as compared to a delivery.[5]

19. Furthermore, the data from Finland is ideally suited to address this issue. Finland's centralized database covering all of the health care provided in their single-payer system allows for the analysis of death certificates and any care rendered for any pregnancy for any reason. Perhaps the most significant of these studies was published in the peer-reviewed American Journal of Obstetrics and Gynecology in 2004.[6] This landmark analysis of nearly 14 years of data related

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[4] Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States.* Obstetrics & Gynecology, Vol. 119, NO. 2, Part 1, February 2012.

[5] *See* Reardon, David, Rebuttal of Raymond and Grimes, Linacre Quarterly, 2012 August: 79(3); 259-260, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6027034/.

[6] Gissler, Mika, et al., *Pregnancy-associated mortality after birth, spontaneous abortion, or induced abortion in Finland, 1987-2000.* American Journal of Obstetrics and Gynecology (2004) 190, 422-7.



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to 1,141,267 births, miscarriages, and induced abortions did not show that abortion is 13 times less likely to cause the death of a woman than childbirth. It showed that the mortality rate after a birth was 28.2/100,000 deliveries and that the mortality rate for induced abortions was 83.1/100,000 induced abortions. Rather than address data that contradicted their desired conclusions, Dr. Raymond and Dr. Grimes chose to pretend that this data simply did not exist. It is inappropriate for the plaintiffs to unequivocally state to the Court that abortion is 13 times less likely to kill a woman than childbirth (Compl. ¶ 32) when the best data in the world says otherwise.

20. Additionally, maternal mortality rates do not decrease in countries that liberalize their abortion laws and become more permissive, and they do not increase in countries that become more restrictive and outlaw abortions.[7]

21. The plaintiffs also claim that other complications following induced abortion are exceedingly rare. Compl. ¶ 33. Data from a report also based on the comprehensive and unbiased Finland data published in the peer-reviewed *Obstetrics & Gynecology* in 2009[8] demonstrates that 5.6% of women having a surgical termination of pregnancy experience at least one significant adverse event, and those having a chemical termination of pregnancy will have at least one significant adverse event 20.0% of the time. Based on the assumption that approximately 40% of abortions in Ohio are chemical and not surgical, these numbers would appropriately lead one to conclude that 2,272 women experience at least one significant adverse event following an induced termination of pregnancy in Ohio annually. This overall would be an approximate rate of 11.4%—hardly what one could appropriately call "exceedingly rare." Furthermore, reliable

[7] Lanfranchi, Angela, et al., *Complications: Abortion's Impact On Women, Second Edition.* Toronto, Canada, The deVeber Institute for Bioethics and Social Research, 2018, p. 17-46.

[8] Niinimaki, Maarit, et al., *Immediate Complications After Medical Compared to Surgical Termination of Pregnancy,* Obstetrics & Gynecology, October 2009 – Volume 114 – Issue 4 – p. 795-804.



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data shows that those within the abortion industry are not even aware of most of the complications experienced by their patients. A comprehensive review of all adverse event reports submitted to the U.S. Food and Drug Administration regarding adverse events following a chemical abortion from September 2000 to February 2019,[9] demonstrated that approximately 60% of the women who required surgical care to treat a complication arising from a chemical abortion were treated by an Emergency Department physician or an on-call GYN provider and were not treated by their abortionist.

22. Plaintiffs refer to a publication from the National Academies of Sciences, Engineering, and Medicine (NAS). Compl. ¶ 32. The published report issued by the NAS in 2018 is titled *The Safety and Quality of Abortion Care in the United States*. The plaintiffs would have the Court believe that this report is unbiased and comprehensive and reliable. This report is, in fact, neither unbiased nor comprehensive. It was funded by individuals and entities who have unrelentingly supported abortion rights here and around the world. Most of the contributors' names I recognized have significant financial ties to the abortion industry and stand to benefit from continued widespread access to abortion. I recognized no names of contributors who could be considered to be neutral on the issue, or to be pro-life. The report cannot be considered to be free from bias, and it would be inappropriate for the Court to consider its findings as evidence that 20,000 Ohioans are not at risk every year because of continued unfettered access to abortion.

23. The report specifically makes the claims that abortion does not increase a woman's risk of breast cancer, that abortion does not substantially increase a woman's risk of premature

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[9] Aultman, Kathi A., et al., *Deaths and Severe Adverse Events after the use of Mifepristone as an Abortifacient from September 2000 to February 2019,* Issues in Law and Medicine, Volume 36, Number 1, 2021., p. 1-27.



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delivery in a future pregnancy, and that abortion does not increase a woman's risk of subsequent mental health disorders.

24. Comprehensive review of the worldwide literature regarding these questions has been accomplished by the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG). The summaries of these reviews are easily available to the public on the AAPLOG website at www.AAPLOG.org.

25. Abortion does have an impact on women and their future reproductive lives.

    A. Breast Cancer

        i. AAPLOG Committee Opinion 8 outlines not only the physiological basis of the linkage between induced abortion and an increased risk of breast cancer, but also summarizes the data and how abortion proponents selectively discuss a minority of the available studies to promote the fiction that there is no relationship.[10]

        ii. To summarize, from 1957 to 2018 there were 76 studies evaluating the relationship between abortion and breast cancer that distinguished between induced abortion and miscarriage. Sixty of the 76 showed an association between induced abortion and increased cancer risk, with 36 of them being statistically significant to the 95th percentile. Of the 24 studies from institutions in the U.S., 19 show an association between induced abortion and breast cancer. The NAS relied on only three of the 76 studies to reach their conclusion that there is no association between induced abortion and an increase in breast cancer risk, and those three were selected from the 16 studies that did not find a risk.

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[10] *See* https://aaplog.org/wp-content/uploads/2020/01/FINAL-CO-8-Abortion-Breast-Cancer-1.9.20.pdf.



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B. Mental Health

i. AAPLOG Practice Bulletin 7 evaluates the complicated data regarding the relationship between induced abortion and future mental health issues.[11] The NAS publication, *The Safety and Quality of Abortion Care in the United States,* not only opines that there is no linkage between abortion and breast cancer, it also asserts that there is no increase in mental health issues in post-abortive women. Their highly selective consideration of only the minority of studies which show no linkage blatantly ignores the majority of available peer-reviewed studies that do show concern. From 1993 to 2018 there were 75 peer-reviewed studies evaluating the risk of mental health complications following induced abortion. Of these, 2/3 showed an increased risk, yet the NAS evaluation only discussed seven studies, all from the minority of studies showing no relationship. Five of the seven were from the problematic Turnaway cohort, a database created by prominent abortionist and abortion researcher Dr. Daniel Grossman. The Turnaway cohort is largely unreliable because it includes data from only 17% of those women originally surveyed, and because it did not evaluate gestational age at the time of the abortion.

ii. Using a comprehensive assessment tool that evaluates the quality of a study, Dr. Priscilla Coleman looks at nine factors when considering a study. Applying this tool to all studies published worldwide from 1993 to 2018, she found that 65% of the studies show a correlation between induced abortion and adverse mental health outcomes. Additionally, in her peer-reviewed article published

[11] *See* https://aaplog.org/wp-content/uploads/2019/12/FINAL-Abortion-Mental-Health-PB7.pdf.



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in the British Journal of Psychiatry,[12] an 81% increase in the risk of adverse mental health outcomes in the post-abortive women is demonstrated. Furthermore, the population attributable risk measure shows that between 9 and 10% of all mental health issues in women are seen in women for whom the only risk factor is having had an abortion.

iii. A database of 173,279 California Medicaid patients evaluated death certificates for women who had either had a delivery or an abortion. Post abortive women were 2.54 times more likely to commit suicide.[13] This data set also shows that teenagers who are post-abortive are 10 times more likely to attempt suicide.

C. Induced Abortion and Subsequent Risk of Preterm Delivery

i. Preterm delivery is one of the most substantial causes of morbidity and mortality in newborns across the country and in the State of Ohio. It is the most common risk factor for cerebral palsy. Preterm delivery imposes costs of more than 26 billion dollars annually in America.[14] AAPLOG has two important documents regarding comprehensive evaluations of the data.[15] Fifty years of published data have evaluated the relationship between induced abortion and subsequent preterm delivery in 168 published studies. The NAS, in an effort to conceal the relationship, chose to discuss only five of these studies even though the overwhelming majority of the 168 papers show a linkage between

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[12] Coleman, P. (2011). *Abortion and mental health: Quantitative synthesis and analysis of research published 1995–2009.* British Journal of Psychiatry, 199(3), 180-186. doi:10.1192/bjp.bp.110.077230.

[13] *See* https://pubmed.ncbi.nlm.nih.gov/12190217/.

[14] *See* https://www.marchofdimes.org/mission/the-economic-and-societal-costs.aspx.

[15] *See* https://aaplog.org/wp-content/uploads/2021/11/PB-5-Overview-of-Abortion-and-PTB.pdf; https://aaplog.org/wp-content/uploads/2021/11/PG-11-A-Detailed-Examination-of-the-Data-on-Surgical-Abortion-and-Preterm-Birth.pdf.



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induced abortion and the risk of preterm birth. The Associate Editor of the American Journal of Obstetrics and Gynecology, the Editor of the British Journal of Obstetrics and Gynecology, and the Royal College of Obstetrics and Gynecology have all acknowledged that abortion increases the risk of preterm delivery, but the American College of Obstetricians and Gynecologists refuses to acknowledge this, and Planned Parenthood specifically denies that a linkage exists.

26. The plaintiffs have persistently stated that women in Ohio will suffer devastating consequences, ongoing irreparable harm, and damage to their physical and psychological and emotional health, as well as that of their families. An objective and comprehensive honest review of the data shows that, in fact, easy abortion access will have more negative consequences. Women will remain at increased risk for death and other severe complications. They will remain at increased risk for breast cancer, preterm labor in their future pregnancies, and mental health disorders. These unfavorable consequences experienced by some women who undergo induced abortion do in many cases cause serious and irreparable harm to their physical, psychological, and emotional health and to that of their families and their future children.

27. Furthermore, I have been made aware of anecdotal accounts submitted to the Court. I would first like to address the allegation that women with ectopic pregnancy have had denied or delayed care. It is noteworthy that many within the community of abortion supporters have, in the wake of *Dobbs*, unrelentingly claimed that women with ectopic pregnancies and women with miscarriages would be denied care due to the change in the legal climate. There are those, some physicians included, who have adamantly stated that induced abortion is the way in which ectopic pregnancies and miscarriages are treated. This is simply not true. If any woman has truly experienced a delay in ectopic care or miscarriage care due to a provider being hesitant



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to provide indicated care for those conditions, care which is never considered an induced abortion, then the problem lies with the ignorance of the provider with whom they sought care and not with any change in the law. The care required for an ectopic is specifically exempted in the Heartbeat Act, and the care required for a miscarriage is also never considered to be an induced abortion.

28. At least two anecdotes involve the care of a woman with cancer being complicated by a new diagnosis of pregnancy during treatment, or a diagnosis of cancer during an existing pregnancy. While these types of situations are certainly heartbreaking, as most occur with pregnancies that otherwise would have been wanted, induced abortion is not always the only solution. In the case of a malignancy best treated immediately, it would always be defensible for a provider who chooses to provide the written documentation that preservation of the woman's life or prevention of the permanent impairment of bodily function makes the induced termination of the pregnancy advisable. However, the current literature offers alternatives. In a chapter titled "Cancer in the Pregnant Patient," the excellent textbook *Critical Care Obstetrics, Sixth Edition,*[16] has a very thorough chapter which provides an introductory discourse regarding the ways in which cancer care can be safely adjusted to allow for pregnancy maturation and delivery in many cases. The chapter bases its discussion on a very thorough and thoughtful evaluation of the literature, and cites 179 different references in reaching its conclusions. An honest review of this information leads the objective observer to the conclusion that abortion, while sometimes a necessary part of the care of the pregnant woman with a malignancy, is not and should never be instantly and unyieldingly offered as the best solution.

[16] Bixel, Kristin, et al., *Critical Care Obstetrics, Sixth Edition,* ed. Phelan, Jeffery, et al., (Hoboken, NJ: John Wiley and Sons, Inc., 2019), 1005-1022.



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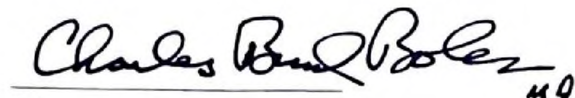
29. The State of Ohio, through its democratic processes, has decided that the State has an interest in protecting the lives of demonstrably living but not yet born human beings, and in so doing has also protected the 20,000 women who otherwise would have sought abortion services each year. The plaintiffs wish to have the Court believe that abortions have only the most exceedingly rare adverse outcomes, and that the current state of medicine in Ohio is inadequate to handle the problems which can occur during a pregnancy—and that abortion must be available to protect every woman who might potentially have a medical problem during a pregnancy. These assertions are not supported by the overwhelming majority of the available evidence and data, when such evidence and data is reviewed in an objective manner.

