

EXHIBIT B

**IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION**

WOMEN'S HEALTH CENTER OF WEST
VIRGINIA,

Plaintiff,

v.

PATRICK MORRISEY *et al.*,

Defendants.

Civil Action No.

Hon.

**DECLARATION OF COY FLOWERS, MD, FACOG,
IN SUPPORT OF PLAINTIFF'S EMERGENCY MOTION FOR
A TEMPORARY RESTRAINING ORDER AND PRELIMINARY
INJUNCTION**

I, Coy Flowers, MD, FACOG, declare and state as follows:

1. I am a board-certified obstetrician-gynecologist (Ob/Gyn) licensed to practice in West Virginia, with nearly 20 years' experience providing comprehensive reproductive health care to women, including referring patients for abortion care. I graduated from West Virginia University School of Medicine in 1998; completed my internship at the National Naval Medical Center in Bethesda, Maryland in 1999; and completed my residency at the National Capital Consortium Residency in Ob/Gyn at the National Naval Medical and Walter Reed Army Medical Centers in Bethesda, Maryland, and Washington, DC in 2002.

2. From 2002 to 2005, I was Lieutenant Commander & Staff Physician at the United States Naval Hospital in Camp Lejeune, North Carolina. From 2006 through 2019, I was in a private practice in Ronceverte, West Virginia. Over the last 15 years, I have held several faculty appointments at West Virginia medical schools.

3. I am a Fellow of, and am currently Chair of the West Virginia Section of, the American College of Obstetricians and Gynecologists (“ACOG”), the nation’s pre-eminent authority on health care for women. I am also an ACOG delegate to the American Medical Association. From 2018–2019, I was President of the West Virginia State Medical Association. I have also served on the West Virginia Department of Health and Human Services Maternal-Infant Advisory Committee. I submit this declaration in my personal capacity, and not on behalf of any of the institutions with which I am affiliated. My *curriculum vitae*, which more fully sets forth my experience and credentials, is attached as Exhibit 1.

4. The facts I state here are based on my personal experience, information, and the personal knowledge I have obtained in the course of my duties as Chair of the West Virginia Section of ACOG, President of the West Virginia State Medical Association, and in my private Ob/Gyn practice. The opinions in this declaration are my expert opinions as an Ob/Gyn. My expert opinions are based on my education, training, professional experience, and review of relevant medical literature. All of my opinions in this declaration are expressed to a reasonable degree of medical certainty. If called and sworn as a witness, I could and would testify competently thereto.

5. I submit this declaration in support of the motion of Plaintiff Women’s Health Center of West Virginia (“WHC”) for a temporary restraining order and preliminary injunction. I am familiar with the Order. Abortion qualifies as urgent, medically necessary care, and as care that cannot be postponed without compromising long-term health. Nonetheless, I understand that to comply with the Order, WHC must deny care to most patients seeking abortion unless and until the patient is nearing ineligibility for medication abortion (approximately 11 weeks in pregnancy) or procedural abortion (approximately 16 weeks in pregnancy). As a result, patients

will be forced to remain pregnant for up to six, or in some cases eleven, weeks, causing them serious and irreparable harm.

6. Moreover, because patients remain pregnant when they are denied timely abortion, prohibiting timely abortions runs contrary to the purpose the Governor stated in the Order: reducing transmission of the virus and preserving medical resources and equipment during the pandemic. That is because even though providing abortion care involves some risk of exposure to the virus and uses some medical resources, both of which providers take steps to minimize, this exposure and use is not reduced by forcing patients to remain pregnant. In fact, forcing patients to remain pregnant means that they will face increased exposure to the inherent risks of pregnancy complications, including miscarriage, which often can lead to the need for further medical care and hospital resources. Thus, prohibiting timely procedures will result in patients facing higher risk of virus exposure and using more medical resources than if the patient had obtained an earlier abortion. The result of delaying an abortion is not that the patient uses no medical resources, it is that the patient remains pregnant and potentially uses *more* medical resources.

