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STATE OF MICHIGAN

COURT OF APPEALS

NORTHLAND FAMILY PLANNING CENTER, NORTHLAND FAMILY PLANNING CENTER INC. EAST, NORTHLAND FAMILY PLANNING CENTER INC. WEST, and MEDICAL STUDENTS FOR CHOICE,

Plaintiffs-Appellees/Cross-Appellants,

v

ATTORNEY GENERAL, DIRECTOR OF THE DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS, and DIRECTOR OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants-Appellees/Cross-Appellees,

and

PEOPLE OF THE STATE OF MICHIGAN,

Intervening Defendant-Appellant/Cross-Appellee.

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No. 375785
Court of Claims
LC No. 24-000011-MM

Before: BORRELLO, P.J., and BAZZI and LIEVENSE, JJ.

BORRELLO, P.J.

This appeal requires us to determine whether certain statutory provisions—specifically, MCL 333.17015 and MCL 333.17015a—violate the recently adopted amendment to the Michigan Constitution, Const 1963, art 1, § 28, establishing a fundamental right to reproductive freedom.

Intervening defendant, the People of the State of Michigan,[1] appeals as of right from the opinion and order of the Court of Claims, which declared certain challenged provisions unconstitutional and permanently enjoined their enforcement. Plaintiffs cross-appeal by leave granted, challenging the Court of Claims's determination that other statutory provisions at issue are not unconstitutional. For the reasons set forth in this opinion, we affirm the Court of Claims in part but vacate any ruling pertaining to whether the statutory coercion-to-abort screening mandate constitutes discrimination under Const 1963, art 1, § 28(2) and remand to the Court of Claims for further proceedings consistent with this opinion solely on that issue.

I. BACKGROUND

In 2022, Michigan voters approved Proposal 3 to amend the Michigan Constitution and establish an individual constitutional right to reproductive freedom. This constitutional right is located in Const 1963, art 1, § 28, which provides as follows:

> (1) Every individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including but not limited to prenatal care, childbirth, postpartum care, contraception, sterilization, abortion care, miscarriage management, and infertility care.
>
> An individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means.
>
> Notwithstanding the above, the state may regulate the provision of abortion care after fetal viability, provided that in no circumstance shall the state prohibit an abortion that, in the professional judgment of an attending health care professional, is medically indicated to protect the life or physical or mental health of the pregnant individual.
>
> (2) The state shall not discriminate in the protection or enforcement of this fundamental right.
>
> (3) The state shall not penalize, prosecute, or otherwise take adverse action against an individual based on their actual, potential, perceived, or alleged pregnancy outcomes, including but not limited to miscarriage, stillbirth, or abortion. Nor shall the state penalize, prosecute, or otherwise take adverse action against someone for aiding or assisting a pregnant individual in exercising their right to reproductive freedom with their voluntary consent.

[1] The People moved to intervene on the basis that the named defendants declined to defend the constitutionality of the challenged laws. Concurrently, the Department of Attorney General established a conflict wall to establish an independent set of Assistant Attorneys General to defend the statutes at issue. The court granted the motion to intervene after the parties did not oppose it.

(4) For the purposes of this section:

A state interest is "compelling" only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making.

"Fetal viability" means: the point in pregnancy when, in the professional judgment of an attending health care professional and based on the particular facts of the case, there is a significant likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

(5) This section shall be self-executing. Any provision of this section held invalid shall be severable from the remaining portions of this section.

Plaintiffs, identifying themselves as abortion providers and advocates, commenced this action seeking declaratory and injunctive relief. Plaintiffs contend that MCL 333.17015 and MCL 333.17015a contravene the recently established state constitutional right to reproductive freedom, rendering these statutes unconstitutional.[2] The constitutional challenges presented are predicated on four specific mandates imposed on abortion procedures as articulated in the statutory language: (1) a 24-hour mandatory waiting period, (2) uniform informed consent requirements, (3) a physician participation mandate, and (4) mandatory screening for coercion.

The 24-hour waiting period prohibits a physician from performing an abortion until at least 24 hours have passed after obtaining the patient's informed written consent, unless a "medical emergency" exists. MCL 333.17015(1), (3), and (10). Under MCL 333.17015(1) and (3), "a physician shall not perform an abortion otherwise permitted by law without the patient's informed written consent," which must be obtained "not less than 24 hours before that physician performs an abortion . . . ." The medical emergency exception is found in MCL 333.17015(10).

Next, various provisions within the challenged statutes impose strict requirements for obtaining statutorily sufficient informed consent from the patient. Under MCL 333.17015(3), "not less than 24 hours before" a physician performs an abortion, the physician or a qualified assistant must "[c]onfirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus"; orally provide the patient with information about the probable gestational age of the fetus, "what to do and whom to contact should medical complications arise from the abortion," and "how to obtain pregnancy prevention information through the department of health and human services"; "[p]rovide the patient with a physical copy of the written standardized summary"[3] regarding accepted medical procedures for performing abortions, the complications that may arise from those procedures, the complications that may arise from live birth, the potential for an individual to experience "depression, feelings

[2] The pertinent provisions of these statutes have been reproduced in the appendix at the conclusion of this opinion.

[3] The contents of the standardized summary are described in MCL 333.17015(11)(b).

of guilt, sleep disturbance, loss of interest in work or sex, or anger" as a "result of an abortion," available services to assist with adoption or foster care placement, and available counseling services should the patient experience adverse psychological effects from the abortion; "[p]rovide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the department of health and human services pursuant to subsection (11)(a) at the gestational age nearest the probable gestational age of the patient's fetus"; "[p]rovide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the department of health and human services . . ."; and "[p]rovide the patient with a physical copy of the prescreening summary on prevention of coercion to abort described in subsection (11)(i)."

The physician must also, "personally and in the presence of the patient," orally inform the patient of specific risks to the patient of any complications associated with the procedure to be performed based on the patient's particular medical condition and history, as well as any specific risks to the patient in light of that same medical condition and history if the patient chooses to continue the pregnancy. MCL 333.17015(6)(b).

Furthermore, pursuant to MCL 333.17015(2)(j), "provide the patient with a physical copy" means "confirming that the patient accessed the internet website described in subsection (5) and received a printed valid confirmation form from the website and including that form in the patient's medical record or giving a patient a copy of a required document by 1 or more of the following means: (*i*) In person[;] (*ii*) By registered mail, return receipt requested[;] (*iii*) By parcel delivery service that requires the recipient to provide a signature in order to receive delivery of a parcel[;] (*iv*) By facsimile transmission."

The third of the challenged mandates is the physician mandate. Because MCL 333.17015(1) states that "a *physician* shall not perform an abortion otherwise permitted by law" (emphasis added), only licensed physicians may perform abortions. This means that other medical clinicians, such as nurse practitioners, certified nurse midwives, and physician assistants, may not provide abortions.

Finally, abortion providers must also "orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11)." MCL 333.17015a(1). This oral screening may occur before the requirements of MCL 333.17015(3) have been satisfied and before or after the expiration of the 24-hour waiting period. MCL 333.17015a(1). Abortion facilities must "post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i)," which states, among other things, that it is illegal to coerce an individual to have an abortion and provides information about resources where help is available for domestic violence and sexual assault. MCL 333.17015a(5); MCL 333.17015(11)(i).

In their cross-appeal, plaintiffs alleged that these provisions unconstitutionally burdened the right to abortion without serving the limited compelling purpose of protecting the health of an individual seeking care, that each provision was inconsistent with accepted clinical standards of practice and evidence-based medicine, that the provisions imposed requirements that intruded on the autonomous decision making of patients, and that the provisions discriminated in the protection and enforcement of the right to reproductive freedom.

The Court of Claims held a bench trial, where it heard the testimony of the parties' experts. Following trial, the Court of Claims issued an extensive, thorough, and well-reasoned written opinion and order holding that the provisions creating the mandatory 24-hour waiting period, the uniform mandatory consent requirement, and the physician mandate, along with other provisions in the statute that were inextricably linked with these provisions, were unconstitutional. The court issued a permanent injunction enjoining enforcement of those provisions, which were MCL 333.17015(1), (2)(d)-(g) and (i)-(j), (3)-(10), (11)(a)-(h), (13)-(14), and (18)-(20). The court found the remaining challenged statutory provisions constitutional and preserved under the severability provision in MCL 333.17015(17).

This appeal followed.