I declare under penalty of perjury that the foregoing is true and correct, and if called as a witness I would testify competently thereto.

Dated: September 28, 2022



C. BRENT BOLES, M.D.



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Charles Brent Boles, M.D.

777 North Ashley Drive, #1509
Tampa, Florida 33602
cbrentboles@outlook.com

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Professional History

- Pediatrix Medical Group, April 2022 to present
- Women's Care Florida, August 2021 to March 2022
- Heartbeat International Abortion Pill Reversal Network Medical Director, May 2021 to present
- LocumTenens.com, April, 2021 to present
- Weatherby Healthcare, Locum Tenens, February, 2021 to present
- Physician and Owner, Covenant Healthcare for Women, P.L.L.C., January, 2006 to December, 2020
- Medical Director of Portico (local crisis pregnancy center) 2008 to present
- Vice Chief of Obstetrics and Gynecology, Middle Tennessee Medical Center, Murfreesboro TN, 2007-2008
- Chief of Obstetrics and Gynecology, Middle Tennessee Medical Center, Murfreesboro TN, 2009-2010
- Associate Clinical Professor in the University of Tennessee Department of Emergency Medicine at Saint Thomas Rutherford Hospital, July 2015 to 2020
- Associate Clinical Professor and Assistant Residency Director for the Saint Thomas Rutherford Campus, Department of Obstetrics and Gynecology, Meharry College of Medicine, July 2006 to December 2020
- Clinical Instructor for the University of Tennessee Physician Assistant School, May 2016 to December 2020
- IC Research, Principal Investigator, December 2018 to December 2020
- Saint Luke Physicians for Women, Laborist position, Saint Luke Hospitals in Florence and Fort Thomas, Kentucky, September 1998 to September 2010.
- OB/GYN Associates, July 2005-December 2005
- Murray Woman's Clinic, July 1996-June 2005

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- Middle Tennessee Medical Center Laborist Program Director, November 2006-March 2011
- Certified on the Da Vinci Xi robotic surgery platform
- Member of the Medical Advisory Board for Heartbeat International
- Member of the Medical Advisory Board for Abortion Pill Reversal

Educational History

- Certified by the American Board of Obstetrics and Gynecology, November 1998 to present
- Chief Administrative Resident, University of Louisville School of Medicine, Department of Obstetrics and Gynecology, July 1995 - June 1996
- Internship and Residency, University of Louisville School of Medicine, Department of Obstetrics and Gynecology, July 1992-June 1996
- Doctor of Medicine, University of Louisville School of Medicine, August 1988-May 1992
- Bachelor of Science in Biology, Murray State University, August 1984-May1988

Licensure

- Florida Board of Medicine, 2021 to present
- Tennessee Board of Medical Examiners, 2004 to present
- Kentucky Board of Medical Licensure, 1993 to 2011
- Drug Enforcement Agency Registration, 1993 to present

Memberships

- American Institute of Ultrasound in Medicine, 1998 to 2005
- International Society for Clinical Densitometry, 1998 to 2005
- Christian Medical and Dental Association
- American Association of Pro-Life Obstetricians and Gynecologists

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## Awards

- Professor of the Year Award, University of Tennessee Health Science Center, Saint Thomas Rutherford Department of Emergency Medicine, 2016
- Meharry Appreciation Award, 2009
- Foundation Award for Clinical Excellence, Department of Obstetrics and Gynecology, University of Louisville School of Medicine, 1994
- Best Clinical Teacher Awards, University of Louisville School of Medicine, 1993, 1994, 1996
- Clinical Research Awards, University of Louisville School of Medicine, Department of Obstetrics and Gynecology, 1995 and 1996
- Laparoscopic Skills Award, University of Louisville School of Medicine, Department of Obstetrics and Gynecology, 1995
- Presidential Scholarship Award, Murray State University, 1984 to 1988

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Exhibit H—Expert Report of Dr. Dennis Sullivan, M.D., M.A.



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**IN THE COURT OF COMMON PLEAS**
**FOR HAMILTON COUNTY, OHIO**

| | | |
|---|---|---|
| **PRETERM-CLEVELAND, *et al.*,** | : | **Case No. A 2203203** |
| *Plaintiffs,* | : | **Judge Christian A. Jenkins** |
| **v.** | : | |
| **DAVE YOST, *et al.*,** | : | |
| *Defendants.* | : | |

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**EXPERT REPORT OF DR. DENNIS SULLIVAN, M.D., M.A.**

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I, Dennis M. Sullivan, declare that the following is true and correct:

1. My name is Dr. Dennis Michael Sullivan. I am a physician, and was licensed in Ohio to practice medicine from 1978 until I retired from clinical practice in 2020. My medical degree (M.D.) is from Case Western Reserve University in Cleveland, Ohio, and I have specialty training in general surgery. I was board certified by the American Board of Surgery and am a Fellow of the American College of Surgeons. I practiced medicine in the U.S. Army for two years of active duty, then worked internationally for 10 years. Between 1996 and 2019, I served on the teaching faculty of Cedarville University, Cedarville, Ohio, where I taught human biology, including advanced anatomy and human embryology. During this time, I obtained an additional graduate degree (M.A.) in bioethics and moral philosophy from Trinity University in Chicago. Between 2006 and 2019, I was director of Cedarville University's Center for Bioethics. During my final six years at Cedarville, I was on the faculty of the School of Pharmacy, where I taught



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courses in pharmacy ethics and pharmacy law. In June 2019, I retired from Cedarville University with the rank of Professor Emeritus of Pharmacy Practice.

2. In addition to my teaching experience, I have an extensive record of scholarship in ethics and moral philosophy, with 28 peer-reviewed publications and six academic non-peer-reviewed papers. I am an editor or reviewer for three academic bioethics journals. As an invited speaker, I have made over 100 scholarly conference presentations, 21 hospital ethics committee presentations, and 49 popular-level appearances in the past 20 years. In 2021, I completed work as the primary author of a textbook on pharmacy ethics for Springer Academic Publishers. I serve as the academic ethics consultant for the Ethics Committee of Premiere Health Hospital System in Dayton, Ohio.
3. I have been retained by the State Defendants to provide expert testimony in this case. I am being compensated at $400 per hour for the preparation of my expert report and $600 per hour for any deposition and courtroom testimony.
4. My comments in this report relate to Ohio's Heartbeat Act, which appears in Sections 2919.19 through 2919.1910 of the Ohio Revised Code. The law requires a clinical measurement to detect the presence of a fetal heartbeat before performing or inducing an abortion. If a heartbeat is detected, the law does not permit an abortion to be performed.
5. S.B. 23, the "Human Rights and Heartbeat Protection Act," was signed by Governor DeWine on April 11, 2019. Since the June 24, 2022, United States Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*, overturning the constitutional right to abortion, this act has become part of the Ohio Revised Code cited above. Various groups, including Preterm Cleveland, Planned Parenthood of Southwest Ohio,



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the Northeast Ohio Women's Center, and the Ohio chapter of the American Civil Liberties Union, have filed a lawsuit against the new law.

6. Among other claims, the plaintiffs allege that the Heartbeat Act will deprive Ohioans of "their fundamental rights under the Ohio Constitution and inflict[s] serious, irreparable harm to their physical, psychological, and emotional well-being, as well as that of their families." Compl. ¶1. They further claim that "[e]ach day that S.B. 23 is in effect, Ohioans are seriously and irreparably harmed and denied their ability to exercise fundamental rights guaranteed by the Ohio Constitution." *Id.* ¶7. The following analysis considers the Heartbeat Act from a clinical ethics perspective.

7. Abortion is a medical procedure not designed to cure a disease, for nothing is more natural than pregnancy or childbirth. Abortion is, in fact, an invasive procedure, one that separates an unborn child from her mother's womb. It is not a part of standard health care, and should only be carried out in the case of serious threats to a woman's health or life. Therefore, reducing the number of abortions should be a goal for everyone in society, which will take education and resources.

8. The legislation at issue in this matter requires the determination of a fetal heartbeat before commencing an abortion, which is not an undue burden for clinical facilities. An office or clinic ultrasound before an abortion is a standard medical procedure readily accepted by healthcare professionals, women, and families.[1] [2]

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[1] Wiebe ER, Adams L. Women's perceptions about seeing the ultrasound picture before an abortion. *The European Journal of Contraception and Reproductive Health Care*. 2009;14(2):97-102. doi:doi:10.1080/13625180902745130.

[2] Kulier R, Kapp N. Comprehensive analysis of the use of pre-procedure ultrasound for first-and second-trimester abortion. *Contraception*. 2011;83(1):30-33.



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9. So what is the significance of the fetal heartbeat? It is not the biological beginning of life, for that moment is when sperm and egg unite in conception. Despite vague speculations about when human life begins, any competent biologist or physician knows that it is at the moment of fertilization of a human ovum by a human sperm. *Larsen's Human Embryology* (5th Ed., 2015) puts it this way: "Fertilization . . . results in the formation of a new cell having a unique genome, different from that of the cells of its mother or father . . . [allowing] subsequent phases of human embryology to occur."[3]

10. At conception, the embryo is complete and entire for its stage of development. To become a mature member of our species, nothing must be added except time and nutrition. Its unique genetic code makes it different from any other human being. Through a complex series of events, the embryo directs its own development. It grows and folds to form a nervous system, a GI tract, and blood vessels. Shortly after abdomen and chest development, the heart forms from the union of two separate tubes. This all occurs at about 21 days after conception, but those tubes have begun to pulsate even before then. By the time fusion takes place, blood is pumping through the heart and blood vessels, often with a blood type different from that of the parents. The beating of the early heart is visible by ultrasound as early as six weeks after conception.[4]

11. For those who observe it, this moment has medical significance. Several studies have documented that detecting a heartbeat in the first trimester of pregnancy by vaginal

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[3] Schoenwolf GC, Bleyl SB, Brauer PR, Francis-West PH. *Larsen's human embryology*. Fifth edition. ed. Churchill Livingstone; 2015:xvi, 554 pages.

[4] Sadler TW. *Langman's medical embryology*. 13th edition. ed. Wolters Kluwer; 2015:xiii, 407 pages.



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or abdominal ultrasound is predictive of a good outcome in 93% to 97% of cases.[5][6][7][8] In one study, even in pregnancies threatened with a miscarriage, the presence of a normal heartbeat predicted fetal survival 96% of the time.[9]

12. More relevant to the subject of abortion is the question of the humanity of a fetus. Even the U.S. Supreme Court in *Roe v. Wade* acknowledged this. In his 1973 majority ruling, Justice Harry Blackmun stated that the Fourteenth Amendment would protect the fetus if its personhood were established. However, the Court declined to rule on that basis, stating, "We need not resolve the difficult question of when life begins."[10] I would contend that the medical and scientific facts are much more evident than in 1973, and we can definitively conclude that the humanity of the unborn begins at conception. Furthermore, establishing a heartbeat is a firm basis for demonstrating fetal viability.

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[5] Montenegro N, Ramos C, Matias A, Barros H. Variation of embryonic/fetal heart rate at 6–13 weeks' gestation. *Ultrasound in Obstetrics and Gynecology: The Official Journal of the International Society of Ultrasound in Obstetrics and Gynecology*. 1998;11(4):274-276.

[6] Rauch ER, Schattman GL, Christos PJ, Chicketano T, Rosenwaks Z. Embryonic heart rate as a predictor of first-trimester pregnancy loss in infertility patients after in vitro fertilization. *Fertility and sterility*. 2009;91(6):2451-2454.

[7] Altay MM, Yaz H, Haberal A. The assessment of the gestational sac diameter, crown–rump length, progesterone and fetal heart rate measurements at the 10th gestational week to predict the spontaneous abortion risk. *Journal of Obstetrics and Gynaecology Research*. 2009;35(2):287-292.

[8] Seungdamrong A, Purohit M, McCulloh DH, Howland RD, Colon JM, McGovern PG. Fetal cardiac activity at 4 weeks after in vitro fertilization predicts successful completion of the first trimester of pregnancy. *Fertility and sterility*. 2008;90(5):1711-1715.

[9] Tannirandorn Y, Sangsawang S, Manotaya S, Uerpairojkit B, Samritpradit P, Charoenvidhya D. Fetal loss in threatened abortion after embryonic/fetal heart activity. *International Journal of Gynecology & Obstetrics*. 2003;81(3):263-266.