Legal Abortion in the United States and West Virginia

7. Legal abortion is one of the safest medical procedures in the United States and is substantially safer than continuing a pregnancy through to childbirth.¹ Abortion-related emergency room visits constitute just 0.01% of all emergency room visits among women of

¹ Nat'l Acads. of Scis. Eng'g & Med., *The Safety & Quality of Abortion Care in the United States* 77–78, 162–63 (2018).

reproductive age in the United States.² Abortion is also extremely common; approximately one in four women in this country will have an abortion by age forty-five.³

8. The risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion, and every pregnancy-related complication is more common among patients giving birth than among those having abortions.⁴ Just as in many states throughout our country, West Virginia women experience a higher risk of both morbidity and mortality during pregnancy due to increased rates of chronic medical diagnoses such as diabetes and hypertension, as well as obesity.

9. There are two main methods of abortion: medication abortion and surgical (or procedural) abortion. Both methods are safe, effective means of terminating a pregnancy.⁵ Medication abortion involves a combination of two pills: mifepristone and misoprostol.⁶ The patient takes the mifepristone and then, typically 24 to 48 hours later, takes the misoprostol at a location of their choosing, most often at their home, after which they expel the contents of the uterus in a manner similar to a miscarriage. Medication abortion is neither a “surgery” nor a “procedure.” Medication abortion is generally available up to 10–11 weeks, as measured from a patient’s last menstrual period (“LMP”).

² Ushma Upadhyay et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16:88BMC Med. 1, 1 (2018).

³ See Guttmacher Inst., *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates* (Oct. 19, 2017), <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates>.

⁴ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (Feb. 2012).

⁵ Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy &*

⁶ Nat’l Acads., *supra* note 1, at 51.

10. For some patients, medication abortion is contraindicated, and/or there are factors that counsel in favor of a procedural abortion, including patients with medical conditions that make procedural abortion a safer and/or more appropriate course.⁷ Contraindications for medication abortion include confirmed or suspected ectopic pregnancy, intrauterine device in place, current long-term systemic corticosteroid therapy, chronic adrenal failure, known coagulopathy or anticoagulant therapy, and intolerance or allergy to mifepristone.⁸ Most clinical trials also have excluded women with severe liver, renal or respiratory disease, or uncontrolled hypertension or cardiovascular disease (angina, valvular disease, arrhythmia, or cardiac failure).⁹ Women are also not good candidates for medication abortion if they are unable or unwilling to adhere to care instructions, require quick completion of the abortion process, are not available for follow-up contact or evaluation, or cannot understand the instructions because of language or comprehension barriers.¹⁰

11. Surgical abortion, despite that name, is not what is commonly understood to be “surgery”—it involves no incision. For that reason, it is also called procedural abortion. In the first and early second trimester, procedural abortions are generally performed using the suction curettage technique, also called aspiration abortion, which involves using a curette connected to a suction apparatus to gently empty the contents of the uterus. This procedure typically takes five to ten minutes. My understanding is that in West Virginia, all outpatient abortion services are either medication abortion or aspiration procedures, and that there are no or almost no abortions are reported after 16–17 weeks LMP. Nationally, later in pregnancy, abortions are generally

⁷ Nat’l Acads., *supra* note 1, at 51–52.

⁸ ACOG, *Medical Management of First-Trimester Abortion* at 6, Practice Bulletin No. 143 (Mar. 2014).

⁹ *Id.*

¹⁰ *Id.*

performed using a method called dilation and evacuation (“D&E”), in which clinicians dilate the cervix further and use instruments as well as suction to empty the uterus.

12. In 2016, the latest year for which the CDC reports data, there were approximately 1400 abortions in West Virginia, of which 61% occurred at or before 8 weeks of pregnancy; 33% occurred at 9–13 weeks; 4% occurred at 14–15 weeks; 2% occurred at 16–17 weeks; and none were reported after 17 weeks.¹¹

13. Over my many years of practice, I have routinely referred patients seeking abortion care to safe abortion providers, including WHC, the state’s sole abortion clinic. I know that my patients have multiple reasons for deciding to end a pregnancy, and that they take the decision extremely seriously. They often speak of their careful consideration of how to proceed with the pregnancy, and the extreme stress and burdens that lead them to decide to have an abortion. They often include in their decision process not just me, but also their family and their pastor. Many tell me they have prayed on the issue. Many lack money and financial support of any kind. National statistics show that 75% of patients who seek abortions are poor or low-income.¹² Historically, half my patients have accessed health care through the Medicaid system. Patients who decide to have an abortion also often lack family and personal support systems to help them raise a child, or to expand their family with another child, at that time in their lives. They describe being at their limit in terms of the people they are already supporting, whether that means their existing children (a majority of women having abortions in the United States already