II. JURISDICTION

At the outset, this Court must address the fundamental question of appellate jurisdiction, as asserted by intervening defendant. Intervening defendant contends that this Court is without jurisdiction to entertain the present appeal as of right on the ground that the Court of Claims did not render a final order resolving all claims asserted in that court. Specifically, intervening defendant maintains that the Court of Claims failed to adjudicate the plaintiffs' cause of action alleging discrimination under Const 1963, art 1, § 28(2), insofar as that claim challenges the statutory coercion-to-abort screening mandate embodied in MCL 333.17015a. Accordingly, intervening defendant posits that the order under review is not a final order and, as such, is not appealable as of right within the meaning of the Michigan Court Rules.

It is axiomatic that this Court may not reach the substantive merits of any appeal unless and until it has first satisfied itself of its jurisdiction to proceed. *Chen v Wayne State Univ*, 284 Mich App 172, 191; 771 NW2d 820 (2009). The existence of subject-matter jurisdiction constitutes a pure question of law, subject to de novo review by this Court. *Id*.

The contours of this Court's appellate jurisdiction as of right are governed by MCR 7.203(A)(1), which authorizes an appeal of right from a final judgment or final order of the circuit court or Court of Claims, as that term is precisely defined by MCR 7.202(6). Under MCR 7.202(6)(a)(i), a "final order" in a civil action, for purposes of appellate review, is defined as "the first judgment or order that disposes of all the claims and adjudicates the rights and liabilities of all the parties." Save for exceptions not relevant to the present dispute, MCR 7.203(A)(1) thus confers upon this Court jurisdiction as of right to review any such final order issued by the Court of Claims or a circuit court. The constitutional provisions implicated herein are found at Const 1963, art 1, § 28. Subsection (1) establishes that "[e]very individual has a fundamental right to reproductive freedom, which entails the right to make and effectuate decisions about all matters relating to pregnancy, including abortion care," while subsection (2) mandates that "[t]he state shall not discriminate in the protection or enforcement of this fundamental right." The dispositive jurisdictional question is therefore whether the May 13, 2025 opinion and order of the Court of Claims finally disposed of plaintiffs' claim that the statutory coercion screening provisions contravene the nondiscrimination mandate of Const 1963, art 1, § 28(2). In the section of its opinion addressing the constitutionality of the coercion screening provisions, the Court of Claims opined as follows:

> Plaintiffs have not met their burden of establishing that the coercion screening requirements burden or infringe upon a patient's access to abortion care. The witnesses agree that coercion screening is a necessary step in abortion care. Informational posters warning patients about the illegality of abortion coercion and providing resources to patients facing such coercion protect patient rights to reproductive care of all kinds. Contrary to the position of some witnesses, nothing in the statutes requires providers to ask specific or direct questions during a coercion screening. The statutes permit provides to tailor their questions and interact with patients in an organic way.

The Court of Claims determined that plaintiffs failed to sustain their burden of demonstrating that the coercion screening requirements imposed by statute either burdened or infringed upon a patient's access to abortion care. The Court found the evidentiary record to reflect consensus among witnesses that coercion screening constitutes an integral and necessary component of abortion care. The Court further noted that the statutory regime's requirements for informational posters—alerting patients to the illegality of abortion coercion and directing them to available resources—operate to safeguard patient rights in the reproductive healthcare context. Importantly, the Court rejected the argument that the statutes require providers to ask predetermined or overly specific questions, concluding instead that the statutory framework permits providers to conduct screening in a flexible, individualized, and organic manner, tailored to the patient's circumstances.

Accordingly, the Court of Claims's finding that the statutory coercion screening requirements neither burden nor infringe the right of access to abortion care—a central facet of the "fundamental right to reproductive freedom" guaranteed by the Michigan Constitution—necessarily operates as a rejection of plaintiffs' discrimination claim under Const 1963, art 1, § 28(2). The Court of Claims, in its conclusion, expressly held that "MCL 333.17015a and MCL 333.17015(11)(i) [the coercion screening provisions] are not unconstitutional," thereby rejecting both Count I and Count II of plaintiffs' complaint as to the constitutionality of the coercion screening provisions. Contrary to intervening defendant's assertions, the final order issued by the Court of Claims disposed of all rights and liabilities of the parties, including any arising under Const 1963, art 1, § 28(2), with respect to the facial challenge to the statutory coercion-to-abort screening requirement. Nothing in the record suggests that any claim was left unadjudicated by the lower court. For these reasons, the finality requirement of MCR 7.202(6) is satisfied, and this Court is vested with appellate jurisdiction of right under MCR 7.203(A)(1).[4]

III. CONSTITUTIONALITY OF MCL 333.17015 AND MCL 333.17015a

[4] Additionally, the Court of Claims explicitly designated its order as final, manifesting its intent to resolve all outstanding issues between the parties. While an explicit declaration of finality is not dispositive, it remains a significant factor in the determination of whether an order is final for appellate purposes. See *McCoy v Berrien Co Clerk*, 348 Mich App 602, 611; 19 NW3d 897 (2023).

On appeal, intervening defendant contends that the Court of Claims committed reversible error in concluding that the mandatory 24-hour waiting period, the mandatory uniform informed consent requirements, and the physician mandate provisions are facially unconstitutional. Intervening defendant asserts that, under established precedent, a statute is only facially unconstitutional if the challengers can demonstrate that "no set of circumstances exists under which the [statutory provisions] would be valid." *United States v Salerno*, 481 US 739, 745; 107 S Ct 2095; 95 L Ed 2d 697 (1987). Accordingly, intervening defendant maintains that plaintiffs failed to meet this exacting standard, and thus, the Court of Claims erred in declaring the provisions facially invalid.

On cross-appeal, plaintiffs contend that the Court of Claims erred in upholding the constitutionality of the statutory provision requiring a screening for coercion prior to an abortion. Plaintiffs assert that this requirement imposes an undue burden on the exercise of the constitutional right to abortion and is not justified by "a compelling state interest." As such, plaintiffs contend that this provision should also have been found unconstitutional.

A. LEGAL FRAMEWORK

Whether a statute is constitutional presents a question of law that this Court reviews de novo. *League of Women Voters of Mich v Secretary of State*, 508 Mich 520, 534; 975 NW2d 840 (2022). We also review de novo matters of constitutional and statutory interpretation. *Coalition of State Employee Unions v State*, 498 Mich 312, 322; 870 NW2d 275 (2015). "This Court reviews a trial court's findings of fact following a bench trial for clear error and reviews de novo the trial court's conclusions of law." *Trader v Comerica Bank*, 293 Mich App 210, 215; 809 NW2d 429 (2011).

"Our primary goal in construing a constitutional provision is to give effect to the intent of the people of the state of Michigan who ratified the Constitution, by applying the rule of 'common understanding.' " *Coalition of State Employee Unions*, 498 Mich at 323 (citation omitted). "The interpretation that should be given it is that which reasonable minds, the great mass of the people themselves, would give it." *Citizens Protecting Michigan's Constitution v Secretary of State*, 503 Mich 42, 61; 921 NW2d 247 (2018) (quotation marks and citation omitted). Accordingly, the common understanding of constitutional language is found by determining "the text's original meaning to the ratifiers, the people, at the time of ratification." *Id*. (quotation marks and citation omitted). We must also "consider the circumstances leading to the adoption of the provision and the purpose sought to be accomplished." *Mothering Justice v Attorney General*, 515 Mich 328, 346; 29 NW3d 346 (2024), opinion clarified 515 Mich 920 (2024) (quotation marks and citations omitted).

"Our Constitution is clear that '[a]ll political power is inherent in the people.' " *Citizens*, 503 Mich at 59, quoting Const 1963, art 1, § 1 (alteration in original). "The people have chosen to retain for themselves, in Const 1963, art 12, § 2, the power to initiate proposed constitutional amendments that, if various requirements are met, will be placed on the ballot and voted on at election time." *Id*. "[T]here is no more constitutionally significant event than when the wielders of '[a]ll political power' under that document, Const 1963, art 1, § 1, choose to exercise their extraordinary authority to directly approve or disapprove of an amendment thereto." *Id*. (some quotation marks and citation omitted).

This case involves a facial challenge to the statutory provisions at issue. Statutes are presumed to be constitutional. *League of Women Voters*, 508 Mich at 534. A statute that may have been constitutional when it was passed may become invalid as the result of a subsequent constitutional amendment. See Const 1963, art 3, § 7 ("The common law and the statute laws now in force, not repugnant to this constitution, shall remain in force until they expire by their own limitations, or are changed, amended or repealed."). Generally, the "party challenging the facial constitutionality of an act must establish that no set of circumstances exists under which the [a]ct would be valid. The fact that the . . . [a]ct might operate unconstitutionally under some conceivable set of circumstances is insufficient . . . ." *League of Women Voters*, 508 Mich at 534-535 (quotation marks and citations omitted; ellipses and alterations in original). The question is whether the challenged statutory provisions are "unconstitutional in the abstract" rather than "as applied" to the particular case. *Id*. at 535.