[10] *Roe v. Wade*, 410 U.S. 113, 159 (1973).



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13. As a trained medical ethicist, I wish to highlight the Hippocratic principle of non-maleficence, which is as essential in the ethical practice of medicine today as it was 2400 years ago.[11] This means that physicians should not do any harm. Induced abortion was explicitly forbidden by the Hippocratic Oath.[12]
14. Out of the ancient framework of Hippocratic medicine, *medical principlism* has become the standard approach to modern clinical ethics. Drawn from the "territory of common morality," its principles are normative and applicable to the broad spectrum of current medical practice.[13] As such, they are self-evident, not requiring prior philosophical reasoning, an idea that dates back to the Enlightenment.[14] This approach has become the *de facto* way to conduct clinical ethics in the academy and at the bedside.
15. In practice, medical principlism uses four widely-accepted principles. As spelled out by Beauchamp and Childress in their authoritative text, *Principles of Biomedical Ethics (8th Ed.)*,[13] these are as follows:
    - *Autonomy* – Patients and their surrogates should be able to make their own decisions.
    - *Non-maleficence* – Healthcare professionals should not cause harm to their patients.

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[11] Bulger RJ, Barbato AL. On the Hippocratic Sources of Western Medical Practice. *The Hastings Center Report*. 2000;30(4):S4-S7. doi:10.2307/3527655.

[12] Edelstein L, Temkin O, Temkin CL. *Ancient medicine; selected papers of Ludwig Edelstein*. Johns Hopkins Press; 1967:xiv, 496 p.

[13] Beauchamp TL, Childress JF. *Principles of biomedical ethics*. Eighth ed. Oxford University Press; 2019.

[14] O'Brien DC. Medical Ethics as Taught and as Practiced: Principlism, Narrative Ethics, and the Case of Living Donor Liver Transplantation. Article. *Journal of Medicine & Philosophy*. 02// 2022;47(1):95-116. doi:10.1093/jmp/jhab039.



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- *Beneficence* – Healthcare professionals must always have the best interests of their patients in mind.
- *Distributive Justice* – The benefits, risks, and costs of health care must be equally distributed among all patients, regardless of age, gender, social class, ethnicity, sexual orientation, ability to pay, religion, handicap, or any other clinically non-relevant trait.

16. These four rules require careful definition and context, specifying what they mean in a given situation, often requiring the weighing and balancing of two or more principles when they conflict. This leads to an important caveat: contrary to common misconceptions, the four principles are not moral absolutes or laws. Instead, they are *prima facie* guidelines. The phrase *prima facie* (Latin: "at first face" or "at first appearance") means that each duty should be fulfilled unless it conflicts, in a particular case, with another equal or stronger obligation.[15] For instance, one might temporarily limit an individual's autonomy if it appears to be in the person's best interests during a complex illness. Or one might justifiably break patient confidentiality to prevent the patient from harming another. When principles conflict, deciding which should prevail is part of the balancing act of ethical deliberation.
17. In popular accounts of principlism, many assume that autonomy is *the* overriding principle that outweighs all others. This assumption is understandable in a society that has become excessively individualistic. However, respect for patient autonomy has only *prima facie* priority, meaning that, all things considered, one should normally respect a patient's autonomous choices. Yet few decisions are entirely personal and

[15] *Prima facie*. 2020. www.merriam-webster.com/dictionary/primafacie.



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fail to impact the choices and actions of others. Public welfare and safety (*e.g.*, a forced quarantine with a dangerous infectious disease outbreak) is an example where overriding moral considerations may require balancing respect for autonomy with other principles such as justice and beneficence.[16]

18. In the matter of induced abortion, the weighing and balancing process of medical principlism means that a pregnant woman's autonomy cannot be the only rule in view where *in utero* life is concerned. The moral principles in conflict are the woman's autonomy against non-maleficence towards the developing fetus. As a matter of medical fact, one can demonstrate that the fetus is viable (at least provisionally) through an ultrasound examination and the determination of a fetal heartbeat. As to the necessity of an abortive procedure, one could specify non-maleficence by stating that a physician should not cause harm unless the harm is necessary (*i.e.*, there is no other alternative) to bring about an essential good (*i.e.*, protecting the woman). In such a case, the balance rests with saving the mother's life and accepting the death of the fetus. If such is not the case, wherein the harm to the fetus is not compellingly necessary, then the balance of duties must favor the continuation of the pregnancy.
19. The plaintiffs allege irremediable actual and potential harms due to Ohio's Heartbeat Act, but their claims are vague and lack documentation. The most serious claim is that limitations to abortion access keep physicians from terminating pregnancies to save a mother's life or prevent serious bodily harm. However, specific exceptions in the Heartbeat Act allow for abortion when it is necessary to prevent a patient's death, as

[16] Truog RD. Expanding the Horizon of Our Obligations in the Clinician-Patient Relationship. *Hastings Center Report*. 2017;47(4):40-41.



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well as when there is "a serious risk of the substantial and irreversible impairment of a major bodily function." R.C. 2919.195(B).

20. Among practicing obstetricians, only 7% perform abortions, which implies that the provision of abortion is not essential for the practice of obstetrics, nor is it necessary for women's health.[17] In the case of a life-threatening maternal medical condition, separation of the fetus can be initiated. The pre-term delivery of a living infant for such a reason, even in the case of pre-viability, does not entail the intent to end fetal life *in utero*, as is the case with induced abortion.

21. The language of the Heartbeat Act is sufficiently clear to allow a competent physician to recognize such conditions as "pre-eclampsia, inevitable abortion, and premature rupture of the membranes, [and] may include, but is not limited to, diabetes and multiple sclerosis, and does not include a condition related to the woman's mental health." R.C. 2919.19(12); R.C. 2919.16(K). Because the law's wording refers explicitly to intrauterine pregnancies, nothing prohibits performing a surgical procedure to remove an ectopic (*e.g.*, tubal) pregnancy, clearly a dangerous condition for women.

22. The often-made claim that abortion is safer than carrying a pregnancy to term should be challenged, since most reports suffer from underreporting, procedural errors, and confirmation bias. An actual meta-analysis reveals a different story. Such a recent study reports the following:

> Of 989 studies, 11 studies from three countries reported mortality rates associated with termination of pregnancy, miscarriage or failed pregnancy. Within a year of their pregnancy outcomes, women experiencing a

[17] Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. *Contraception*. 2018;97(4):297-302.



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pregnancy loss are over twice as likely to die compared to women giving birth. The heightened risk is apparent within 180 days and remains elevated for many years.[18]

23. In terms of mental health outcomes, one careful survey of over 3,000 women demonstrated that those who had an abortion had a 61% increased risk for mood disorders, a 61% increased risk for social phobia, and a 59% increased risk of suicidal ideation. The increased risks for alcohol abuse, alcohol dependence, drug abuse, drug dependence, and any substance use disorder were 261%, 142%, 313%, 287%, and 280%, respectively. A range of 5.8% to 24.7% of the national prevalence of all the above disorders was related to abortion.[19]

24. As mentioned earlier, a meta-analysis offers the most comprehensive and bias-free assessment of these issues. One such recent report considered 22 studies from six countries, with over 800,000 participants, of whom 163,831 had undergone an abortion. There was an 81% increased risk of mental health problems after abortion. The report demonstrated separate increased risks for anxiety disorders, depression, alcohol and substance use/abuse, and suicidal behaviors. Comparing "unintended pregnancy delivered" with "pregnancy aborted," there was a 55% increased risk for women within the latter group to experience a mental health problem.[20]

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[18] Reardon DC, Thorp JM. Pregnancy associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses: A systematic review with a narrative synthesis and meta-analysis. *SAGE Open Med.* 2017;5:2050312117740490. doi:10.1177/2050312117740490.

[19] Mota NP, Burnett M, Sareen J. Associations between abortion, mental disorders, and suicidal behaviour in a nationally representative sample. *Can J Psychiatry.* Apr 2010;55(4):239-47. doi:10.1177/070674371005500407.

[20] Coleman PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *The British Journal of Psychiatry.* 2011;199(3):180-186.



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25. In a large registry study of women in Finland, the mortality rate from suicide was 3.3/100,000 for ongoing pregnancies and for pregnancies ending in birth. By contrast, the mortality from suicide was 21.8/100,000 after termination of pregnancy, compared to 10.2/100,000 among non-pregnant women.[21]

26. Finally, the plaintiffs have repeatedly claimed that the provision of abortion after rape is necessary to preserve a woman's physical and mental health. In a 2015 report on over 19,000 women in two public facilities in Chicago, 1.9% requested abortion as a result of rape.[22] Some members of the medical community may assume that a woman who conceives as a result of rape may have no interest in carrying such a pregnancy to term,[23] but the reality is different. In one study, almost half of women in this situation chose not to abort.[22] For these reasons, abortion should not be considered a mental health treatment after the trauma of abortion.

27. In summary, this analysis has demonstrated that the requirement of an ultrasound examination to determine the presence of a fetal heartbeat is reasonable and consistent with good medical practice. Clinical ethics grounded in medical principlism does not and should not elevate personal autonomy above the duties of beneficence and non-maleficence required of the medical profession. The State of Ohio has a

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[21] Karalis E, Ulander VM, Tapper AM, Gissler M. Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012. *BJOG: An International Journal of Obstetrics & Gynaecology*. 2017;124(7):1115-1121.

[22] Perry R, Zimmerman L, Al-Saden I, Fatima A, Cowett A, Patel A. Prevalence of rape-related pregnancy as an indication for abortion at two urban family planning clinics. *Contraception*. 2015;91(5):393-397.

[23] Prewitt SR. Giving Birth to a Rapist's Child: A Discussion and Analysis of the Limited Legal Protections Afforded to Women Who become Mothers through Rape. *Geo LJ*. 2009;98:827



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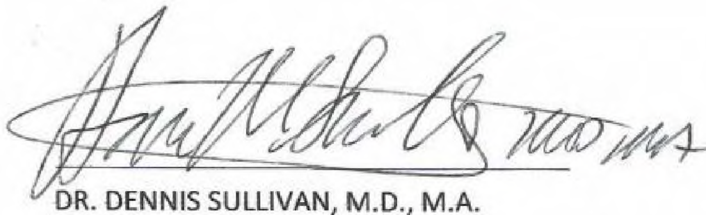
rational basis for limiting the invasive procedure of abortion to cases of true medical necessity. Claims of serious harms to women from such limitations are hypothetical and vague.

28. An elevated view of human life is a common instinct held by most citizens. The unborn human fetus is a complete, developmentally appropriate human being, worthy of a moral status that should grant certain rights and privileges. There is an inherent value to this status, which exists on a continuum from conception until death. As a matter of mere prudence, the State of Ohio has a compelling interest in protecting the lives of the unborn. The Heartbeat Act is a reasonable limitation on the medical community and patients.

I declare under penalty of perjury that the foregoing is true and correct, and if called as a witness I would testify competently thereto.

Dated: September 28, 2022



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September, 2022

# Dennis Michael Sullivan, MD, MA (Ethics), FACS

Professor Emeritus of Pharmacy Practice
Cedarville University
*Curriculum Vitae*

***Degrees***

B.S. (Chemistry, 1974): Youngstown State University, Youngstown, Ohio
M.D. (1978): Case Western Reserve University, Cleveland, Ohio
M.A. (Bioethics, 2004): Trinity Graduate School, Deerfield, Illinois

***Additional Postgraduate Training***

1978-1980: University of Kentucky Medical Center, Department of Surgery, Lexington, Kentucky
1980-1983: Wright State University Affiliated Surgical Program, Dayton, Ohio
1986-1988: 36 Semester Hours towards M.Div., Luther Rice Seminary (New Testament emphasis)
1987-1988: Immersion French language study, University of Laval, Quebec City, Quebec, Canada
1995: Training in ophthalmologic surgery, ECWA Eye Hospital, Kano, Nigeria (3 months)

***Hospital Appointments***

Staff Surgeon, U.S. Army
Colonel Florence A. Blanchfield Army Community Hospital
Fort Campbell, Kentucky
July, 1983 to October, 1985

Staff Surgeon
Emmanuel Medical Center
Cayes-Jacmel, Haiti, West Indies
October, 1988 to July, 1991

Medical Director
Baptist Mid-Missions Hospital
Ippy, Central African Republic
August, 1993 to May, 1996

***Academic Positions Held***

Professor Emeritus of Pharmacy Practice, Cedarville University (1996-2019)
Director, Center for Bioethics, Cedarville University (2006-2019)
Book Review Editor, *Ethics & Medicine* (2020 – present).