¹¹ Tara C. Jatlaoui, Lindsay Eckhaus, Michele G. Mandel *et al.*, Abortion Surveillance — United States, 2016. *MMWR Surveill. Summ* Nov. 29, 2019; 68(No. SS-11): at 26 Table 7, <https://www.cdc.gov/mmwr/volumes/68/ss/pdfs/ss6811a1-H.pdf>.

¹² Jerman J, Jones RK and Onda T, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, New York: Guttmacher Institute, 2016, <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>.

have at least one child¹³) and/or other family members, including parents. Still others choose abortion for medical reasons that would put their health in particular jeopardy were they to remain pregnant and give birth.¹⁴

14. Once they decide to seek abortion care, my patients try to access it as quickly as they can, but many of them, especially those with low incomes, face great obstacles in obtaining that care.

- a. First, some patients do not discover they are pregnant until later in their pregnancies. Adolescent patients in particular often simply do not recognize the signs of pregnancy, and may deny the signs if their family circumstances lead them to feel ashamed. Some patients experience shame over the sexual assault through which they became pregnant—whether by a stranger, a date, or a family member—and their shame can obstruct their recognition of the pregnancy.
- b. Second, many of my patients face logistical obstacles that can delay access to abortion care. Lack of money, transportation, and childcare are huge obstacles. West Virginia’s road system is difficult even for patients with decent cars, but for patients with vehicles in poor condition, or no vehicle, having to travel many miles to WHC or an out of state clinic is daunting—

¹³ Guttmacher Inst., *Induced Abortions in the United States* 1 (Sept. 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; *see also* Jenna Jerman *et al.*, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. 6, 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

¹⁴ M. Antonia Biggs *et al.*, *Understanding Why Women Seek Abortions in the US*, 13:29 *BMC Women’s Health* 1, 7 (2013).

and greatly delays their abortions—or even prohibitive. Adolescent patients may delay seeking care because they fear discovery and retribution, sometimes violent, by family members. Working poor patients, who lack access to Medicaid and cannot afford health insurance, often apply for Medicaid once pregnant, and are delayed as much as 4–8 weeks in obtaining their Medicaid cards. That card allows them to visit an Ob/Gyn when they can get a day off work (often without pay), but it does not cover abortion, which many of them do not realize. They are then in the position of having to take off another (often unpaid) day from work, and to raise funds to pay for a later, and therefore more expensive, abortion, and to pay for transportation to a distant clinic, as well as child care as needed.¹⁵

15. These obstacles are even greater during the COVID-19 crisis. So many West Virginians have lost their jobs or large portions of their paid work. Because schools are closed, school-hours childcare that patients had counted on is now gone. The crisis has also made it more difficult and riskier to access what little public transportation that exists in West Virginia.

16. As ACOG and other well-respected medical professional organizations have observed, abortion “is an essential component of comprehensive health care” and “a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the

¹⁵ Sarah E. Baum *et al.*, *Women’s Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer *et al.*, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *Contraception* 334, 335 (2006).

risks [to patients] or potentially make it completely inaccessible.”¹⁶ That is why ACOG and other preeminent medical authorities advise: “To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure.”¹⁷ That statement is attached as Exhibit 2.

17. On April 4, 2020, the World Health Organization (“WHO”) issued a similar statement concluding that “[a]bortion is considered an essential service during the corona virus pandemic” and that “services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak.”¹⁸

18. The American Medical Association (“AMA”)—the country’s largest medical organization and one of its foremost authorities on medical and public health matters—concur with this conclusion. The AMA’s March 30, 2020 Statement on Government Interference in Reproductive Health Care disapproves of efforts “to ban or dramatically limit women’s reproductive health care” during the COVID-19 outbreak by “labeling procedures as ‘nonurgent.’”¹⁹

¹⁶ ACOG *et al.*, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>, attached as Exhibit 2.