However, constitutionally protected fundamental rights receive heightened protection from governmental interference. *Washington v Glucksberg*, 521 US 702, 720; 117 S Ct 2258; 138 L Ed 2d 772 (1997). Some fundamental rights are specifically enumerated in constitutional text. *Id*. The present case involves a right that is specifically designated as "fundamental" by our state constitution. Const 1963, art 1, § 28 expressly designates the "right to reproductive freedom," which includes the right to make decisions about "all matters relating to . . . abortion care," as a "fundamental right."

Furthermore, this constitutional provision specifically provides that an "individual's right to reproductive freedom shall not be denied, burdened, nor infringed upon unless justified by a compelling state interest achieved by the least restrictive means." Const 1963, art 1, § 28. The reproductive freedom amendment thereby expressly incorporates the most demanding test used by courts for analyzing the constitutionality of alleged governmental interference with fundamental rights: strict scrutiny. "The most heightened review, strict scrutiny, applies when the provision interferes with a fundamental right . . . [u]nder a strict scrutiny analysis, the government may not infringe upon a fundamental liberty interest unless the infringement is narrowly tailored to serve a compelling state interest." *Barrow v City of Detroit Election Comm*, 301 Mich App 404, 420; 836 NW2d 498 (2013). Strict scrutiny "requires that a law be the least restrictive means of achieving a compelling state interest." *Free Speech Coalition, Inc v Paxton*, 606 US 461, 471; 145 S Ct 2291; 222 L Ed 2d 643 (2025) (quotation marks and citation omitted). See also *Zablocki v Redhail*, 434 US 374, 388; 98 S Ct 673; 54 L Ed 2d 618 (1978) ("When a statutory classification significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests.").

"Strict scrutiny—which requires a restriction to be the least restrictive means of achieving a compelling governmental interest—is the most demanding test known to constitutional law." *Free Speech Coalition*, 606 US at 484 (quotation marks and citation omitted). Importantly, it is the government's burden under strict scrutiny to prove that the challenged laws "are narrowly tailored measures that further compelling governmental interests." *Johnson v California*, 543 US 499, 505; 125 S Ct 1141; 160 L Ed 2d 949 (2005).

Turning to the language of the constitutional provision at issue, an "individual's right to reproductive freedom," which includes "the right to make and effectuate decisions about all

matters relating to . . . abortion care," "shall not be denied, burdened, nor infringed upon *unless justified by a compelling state interest achieved by the least restrictive means*." Const 1963, art 1, § 28(1) (emphasis added). For purposes of this constitutional provision, a "state interest is 'compelling' *only if it is for the limited purpose of protecting the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine, and does not infringe on that individual's autonomous decision-making*." Const 1963, art 1, § 28(4) (emphasis added). This section of our state Constitution protecting the fundamental right to reproductive freedom is "self-executing." Const 1963, art 1, § 28(5). "When the language of the Constitution is self-executing, [o]bligations other than those so imposed may not be added." *League of Women Voters*, 508 Mich at 541 (quotation marks and citation omitted; alteration in original). Accordingly, the statutory provisions challenged in the present case may only stand if they are *both* "justified by a compelling state interest" *and* achieve that compelling interest "by the least restrictive means."

In addressing the issues presented in this appeal, we first undertake an analysis of whether the statutory provisions at issue "deny, burden, or infringe" upon the constitutional "right to make and effectuate decisions about all matters relating to . . . abortion care" as articulated in Const 1963, art 1, § 28. Should we determine that a particular statutory provision does not deny, burden, or infringe upon that right, it necessarily follows that such a provision does not violate the Michigan Constitution. If, however, we find that the statutory provision implicates the protected right, we must then proceed to examine the governmental interest purportedly advanced by the provision. To withstand constitutional scrutiny, the challenged statutory provisions must "protect the health of an individual seeking care, consistent with accepted clinical standards of practice and evidence-based medicine," and must not infringe upon that individual's autonomous decision-making. Assuming that a sufficient state interest is identified, we then evaluate whether the intervening defendant, as the party defending the challenged statutes, has established that the asserted interest cannot be achieved by less restrictive means. Only if the statutory provision is the least restrictive means of achieving the articulated interest can it survive constitutional challenge. With this framework in mind, we proceed to address each of the challenged statutory provisions in turn.

B. MANDATORY 24-HOUR WAITING PERIOD

The 24-hour waiting period prohibits a physician from performing an abortion until at least 24 hours have passed after obtaining the patient's informed written consent, unless a "medical emergency" exists. MCL 333.17015(1), (3), and (10).

At trial, the Court of Claims heard testimony from witnesses with practical and research experience in the fields of abortion care and medical ethics. These witnesses included doctors, administrators, a certified nurse midwife and nurse practitioner, and university professors. The Court of Claims found:

> Based on the testimony presented at trial, and after weighing the relative credibility of the witnesses and examining the evidence presented, the Court finds that the mandatory 24-hour waiting period burdens and infringes upon patients' rights to reproductive freedom. The mandatory delay exacerbates the burdens that patients experience seeking abortion care, including by increasing costs, prolonging

wait times, increasing the risk that a patient will have to disclose their decision to others, and potentially forcing the patient to forgo a medication abortion for a more invasive procedure.

Having found that the mandatory 24-hour waiting period burdened and infringed the right to reproductive freedom, the Court of Claims acknowledged that the "ostensible goal" of the challenged provision was to protect patient health. However, the Court of Claims found that the mandatory 24-hour waiting period did not achieve that goal by the least restrictive means, consistent with accepted clinical standards of practice and evidence-based medicine. The Court of Claims reasoned,

> Against the mountain of expert opinions and citation of accepted clinical standards and medical literature submitted by plaintiffs establishing that the challenged laws *do not* protect patient health and *are contrary* to accepted clinical standards of practice and evidence-based medicine (set forth in extensive detail in preceding sections), intervening defendant has produced two witnesses deeply entrenched in the national anti-abortion movement who have frequently and widely testified in favor of complete abortion bans. These witnesses believe abortion is murder and an offense to God. Dr. Wubbenhurst's testimony was based on theologically skewed studies from journals known to support anti-abortion views. Dr. Wubbenhurst's testimony also made clear that she interpreted the findings of studies in ways the studies' authors cautioned against. Intervening defendant has not attacked the qualifications or credibility of plaintiffs' experts.
>
> The plain language of [Const 1963, art 1, § 28] unambiguously requires that the challenged laws *achieve* the goal of protecting patient health and be consistent with established clinical standards and evidence-based medicine. The only way for the Court to inquire into this element is to rely on the expert evidence submitted by the parties. The defense experts' evidence is too impeached to assist their position.
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> Plaintiffs' experts have opined that the 24-hour waiting period does not protect the health of a patient seeking care and, in fact, hinders patient care by delaying care by an arbitrary 24-hours. Clinical research has shown that there is no correlation between having a patient wait 24 hours and the patient achieving better physical and psychological outcomes. Contrary to Dr. Wubbenhurst's testimony, there is no evidence that the delay is used by providers to review a patient's medical history to ensure the safety of the procedure for the patient. Rather, the delay is used solely to force the patient to further consider their choice, i.e., to dissuade the patient from securing an abortion. The Turnaway Study supports that the vast majority of patients seeking an abortion have high decisional certainty and low levels of regret following the procedure.
>
> The mandatory 24-hour waiting period also is not consistent with the accepted standard of care and evidence-based medicine. Again, the Turnaway Study demonstrated that patients seeking an abortion do not universally need additional time to reflect on their decision. No other reproductive care available to men or women is governed by the Legislature in this manner.

> Moreover, the mandatory 24-hour waiting period infringes upon autonomous decision-making. The waiting period forces needless delay on patients after they are able to consent to a procedure, thus burdening and infringing upon a patient's access to abortion care.

On appeal, intervening defendant asserts that the Court of Claims erred in declaring the mandatory 24-hour waiting period provision facially invalid. Intervening defendant relies on record evidence, including admissions by plaintiffs' witnesses—that some patients independently elect to wait before making an abortion decision after receiving the required information. On this basis, intervening defendant contends that the statutory waiting period is not inherently coercive, as it does not burden the rights of those patients who would choose to wait. Intervening defendant further argues that the statute is not unconstitutional in all its applications and that the Court of Claims failed to apply the correct standard for facial invalidity, which requires a showing that no set of circumstances exists under which the law would be valid. See *Salerno*, 481 US at 745. However, this argument fails to account for the heightened protection afforded to fundamental rights under the Michigan Constitution. When a challenged statute implicates a fundamental right, the state must demonstrate that the law is narrowly tailored to advance a compelling governmental interest and is the least restrictive means available, a standard that supersedes the general *Salerno* framework. See Const 1963, art 1, § 28(1).