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***Honors and Awards***

Omicron Lamda Biology Honorary Fraternity: 1974
Phi Kappa Phi National Honor Society: 1974
Summa cum Laude Undergraduate Degree: 1974
Diplomate, American Board of Surgery: 1985 (Recertified: 1996)
Fellow, American College of Surgeons: 1996
Full Professor with Tenure, Cedarville University: 2003
Faculty Teaching Effectiveness Award: 2009
Emeritus Professor: 2019

***Professional Affiliations***

American Medical Association: since 1983
Christian Medical and Dental Association: since 1996, Ohio Representative since 2015
Center for Bioethics and Human Dignity: since 1999
American Academy of Medical Ethics: Ohio Co-Director since 2019

***Teaching Experience***

1988-1996: Haiti and Central African Republic:
Human Anatomy and Physiology (classroom courses conducted in French)
Pathophysiology, pharmacology, surgical technique (informal instruction in hospital, clinic, and operating room)
1992: Cedarville College: Human Structure and Function (adjunct)
1996-2015: Cedarville University:
Human Anatomy and Physiology
Advanced Anatomy
Pathophysiology
Principles of Bioethics
Bioethics and the Human Experience
Developmental Biology
Bioethics Colloquium
Body and Soul: Foundations of Human Personhood (Honors Seminar)
Bioethics for Educators (graduate course, M.Ed. program)
Graduate Course: Principles of Bioethics (online)
2014-2019: Graduate Course: Pharm. D. curriculum: Bioethics
Graduate Course: Pharm. D. curriculum: Advanced Bioethics
Graduate Course: Pharm. D. curriculum: Pharmacy Law
2009: Trinity Graduate School, Trinity University (adjunct):
Teaching Bioethics (graduate course, MA Bioethics program)
1014, 2016: Bioethics Capstone manager
2016: Wright State University School of Medicine (adjunct)
Introduction to Medical Ethics

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***Research and Writing Interests***

Biomedical Ethics
Developmental Biology
Reproductive Biology and Ethics
End of Life Ethics
Metaphysics and Natural Law
Constitutional Law

***Community Service***

Miami Valley Women's Center – Medical Advisory Board: 2005-2012
Ohio Right to Life: 2007-2012
    Member, Board of Trustees
    Chair, Education Committee
    Chair, Governance and Nominating Committee
    Vice-Chairman of the Board (2009-2012)
Dayton Children's Hospital Ethics Committee – member 2013-2019
IRB Conflict of Interest Committee, Kettering Medical Center – since 2012
Springfield Regional Medical Center Ethics Committee – member 2016-2021
Miami Valley Hospital Ethics Committee – member since 2017

***Faculty Committees***

Pre-Medical Advisory Committee (2003-2009, Chair 2004-2009)
Critical Concern Series Panel (2010-1013)
Faculty Tenure and Promotion Committee (2012-2014; 2015-2018, Chair 2016-2017)
Institutional Review Board (Chair, 2011-2019)

***Publications: Peer-Reviewed***

1. Sullivan DM, Hook TR, Griffen WO, "Biliary Tract Surgery in the Elderly." American Journal of Surgery, 143:218, 1982.

2. Hyde GL, and Sullivan DM, "Fogarty Catheter Tamponade of Ruptured Abdominal Aortic Aneurysms." Surgery, Gynecology, and Obstetrics, 154:197, 1982.

3. Sullivan DM, Francis JW, and Sellers JA, "Reviving the Saracen's Head: A Commentary on the New Biotechnologies," *Ethics & Medicine*, *15*:3, 1999.

4. Sullivan, DM, "A Thirty-Year Perspective on Personhood: How Has the Debate Changed?" *Ethics & Medicine, 17*:3 (2001).

5. Sullivan, DM, "The Conception View of Personhood: A Review," *Ethics & Medicine, 19*:1 (2003).

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6. Sullivan, DM, "Euthanasia Versus Letting Die: Christian Decision-Making in Terminal Patients," *Ethics & Medicine, 21*:2, 2005.

7. Sullivan, DM, "The Oral Contraceptive as Abortifacient: An Analysis of the Evidence," *Perspectives on Science and Christian Faith*, *58*:3, 2006.

8. Sullivan, DM, "Stem Cells 101," Center for Bioethics and Human Dignity, www.bioethics.com/stem-cells-101, September 22, 2006.

9. Sullivan, DM, "End of Life Decisions 101," Center for Bioethics and Human Dignity, www.bioethics.com/end-of-life-101, November 17, 2006.

10. Sullivan, DM, "Reproductive Technologies 101," www.bioethics.com/reproductive-technologies-101, Center for Bioethics and Human Dignity, February 14, 2007.

11. Sullivan, DM and SA Salladay, "Gene Therapy: Restoring Health or Playing God?" *Journal of Christian Nursing 24:*4, 2007.

12. Sullivan, DM and K Schoonover-Shoffner, "Sorting through the Stem Cell Hype," *Journal of Christian Nursing 24:*4, 2007.

13. Sullivan, DM, "Defending Human Personhood: Some Insights from Natural Law," *Christian Scholars Review 37*:3 (Spring 2008).

14. Sullivan, DM and A Costerisan, "Complicity and Stem Cell Research: Countering the Utilitarian Argument," *Ethics & Medicine 24*:3 (Fall, 2008).

15. Sullivan, DM and SA Salladay, "Clinical Ethics Case Consultation: Is It Permissible To Forgo Emergent Restorative Surgery In This Case?" *Ethics & Medicine, 25*:1, Spring, 2009.

16. Sullivan, DM, "Genetic Ethics 101," www.bioethics.com/genetic-ethics-101, Center for Bioethics and Human Dignity, October, 2010.

17. Lewis, JD, and Sullivan, DM, "The Abortifacient Potential of Emergency Contraceptives." *Ethics & Medicine 28*:3, Fall, 2012.

18. Anderson, DC, and Sullivan, DM, "Plan B and the German Catholic Bishops," *Annals of Pharmacotherapy 47*: 1079-1080, July 2013.

19. Sullivan, DM, "Ebola: Ethical and Legal Ramifications of Using Experimental Drugs," *Westlaw Journal Health Law*, 22 No. 7, December 2014.

20. Sullivan, DM, and John, TM, "Human Embryo Metaphysics and the New Biotechnologies," *Christian Scholar's Review 45:4* (Summer, 2016).

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21. Lail, A and Sullivan, DM, "Removing Implantable Defibrillators at the End of Life: An Ethical Analysis." *Bioethics Network of Ohio Quarterly 27*:3, 2017.

22. Sullivan, DM and Taylor, RM, "The Ethical Landscape of Assisted Suicide: A Balanced Analysis," *Ethics & Medicine 34*:1 (Spring, 2018).

23. Ward, JA, Anderson, DC, and Sullivan, DM, "A Pharmacists Dilemma," Ethics & Medicine 35:1, Spring, 2019.

24. Sullivan, DM, "Professionalism, Autonomy, and the Right of Conscience: A Call for Balance," *Ethics, Medicine, and Public Health 11*:11-15, December, 2019.

25. Handy, J and Sullivan, DM, "Is Medical Education Ethical?" *Bioethics in Faith and Practice 4*:1; December, 2019.

26. Gross, S and Sullivan, DM, "Conscience Rights and Patient Trust in Pharmacy Practice," *Northern Plains Ethics Journal 8*:1, Fall, 2020.

27. Paul Hoehner, David H. Beyda, William P. Cheshire, Robert E. Cranston, John T. Dunlop, John E. Francis, C. Ben Mitchell, Cheyn Onarecker, D. Joy Riley, Allen H. Roberts, II, Dennis M. Sullivan, Christine C. Toevs, Ferdinand D. Yates, Jr., Christopher Hook, "Triage and resource allocation during crisis medical surge conditions (pandemics and mass casualty situations): A position statement of the Christian Medical and Dental Associations." *Christian Journal for Global Health*, 2020; 7(1):45-55.

28. Haymond, ML, Cailor, SM, and Sullivan, DM, "Immunocontraceptive Vaccines: An Ethical Analysis." *Dignitas 26*:1, January, 2021.

***Publication: Textbook:***

Sullivan, DM, Anderson, DC, and Cole, JW, *Ethics in Pharmacy Practice: A Practical Guide*. Springer Nature (2021).

***Publications: Academic, Non-Peer Reviewed:***

1. Sullivan, DM, "The Need for Exceptions to Ethical Guidelines," policy comment on "Ethical and Policy Issues in Research Involving Human Participants," *National Bioethics Advisory Commission*, Feb. 16, 2001.

2. Sullivan, DM, Research Proposal (CCCU): *Transhumanist Ethics in a Post-Modern World*, January 2004.

3. Sullivan, DM, "Would God 'Play' This Way?" (letter), *Perspectives on Science and Christian Faith*, *56*:3, September, 2004.

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4. Sullivan, DM, "Stem Cell Research and Moral Complicity," published at www.pregnantpause.org/ethics/complicity.htm, February 15, 2006.

5. Sullivan, DM and HG Kuruvilla, "Thinking the Unthinkable: A Response to 'After-Birth' Abortion," *Christianity and Pharmacy, 15*:1, June, 2012.

6. Sullivan, DM, "Medical Ethics: Rooted in Natural Law." White Paper for the American College of Pediatricians, October, 2016. Available at: www.acpeds.org.

7. Hoehner, P and Sullivan, D, "An Introduction to Medical Principlism," teaching paper for medical education.

***Publications: Popular-Level:***

1. Sullivan, DM, "Common Sense Should Rule the Debate," (editorial article on partial-birth abortion), *Dayton Daily News*, January 28, 2001.

2. Sullivan, DM, "Making Sense of the Stem Cell Controversy," *Cedarville University Torch*, Spring, 2007.

3. Sullivan, DM, "A Blessing in Disguise," *Cedarville University Torch*, Spring, 2007.

4. Sullivan, DM, "The Missing Peace," *Cedarville University Torch*, Spring, 2010.

5. Sullivan, DM, "We Are Not Our Own," *Christianity Today*, July, 2011.

6. Sullivan, DM, "Gene Editing and Designer Babies: Why the Future Desperately Needs Us," *Answers Magazine*, January-March, 2016.

7. Sullivan, DM, "We Believe in Human Life as Fearfully and Wonderfully Made," *Cedarville Magazine*, Spring/Summer, 2016.

8. Sullivan, DM, "Should We Try to Live Forever?" *Answers Magazine*, October-November, 2016.

9. Sullivan, DM, "Should We Update God's Design?" *Answers Magazine*, July-August, 2017.

10. Sullivan, DM, "Thinking it Through: Chinese video creates an ethics firestorm," (editorial article on gene-edited babies), *Dayton Daily News*, November 30, 2018.

11. Sullivan, DM, "Gene-Edited Babies: Deep Ethical Concerns," (editorial article), *Columbus Dispatch*, December 6, 2018.

***Book Reviews:***

1) Sullivan, DM, "Review of Shannon TA & Aulisio MP: *Genetics: Science, Ethics, and Public Policy (Readings in Bioethics)*," *Ethics & Medicine 23:*1, Spring, 2007.

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2) Sullivan, DM, "Review of Collins F: *The Language of God: A Scientist Presents Evidence for Belief*," *Ethics & Medicine 23:*2, Summer, 2007.

3) Sullivan, DM, "Review of Mitchel CB: *Biotechnology and the Human Good*," *Journal of Markets and Morality 11*:1, Spring 2008.

4) Sullivan, DM, "Review of George RP and Tollefsen C: *Embryo: A Defense of Human Life*," *Ethics & Medicine, 26*:1, Spring, 2010.

5) Sullivan, DM, "Review of Peterson J: *Changing Human Nature: Ecology, Ethics, Genes, and God*," *Journal of Christian Nursing 29*(1), January-March, 2012.

6) Sullivan, DM, "Review of Wilkens S: *Beyond Bumper Sticker Ethics: An Introduction to Theories of Right and Wrong (2nd Ed.)*, *Ethics & Medicine, 28*:2, Summer, 2012.

7) Sullivan, DM, "Review of Foley EP: *The Law of Life and Death*," *Ethics & Medicine 28*:3, Fall, 2012.

8) Sullivan, DM, "Review of: Balaguer M: *Free Will*," *Ethics & Medicine 32*:1, Spring, 2016.

9) Sullivan, DM, "Review of Losing Our Dignity: How Secularized Medicine is Undermining Fundamental Human Equality, by Charles C. Camosy, *Ethics & Medicine,* early access May, 2022 (online: www.ethicsandmedicine.com/book-review-losing-our-dignity/).

***Scholarly Review Activities:***

1. Reviewer, *Hole's Human Anatomy and Physiology*, 8th Ed., by Shier D, Butler J, and Lewis R, WCB/McGraw-Hill Publishers, 1998.