¹⁷ *Id.*

¹⁸ Mary Margaret Olohan, *World Health Organization: Abortion Is ‘Essential’ During Coronavirus Pandemic*, Daily Caller, Apr. 4, 2020, <https://dailycaller.com/2020/04/04/who-abortion-essential-coronavirus-covid-19/> (summarizing the WHO’s statement).

¹⁹ Am. Med. Ass’n, *AMA statement on government interference in reproductive health care*, Mar. 30, 2020, <https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care>.

Consequences of Delaying Abortion Care

19. For many patients and their families, at many times in their lives, a pregnancy is a profound joy and a blessing. Nonetheless, even an uncomplicated pregnancy poses challenges to a woman's entire physiology and stresses most major organs. From the onset of pregnancy, every patient is at risk of complications, which is why physicians encourage prenatal evaluation as early as possible.

20. During pregnancy, a woman's lungs must work harder to clear both the carbon dioxide produced by her own body and the carbon dioxide produced by the embryo or fetus. Yet her ability to breathe is hampered by the pregnancy growing in her abdomen, putting pressure on her lungs from below, leaving many, if not most, patients feeling chronically out of breath. If the shortness of breath or other pulmonary symptoms reach a certain level of severity, the patient may seek medical evaluation. Because such symptoms are not dissimilar from the symptoms of COVID-19, patients may be more likely to seek urgent or emergent care for these symptoms during the COVID-19 crisis and healthcare providers treating these patients will take the increased precautions, including use of increased personal protective equipment ("PPE"), that are necessary when treating suspected COVID-19 patients.

21. Pregnant patients are very likely to experience gastrointestinal symptoms like increased nausea and vomiting. These symptoms can occur throughout pregnancy, but often start early in pregnancy. In the most severe cases, patients can experience hyperemesis gravidarum, which occurs where the patient's nausea and vomiting are so severe that she becomes dehydrated. Patients experiencing this may require an IV to rehydrate and receive medication.

22. During pregnancy the patient's heart rate increases in order to pump 30–50% more blood. Starting in the second trimester and throughout the third, the heart is working 50%

harder than usual. Because of the increased blood flow, a woman's kidneys become enlarged and the liver must produce more clotting factors to prevent the woman from bleeding to death. However, this latter change increases the risks of blood clots or thrombosis. Patients may experience increased leg pain or leg swelling that leads them to seek medical evaluation.

23. Patients who suffer from chronic conditions including asthma, diabetes, hypertension, gallbladder disease, immunological conditions, thyroid disease, lung disease and diagnosed or undiagnosed cardiac conditions are more likely to experience symptoms that will lead them to seek medical evaluation early in pregnancy. While some patients might be aware of their preexisting conditions and seek nonurgent evaluation, other patients (particularly those who have never been pregnant) might not be aware that they have preexisting conditions and only seek care when their symptoms become urgent or emergent.

24. Although abortion is an extremely safe medical procedure, the health risks associated with it increase as pregnancy advances.²⁰ The risk of death associated with abortion increases as pregnancy progresses—increasing 38% each week.²¹ The risk of death is lowest earlier in pregnancy: 0.3 per 100,000 abortions at eight weeks or less, 0.5 at 9–13 weeks, 2.5 at 14–17 weeks, and 6.7 at 18 weeks and greater. Thus, the mortality risk at 14–17 weeks is more than eight times greater than at eight weeks or less.²² Delaying an abortion by a week in the second trimester significantly increases the mortality risk. Accessing abortion as early in pregnancy as possible is the single most important factor for ensuring the safety of abortion.

²⁰ Nat'l Acads., *supra* note 1, at 77–78, 162–63.

²¹ Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 *Obstetrics & Gynecology* 729, 731 (2004).