We note that the absence of a *mandatory* waiting period does not inhibit any patient from deliberating or reconsidering an abortion decision at her own pace. Indeed, the evidentiary record before this Court demonstrates that patients approach the decision to terminate a pregnancy with varying degrees of contemplation, and that the time required for a considered decision is highly individualized. The imposition of a categorical 24-hour waiting period, therefore, is not only untethered from patient autonomy but also operates as a blanket restriction that fails to accommodate the spectrum of patient circumstances. Under Michigan constitutional law, when a statute burdens a fundamental right, it must satisfy strict scrutiny by being narrowly tailored and the least restrictive means to advance a compelling state interest. See Const 1963, art 1, § 28(1); *Free Speech Coalition*, 606 US at 471. Here, intervening defendant has failed to identify any compelling empirical support—either in the record or by reference to legislative findings—that the rigid 24-hour waiting period furthers patient health, safety, or informed consent in a manner less restrictive alternatives could not achieve. The Court of Claims correctly found no evidence of a nexus between the statutory waiting period and any measurable improvement in patient physical or psychological outcomes. Moreover, the arbitrary and inflexible nature of the waiting period undermines any contention that it is narrowly drawn or necessary to achieve the state's asserted aims.

Notably, intervening defendant does not contest the Court of Claims's factual finding that no causal relationship exists between the statutory waiting period and improved patient outcomes. Instead, intervening defendant posits that because some patients elect not to proceed with an abortion after an initial clinic visit, the 24-hour waiting period must be constitutional in at least some applications, thereby precluding facial invalidity. This contention fundamentally misconstrues the strict scrutiny standard and the burden-shifting framework applicable to statutes that infringe on fundamental rights under the Michigan Constitution. See *Johnson*, 543 US at 505. Once a plaintiff demonstrates that a statutory provision burdens a fundamental right, the burden

shifts squarely to the state to establish that the provision is the least restrictive means to achieve a compelling state interest. Here, intervening defendant failed to make such a showing both in the Court of Claims and on appeal, offering neither evidentiary support nor cogent argument that the 24-hour waiting period is, in fact, the least restrictive means to serve its asserted purpose. The absence of such justification is fatal to the statute's survival under constitutional scrutiny. Accordingly, the provision cannot withstand review under Const 1963, art 1, § 28, and must be invalidated as an impermissible infringement on the right to reproductive autonomy.

C. INFORMED CONSENT

Next, multiple provisions of the statutes at issue establish rigorous requirements for securing legally adequate informed consent from patients. These statutory mandates obligate providers to disclose information regarding pregnancy prevention, the potential psychological sequelae of abortion—including depression, guilt, sleep disturbances, diminished interest in work or sexual activity, and anger—along with information about adoption or foster care resources, prenatal care, and parenting options.

In its written opinion and order following trial, the Court of Claims found as follows on this issue:

> The Court finds that many provisions in MCL 333.17015 burden and infringe upon a patient's right to make and effectuate decisions about abortion care. The entirety of Subsection (3) fails strict-scrutiny review. As already noted, the mandatory 24-hour waiting period of MCL 333.17015(3) burdens and infringes upon access to abortion care.
>
> Subsection (3)(a) requires a provider to confirm that a patient seeking an abortion is pregnant and to determine the likely gestational age of the fetus. This is obviously a standard-of care issue. No doctor would perform any abortion on a patient who is not pregnant and no doctor would recommend or perform an abortion procedure without confirming gestational age. Failure to do either of these steps would surely lead to a medical malpractice case.
>
> Subsection (3)(b) requires the provider to orally describe certain information in a manner designed to ensure that the particular patient understands. That information is (*i*) gestational age, (*ii*) where to seek help for abortion complications, and (*iii*) how to obtain contraception information from the DHHS. Again, provision of the information in Subsections (3)(b)(*i*) and (*ii*) is part of the standard of care, making the statutory provisions unnecessary. Subsection (3)(b)(*iii*) is, however, problematic. Patients visit abortion providers for one purpose, to secure an abortion, not for general gynecological care. Further, many women want to be pregnant but seek an abortion to preserve their health or because the pregnancy is not viable. It would burden or infringe upon reproductive rights to ask if such a patient would like information about contraception. Forcibly giving DHHS-produced materials on the subject without a request is paternalistic and stigmatizing, making the patient feel belittled for becoming pregnant.

Subsection (3)(c) requires a physician to provide the DHHS standard summary of the particular procedure to be performed. Plaintiff's experts explained that these descriptions inflate the risks of the abortion procedures while downplaying the risks of childbirth. Only defense witness Dr. Curlin claimed that abortion is riskier than childbirth. Although this subsection requires the provider to share only the summary of the planned procedure, this cannot "unring the bell" of the information gleaned from materials required to be provided at least 24 hours before the procedure. The conversation between patient and provider under Subsection (3) is the second step in the mandatory informed-consent process. At least 24 hours earlier, the patient must review the entire packet of DHHS-created materials, including descriptions of each type of abortion procedure. MCL 333.17015(5). The patient's access to abortion care has already been burdened and infringed upon by being forced to review irrelevant and inaccurate materials.

Subsection (3)(d) also infringes upon and burdens a patient's right to access reproductive care. Plaintiff's experts universally agreed that fetal development charts are irrelevant for a patient seeking abortion care. A patient seeking to terminate a pregnancy does not require information about the growth of a fetus. The information is coercive and stigmatizing as the only reason for requiring it is to dissuade an abortion patient. Providing the chart to a patient seeking an abortion for a nonviable pregnancy or severe fetal anomalies is cruel. For the same reasons, subsection (3)(e)'s requirement that all patients receive information about prenatal care and parenting burdens and infringes upon patient rights.

MCL 333.17015(4), (5), and (6) govern the provision of information under the subsections of MCL 333.17015(3). Subsection (7) is inextricably linked to the presentation of information required in Subsections (3) and (6). Similarly, Subsections (8)-(10) are integrated with the informed-consent process. If Subsections (3) and (6) burden and infringe upon a patient's rights, Subsections (4), (5), (8), and (10) do as well.

Subsection (11) explains the duty of the DHHS to produce the material to be provided to abortion patients under Subsections (3) and (6). Subsection (11)(a) requires provision of the DHHS-created fetal development chart. As noted, the provision of a fetal development chart without a request from the patient is inconsistent with the standard of care, and the material is irrelevant to the provision of abortion care.

Subsection (11)(b) governs the production of the procedure summaries that will be provided to patients. This subsection requires the DHHS to develop separate descriptions for each procedure type and to include information about potential complications with each type.[5] Subsection (11)(b)(*iii*) requires each

[5] In a footnote here, the Court of Claims states: "Subsection (11)(e) limits the DHHS to including only information about Federal Drug Administration-approved drugs in the procedure summaries.

summary to state that as a result of having an abortion, a patient "may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger." Plaintiff's experts testified that there is no causation between abortion and negative emotions or adverse mental health outcomes. The Turnaway Study found no substantial difference between the negative emotions felt by patients who secured an abortion and those who were denied an abortion shortly after the legal cut-off date. The witnesses testified that the same negative emotions accompany pregnancy, miscarriages, and various surgical procedures. Moreover, studies show that negative emotions connected to abortion are more often caused by the situation that led to the abortion, rather than the abortion itself. The provision of this information is not evidence-based, and instead results in stigmatizing patients seeking abortions. Subsection (11)(b)(*iv*) requires the DHHS to indicate that not all patients will experience all complications described in the procedure summaries. This statement is insufficient to ease the burden of receiving inaccurate and coercive information about mental health outcomes.

Subsections (11)(b)(*v*) and (*vi*) require the DHHS to identify services to assist patients during their pregnancy and with parenting, as well as information about foster care and adoption should the patient choose to carry to term. The Court discerns no issue with providing this type of information if requested by an undecided patient. However, such information is irrelevant to a patient who has chosen abortion. The provision of this material is intended to increase the guilt of a patient choosing abortion, thereby unduly burdening and infringing upon the patient's access to abortion care.

Subsection (11)(c) makes clear that abortion providers must share all the information from the DHHS materials with each patient, regardless of its accuracy or relevance to the particular patient. The DHHS must develop a standardized acknowledgment and consent form, attesting, in part, that the patient received information about the development of a fetus, the selected procedure, the potential complications of the procedure, and prenatal and parenting information. This subsection thereby also unduly burdens the patient's care.