2. Reviewer, *Anatomy and Physiology: The Unity of Form and Function*, 2nd Ed., by Saladin, Kenneth S, WCB/McGraw-Hill Publishers, reviewed December, 1998, publication date January 2000.

3. Reviewer, *Anatomy and Physiology*, 5th Ed., by Seeley R, Stephens T, and Tate P, WCB/McGraw-Hill Publishers, reviewed December, 1998, publication date January 2000.

4. Human Interactive Physiology Project, Advisory Panel (McGraw Hill Publishers), August 1999 – June 2001.

5. Reviewer, *Human Anatomy and Physiology: A Functional Approach*, by Joseph Crivello, McGraw-Hill Publishers, reviewed October, 2003.

6. Reviewer, Bioethics: *An Introduction for the Biosciences*, published by Oxford University Press, 2005.

7. Reviewer, Bioethics: *An Introduction for the Biosciences* (3rd Ed.), published by Oxford University Press, 2010.

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8. Reviewer, *Vaccine*, published by Elsevier, 2004 – 2006.

9. Reviewer, *Oncology & Hematology Review*, 2014.

10. Conference Paper Review Committee, Center for Bioethics and Human Dignity, 2015 – 2017.

11. Senior Editor, *Bioethics in Faith and Practice* (Cedarville University Center for Bioethics), 2015 – 2019.

12. Reviewer, Creation Science Fellowship, 2016 – present.

13. Editorial Review Board, *Dignitas Journal*, 2017 – present.

14. Editorial Review Board, *Issues in Law and Medicine*, 2018 – present.

15. Reviewer, *Christian Journal for Global Health*, 2018 – present.

16. Guest Editor, *Ethics, Medicine, and Public Health*, December, 2019 issue.

17. Book Review Editor, *Ethics & Medicine*, 2020 – present.

***Research / Training Grants:***

1) Cedarville Technology Incentive Grant, "Human Histology Web Site," May 1998.

2) Cedarville Faculty Scholarship Summer Grant, "The Bioethical Implications of Personhood," May 2000.

3) Cedarville Technology Incentive Grant, "A Web Site for Bioethics" May 2001.

4) Cedarville Faculty Scholarship Summer Grant, "Stem Cells and Moral Analogies," May, 2003.

5) Cedarville Faculty Scholarship Summer Grant, "Non-Destructive Sources for Embryonic Stem Cells: A Moral Analysis," May, 2007.

6) Cedarville Faculty Scholarship Summer Grant, "The Abortifacient Potential of Emergency Contraceptives," with Jeffrey D. Lewis, May, 2010.

7) Cedarville Faculty Scholarship Summer Grant, "Embryos, Metaphysics, and Morals: Human Personhood and the New Biotechnologies," May, 2013.

## *Selected Additional Scholarly Activities:*

***International Teaching Projects:***

1) Visiting Professor, Republic of Vietnam, June 15 – June 25, 1998:

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a. Five-day seminar: "Cardiovascular Anatomy and Physiology: An Integrated Approach," Medical College of Hue, Republic of Vietnam, June 16-20, 1998.
b. Clinical lectures: "The Abdominal Exam," and "Highly Selective Vagotomy," Hue General Hospital, Republic of Vietnam, June 18-19, 1998.
c. Seminar: "Methods of Anatomy/Physiology Integration" Medical College of Hanoi, Republic of Vietnam, June 23, 1998.
d. Seminar: "Teaching Exercise Physiology" (taught in French), Medical College of Haiphong, Republic of Vietnam, June 25, 1998.

2) Visit to Koumra Medical Center, Chad, Africa: July 21 – August 20, 1999:
   a. Twenty-hour seminar: "Cardiovascular Anatomy and Physiology: An Integrated Approach," Koumra Medical Center, Koumra, Chad (taught in French).
   b. Clinical Instruction in Pathophysiology and Clinical Medicine for African health care workers
   c. Operating room instruction in General Surgery (taught in French).
   d. Instruction in medicine, surgery, and obstetrics for Cedarville College students

3) Visiting Professor, Republic of Vietnam, December 4, 1999 – December 21, 1999:
   a. Five-day Medical Student Seminar: "Clinical Neuroanatomy and Neurophysiology: An Integrated Approach," Hanoi Medical College, Republic of Vietnam, December 6-10, 1999.
   b. Clinical lecture: "Exercise Physiology," Hanoi, Republic of Vietnam, December 10, 1999.
   c. Two-day Medical Student Seminar: "Selected Topics in Neuroanatomy and Neurophysiology," Medical College of Hue, Republic of Vietnam, December 16-17, 1999.
   d. Medical Faculty Seminar: "Teaching Critical Thinking in Anatomy and Physiology," Medical College of Hue, Republic of Vietnam, December 17, 1999.

4) Visit to Ippy Medical Center, Central African Republic: August 2, 2000 – August 28, 2000:
   a. Twelve-hour seminar: "Cardiovascular Anatomy and Physiology: An Integrated Approach," Ippy Medical Center, Ippy, CAR (taught in French).
   b. Clinical Instruction in Pathophysiology and Clinical Medicine for African health care workers (taught in French).
   c. Operating room instruction in General and Ophthalmic Surgery (taught in French).
   d. Instruction in medicine, surgery, and obstetrics for Cedarville University students.

5) Visiting Professor, New Delhi, India: July 24 – July 29, 2011. Workshop on Clinical Ethics, Emmanuel Hospital Association, Clarion Hotel.

***Public Legislative Testimony:***

1) Public Testimony, Ohio House Health Committee: Support of H.B. 228, "Comprehensive Abortion Ban," Statehouse, Columbus, Ohio, June 13, 2006.

2) Public Testimony, Ohio Senate Civil Justice Committee: Support of S.B. 174, "Human Cloning Ban," Statehouse, Columbus, Ohio, March 11, 2008.

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3) Public Testimony, Ohio Senate Human Services & Aging Committee: Support of SUB H.B. 125 "Heartbeat Informed Consent Bill," Ohio Statehouse, Columbus, Ohio, December 13, 2011.

4) Public Testimony, Ohio House Health Committee: Support of HB 171 "Ban on Human Cloning and Animal-Human Hybrids," Ohio Statehouse, Columbus, Ohio, December 14, 2011.

5) Public Testimony, Ohio House Community and Family Advancement Committee: Support of H.B. 135 "Down Syndrome Non-Discrimination Act," Ohio Statehouse, Columbus, Ohio, May 20, 2015.

6) Public Testimony, Ohio Senate Judiciary Committee: Support of S.B. 145, "Dismemberment Abortion Ban," Ohio Statehouse, Columbus, Ohio, June 20, 2017.

7) Public Testimony, Ohio Senate Health, Human Services, and Medicaid Committee: Support of S.B. 164, "Down Syndrome Non-Discrimination Act," Ohio Statehouse, Columbus, Ohio, August 22, 2017.

8) Public Testimony, Ohio House Health Committee: Support of H.B. 124, "Down Syndrome Non-Discrimination Act," Ohio Statehouse, Columbus, Ohio, September 20, 2017.

9) Public Testimony, Ohio Senate Health, Human Services, and Medicaid Committee: Support of S.B. 23, "Human Heartbeat Protection Act," Ohio Statehouse, Columbus, Ohio, March 6, 2019.

***Public Ethics Debates:***

1) Public Debate: "Ethics of Human Embryonic Stem Cell Research," with Robert Reese, Ph.D. (Wright State University School of Medicine), and Ann McWilliams, Ph.D. (United Theological Seminary), First Presbyterian Church of Fairborn, October 18, 2005.

2) Public Debate: "Assisted Suicide: Compassionate Care or Slippery Slope?" with Robert Reese, Ph.D. (Wright State University School of Medicine), and Ann McWilliams, Ph.D. (United Theological Seminary), Cedarville University, April 4, 2006.

3) Public Debate: "Free Will: Does it Exist? Does it Matter?" with William Provine, PhD (Cornell University), Grace Community Church, Washington Courthouse, Ohio, March 13, 2010.

4) Debate Moderator: "The Ethics of Abortion," University of Cincinnati School of Medicine (co-sponsored by Christian Medical Association and Medical Students for Choice), February 18, 2014.

5) Academic Panel Moderator, Case Study Debates: 1) Lethal Injection and the Pharmacy Profession, and 2) Contraceptives and Pharmacist Rights of Conscience. Ohio Pharmacists Association Annual Meeting, Columbus, April 23, 2017.

6) Debate Moderator: "Addressing the Opioid Crisis: What is the Best Strategy?" Cedarville University, October 30, 2017.

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7) Academic Panel Moderator, Case Study Debates: 1) Limitations on Naloxone Use for Opioid Addiction, and 2) Making Marijuana a C-III Drug. Ohio Pharmacists Association Annual Meeting, Columbus, April 22, 2018.

***Hospital Ethics Committee Presentations:***

1) Invited Presentation: "Organ Donation after Cardiac Death," Greene Memorial Hospital Ethics Committee, Xenia, Ohio, May 10, 2007.

2) Invited Presentation: "Organ Donation after Cardiac Death (part II)," Greene Memorial Hospital Ethics Committee, Xenia, Ohio, June 27, 2007.

3) Invited Presentation: "Where Do Ethical Rules Come From?" Greene Memorial Hospital Medical Ethics Committee, Xenia, Ohio, August 21, 2007.

4) Invited Presentation: "Clinical Decision-Making in Terminal Patients," Greene Memorial Hospital Medical Ethics Committee, Xenia, Ohio, November 20, 2007.

5) Invited Presentation: "Clinical Case Analysis: Ventilator Withdrawal," Greene Memorial Hospital Medical Ethics Committee, Xenia, Ohio, January 31, 2008.

6) Invited Presentation: "Medical Futility," Greene Memorial Hospital Medical Ethics Committee, Xenia, Ohio, March 25, 2008.

7) Invited Presentation: "Resource Management Case Study" Greene Memorial Hospital Medical Ethics Committee, Xenia, Ohio, November 25, 2008.

8) Invited Presentation "The Hippocratic Tradition in Medicine," William Beaumont Hospital System, Grosse Point, Michigan, Dec. 8, 2008.

9) Invited Presentation, "Where Do Ethical Rules Come From?" Ethics Committee, Dayton Children's Hospital, November 11, 2014.

10) Invited Presentation, "Health Care Rights of Conscience: What are the Limits?" Mercy Memorial Hospital, May 8, 2015.

11) Invited Presentation, "The Ethics of the Charlie Gard Case" Ethics Committee, Dayton Children's Hospital, August 15, 2017.

12) Invited Presentation, "Physician-Assisted Suicide: A Balanced Perspective," Miami Valley Hospital Ethics Committee, Dayton, Ohio, October 25, 2017.

13) Invited Presentation, "Cross-Cultural Differences in Communication," Ethics Committee, Dayton Children's Hospital, November 14, 2017.

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14) Invited Presentation, "Brain Death and Organ Donation: New Ethical Controversies," Miami Valley Hospital Ethics Committee, Dayton, Ohio, January 24, 2018.

15) Invited Presentation, "Medical Futility," Ethics Committee, Dayton Children's Hospital, July 9, 2018.

16) Invited Presentation, "Normative Ethics," Soin Medical Center Medical Executive Committee, July 12, 2018.

17) Invited Presentation, "The Ethics of Medical Marijuana," Miami Valley Hospital Ethics Committee, Dayton, Ohio, November 24, 2018.

18) Invited Presentation, "Ethics and the Mount Carmel Hospital Scandal," Miami Valley Hospital Ethics Committee, Dayton, Ohio, April 24, 2019.

19) Invited Presentation, "Case Study: Defining Life-Sustaining Treatments," Miami Valley Hospital Ethics Committee, Dayton, Ohio, January 22, 2020.

20) Invited Presentation, "Ethical Lessons from the Pandemic," Miami Valley Hospital Ethics Committee, Dayton, Ohio, April 28, 2021.

21) Invited Presentation, "The Ethics of Direct-to-Consumer Genetic Testing," Miami Valley Hospital Ethics Committee, Dayton, Ohio, July 28, 2021.

***Other Scholarly Activities:***

1) Faculty Seminar Presentation: "A Physician Looks at Crucifixion," Cedarville University, April 10, 1998.

2) Chairman and Co-coordinator, Conference on Bioethical Issues, Cedarville University / Mount Vernon Nazarene University (annually in the fall): 2000 – 2007.

3) Panel Discussion: *Religion and Medicine*, Medical University of Ohio (Toledo), April 20, 2005.

4) Presentations: "Human Personhood and Bioethics," Summit Ministries, June 28, 2005.