²² Suzanne Zane et al., *Abortion-Related Mortality in the United States 1998–2010*, 126(2) *Am. J. Obstetrics & Gynecology* 258, Table 2 (2015)

25. Complications from abortion are likewise rare, but the risks of complications increase as pregnancy advances. When complications do occur, they can usually be managed in an outpatient clinic setting, most likely at the time of the abortion, or, if not then, in a follow-up visit. Complications occur in 1.26% of first-trimester surgical abortions and 1.47% of second-trimester cases.²³ Major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester in-clinic abortion cases, and in 0.41% of in-clinic cases in the second trimester or later.²⁴ Major complications occur nearly twice as frequently in second-trimester abortions as in first-trimester abortions.

26. While the risk of abortion-related mortality and morbidity is very low, there is no way to know in which patients those risks will materialize and cause harm. Because, statistically, the risks associated with abortion increase with each week of pregnancy, a provider forced to select certain patients to delay would be needlessly increasing the risks to patients' physical safety.

27. Health care providers must be able to use their medical judgment to determine whether a patient's abortion can be delayed. Indeed, even prior to the pandemic, we use our medical training, experience, and professional guidance, as well as patient-specific considerations—including not only her physical health but also psychosocial factors—to inform our recommendations to patients. The same is no less true during this crisis.

²³ Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecol.* 177 (2015).

Lack of Medical Justification for the Order

28. There is no medical justification for the assertion that delaying abortions will minimize COVID-19 transmission or preserve medical resources including PPE. That is because a patient who desires an abortion but cannot get one remains pregnant, and will thus require much more contact with the health care system and use of many more medical resources, including PPE.

29. The vast majority of abortions take place in outpatient settings. Abortion care in general does not require a sterile field and does not use extensive PPE, and that is certainly true of the early medication abortions and aspiration abortions available at WHC.

30. Neither medical nor procedural abortion performed at the clinic requires extensive PPE. Medication abortion requires almost no PPE at all and administering the medication requires minimal clinician-patient contact. Aspiration abortions requires some PPE and greater patient contact, but still far less than the patient would need if the patient needed pregnancy-related or emergency medical care.

31. I am familiar with the PPE protocol for abortion treatments because I have long provided the same treatments for patients suffering from early uncomplicated miscarriage: prescribing a patient pills to empty the uterus, or performing a suction curettage (aspiration). In either scenario—abortion or miscarriage—the use of PPE is the same. Although treating miscarriage uses greater medical resources than an induced abortion, under the standard of care across West Virginia, N-95 masks would not be used for either abortion or miscarriage. It is the N-95 masks that are in critically short supply right now. In addition, WHC services are all outpatient and use no hospital resources, staff, supplies, or beds, and certainly no intensive care unit (ICU) beds. They use no ventilators.

32. An abortion at WHC requires a single in-person visit to the clinic. Patients with continuing pregnancies require *significantly* more interaction with the health care system and more PPE. Pregnant patients routinely go to the hospital for evaluation multiple times. Each time they do, they interact with hospital staff and increase the use of PPE.

33. A substantial proportion of pregnant women present to the emergency department at least once before delivery.²⁵ In one recent study of young, low-income pregnant women, 49% visited the emergency department at least once, and 23% visited twice or more.²⁶ Patients with comorbidities, such as asthma, obesity, or diabetes, are significantly more likely to seek emergency care.²⁷ West Virginians experience increased rates of chronic medical diagnoses such as diabetes, hypertension, and obesity. Patients with unplanned pregnancies or without an obstetrician are more likely to present to the emergency department for urgent and non-urgent care.²⁸

34. ACOG and the Society for Maternal Fetal Medicine recommend that pregnant patients who are at “elevated risk”—that is, those who have severe symptoms consistent with COVID-19—should immediately seek care in the emergency department or an equivalent unit that treats pregnant women.²⁹ When seeing these patients in the emergency department, health care providers will use the appropriate amount of PPE for a suspected COVID-19 patient.

²⁵ Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 26 *Acad. Emergency Med.* 940, 942 (2017).

²⁶ *Id.* at 941.

²⁷ *Id.* at 942.

²⁸ Kimberly A. Kilfoyle et al., *Non-Urgent and Urgent Emergency Department Use During Pregnancy: An Observational Study*, 216 *Am. J. Obstetrics & Gynecology* 181.e1 at 5 (2017).