Subsection (11)(f) requires the DHHS to develop a form that local health departments may use to certify the fact of a pregnancy for a requesting patient. This form is rendered unnecessary by the invalidation of other statutory provisions. The same is true of Subsection (18), as it is tied solely to the requirements of Subsection (11)(f).

Subsection (11)(d) requires the DHHS to make available to abortion providers all materials developed under Subsections (11)(a), (b), (c), (f), and (i).

Although the provision is not objectionable standing alone, it has no purpose without subsection (11)(b)."

As all but Subsection (11)(i) burden and infringe upon patient rights, Subsection (11)(d) must be radically revised to survive constitutional scrutiny.

Subsection (11)(g) requires the DHHS to create a website from which a patient could access the materials required to be provided 24 hours in advance of an abortion procedure. The DHHS was required to develop a final page from which a patient could print a time and date-stamped confirmation form, attesting that the patient reviewed the information. However, the information mandated under Subsection (3) and (6) burdens and infringes upon a patient's access to abortion care. Patients can no longer be required to access the DHHS website and print out a confirmation to bring to the abortion provider. This provision, too, burdens and infringes upon patient rights.

Subsection (11)(h) requires the DHHS to include a list of free ultrasound providers on its informed-consent website. That website will no longer be required following this judgment and so no longer will this requirement. Subsection (13) is also no longer required; it provides that the form printed from the DHHS website creates a presumption that the patient's consent is valid. Similarly, Subsection (14)'s creation of a presumption that a health department's certification under Subsection (11)(f) is valid is no longer required.

Subsections (19) and (20) maintain the confidentiality of patients required to review information and seek certifications and confirmations in invalidated portions of MCL 333.17015. While the anonymity and privacy of all patients is of utmost important, there will no longer be a link between the DHHS or local health departments and patients seeking abortion. These provisions will no longer have a subject to protect.

Overall, the Court finds that the discussed statutory provisions burden and infringe upon a patient's right to make and effectuate decisions about abortion care. Those provisions include those requiring the DHHS to develop and providers to present information to abortion patients about the risks associated with live birth (when the medical procedure at-issue is abortion care); illustrations and depictions of the fetus; prenatal care, parenting and adoption; and offering the patient to see images of any ultrasound performed are designed to guide a patient away from the choice of having an abortion by juxtaposing content that is clearly more relevant and suitable to those seeking to complete a pregnancy. Such information certainly impacts the patient's choice to seek abortion care and encroaches on the patient's decision-making process. The provisions therefore burden and infringe upon a patient's right to make and effectuate decisions about abortion care.

Similarly, by directing the DHHS what it must do in order to implement the mandatory informed-consent requirements, the Legislature further burdens and infringes upon a patient's right to make and effectuate decisions about abortion care. In this way, Subsection (11) squarely inserts the DHHS into the patient-provider relationship. The mandatory nature of the information that the DHHS is required to develop and disseminate, and the very fact that the DHHS is placed in

> between the patient and provider, has an impact on how a patient makes and effectuates decisions regarding abortion care. This impact is not merely incidental or tangential. The informed-consent provisions, read as whole, are designed to force a patient to consider the alternative of not having an abortion. The manner in which the information is presented is not neutral; it is designed to eschew abortion in favor of completing a pregnancy and further stigmatize a patient seeking abortion care. This forced deliberation, through the mandatory informed-consent process, burdens and infringes upon a patient's right to make and effectuate decisions about abortion care. The State is metaphorically putting its finger on the scale, thereby infringing upon a patient's deliberative process.

The Court of Claims recognized that while the stated purpose of these provisions was to protect patient health, the court determined that plaintiffs had presented substantial evidence demonstrating that the challenged laws "do not protect patient health and are contrary to accepted clinical standards of practice and evidence-based medicine." In contrast, the evidence submitted by intervening defendant was so impeached as to lack credibility. The court concluded:

> The mandatory standard informed-consent provisions likewise fail strict-scrutiny review because plaintiffs' experts, as well as . . . other nationally recognized organizations, conclude that the uniform standard-of-care provisions are inconsistent with the highly individualized and patient-specific informed-consent process. There is no reason to deviate from individualized informed consent, and no basis to argue that qualified licensed medical providers will deviate from their ethical and professional obligations without state interference. The evidence submitted by plaintiffs establishes the overwhelming medical consensus is that mandatory informed-consent schemes, enacted to persuade people to continue pregnancies despite their personal circumstances and wishes, do not serve patient health and decision-making and are contrary to the standard of care. Intervening defendants' evidence to the contrary is incredible and not scientifically strong. It does not overcome the evidence produced by plaintiffs before and at trial.

On appeal, intervening defendant asserts that the Court of Claims erred in concluding that the mandatory uniform informed consent provisions are facially invalid. Intervening defendant maintains that these provisions are constitutional, as they are purportedly intended to ensure that patients receive accurate medical information sufficient to enable a fully informed decision regarding abortion. Thus, intervening defendant contends that the informed consent requirements further, rather than hinder, the patient's exercise of the fundamental right to reproductive freedom.

It is well-established that a patient is entitled to necessary and appropriate information regarding a medical procedure to make an informed decision and provide valid consent. See, e.g., *Lincoln v Gupta*, 142 Mich App 615, 625; 370 NW2d 312 (1985); *Wlosinski v Cohen*, 269 Mich App 303, 309; 713 NW2d 16 (2005). The Court of Claims recognized this principle as an essential component of the medical standard of care. However, the challenged uniform informed consent statutory provisions suffer from a critical flaw: the imposition of a rigid, one-size-fits-all approach that is fundamentally incompatible with both established medical ethics and the realities of clinical practice. Trial testimony established that competent, informed consent requires flexibility and

sensitivity to the unique medical, psychological, and social circumstances of each patient. By mandating identical disclosures regardless of an individual's needs or context, the statute disregards the professional judgment of healthcare providers and the autonomy of patients. Moreover, intervening defendant cites no record evidence that the statutory requirements are neutral, necessary, or effective for all abortion patients in every situation. Rather, the evidence demonstrates that the statutory scheme imposes unnecessary burdens, potentially causing confusion, distress, or delays that may adversely affect patient care and outcomes.

Further, intervening defendant's reliance on *Mahaffey v Attorney General*, 222 Mich App 325; 564 NW2d 104 (1997), is misplaced. *Mahaffey* was decided before the explicit recognition of the fundamental right to reproductive freedom in the Michigan Constitution. Consequently, any discussion within *Mahaffey* relating to the constitutionality of abortion informed consent statutes under the law as it stood in 1997 does not compel the conclusion that the current uniform informed consent provisions in MCL 333.17015 satisfy the requirements of Const 1963, art 1, § 28.

Turning to the strict scrutiny analysis, we conclude that the uniform informed consent provisions cannot withstand constitutional review. Strict scrutiny requires the government to demonstrate a compelling interest and that the law is narrowly tailored, using the least restrictive means available to achieve that interest. While protecting patient health is unquestionably a compelling governmental objective, the statutory scheme fails the narrow tailoring requirement. The record and trial testimony show that effective informed consent is inherently individualized, requiring providers to assess and communicate with patients based on their specific needs, circumstances, and preferences. The statute's rigid, standardized framework ignores this reality, supplanting clinical judgment with a legislative mandate that may be irrelevant or even detrimental in particular cases. This approach not only fails to enhance patient understanding but may actively obstruct the decision-making process by overwhelming patients with information that is immaterial or distressing. The Court of Claims properly found, and the record substantiates, that competent medical practice demands a flexible, patient-specific informed consent process—one that recognizes the complex medical, emotional, and social factors unique to each patient considering abortion care. No evidence shows that less restrictive, more individualized alternatives were seriously considered or rejected for valid reasons. The failure to pursue such alternatives further undermines the statute's constitutionality under strict scrutiny.

Additionally, intervening defendant offers no credible justification for requiring every patient considering abortion to receive the full array of mandated information, regardless of whether it is pertinent to that patient's situation. This broad and rigid approach does not enhance patient health; rather, it risks undermining patient autonomy and trust. The record demonstrates that providing information such as parenting or adoption options, when specifically requested by the patient, fully respects both the patient's right to make autonomous decisions and the state's interest in informed consent. Imposing additional, unsolicited information serves no legitimate purpose related to patient health and appears instead to burden the exercise of a fundamental right through the imposition of shame or guilt.