5) Paper presentation: "Teaching Bioethics across the Disciplines: A 'Survival Kit' for Undergrads," International Bioethics Conference, Chicago, IL: Center for Bioethics and Human Dignity, July 16, 2005.

6) Paper Presentation: "Stem Cells and Moral Analogies," Pro-Life Science and Technology Symposium, Dayton, OH, September 24, 2005.

7) Panel Discussion: *Religion and Medicine*, Medical University of Ohio (Toledo), April 20, 2006.

8) Presentations: "Human Personhood and Bioethics," Summit Ministries, June 29, 2006.

9) Paper Presentation: "Complicity and Stem Cell Research: Countering the Utilitarian Argument," International Bioethics Conference, Chicago, IL: Center for Bioethics and Human Dignity, July 15, 2006.

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10) Invited Conference Speaker, "Bioethics in the New Millennium:" Midwest Regional Physician's Symposium for the Christian Medical and Dental Association, October 27-29, 2006 (five presentations).

11) Invited Presentation: "The Ethics of Stem Cell Research," Christian Medical Association, University of Cincinnati School of Medicine, November 9, 2006.

12) Invited Presentation: "Reproductive Ethics," Christian Legal Association, University of Dayton Law School, November 16, 2006.

13) Invited Presentation: "Stem Cells and Moral Complicity," American Association of Pro-Life Obstetricians and Gynecologists Annual Meeting, Fort Lauderdale, Florida, January 27, 2007.

14) Keynote Speaker, Ethics Conference, Kentucky Christian University, March 1-2, 2007 (four presentations).

15) Honors Seminar Panel: "Abortion and Personhood," Mount Vernon Nazarene University, March 5, 2007.

16) Faculty Workshops: "Blogging and Podcasting for the Classroom," May 14 & 16, 2007. Cedarville University.

17) Invited Presentations: Christian Medical and Dental Association Annual Meeting, Orlando, Florida:
    a. Two-hour Workshop: "Using Scripture in Moral Debate," June 21 & 23, 2007
    b. Two-hour Workshop: "End of Life Case Studies," June 22 & 23, 2007.

18) Presentations: "Human Personhood and Bioethics," Summit Ministries, June 28, 2007.

19) Panel Presentation: "New Technologies for Teaching Bioinformatics," Ohio Collaborative Conference on Bioinformatics, Miami University, Oxford, Ohio, July 11, 2007.

20) Invited Faculty, "Beginning of Life Issues," Bioethics Institute, Trinity International University, Chicago, IL, Jul 12, 2007.

21) Paper Presentation, "Embryonic Stem Cells from Non-Destructive Sources: A Way Out of the Ethical Quagmire?" American Scientific Affiliation Annual Meeting, Edinburgh University, Edinburgh, Scotland, August 4, 2007.

22) Invited Presentation: "The Ethics of Physician-Assisted Suicide," University of Cincinnati School of Medicine (Christian Medical Association), November 14, 2007.

23) Invited Presentation: "The Ethics of Physician-Assisted Suicide," University of West Virginia School of Medicine (Christian Medical Association), November 16, 2007.

24) Invited Presentation, "New Ideas in Stem Cell Research," American Association of Pro-Life Obstetricians and Gynecologists (Annual Meeting), Fort Lauderdale, Florida, January 19, 2008.

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25) Invited Presentation: "The Ethics of Stem-Cell Research," Wright State University School of Medicine, January 29, 2008.

26) Invited Presentation, "Ethical Analysis of the Savita Halappanavar Case: Conflicts of Duty and Unintended Consequences," American Association of Pro-Life Obstetricians and Gynecologists (Annual Meeting), Washington, DC, February 22, 2008.

27) Invited Presentation: "A Physician Looks at Crucifixion," University of Cincinnati School of Medicine (Christian Medical Association), March 5, 2008.

28) Keynote Speaker: Annual Meeting of Association of Healthcare Documentation, March 15, 2008:
    a. "Where do Ethical Rules Come From?"
    b. "Physician-Assisted Suicide"

29) Invited Presentation: "Health Care Rights of Conscience: The Current Crisis," University of Indiana School of Medicine, Indianapolis, Indiana, March 25, 2008.

30) Keynote Speaker: Nurses Christian Fellowship Conference, Wichita, Kansas, April 11, 2008:
    a. "Introduction to Ethical Theory"
    b. "Stem Cell Research: Medical Promise and Moral Perils"
    c. "Stem Cell Research: New Developments and Ethical Implications"
    d. "Genetic Enhancement: What Are the Biblical Limits?"
    e. "Bioethics, Christianity, and Culture"

31) Invited Presentation: "Physician Rights of Conscience," Christian Medical and Dental Association, Wichita, Kansas, April 11, 2008.

32) Invited Presentation: "Abortion: Both Sides of the Story," Christian Graduate Student Association, Ohio State University, May 9, 2008.

33) Presentations: "Human Personhood and Bioethics," Summit Ministries, June 19, 2008.

34) Panel Moderator: "Medical Tourism," Combined Bioethics Institutes, Trinity International University, Chicago, IL, July 16, 2008.

35) Invited Faculty, "Beginning of Life Issues," Bioethics Institute, Trinity International University, Chicago, IL, Jul 17, 2008.

36) Invited Presentation: "Health Care Rights of Conscience," Christian Medical Association, Wright State University, October 22, 2008.

37) Invited Plenary Address: "Human Personhood at the Beginning of Life: Medical and Philosophical Reflections." Evangelical Philosophical Society Annual Conference, March 21, 2009.

38) Invited Presentation: "The Ethics of Physician-Assisted Suicide," University of Cincinnati School of Medicine (Christian Medical Association), March 25, 2010.

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39) Panel Discussion: "Health Care Rights of Conscience," Ohio State University Law School (Christian Legal Society), April 9, 2010.

40) Ohio University School of Medicine (Athens, Ohio): Bioethics Seminar (May 11-12, 2010). Three presentations:
    - Update on Stem Cell research
    - Conscience Rights in Health Care
    - Health Care Reform

41) Paper Presentation: "Free Will and Bioethics," International Bioethics Conference, Chicago, IL: Center for Bioethics and Human Dignity, July 17, 2010.

42) Paper Presentation: Human Free Will and its Relationship to Bioethics," Baylor Symposium on Faith and Culture, Baylor, Texas, October 30, 2010.

43) Event Coordinator, Health Care Ethics 2011: Ministering at the End of Life, Cedarville University, September 15-16, 2011.

44) Invited Presentation: "Brain Death: New Ethical Controversies," Health Care Ethics 2011: Ministering at the End of Life, Cedarville University, September 16, 2011.

45) Keynote Speaker: "Bioethics in a Culture of Choice." Midwest Regional Conference, Christian Medical and Dental Association, October 21-23, 2011, Maranatha Conference Center, Muskegon, MI (five presentations).

46) Invited Presentation: "Pharmacy Rights of Conscience," Christian Pharmacy Fellowship Students Chapter, Ohio Northern University, Ada, Ohio, February 14, 2012.

47) Paper Presentation: "Promoting Respect for Moral Integrity in Undergraduate Education," International Conference for Education in Ethics, Duquesne University, Pittsburgh, PA, May 2, 2012.

48) Invited Presentation, "Ethical Dilemmas in Missions," Global Missions Health Conference, November 8, 2012.

49) Keynote Speaker, "Medical Ethics in the 21st Century" (three presentations), Virginia College of Osteopathic Medicine, February 28 – March 2, 2013.

50) "Ethical Dilemmas in Missions" (three presentations), Medical Missions Interface, Association of Baptists for World Evangelism, Harrisburgh, PA, June 7, 2013.

51) "Ethics Training for Med Students," Webcast, Medical Students for Life, June 20, 2013.

52) "Medical Professionalism," presentation to first year med students, Boonshoft School of Medicine, Wright State University, October 16, 2013.

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53) Invited Presentation: "Medical Futility: Who Decides?" VITAS Hospice Care, Cincinnati, Ohio, October 17, 2013.

54) Keynote speaker, Christian Bioethics Conference (three presentations), Virginia College of Osteopathic Medicine, Blacksburg, VA, November 1-2, 2013.

55) Paper Presentation: "Embryos, Metaphysics, and Morals: Human Personhood and the New Biotechnologies," Society of Christian Philosophers, Mountain-Pacific Region Annual Meeting, April 4, 2014.

56) Published Interview, "ACA shifts liability to patients: Bioethicists must be 'watchdogs' to ensure ethical care." *Medical Ethics Advisor, Vol. 30*, No. 12, December 2014.

57) Professional Development: Clinical Ethics Immersion, MedStar Washington Hospital Center, Washington, D.C., November 7-10, 2014.

58) Academic Consultation on Emergency Contraception, Center for Bioethics and Human Dignity, Trinity University, Chicago, IL, February 6, 2015.

59) Published Interview, "Ethical controversy erupts over minors' autonomy." *Medical Ethics Advisor, Vol. 31*, No. 3, March 2015.

60) Vaccine Forum (Panel Member), Cedarville University, April 14, 2015.

61) Invited Presentation, "Physician Assisted Suicide," Christian Medical and Dental Association Annual Meeting, May 2, 2015.

62) Invited Presentation, "Ebola: The Ethics of Experimental Drugs," Christian Medical and Dental Association Annual Meeting, May 2, 2015.

63) Invited Presentation, "Where Do Ethical Rules Come From?" Springfield Regional Medical Center, May 7, 2015.

64) Intensive Media Training, Christian Medical and Dental Association, Bristol, Tennessee, June 1-2, 2015.

65) Refereed Presentation, "Moral Complicity in Healthcare Conscience Claims," International Conference on Bioethics, Trinity University, June 19, 2015.

66) Published Interview, "Patient records doctor's insulting comments." *Medical Ethics Advisor. Vol. 31*, No. 8, August, 2015.

67) Published Interview, "Dealing with Inter-Professional Ethical Conflicts." *Medical Ethics Advisor, Vol. 31*, No. 11, November, 2015.

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68) Invited Presentation, "Proportionality and Double-Effect: Treatment Withdrawal in Young Patients," Dayton Children's Hospital Grand Rounds, December 16, 2015.

69) Annual Convention, Christian Medical and Dental Association, Asheville, North Carolina, April 21-24, 2016.

70) Advanced Directives Policy Review and Revision, Springfield Regional Medical Center Ethics Committee, July 27, 2016.

71) Medical Ethics Teaching at Boonshoft School of Medicine, Wright State University, July 25-August 4, 2016.

72) Invited Presentation, "The Ethics of Assisted Suicide," Boonshoft School of Medicine, Wright State University, November 9, 2016.

73) Academic Consultation on Healthcare Conscience Rights, Center for Bioethics and Human Dignity, Trinity University, Chicago, IL, December 3, 2016.

74) Invited Presentation, "Overriding Parental Rights in a Pediatric Patient," Dayton Children's Hospital Grand Rounds, December 7, 2016.

75) Keynote Address, "Current Controversies in Medical Ethics," Christian Medical and Dental Association, Cincinnati Chapter, April 23, 2017.

76) Keynote Address, "Assisted Suicide: Shifting Paradigms of Physician Assisted Death." Bioethics Network of Ohio Annual Conference, Columbus, Ohio, April 28, 2017.

77) Invited Presentation: "Rights of Conscience: Lessons from the Stormans Case." Christian Medical and Dental Association Annual Meeting, Asheville, North Carolina, May 6, 2017.

78) Invited Presentation: "Brain Death: New Ethical Controversies," Christian Medical and Dental Association, Ohio State University, August 29, 2017.

79) Invited Presentations: Annual Chaplains Conference, Holzer Health System, Gallipolis, Ohio, October 19, 2017: "Philosophical and Spiritual Aspects of Suicide"

80) Invited Presentation: Kettering Medical Center Grand Rounds: "Medical Futility." April 13, 2018.

81) National Webinar: "The Changing Ethical Landscape of Assisted Suicide," Leading Edge Hospice Group, April 18 and April 19, 2018.

82) Invited Presentation: "Update on Assisted Suicide." Christian Medical and Dental Association Annual Convention, Asheville, North Carolina, April 27, 2018.

83) Invited Presentation: "The Ethics of Gene Editing." Christian Medical and Dental Association Annual Convention, Asheville, North Carolina, April 28, 2018.

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84) Invited Presentation: "Normative Ethics and Professionalism," Fourth Annual OSU Ethics Conference, Ohio State University, Columbus, Ohio, October 5, 2018.

85) Professional Development: Clinical Ethics Immersion, MedStar Washington Hospital Center, Washington, D.C., November 2-5, 2018.

86) Invited Presentation: "Pharmacists and Assisted Suicide," CPE Morning Lecture, Springfield Regional Medical Center, Springfield, Ohio, November 14, 2018.