²⁹ ACOG & Soc’y for Maternal Fetal Med., *Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Apr. 10, 2020),

35. Pregnant patients also commonly miscarry at various points in pregnancy. Approximately 17% of pregnancies end in miscarriage.³⁰ Treatment for uncomplicated miscarriage is similar to abortion care but becomes much more involved the later in pregnancy the miscarriage occurs, which would require more intensive care and, therefore, more interaction with the medical system and consumption of resources, including PPE. Patients miscarrying regularly seek hospital care and often make multiple visits to hospitals, as, for example, they bleed outside office hours, get sent home, return if their symptoms worsen, and so forth.

36. Patients who carry to term and deliver will require extensive PPE. Pregnancy generally lasts 38 weeks (40 LMP). Though providers are encouraged to maximize the use of telehealth appoints during the COVID-19 pandemic, an *uncomplicated* pregnancy generally requires at least one prenatal appointment per month, and additional appointments for laboratory tests and ultrasounds. Any in-person encounter with a medical provider entails the use of gloves, a face mask, and other PPE. For a complicated or high-risk pregnancy, the number of visits can double. During each visit, the clinician will wear at least gloves and, during the COVID-19 crisis, may also wear a mask. During an actual birth, almost all of which occur in hospitals in West Virginia, multiple medical providers attend the patient, including nursery personnel, a labor and delivery nurse, an OB tech, a physician, and an anesthesiologist. That care requires *multiple* gowns, masks, and sterile gloves. A patient with an uncomplicated pregnancy remains in the

<https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf>.

³⁰ Stephanie J. Ventura et al., Estimated Pregnancy Rates and Rates of Pregnancy Outcomes for the United States, 1990–2008, National Vital Statistics Reports, National Vital Statistics Reports Vol. 60, No. 7 at 2 & 4 (June 20, 2012), available at https://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_07.pdf. (“The proportion of pregnancies ending in fetal losses [as opposed to live births or induced abortions] was 17 percent in 2008 compared with 15 percent in 1990”).

hospital 24–48 hours for a vaginal birth and 72–96 hours for a cesarean section (“c-section”). Vaginal deliveries are safer than c-sections, but can nonetheless lead to injuries, such as injury to the pelvic floor. One third of West Virginia births are c-sections, a significant abdominal surgery that carries risks of hemorrhage, infection, and injury to internal organs. A patient who goes into labor with an already complicated pregnancy may remain in the hospital even longer—requiring yet more time in a hospital bed, more attention of hospital staff, and more PPE.

37. My career involves prenatal and labor and delivery care, and during this time, we must provide that care to patients who are pregnant and give birth. But for patients who are desperate *not* to be pregnant, we need to respect their decisions. We must not pretend that forcing them to remain pregnant in any way mitigates COVID-19 transmission or preserves medical resources and PPE. On the contrary, forcing patients who want an abortion to remain pregnant would increase their health risks—from unwanted pregnancy and from increased exposure to the risk of COVID-19 in hospital visits.³¹ It would also greatly expand demands on clinicians and PPE.

Harms to Patients

38. The Order has no end date and will apply throughout the COVID-19 emergency.

39. Under the Order, the vast majority of patients will be forced to wait weeks, some months, to obtain an abortion in West Virginia. In addition to the increased medical risks of remaining pregnant described above, remaining pregnant will entail increased financial costs and stress.

³¹ Nat’l Acads., *supra* note 1, at 77–78; Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women* (last updated Mar. 16, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html>.

40. Forcing patients who want abortions to remain pregnant would cruelly impose even greater anxiety on patients during the COVID-19 crisis. They may, with justification, fear that their hospital visits and other pregnancy-related medical care will expose them to COVID-19, which they would then bring home to their children, parents, and other family members.

41. Forcing a patient to remain pregnant will cause emotional and psychological harm to patients. Once a patient has decided to terminate her pregnancy, being forced to wait an unknown period of time can be stressful. This is especially true for patients who lack social support or have underlying psychosocial conditions.

42. For patients whose pregnancies are the result of episodes of violence, including those who have been raped or assaulted, being forced to carry an unwanted pregnancy for weeks is an unconscionable burden.