Intervening defendant further argues that the informed consent provisions cannot be held facially invalid unless plaintiffs demonstrate that there exist no circumstances under which they would be constitutional. This argument, however, is unpersuasive when considering the Michigan

Constitution's explicit guarantee of the right to reproductive freedom as a fundamental right. The categorical protection provided by Const 1963, art 1, § 28, demands a more rigorous review than that urged by intervening defendant. When a law burdens a fundamental right, strict scrutiny applies: the State must demonstrate that the law is narrowly tailored and is the least restrictive means to serve a compelling governmental interest. *Washington*, 521 US at 720; *Johnson*, 543 US at 505. Here, intervening defendant has failed to meet this demanding standard. The informed consent provisions, as applied, intrude upon the constitutional guarantee of reproductive freedom and cannot withstand the required constitutional scrutiny. Accordingly, because the informed consent provisions fail to meet the strict scrutiny required by our Constitution and impermissibly infringe on the fundamental right to reproductive freedom, we concur with the conclusion of the Court of Claims that they violate Const 1963, art 1, § 28, and must be declared invalid.

D. PHYSICIAN MANDATE

Regarding the statutory requirement under MCL 333.17015(1) that only physicians may perform abortions, the Court of Claims found as follows:

> The Court finds that the APC [i.e. advanced practice clinicians, which includes nurse practitioners, certified nurse midwives, and physician assistants] provider ban arbitrarily limits abortion providers to physicians only, and burdens and infringes upon a patient's freedom to make and effectuate decisions about abortion care. Having access to a provider is necessarily linked to being able to make and effectuate decisions about whether to seek abortion care. The artificial limitation on the available pool of abortion providers imposes logistical barriers to abortion access, increasing patient wait time and travel distances. This exacerbates existing provider shortages, leading to large swathes of Michigan without access to nearby abortion care. By allowing APCs to perform some abortion services, the number of healthcare professionals available to individuals seeking care would increase dramatically. The increased number of healthcare professionals would, in turn, increase access to abortion care for individual patients.
>
> * * *
>
> The APC provider ban likewise does not withstand strict-scrutiny constitutional review. The APC ban excludes qualified clinicians from providing abortion care without any medical justification. APCs are fully capable of providing early abortion care. APCs in Michigan currently provide the very same care to patients experiencing miscarriage as they could for patients seeking early abortions. Numerous other states allow APCs to provide early abortions. And leading medical authorities have concluded that laws prohibiting qualified APCs from providing these services are without medical foundation and erect barriers to care.
>
> Intervening defendant argues that restricting abortion-care providers to physicians will ensure patients receive only the highest quality care, thus making the ban constitutional. This argument is not persuasive, especially in light of the strong evidence presented by plaintiffs that many APCs already provide care

> similar to medication abortion and dilation procedures safely and effectively. The Court agrees with plaintiffs' argument and concludes that the APC provider ban fails strict-scrutiny constitutional review.

On appeal, intervening defendant contends that the Court of Claims erred in facially invalidating this provision, asserting that the statute may operate constitutionally in certain circumstances—such as when physicians are required to perform second-trimester abortions using the dilation-and-evacuation procedure. However, this argument fundamentally misapprehends the controlling legal standard. The Michigan Constitution requires courts to evaluate whether a statute is unconstitutional on its face if it infringes protected rights in a substantial number of its applications, regardless of whether some hypothetical constitutional applications exist. See *Johnson*, 543 US at 505; see also *Broadrick v Oklahoma*, 413 US 601, 615-16; 93 S Ct 2908; 37 L Ed 2d 830 (1973) (explaining that facial challenges are appropriate where the law sweeps too broadly and impermissibly restricts constitutional rights). Under Michigan's constitutional framework and the strict scrutiny applicable here, it is the government's burden to demonstrate that the challenged law is narrowly tailored to serve a compelling state interest. Mere conjecture about potential constitutional scenarios is insufficient; the state must provide concrete evidence that the law, in its broad sweep, does not infringe upon the rights protected by Const 1963, art 1, § 28. Intervening defendant has failed to meet this burden. Simply positing hypothetical constitutional applications does not salvage a statute that, on its face, infringes the rights protected by Const 1963, art 1, § 28. Instead, where a statute facially burdens a fundamental right, as is the case here, courts are required to invalidate the law unless the state can carry its heavy burden of justification, which has not been done. Accordingly, we again concur with the Court of Claims and hold that the physician mandate cannot withstand constitutional scrutiny and is invalid. Our analysis is consistent with the broader principles of constitutional adjudication, ensuring that fundamental rights are robustly protected and that statutes which impermissibly burden those rights cannot stand, even if they might conceivably be constitutionally applied in isolated circumstances.

On cross-appeal, plaintiffs argue that the Court of Claims erred by finding that the provision requiring screening for coercion to abort did not deny, burden, or infringe upon the fundamental right to reproductive freedom. Plaintiffs also argue that the Court of Claims further erred by failing to adjudicate plaintiffs' claim that the provision violated the nondiscrimination clause of Const 1963, art 1, § 28(2).

As stated previously, abortion providers must "orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11)." MCL 333.17015a(1). Abortion facilities must also "post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i)," which states, among other things, that it is illegal to coerce an individual to have an abortion and provides information about resources where help is available for domestic violence and sexual assault. MCL 333.17015a(5); MCL 333.17015(11)(i).

As previously alluded to in part, the Court of Claims found as follows:

> Plaintiffs have not met their burden of establishing that the coercion screening requirements burden or infringe upon a patient's access to abortion care.

> The witnesses agree that coercion screening is a necessary step in abortion care. Informational posters warning patients about the illegality of abortion coercion and providing resources to patients facing such coercion protect patient rights to reproductive care of all kinds. Contrary to the position of some witnesses, nothing in the statutes requires providers to ask specific or direct questions during a coercion screening. The statutes permit providers to tailor their questions and interact with patients in an organic way.
>
> * * *
>
> As noted, the coercion screening requirements of MCL 333.17105(11)(i) and MCL 333.17015a do not burden or infringe upon patients' reproductive freedom. Accordingly, the Court need not consider whether these provisions promote the compelling state interest of protecting patient health, whether the screening requirements achieve their goal by the least restrictive means, or whether they are consistent with the accepted standard of care and supported by evidence-based medicine.

Upon a thorough review of the record, we find no error in the Court of Claims's conclusion that the statutory provision at issue appears, on its face, to be neutral in its protection of patients' rights to make decisions regarding abortion free from coercion. The Court of Claims correctly observed that this facial neutrality ensures the statute does not expressly favor or disfavor any particular reproductive choice; rather, it purports to safeguard an individual's autonomy in the context of abortion decisions. Nevertheless, we are compelled to undertake a more searching analysis, as the mere appearance of neutrality is not dispositive of the statute's constitutional validity under Michigan law.

Contrary to the implicit findings of the Court of Claims, we hold that the facial neutrality of the statute is insufficient to resolve whether its enforcement leads to unequal protection of constitutional rights. The Michigan Constitution, Const 1963, art 1, § 28(2), unequivocally guarantees the right to reproductive freedom, encompassing the autonomy to make decisions both to terminate and to continue a pregnancy. The statutory scheme at issue prohibits only coercion to abort, yet it fails to equally prohibit coercion to become pregnant or to continue a pregnancy. This legislative asymmetry may result in a statutory framework that, in practice, protects only one facet of the spectrum of reproductive autonomy. Such a statutory omission raises a significant constitutional question under the Equal Protection Clause of the Michigan Constitution.

A law that proscribes coercion in one direction, but not the other, risks operating in a manner that discriminates against individuals who seek to exercise the full range of reproductive choices guaranteed by our Constitution. In this case, the Court of Claims did not engage in the requisite inquiry—namely, whether the law, as applied, impermissibly discriminates in the enforcement of reproductive rights by creating a disparate impact on those who do not wish to continue a pregnancy, or who are coerced to become pregnant. The absence of such analysis renders the lower court's decision incomplete with respect to the constitutional issues presented.

Accordingly, we vacate any implicit or explicit ruling by the Court of Claims regarding whether the statute, as applied, discriminates in the enforcement of reproductive rights and remand

this matter to the Court of Claims for further proceedings. On remand, the Court of Claims must determine whether the statutory framework, both in its language and in its application, comports with the constitutional mandate of equal protection in the enforcement of the right to reproductive freedom. This inquiry shall require a searching examination not only of the statutory text, but also of the real-world consequences of its enforcement. Only through such rigorous analysis can we ensure that the constitutional protections afforded to reproductive autonomy are meaningful, robust, and equally available to all individuals, regardless of the specific reproductive choices they seek to make.