87) Conference Chairman: "Healthcare Rights of Conscience," co-sponsored by Cedarville University and the International Academy of Medical Ethics and Public Health, Cedarville, Ohio, June 6-8, 2019.

88) Published Interview, "Ethical Policies if Critical Care Resources Become Scarce, *Medical Ethics Advisor*, April 15, 2020.

89) Invited Presentation: "Assisted Suicide," Christian Medical and Dental Association, University of Cincinnati, January 13, 2020.

90) Invited Presentation: "Moral Complicity," Christian Medical and Dental Association, University of Cincinnati, July 13, 2020.

91) Invited Presentation: "Medical Principlism" Christian Medical and Dental Association Annual Convention, April 28, 2021.

92) Invited Presentation: "Ethical Lessons from the Pandemic," Christian Medical and Dental Association, Chicago Chapter, May 20, 2021.

93) Invited Presentation: "Moral Complicity," Christian Medical and Dental Association, Chicago Chapter, June 24, 2021.

***Popular-Level Presentations:***

94) Invited Presentation: "Ethical Controversies in Stem Cell Research," Cafe Scientifique, Cox Arboretum, Dayton, Ohio, January 26, 2006.

95) Invited Presentation: "Stem Cell Research: Medical Promise and Moral Problems," MENSA Annual Regional Gathering, April 1, 2006, Doubletree Hotel, Dayton, Ohio.

96) Paper Presentation: "Terri Schiavo: the 'Real' Story," Pro-Life Science and Technology Symposium, Engineers Club, Dayton, Ohio, September 23, 2006.

97) WLQT Radio Interview: aired January 7, 2007: "The Center for Bioethics at Cedarville University."

98) Invited Presentation: "Stem Cell Research: Consider the Source," Dayton Right to Life Rally, University of Dayton, March 4, 2007 (two presentations).

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99) Cedarville University Chapel Address, "The Ethics of Homosexuality," March 29, 2007.

100) Invited Presentation: "The Ethics of Stem Cell Research," University of Dayton Students for Life, April 12, 2007.

101) Paper Presentation: "New Ideas in Stem Cell Research," Pro-Life Science and Technology Symposium, Engineers Club, Dayton, Ohio, September 22, 2007.

102) Trinity Lecture Series: "Being Human in the Twenty-First Century," Trinity Reformed Episcopal Church, Mason, Ohio, November 10, 2007 (three presentations).

103) Invited Presentation: "Human Experimentation: An Unhappy Legacy," Legatus of Cincinnati, August 12, 2008.

104) Invited Presentation: "Ethics and the Embryo," Pro-Life Science and Technology Symposium, Dayton, Ohio, September 20, 2008.

105) Weekly presentation: "Christian Ethics," a 20-hour course taught at Shawnee Hills Baptist Church, September 15, 2008 – November 17, 2008.

106) Cedarville University Chapel Address: "The Coming Bioethics Tsunami," February 12, 2009.

107) Invited Presentation: "Ohio Efforts to Ban Human Cloning," Pro-Life Science and Technology Symposium, Dayton, Ohio, September 19, 2009

108) Seminar: End of Life Ethics (three presentations), God Cares Ministry, Middleburg Heights, Ohio, October 24, 2009.

109) Invited Presentation: "The Ethics of Health Care Reform," Grace Baptist Church, November 15, 2009.

110) Invited Presentation: "Ethics at the End of Life," Grace Baptist Church, January 17, 2010.

111) Invited Presentation: "Human Personhood and Roe v. Wade," Bethel University Chapel, Mishawaka, Indiana, January 22, 2010.

112) Panel Discussion: "Abortion and Minorities," Life Solidarity Conference, Legacy Center, Xenia, Ohio, April 22, 2010.

113) Invited Presentation: "Update on Stem Cell research," Values Action Committee, Ohio Statehouse, Columbus Ohio, June 8, 2010.

114) Invited Presentation: "Animal-Human Hybrids," Pro-Life Science and Technology Symposium, Dayton, Ohio, September 11, 2009

115) Event Coordinator, Health Care Ethics 2010 (interdisciplinary bioethics conference), Cedarville University, September 15-17, 2010.

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116) Television Presentation: "Stem Cell Research: Medical Progress or Moral Peril?" ThinkTV – Channel 16, Dayton, Ohio, February 13, 2011.

117) Invited Public Presentation: "Defending Life: How to Have an Impact Without Losing Your Cool," Clark County Right to Life, Clark County Library, Springfield, Ohio, January 15, 2011.

118) WCDR Radio Program: The Bioethics Minute," three times daily, February 14 to August 15, 2011.

119) Invited Presentation: "New Developments in Stem Cell Research," Pro-Life Science and Technology Symposium, Dayton, Ohio, September 10, 2011

120) Keynote Speaker, Sanctity of Life Sunday: "Human Dignity in the Shadow of Roe," Marion Christian Center, Marion, Ohio, January 22, 2012.

121) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 11, 2012.

122) Invited Presentation: "Human Personhood and the Church," Grace Brethren Church, Huber Heights, Ohio, March 18, 2012.

123) Conference Chairman, Pro-Life Science and Technology Symposium, Dayton, Ohio, September 8, 2012.

124) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 17, 2013.

125) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 16, 2014.

126) Invited Presentation, "Stem Cell Research and the Image of God," Biblical Worldview Conference, Emmanuel Christian Academy, April 12, 2014.

127) Radio Interview: "Ebola and Ethics," WRFD (Columbus, Ohio), Bob Burney Live, October 8, 2014.

128) Ebola Forum (Panel Member)," Patterson Park Church, Beavercreek, Ohio, October 23, 2014.

129) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 8, 2015.

130) Radio Interview: KRRC "The Bridge" Radio, Morning Show: "Contraceptives and Ethics," June 5, 2015.

131) Invited Presentation: "Evolution and the Christian," Rhema Christian Center, Columbus, Ohio, February 28, 2016.

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132) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 20, 2016.

133) Keynote Speaker, "Gene Editing and Designer Babies," Life Tech Conference, University of Dayton, September 24, 2016.

134) Keynote Speaker, "Modern Ethics Controversies," Kiwanis Club, Springfield, Ohio, September 27, 2016.

135) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 19, 2017.

136) Conference Presenter: "Making Godly Decisions at the End of Life" (three presentations), God Cares Ministries, Cleveland, Ohio, May 20, 2017.

137) Invited Presentation, "Ethics, Persons, and Policies: Bioethics for Today." Leadership Summit, Network of Local Churches, Columbus, Ohio, August 2, 2017.

138) Invited Presentation, "Brain Death: New Ethical Controversies," LifeTech Conference, Cedarville University, September 16, 2018.

139) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 11, 2018.

140) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 10, 2019.

141) Radio Interview: "The Hippocratic Oath Today," Medicine on Call with Dr. Elaina George, Liberty Talk Radio, October 22, 2019.

142) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, March 15, 2020.

143) Invited Presentation: "Bioethics and the Christian," Rhema Christian Center, Columbus, Ohio, May 23, 2021.

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Exhibit I—Expert Report of Dr. Michael Parker, M.D.



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**IN THE COURT OF COMMON PLEAS**
**FOR HAMILTON COUNTY, OHIO**

| | | |
|---|---|---|
| **PRETERM-CLEVELAND,** ***et al.*****,** | : | |
| | : | **Case No. A 2203203** |
| *Plaintiffs*, | : | |
| | : | **Judge Christian A. Jenkins** |
| **v.** | : | |
| | : | |
| **DAVE YOST,** ***et al.*****,** | : | |
| | : | |
| *Defendants*. | : | |
| | : | |
| | : | |

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**EXPERT REPORT OF DR. MICHAEL S. PARKER, M.D.**

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I, Michael S. Parker, M.D., state as follows:

1. I am a board-certified obstetrician-gynecologist licensed to practice medicine in Ohio.

2. I have been providing care to women as a private practitioner for 22 years and as an obstetric hospitalist for seven years. In this capacity, I have cared for women faced with difficult decisions regarding pregnancy complications, including abnormal structural and genetic findings in the unborn child, medical complications of pregnancy, adverse pregnancy outcomes, and emotional trauma suffered after having an abortion. I have also had to treat complications related to abortion as a consultant to Emergency Rooms.

3. I have volunteered as a Medical Advisor to several crisis pregnancy centers in central Ohio and serve as the current medical advisor and Board Member for the Women's Care Center of Columbus. In this capacity, I have had the opportunity to counsel many abortion-focused women on their medical and social circumstances, which influence their decisions regarding pregnancy.



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4. I have been retained by the State Defendants to provide expert testimony in this case. I am currently being compensated at an hourly rate of $400.00. The facts and opinions expressed in this expert report reflect my medical knowledge and personal experience serving in the above capacities. I will provide my opinions on Senate Bill 23 (the "Heartbeat Act") as a general obstetrician who needs to understand the law to be able to counsel my patients. I will also produce facts and opinions to refute statements made in the affidavits that support the Plaintiffs and in the Plaintiffs' complaint.

5. Uncertainty regarding the impact of new statutes is common. I recall the tension and anxiety of medical professionals and hospitals with the enactment of Ohio's 20-week abortion statute. (See section 2919.18 of the Revised Code.)

6. But in my expert opinion, the Heartbeat Act imposes appropriate requirements and can be easily understood by a competent physician. The Plaintiffs' affidavits indicate these professionals have a clear understanding of the law.

7. As an initial matter, the Heartbeat Act's prohibitions apply only to intrauterine pregnancies. (See R.C. 2919.191.)

8. Further, the law's requirements are clear and easy to understand. In relevant part, the Heartbeat Act clearly prohibits performing an abortion without checking for a fetal heartbeat. R.C. 2919.193(A). And it clearly prohibits doctors from performing an abortion once a fetal heartbeat is detected unless specific exceptions are present. R.C. 2919.195(A). These exceptions are clearly delineated and include abortions which, "in the physician's reasonable medical judgment," are (1) "designed or intended to prevent the death of the pregnant woman" or (2) "to prevent a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman." R.C. 2919.195(B).



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9. An experienced and capable physician should be able to determine if these exceptions apply, as doctors have long been required to make similar determinations before performing post-viability abortions. R.C. 2919.16(F) and R.C. 2919.18.

10. The language in the exceptions is open-ended, not vague. It allows doctors to apply the discretion of a "reasonably prudent physician" knowledgeable about the case to determine the medical necessity. Creating a detailed list, as opposed to an open-ended standard, would make me more concerned about the criminal penalty if I acted on a diagnosis not included on this list. The Heartbeat Act's wording leaves the decision to competent physicians and not legislators.

11. In my expert opinion, no compètent physician would struggle to understand or apply these exceptions. Anyone hesitant to act on their decision due to lack of understanding or fear of consequences can seek a second opinion or legal advice from appropriate entities. It is common practice to seek the opinion of a physician sub-specialty trained in Maternal-Fetal Medicine in complex pregnancy-related issues.

12. Beyond the exceptions, medical or surgical treatment of miscarriage where no fetal cardiac activity is seen is not a violation of Ohio law.

13. Abortion destroys a genetically unique human offspring that has never been seen before and will never be created again.

14. Elective abortion is not a therapeutic procedure that treats or cures any long-term medical condition. By therapeutic, I mean the treatment of a disease or condition of the mother. For example, abortion is not a prescribed treatment to reduce blood glucose levels in a woman with diabetes, to reverse autoimmune conditions, or to reverse heart conditions.

15. Patients' emotional concerns mentioned in the Plaintiffs' affidavits express the grief process related to the loss of expected outcomes. The vignettes classically demonstrate the initial stages



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of denial, anger, bargaining, and depression. In my experience, and with proper support and resources, women can reach the final stage of acceptance. With acceptance, they will not likely seek illegal means of ending the pregnancy.

16. In my years of counseling women, I do not feel I have met a woman who "wanted" to have an abortion. I have met hundreds who thought they had no other choice.

17. The Plaintiffs claim that women who suffer from medical conditions that may be exacerbated by pregnancy—including diabetes, hypertension, autoimmune disorders, heart disease or renal disease—are at higher risk of medical complications. But all of these conditions can be treated without abortion. To the extent a doctor reasonably concludes that a particular patient needs an abortion to save her life, or to prevent the substantial and irreversible impairment of a major bodily function, the doctor can perform the abortion without violating the Heartbeat Act.

18. Women with medical conditions are at higher risk of surgical and anesthetic complications, even during abortion procedures. Risks of death and serious complications in patients with underlying medical conditions remain whether a woman chooses to terminate the pregnancy or continue the pregnancy to a natural end.