43. Prohibiting timely abortion care may also compromise the patient's privacy. As described above, patients will most likely be experiencing increased nausea and vomiting as the pregnancy progresses. These symptoms are difficult to hide, especially if they become severe enough to result in dehydration. Patients might experience symptoms of miscarriage, which can also be difficult to hide. Further, at about ten to twelve weeks of pregnancy, the uterus goes from being a pelvic organ to an abdominal organ, thus around this time the pregnancy will start showing.

44. Further, limiting abortion to two small windows will likely result in some patients being denied care entirely. As I described above, many patients, especially those with low incomes, already face extreme difficulty in accessing care. The constellation of obstacles that are inherent to poverty in West Virginia—including lack of transportation, support, and childcare—make it difficult for patients to access care at any point in pregnancy. Restricting access to

abortion to two very specific points in pregnancy adds yet another hurdle that some patients will not be able to overcome.

45. Even if the COVID emergency ends sooner than expected, patients will have suffered greatly increased health risks and much added psychological distress from the weeks of pregnancy they were forced to endure.³² Further, because WHC is the only clinic in the state, patients will be delayed in obtaining care after the Order is lifted because one clinic will simply not have the capacity to immediately meet the pent-up demand that accrued while the Order was in place.

46. The vast majority of patients seeking timely abortion care will be forced to travel out of state, if they have the resources to do so. As described above, travel is always a great burden, especially to patients with low incomes, and those burdens are heightened because of COVID-19. Today, travel is harder, is more expensive, takes longer, and entails the risk of exposure to the virus. Travel will also delay care, pushing some patients past point at which they can have a suction aspiration abortion. Those patients, if they can access care at all, would have to have a more complicated procedure, a D&E, which carries a higher risk than an aspiration abortion, and is often a two-day procedure; it would therefore entail greater risk of transmission of the virus and use of more medical resources.

47. Those patients who are unable to travel out of state and are unable to obtain care at WHC in the narrow windows imposed by the Order may remain pregnant against their will, as discussed above, or may seek to end their pregnancies outside the regulated medical setting, which can result in serious complications that necessitate urgent or emergent medical care. It is unthinkable that West Virginia would deny patients safe, legal care. The need for urgent hospital

³² Nat'l Acads., *supra* note 1, at 77–78 (2018).

care for some of these patients will likewise increase pressure on our overburdened health care system.

48. Forcing patients to remain pregnant for of weeks, and in some cases months, is unconscionably cruel and unconscionably profligate with our medical resources during this COVID-19 crisis.

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

Executed April 24, 2020

/s Coy Flowers

Coy Flowers, MD, FACOG

EXHIBIT 1

COY A. FLOWERS, MD, FACOG

EMPLOYMENT

NOV 2006 – DEC 2019: Greenbrier Physicians Inc., Obstetrics & Gynecology
NOV 2006 – Present: West Virginia School of Osteopathic Medicine, Clinical Assistant Professor
JAN 2017 – Present: Lincoln Memorial University-DeBusk College of Osteopathic Medicine, Clinical Assistant Professor
AUG 2005 – OCT 2006: West Virginia University-Charleston Division, Department of Obstetrics & Gynecology, Assistant Professor
Director, Women's Urinary Continence Center
JUL 2002 – AUG 2005: United States Navy, Naval Hospital Camp Lejeune, North Carolina
Lieutenant Commander & Staff Physician
Division Head, The Women's Health Center for Cervical Dysplasia
Division Officer, Outpatient Clinic Administration
OBGYN GME Coordinator for Family Medicine Residency Program

EDUCATION

Residency National Capital Consortium Residency in Obstetrics & Gynecology
National Naval Medical Center, Bethesda, Maryland
Walter Reed Army Medical Center, Washington, DC
July 1999 – June 2002

Internship National Naval Medical Center, Categorical Obstetrics & Gynecology
Bethesda, Maryland
July 1998 – June 1999

M.D. West Virginia University School of Medicine
Morgantown, West Virginia
May 1998

B.A. West Virginia University Eberly College of Arts & Sciences
Summa Cum Laude & University Honors Scholar Graduate
Major: Biology Minors: Chemistry & Spanish
May 1994