Affirmed in part and remanded for further proceedings consistent with this opinion. We do not retain jurisdiction. No costs are awarded to either party, a public question being involved. MCR 7.216(A)(7) and MCR 7.219(A). *City of Bay City v Bay Co Treasurer*, 292 Mich App 156, 172; 807 NW2d 892 (2011).

APPENDIX

MCL 333.17015 provides in relevant part as follows:

> (1) Subject to subsection (10), a physician shall not perform an abortion otherwise permitted by law without the patient's informed written consent, given freely and without coercion to abort.
>
> (2) For purposes of this section and section 17015a:
>
> * * *
>
> (d) "Fetus" means an individual organism of the species Homo sapiens in utero.
>
> (e) "Local health department representative" means an individual who meets 1 or more of the licensing requirements listed in subdivision (h) and who is employed by, or under contract to provide services on behalf of, a local health department.
>
> (f) "Medical emergency" means a condition which, on the basis of the physician's good-faith clinical judgment, so complicates the medical condition of a pregnant individual as to necessitate the immediate abortion of the individual's pregnancy to avert the individual's death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.
>
> (g) "Medical service" means the provision of a treatment, procedure, medication, examination, diagnostic test, assessment, or counseling, including, but not limited to, a pregnancy test, ultrasound, pelvic examination, or an abortion.
>
> * * *

(i) "Probable gestational age of the fetus" means the gestational age of the fetus at the time an abortion is planned to be performed.

(j) "Provide the patient with a physical copy" means confirming that the patient accessed the internet website described in subsection (5) and received a printed valid confirmation form from the website and including that form in the patient's medical record or giving a patient a copy of a required document by 1 or more of the following means:

(*i*) In person.

(*ii*) By registered mail, return receipt requested.

(*iii*) By parcel delivery service that requires the recipient to provide a signature in order to receive delivery of a parcel.

(*iv*) By facsimile transmission.

(3) Subject to subsection (10), a physician or a qualified person assisting the physician shall do all of the following not less than 24 hours before that physician performs an abortion upon a patient who is pregnant:

(a) Confirm that, according to the best medical judgment of a physician, the patient is pregnant, and determine the probable gestational age of the fetus.

(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:

(*i*) The probable gestational age of the fetus the patient is carrying.

(*ii*) Information about what to do and whom to contact should medical complications arise from the abortion.

(*iii*) Information about how to obtain pregnancy prevention information through the department of health and human services.

(c) Provide the patient with a physical copy of the written standardized summary described in subsection (11)(b) that corresponds to the procedure the patient will undergo and is provided by the department of health and human services. If the procedure has not been recognized by the department of health and human services, but is otherwise allowed under Michigan law, and the department of health and human services has not provided a written standardized summary for that procedure, the physician shall develop and provide a written summary that describes the procedure, any known risks or complications of the procedure, and risks associated with live birth and meets the requirements of subsection (11)(b)(*iii*) through (*vii*).

(d) Provide the patient with a physical copy of a medically accurate depiction, illustration, or photograph and description of a fetus supplied by the department of health and human services pursuant to subsection (11)(a) at the gestational age nearest the probable gestational age of the patient's fetus.

(e) Provide the patient with a physical copy of the prenatal care and parenting information pamphlet distributed by the department of health and human services under section 9161.

(f) Provide the patient with a physical copy of the prescreening summary on prevention of coercion to abort described in subsection (11)(i).

(4) The requirements of subsection (3) may be fulfilled by the physician or a qualified person assisting the physician at a location other than the health facility where the abortion is to be performed. The requirement of subsection (3)(a) that a patient's pregnancy be confirmed may be fulfilled by a local health department under subsection (18). The requirements of subsection (3) cannot be fulfilled by the patient accessing an internet website other than the internet website that is maintained and operated by the department of health and human services under subsection (11)(g).

(5) The requirements of subsection (3)(c) through (f) may be fulfilled by a patient accessing the internet website that is maintained and operated by the department of health and human services under subsection (11)(g) and receiving a printed, valid confirmation form from the website that the patient has reviewed the information required in subsection (3)(c) through (f) at least 24 hours before an abortion being performed on the patient. The website must not require any information be supplied by the patient. The department of health and human services shall not track, compile, or otherwise keep a record of information that would identify a patient who accesses this website. The patient shall supply the valid confirmation form to the physician or qualified person assisting the physician to be included in the patient's medical record to comply with this subsection.

(6) Subject to subsection (10), before obtaining the patient's signature on the acknowledgment and consent form, a physician personally and in the presence of the patient shall do all of the following:

(a) Provide the patient with the physician's name, confirm with the patient that the coercion to abort screening required under section 17015a was performed, and inform the patient of the right to withhold or withdraw consent to the abortion at any time before performance of the abortion.

(b) Orally describe, in language designed to be understood by the patient, taking into account the patient's age, level of maturity, and intellectual capability, each of the following:

(*i*) The specific risk, if any, to the patient of the complications that have been associated with the procedure the patient will undergo, based on the patient's particular medical condition and history as determined by the physician.

(*ii*) The specific risk of complications, if any, to the patient if the patient chooses to continue the pregnancy based on the patient's particular medical condition and history as determined by a physician.

(7) To protect a patient's privacy, the information set forth in subsection (3) and subsection (6) must not be disclosed to the patient in the presence of another patient.

(8) If at any time before the performance of an abortion, a patient undergoes an ultrasound examination, or a physician determines that ultrasound imaging will be used during the course of a patient's abortion, the physician or qualified person assisting the physician shall provide the patient with the opportunity to view or decline to view an active ultrasound image of the fetus, and offer to provide the patient with a physical picture of the ultrasound image of the fetus before the performance of the abortion. After the expiration of the 24-hour period prescribed under subsection (3) but before performing an abortion on a patient who is pregnant, a physician or a qualified person assisting the physician shall do all of the following:

(a) Obtain the patient's signature on the acknowledgment and consent form described in subsection (11)(c) confirming that the patient has received the information required under subsection (3).

(b) Provide the patient with a physical copy of the signed acknowledgment and consent form described in subsection (11)(c).

(c) Retain a copy of the signed acknowledgment and consent form described in subsection (11)(c) and, if applicable, a copy of the pregnancy certification form completed under subsection (18)(b), in the patient's medical record.

(9) This subsection does not prohibit notifying the patient that payment for medical services will be required or that collection of payment in full for all medical services provided or planned may be demanded after the 24-hour period described in this subsection has expired. A physician or an agent of the physician shall not collect payment, in whole or in part, for a medical service provided to or planned for a patient before the expiration of 24 hours from the time the patient has done either or both of the following, except in the case of a physician or an agent of a physician receiving capitated payments or under a salary arrangement for providing those medical services:

(a) Inquired about obtaining an abortion after the patient's pregnancy is confirmed and the patient has received from that physician or a qualified person assisting the physician the information required under subsection (3)(c) and (d).

(b) Scheduled an abortion to be performed by that physician.

(10) If the attending physician, utilizing the physician's experience, judgment, and professional competence, determines that a medical emergency exists and necessitates performance of an abortion before the requirements of subsections (1), (3), and (6) can be met, the physician is exempt from the requirements of subsections (1), (3), and (6), may perform the abortion, and shall maintain a written record identifying with specificity the medical factors upon which the determination of the medical emergency is based.

(11) The department of health and human services shall do each of the following:

(a) Produce medically accurate depictions, illustrations, or photographs of the development of a human fetus that indicate by scale the actual size of the fetus at 2-week intervals from the fourth week through the twenty-eighth week of gestation. Each depiction, illustration, or photograph must be accompanied by a printed description, in nontechnical English, Arabic, and Spanish, of the probable anatomical and physiological characteristics of the fetus at that particular state of gestational development.

(b) Subject to subdivision (e), develop, draft, and print, in nontechnical English, Arabic, and Spanish, written standardized summaries, based upon the various medical procedures used to abort pregnancies, that do each of the following:

(*i*) Describe, individually and on separate documents, those medical procedures used to perform abortions in this state that are recognized by the department of health and human services.

(*ii*) Identify the physical complications that have been associated with each procedure described in subparagraph (*i*) and with live birth, as determined by the department. In identifying these complications, the department shall consider studies concerning complications that have been published in a peer review medical journal, with particular attention paid to the design of the study, and shall consult with the Centers for Disease Control and Prevention, the American Congress of Obstetricians and Gynecologists, the Michigan State Medical Society, or any other source that the department of health and human services determines appropriate for the purpose.

(*iii*) State that as the result of an abortion, some individuals may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if these symptoms occur and are intense or persistent, professional help is recommended.