19. Complications from abortion are very likely underreported. Only 28 states require providers to report complications. Some of these states not reporting complications are the most populated, including Massachusetts, Florida, Virginia, Texas, and the District of Columbia. (*See* "Abortion Reporting Requirements," Guttmacher Institute (updated Sept. 1, 2022), https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements).
Therefore, assertions on the degree of safety of medical or induced abortions are an inaccurate justification for abortion.



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20. The risk of surgical abortion includes minor (pain, bleeding, infection, and anesthetic complications) or major complications (uterine agony with subsequent hemorrhage, uterine perforation, injuries to adjacent organs, cervical lacerations, failed abortion, septic abortion, and disseminated intravascular coagulation). (Stat Pearls, Abortion Complications, https://www.ncbi.nlm.nih.gov/books/NBK430793/#:~:text=Besides%20acute%20hemorrhage%2C%20post%2Dabortion,can%20lead%20to%20high%20mortality). The Plaintiffs state that the risk of complications does increase as gestational age increases.

21. Prior surgical abortion is an independent risk factor for preterm birth in subsequent pregnancies.

22. New recommendations for pre-pregnancy and prenatal care reduce the likelihood of obstetric complications. For example, it may be appropriate to administer baby aspirin initiated between 12 and 28 weeks in women with one of several moderate risk factors for preeclampsia. These risk factors include a history of preeclampsia, multi-fetal gestations, renal disease, autoimmune disease, diabetes, and chronic hypertension. This treatment has helped to prevent or delay the onset of preeclampsia. ("Low-Dose Aspirin Use during Pregnancy," ACOG Committee Opinion, July 2018, https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/07/low-dose-aspirin-use-during-pregnancy). The use of progesterone reduces the incidence of recurrent preterm labor and prolongs pregnancies in women with a short cervix at high risk for premature delivery. Administering Folic acid supplementation is standard practice to prevent neural tube and cardiac defects. Maintaining good glucose and blood pressure control also reduces risk.

23. Regardless of whether a woman decides to abort her pregnancy or continue the pregnancy, many concerns that might have encouraged her to seek an abortion, such as intimate partner violence



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and domestic abuse, will remain. The ability to obtain or not obtain an abortion will not change this. *All* doctors should provide a safe environment for every woman, report any domestic violence, abuse, sexual assault, or sex trafficking, and provide resources for the woman to obtain financial or other services to help her in this time of need.

24. The Plaintiffs' submitted affidavits remark that Ohio-based facilities might close due to a lack of abortion patients. This decision is an economic one by the directors and owners. They could remain financially viable and accomplish the aims of helping to reduce and prevent maternal morbidity and mortality by repurposing their facilities to provide high-quality prenatal care and support for these vulnerable women.

25. Conditions of preterm labor, preeclampsia, gestational diabetes, and others that the Plaintiffs may have mentioned do not occur until after 20 weeks gestation. The management of these patients consists of treating the illness. Progression of the disease necessitates the delivery of the fetus. In my experience, this can be delayed until 22-24 weeks of gestation. Should delivery be necessary before this time, it would not violate Ohio law and does not constitute an abortion. The intent is to deliver a living fetus, irrespective of prematurity or adverse diagnosis.

26. The gestational age at which premature fetuses can survive is becoming earlier in gestation due to advances in the management of "micro-premies." At the institutions where I work, neonatologists consult with the families and offer antenatal steroids and attempts at life-sustaining care if the family desires, beginning at 22 weeks, 5 days-23 weeks gestation. If the family does not desire this, then supportive comfort care is given to these infants if born alive.

27. In the case of melanoma diagnosed during pregnancy, immunotherapy is contraindicated. Surgery for excision and sentinel lymph node biopsy under general anesthesia can be delayed to the second trimester. However, it could be done in the first trimester. Suppose no other alternatives to



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treatment were available other than immunotherapy. In that case, a doctor could believe in good faith that the pregnancy would pose the risk of "substantial and irreversible impairment of a major bodily function of the pregnant woman." R.C. 2919.195(B). In that circumstance, no reasonable physician would consider him or herself barred by law from performing the procedure under the Heartbeat Act.

28. "Chemotherapy may be safe for the fetus if given in the second or third trimester of pregnancy, but may need to be avoided in the first trimester." ("Treating Breast Cancer During Pregnancy," American Cancer Society, https://www.cancer.org/cancer/breast-cancer/treatment/treating-breast-cancer-during-pregnancy.html). "Chemotherapy must be avoided in the first trimester of pregnancy to avoid interference with organogenesis. After 12-14 weeks of gestation, administration of most cytotoxic drugs is feasible and considered relatively safe." (Wolters, V. et al.; "management of Pregnancy in women with cancer," International Journal of Gynecological Cancer, Vol. 31, Issue 3.)

29. Gynecological cancers that require the removal of the pregnant uterus do not constitute a direct abortion due to the law of double effect. Treating the cancer requires removing a diseased organ of the woman. Removal of the diseased organ is intended to cure the woman, not to kill the fetus inside the uterus. The death of the fetus is a foreseeable consequence of the treatment. The loss of the fetus was not intended and no direct act was taken to end the life of the fetus. Therefore, this does not constitute an abortion. No reasonable physician would consider him or herself barred by law from performing the procedure in appropriate circumstances under the Heartbeat Act.

30. In paragraph 36 of their Complaint, the Plaintiffs argue that "[p]regnancy stresses most major organs" as an argument for allowing abortion. These changes in the woman's body are considered



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normal. These normal physiologic changes support the developing fetus and help the mother adapt to the normal requirements of pregnancy. These changes can exacerbate underlying health conditions. However, these conditions can be managed through medical treatment.

I declare under penalty of perjury that the foregoing is true and correct, and if called as a witness I would testify competently thereto.

Dated: September 28, 2022

MICHAEL S. PARKER, M.D.



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# Michael S. Parker, MD

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614-832-0768 (Cell)


## Professional Experience:

August, 2022- Present — **Mount Carmel St. Ann Hospital**
Columbus, OH — **OB/GYN Hospitalist**

May 2020-August, 2022 — **System Medical Director, OB Employed Physicians**

Tasks and Responsibilities:

- Establish and convey standards of responsiveness and documentation to coverage physicians
- Evaluate the performance of Employed and Contracted OB House Attendings
- Contracting and contract renewal for OB House attendings
- Recruitment and training of new OB HOuse Attendings
- OBGYN Peer review and Process Improvement Committees
- Scheduling and Leading Simulations and Educational Review Sessions for physician and nursing staffs
- Evaluation, treatment, and disposition of patients presenting to Labor and Delivery
- Documentation and billing for provided services.
- Coordinate and lead rounds with residents and attending
- Effectively lead and coordinate safety rounds with nursing, anesthesia, residents, and attending staff
- Assure Quality and Safety of patient care through effective communication of care protocols
- Resident and Medical Student education and supervision
- Supervision of Nurse-Midwives including operative vaginal delivery and surgical procedures
- Coordinate with Maternal-Fetal Medicine the care and management of high-risk deliveries and transfer patients
- Meet with Department Chairperson and Chief Medical Officer monthly to discuss performance improvement
- Meet with the Director of Women's Health Service Line to discuss the progress of program and Quality Improvement Initiatives

**Accomplishments:**

- Recruitment and hiring of 4 Full-time OB Hospitalists
- Implementation of "Safety Rounds" to increase situational awareness and communication of patient care on Labor and Delivery. This will be implemented at all Mount Carmel campuses
- Coordinate and lead rounds with residents and attending
- Implementation of a process for scheduling of OB Procedures from community health clinics that assures proper communication of vital information
- Participation in Peer Review, Sentinel events, and ACA evaluations of adverse outcomes.

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- Fetal Monitoring Strip Review Sessions with physician and nursing staff
- Certification of all OB providers on Physician Performed Testing (PPT)
- Implementation of Amion Scheduling software to streamline physician and midwife scheduling and automate the payroll process. Program to be implemented system-wide. Allows for OB Hospitalists to be deployed to all campuses to assure adequate coverage
- Worked with Nursing Leadership to implement Full-coverage Nurse Midwife Program
- Developed and distributed evaluation surveys on House Officer performance which are completed by Charge Nurses and OB residents
- Yearly evaluations of OB Hospitalist performance, ongoing
- Collaboration with Nurse Leaders to develop simulations on OB Hemorrhage, Shoulder Dystocia, and SBAR Communication
- Active participant and contributor to Women's Service Line COVID 19 response for Labor and Delivery
- EMS Training on Obstetrical Emergencies (2020)
- ACLS/BLS Certification of all OB Hospitalists (current)
- Call Sharing Agreement between OB Hospitalists and Private Physicians

Sep. 2015 -Dec. 2018. **Cleveland Clinic Foundation**
Cleveland, OH **Regional OB/GYN Obstetric Laborist**

Tasks and Responsibilities:

- Evaluation, treatment, and disposition of patients presenting to Labor and Delivery
- Documentation and billing for provided services.
- Coordinate and lead rounds with residents and attending
- Assure Quality and Safety of patient care through effective communication of care protocols
- Resident and Medical Student education and supervision
- Supervision of Nurse-Midwives including operative vaginal delivery and surgical procedures
- Effectively lead and coordinate safety rounds with nursing, anesthesia, residents, and attending staff
- Coordinate with Maternal-Fetal Medicine the care and management of high-risk deliveries and transfer patients

**Director of Caregiver Well-being**

Tasks and Responsibilities:

- Effectively coordinate and lead Caregiver Well-being Committee
- Develop a strategic plan to address physician burnout in the Women's Health Institute
- Develop ideas and produce articles for the Women's Health Institute Newsletter

**Advanced Peer Coach**

- Provide executive coaching to peers to improve professional staff satisfaction, recruitment, retention, academic output, and resilience.
- Skills developed include: effective listening and observation skills, asset-based thinking, organizational strategies, and accountability

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|---|---|
| August 1993 - 9/2015 | **MaternOhio Clinical Associates- Northeast Division** |
| Gahanna, OH | Private Practice OB/GYN<br>Partner, Division President |
| 1996 - 9/2015 | **Ohio Women's Health Partners** |
| Columbus, OH | Grant Medical Center<br>Staff Laborist |
| 2012 - 9/2015 | **Westerville OB Associates** |
| Westerville, OH | St. Ann's Hospital<br>Staff Laborist |
| 2013 - 9/2015 | **The Ohio State University College of Medicine** |
| Columbus, OH | Adjunct Instructor |
| 2014, 1998-2002 | **Grant Medical Center, Columbus, Ohio**<br>Chairman, Department of Obstetrics and Gynecology<br>Peer Review Committee Chairman<br>Medical Executive Committee |
| July 1996-1998 | **Grant Medical Center, Columbus, Ohio**<br>Chairman, Clinical Performance Improvement Team<br>Major Initiative: To Reduce overall cesarean section rate through labor management protocols that reduced primary cesarean section rate and encouraged Trial of Labor after Cesarean |

**Education:**

| | |
|---|---|
| 1989-1993 | The Ohio State University College of Medicine<br>Department of OB/GYN - Residency Training |
| 1989 | The Ohio State University College of Medicine<br>Doctorate of Medicine |

**Certifications:**

American Board of Obstetrics and Gynecology
Board Certified, 2019 (renewal)
Gnosis Obstetrical Hemorrhage Certificate 2018
Gnosis Fetal Assessment and Monitoring Certificate 2017
Gnosis Hypertensive Disorders in Pregnancy Certificate 2017
Gnosis Shoulder Dystocia Certificate 2017
Advanced Peer Coaching Certificate 2017
NCC EFM Certified 2019

**Professional Affiliations:**

American Board of Obstetrics and Gynecology
The Catholic Medical Association- National President

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Mount Carmel St. Anne- Active Staff OB/GYN
Mount Carmel Grove City and East- Active Staff OB/GYN
Cleveland Clinic - Fairview Hospital, Active Staff OB/GYN

**Presentations**

**"What Does it Mean to be a Pro-Life Physician"**
Legatus, Columbus Chapter
January 2017

"**Prepare the way: Perinatal epigenetics for a Healthy Pregnancy**"
American Academy of FetilityCare Specialists, South Bend, IN
July 2016

**"NaPro Diet? The Effect of Diet on Fertility"**
American Academy of FetilityCare Specialists, Tampa, FL
July 2015

**"NaProTechnology in The Treatment of Dysmenorrhea in Young Women"**
American Academy of FetilityCare Specialists, Tampa, FL
July 2015

**"Naprotechnology and the Treatment of Endometriosis"**
University of Texas, Southwestern Medical School
March 2015

**"Methods of Natural Family Planning, Effectiveness and Application**"
Catholic Medical Student Association, Minneapolis, MN
October 2103

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