PROFESSIONAL ORGANIZATIONS & COMMITTEES

Fellow, American College of Obstetrics & Gynecology (ACOG), 2005-Present
ACOG AMA Delegate 2019-Present
District IV, West Virginia Section 2008-Present
WV Section Chair, 2019-Present
WV Section Vice Chair, 2016-2019
WV Section Legislative Chair, 2014-Present
District IV PSQI Committee, 2016-2019
District IV Legislative Committee, 2016-Present
Congressional Leadership Conference, 2015/2016/2017/2018/2020

Armed Forces District 2005-2008
Junior Fellow, ACOG, Armed Forces District, 2002-2004, Secretary-Treasurer, 2003-04
American Medical Association
West Virginia State Medical Association
 President, 2018-2019
 President-Elect, 2017-2018
 Vice President, 2016-2017
 Legislative Affairs Committee, 2006-Present
Greenbrier Valley Medical Society, President, 2008-Present
Greenbrier Valley Medical Center
 Chair, Department of Surgery, 2010-2011, 2018-Present
 Medical Executive Committee, 2010-2011, 2018-Present
 Maternal/Infant Service Improvement Committee, 2006-Present
 Peer Review Committee, 2007-2013
 Graduate Education Committee, 2008-2012
 Safety & Infection Control Committee, 2015-Present
 Community Health Systems OB Collaborative Committee, 2017-Present
West Virginia State Perinatal Partnership
 Chair, Maternity Care Shortage Committee, 2010-2012
 Telecommunications in Rural Medicine Committee, 2007-2013
 AIM Safety Bundles State Co-Chair, 2017-Present
West Virginia Department of Health and Human Services Maternal-Infant Advisory Committee

COMMUNITY & STATE ORGANIZATIONS

Fairness West Virginia - Founder, Board Member, Treasurer, and President
Greenbrier Valley Theatre - Board Member & Strategic Planning Committee
The Tutoring Center Foundation - Capital Campaign Committee, Chairman
G.R.O.W: Greenbrier Residents Outreach to the World - Board Member

AWARDS & HONORS

Robert C. Cefalo National Leadership Institute/ACOG, UNC Chapel Hill, March 2018
West Virginia Free Helaine Rotkin "Champion of Choice" 2014
West Virginia State Journal 2012 Generation Next Honoree, "Forty Under 40"
West Virginia Executive 2013 Young Gun
Uniformed Services University of the Health Sciences
 Adjunct Instructor, 2003-2005
 Clinical Teaching Fellow, 1999-2002
 Outstanding Resident Teaching Award, 2000
Wyeth-Ayerst Resident Reporter Program, 2001
West Virginia University International Health Medicine Award, Zimbabwe, Africa
West Virginia University School of Medicine Class Officer, 1994-1996
West Virginia University Foundation Scholar & Honors Program
Phi Beta Kappa
Howard Hughes Research Fellow

EXHIBIT 2



Clinical | Mar 18, 2020

Joint Statement on Abortion Access During the COVID-19 Outbreak

The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, released the following statement:

“As hospital systems, clinics, and communities prepare to meet anticipated increases in demand for the care of people with COVID-19, strategies to mitigate spread of the virus and to maximize health care resources are evolving. Some health systems, at the guidance of the CDC, are implementing plans to cancel elective and non-urgent procedures to expand hospitals’ capacity to provide critical care.

“While most abortion care is delivered in outpatient settings, in some cases care may be delivered in hospital-based settings or surgical facilities. To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure. Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being.

“The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, do not support COVID-19 responses that cancel or delay

abortion procedures. Community-based and hospital-based clinicians should consider collaboration to ensure abortion access is not compromised during this time.”

Topics

Coronavirus

COVID-19

Delivery of health care

Health services accessibility

Induced abortion

Medical societies

Obstetric surgical procedures

Organizations

Virus diseases

Women's health services

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ACOG Statement on Birth Settings

Apr 20, 2020

ACOG Releases Updated Guidance on Exercise in Pregnancy and Postpartum, Includes Recommendations for Athletes

Mar 26, 2020

Joint Statement on Elective Surgeries

Mar 16, 2020

ACOG Updates on Novel Coronavirus Disease 2019 (COVID-19)

Mar 6, 2020

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