(*iv*) State that not all of the complications listed in subparagraph (*ii*) may pertain to that particular patient and refer the patient to the patient's physician for more personalized information.

(*v*) Identify services available through public agencies to assist the patient during the patient's pregnancy and after the birth of the child, should the patient choose to give birth and maintain custody of the child.

(*vi*) Identify services available through public agencies to assist the patient in placing the child in an adoptive or foster home, should the patient choose to give birth but not maintain custody of the child.

(*vii*) Identify services available through public agencies to assist the patient and provide counseling should the patient experience subsequent adverse psychological effects from the abortion.

(c) Develop, draft, and print, in nontechnical English, Arabic, and Spanish, an acknowledgment and consent form that includes only the following language above a signature line for the patient:

"I, _____ , voluntarily and willfully hereby authorize Dr. _____ ("the physician") and any assistant designated by the physician to perform upon me the following operation(s) or procedure(s):

_____

(Name of operation(s) or procedure(s))

_____

A. I understand that I am approximately _____ weeks pregnant. I consent to an abortion procedure to terminate my pregnancy. I understand that I have the right to withdraw my consent to the abortion procedure at any time before performance of that procedure.

B. I understand that it is illegal for anyone to coerce me into seeking an abortion.

C. I acknowledge that at least 24 hours before the scheduled abortion I have received a physical copy of each of the following:

1. A medically accurate depiction, illustration, or photograph of a fetus at the probable gestational age of the fetus I am carrying.

2. A written description of the medical procedure that will be used to perform the abortion.

3. A prenatal care and parenting information pamphlet.

D. If any of the documents listed in paragraph C were transmitted by facsimile, I certify that the documents were clear and legible.

E. I acknowledge that the physician who will perform the abortion has orally described all of the following to me:

1. The specific risk to me, if any, of the complications that have been associated with the procedure I am scheduled to undergo.

2. The specific risk to me, if any, of the complications if I choose to continue the pregnancy.

F. I acknowledge that I have received all of the following information:

1. Information about what to do and whom to contact in the event that complications arise from the abortion.

2. Information pertaining to available pregnancy related services.

G. I have been given an opportunity to ask questions about the operation(s) or procedure(s).

H. I certify that I have not been required to make any payments for an abortion or any medical service before the expiration of 24 hours after I received the written materials listed in paragraph C, or 24 hours after the time and date listed on the confirmation form if the information described in paragraph C was viewed from the state of Michigan internet website.".

(d) Make available to physicians through the board and the Michigan board of osteopathic medicine and surgery, and to any person upon request, the copies of medically accurate depictions, illustrations, or photographs described in subdivision (a), the written standardized summaries described in subdivision (b), the acknowledgment and consent form described in subdivision (c), the prenatal care and parenting information pamphlet described in section 9161, the pregnancy certification form described in subdivision (f), and the materials regarding coercion to abort described in subdivision (i).

(e) In developing the written standardized summaries for abortion procedures under subdivision (b), include in the summaries only medication that has been approved by the United States Food and Drug Administration for use in performing an abortion.

(f) Develop, draft, and print a certification form to be signed by a local health department representative at the time and place a patient has a pregnancy confirmed, as requested by the patient, verifying the date and time the pregnancy is confirmed.

(g) Develop, operate, and maintain an internet website that allows a patient considering an abortion to review the information required in subsection (3)(c) through (f). After the patient reviews the required information, the department of health and human services shall ensure that a confirmation form can be printed by

the patient from the internet website that will verify the time and date the information was reviewed. A confirmation form printed under this subdivision becomes invalid 14 days after the date and time printed on the confirmation form.

(h) Include on the informed consent internet website operated under subdivision (g) a list of health care providers, facilities, and clinics that offer to perform ultrasounds free of charge. The list must be organized geographically and include the name, address, and telephone number of each health care provider, facility, and clinic.

(i) After considering the standards and recommendations of the Joint Commission on Accreditation of Healthcare Organizations, the Michigan Domestic and Sexual Violence Prevention and Treatment Board, the Michigan Coalition to End Domestic and Sexual Violence or successor organization, and the American Medical Association, do all of the following:

(*i*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a notice that is required to be posted in facilities and clinics under section 17015a. The notice must be at least 8- ½ inches by 14 inches, be printed in at least 44-point type, and contain at a minimum all of the following:

(A) A statement that it is illegal under Michigan law to coerce an individual to have an abortion.

(B) A statement that help is available if an individual is being threatened or intimidated; is being physically, emotionally, or sexually harmed; or feels afraid for any reason.

(C) The telephone number of at least 1 domestic violence hotline and 1 sexual assault hotline.

(*ii*) Develop, draft, and print or make available in printable format, in nontechnical English, Arabic, and Spanish, a prescreening summary on prevention of coercion to abort that, at a minimum, contains the information required under subparagraph (*i*) and notifies the patient that an oral screening for coercion to abort will be conducted before giving written consent to obtain an abortion.

(*iii*) Develop, draft, and print screening and training tools and accompanying training materials to be utilized by a physician or qualified person assisting the physician while performing the coercion to abort screening required under section 17015a. The screening tools must instruct the physician or qualified person assisting the physician to orally communicate information to the patient regarding coercion to abort and to document the findings from the coercion to abort screening in the patient's medical record.

(*iv*) Develop, draft, and print protocols and accompanying training materials to be utilized by a physician or a qualified person assisting the physician if a patient discloses coercion to abort or that domestic violence is occurring, or both, during the coercion to abort screening. The protocols must instruct the physician or qualified person assisting the physician to do, at a minimum, all of the following:

(A) Follow the requirements of section 17015a as applicable.

(B) Assess the patient's current level of danger.

(C) Explore safety options with the patient.

(D) Provide referral information to the patient regarding law enforcement and domestic violence and sexual assault support organizations.

(E) Document any referrals in the patient's medical record.

(12) A physician's duty to inform the patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under this article would possess.

(13) A written consent form meeting the requirements set forth in this section and signed by the patient is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that consent was obtained through fraud, negligence, deception, misrepresentation, coercion, or duress.

(14) A completed certification form described in subsection (11)(f) that is signed by a local health department representative is presumed valid. The presumption created by this subsection may be rebutted by evidence that establishes, by a preponderance of the evidence, that the physician who relied upon the certification had actual knowledge that the certificate contained a false or misleading statement or signature.

* * *

(18) Upon a patient's request, a local health department shall comply with the following:

(a) Provide a pregnancy test for that patient to confirm the pregnancy as required under subsection (3)(a) and determine the probable gestational stage of the fetus. The local health department need not comply with this subdivision if the requirements of subsection (3)(a) have already been met.

(b) If a pregnancy is confirmed, ensure that the patient is provided with a completed pregnancy certification form described in subsection (11)(f) at the time the information is provided.

(19) The identity and address of a patient who is provided information or who consents to an abortion pursuant to this section is confidential and is subject to disclosure only with the consent of the patient or by judicial process.

(20) A local health department with a file containing the identity and address of a patient described in subsection (19) who has been assisted by the local health department under this section shall do both of the following:

(a) Only release the identity and address of the patient to a physician or qualified person assisting the physician in order to verify the receipt of the information required under this section.

(b) Destroy the information containing the identity and address of the patient within 30 days after assisting the patient under this section.

MCL 333.17015a provides:

(1) At the time a patient first presents at a private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed for the purpose of obtaining an abortion, whether before or after the expiration of the 24-hour period described in section 17015(3), the physician or qualified person assisting the physician shall orally screen the patient for coercion to abort using the screening tools developed by the department under section 17015(11). The oral screening required under this subsection may occur before the requirements of section 17015(3) have been met with regard to that patient.

(2) If a patient discloses that she is the victim of domestic violence that does not include coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).

(3) If a patient discloses coercion to abort, the physician or qualified person assisting the physician shall follow the protocols developed by the department under section 17015(11).

(4) If a patient who is under the age of 18 discloses domestic violence or coercion to abort by an individual responsible for the health or welfare of the minor patient, the physician or qualified person assisting the physician shall report that fact to a local child protective services office.

(5) A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall post in a conspicuous place in an area of its facility that is accessible to patients, employees, and visitors the notice described in section 17015(11)(i). A private office, freestanding surgical outpatient facility, or other facility or clinic in which abortions are performed shall make available in an area of its facility that is accessible to patients, employees, and visitors publications that contain information about violence against women.

(6) This section does not create a right to abortion. Notwithstanding any other provision of this section, a person shall not perform an abortion that is prohibited by law.

/s/ Stephen L. Borrello
/s/ Mariam S. Bazzi
/s/ Andrew J. Lievense