IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

WEST ALABAMA WOMEN'S CENTER et al., Plaintiffs, v. DR. THOMAS M. MILLER, in his official capacity as State Health Officer of the State of Alabama, et al., Defendants.	CIVIL ACTION Case No. 2:15-CV-497-MHT

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTIVE RELIEF

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

Regulations

INTRODUCTION

In recent years, the State of Alabama has engaged in relentless attacks on abortion rights, enacting a multitude of restrictions designed to shut down clinics and impose burdens on women seeking abortion services. Plaintiffs seek a temporary restraining order and/or preliminary injunctive relief to prevent Defendants from enforcing three such restrictions, which, if permitted to take effect, would have a devastating impact on women in need of safe, legal abortion care in Alabama.

The first restriction, Alabama Senate Bill 205, Reg. Sess. 2016 ("SB 205" or the "clinic closure requirement"), *see* Suppl. Compl. (doc. no. 50) Ex. B, bars the Alabama Department of Public Health ("ADPH") from issuing or renewing a license to an abortion clinic located within 2,000 feet of a K-8 public school. This law would shutter the only abortion clinics in Tuscaloosa and Huntsville—clinics that provide well over half the abortions in Alabama and the only clinics providing abortion services after approximately 15 weeks of pregnancy. The second restriction, Alabama Senate Bill 363, Reg. Sess. 2016 ("SB 363" or the "D&E ban"), *see* Suppl. Compl. (doc. no. 50) Ex. C, criminalizes the performance of the safest and most common method of second-trimester abortion and the only method available in outpatient settings in Alabama, dilation and evacuation ("D&E"). The third restriction, Ala. Admin. Code r. 420-5-1-.03(6)(c)(4) (the "medical records requirement"), forces every abortion patient at Plaintiff West Alabama Women's Center ("WAWC") to receive a copy of her medical records, even over the patient's objection and even if receiving a patient-identifying paper trail of her medical history (including her decision to have an abortion) would jeopardize her confidentiality or even her safety.

These restrictions—individually and collectively—would impose severe and unwarranted burdens on women seeking abortion care. To prevent this irreparable and unconstitutional harm, Plaintiffs seek a temporary restraining order and/or preliminary injunctive relief before the restrictions take effect, which is August 1, 2016 in the case of the clinic closure requirement and the D&E ban, and August 24, 2016 in the case of the medical records requirement.

PRIOR PROCEEDINGS IN THIS ACTION

Plaintiffs WAWC and Dr. Parker commenced this action on July 10, 2015, to challenge an Alabama Department of Public Health ("ADPH") regulation, *see* Ala. Admin. Code r. 420-5-1-.03(6)(b), which at the time required all physicians working at an abortion clinic to have staff privileges at a local hospital ("staff-privileges requirement") or, in the alternative, that the clinic enter into a written agreement with a local physician with such privileges to serve as an outside covering physician ("covering physician requirement"). *See* Compl. (doc. no. 1). For reasons unrelated to their ability to provide safe abortion care, WAWC and Dr. Parker had been unable to comply with this regulation, and were forced to suspend abortion services, which resulted in substantial and irreparable harm to women in need of those services.[1] *See W. Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1317 (M.D. Ala. 2015).

On August 4, 2015, this Court entered a temporary restraining order ("TRO") blocking ADPH from enforcing the regulation against WAWC, explaining that the justifications for applying the regulation to WAWC were weak, the harms of forcing the clinic to close were severe, and thus Plaintiffs were likely to prevail in proving that enforcement of the regulation, which had resulted in the closure of WAWC, imposed an undue burden. *Id.* Thereafter, ADPH

[1] Because the remaining clinics in the state satisfied either the staff-privileges or covering physician requirements, WAWC and Dr. Parker sought only as-applied relief. *See* Compl. (doc. no. 1) at ¶ 1.

granted WAWC a one-year waiver from the regulatory requirement (which is valid through August 24, 2016), and upon the parties' motion, the Court stayed this case in order for ADPH to amend the regulation to bring it into compliance with constitutional requirements. *See* Stay Order (doc. no. 31).

While this case was stayed, on the very last day of the 2016 legislative session, the legislature enacted SB 205 and SB 363—statutes that would not only re-inflict, but also compound, the very harms that this Court sought to prevent by entering the TRO. Additionally, ADPH promulgated an amended regulation imposing the medical records requirement on WAWC—a requirement that would harm the privacy and well-being of WAWC's patients. The amended regulation was filed with the Legislative Reference Service on April 18, 2016, and under Alabama law, it became effective 45 days after that filing date, on June 2, 2016. *See* Ala. Code § 41-22-6(c). Pursuant to the Stay Order, on June 2, 2016, Plaintiffs moved to lift the stay and supplement their Complaint to challenge the three restrictions. Pls.' Mot. to Lift Stay and File Suppl. Compl. (doc no. 32). This Court granted Plaintiffs' motion on July 5, 2016.

FACTS

I. ABORTION IN ALABAMA

Plaintiffs WAWC and Alabama Women's Center ("AWC") are two of only five abortion clinics in Alabama. *See* Second Declaration of Gloria Gray ("Second Gray Decl."), attached hereto as Exhibit 1, at ¶ 11; Second Declaration of Dalton Johnson ("Second Johnson Decl."), attached hereto as Exhibit 2, at ¶ 2. Each of the state's five largest cities has one clinic—WAWC in Tuscaloosa, AWC in Huntsville, Reproductive Health Services ("RHS") in Montgomery, and Planned Parenthood Southeast ("PPSE") health centers in Birmingham and Mobile. *See* Second Gray Decl. ¶ 11; Second Johnson Decl. ¶ 7. The last clinic to open in Alabama was AWC, in

2001; at that time, there were twelve clinics in the state, but that number has since declined, and no new clinic has opened in the fifteen years since Mr. Johnson founded AWC. *See* Second Johnson Decl. ¶ 7; *see also Planned Parenthood Se., Inc. v. Strange* ("*PPSE III*"), 33 F. Supp. 3d 1330, 1334 (M.D. Ala. 2014).

Apart from periods when they were temporarily forced to close, WAWC and AWC have been the highest-volume abortion clinics in the state, combining to provide well over half the abortions in Alabama in every year for which published statistics are available.[2] *See* Second Gray Decl. ¶ 12; Second Johnson Decl. Ex. D. WAWC and AWC are also the only clinics in Alabama that provide abortion services after approximately 15 weeks of pregnancy, as measured from the woman's last menstrual period ("LMP").[3] *See* Second Gray Decl. ¶ 11; Second Johnson Decl. ¶ 9.

As is true of abortion patients nationally, *see* Second Declaration of Stanley K. Henshaw, Ph.D. ("Second Henshaw Decl."), attached hereto as Exhibit 3, at ¶ 9, the vast majority of Plaintiffs' patients are low-income women, *see* Second Gray Decl. ¶ 45; Second Johnson Decl. ¶ 46. Many of these women already struggle to find the means to access and pay for an abortion and to cover other costs related to the procedure, such as transportation, childcare, and lost wages. *See* Second Gray Decl. ¶ 45; Second Johnson Decl. ¶¶ 46-51.

---

[2] In 2014, WAWC and AWC performed 5,833 of the state's 8,080 abortions (72%); in 2013, they performed 5,069 of the state's 8,485 abortions (60%); in 2012, they performed 4,954 of the state's 9,076 abortions (55%). *See* Second Johnson Decl. Ex. D. Excluding WAWC and AWC, the highest number of abortions performed by any other abortion clinic in any year was PPSE-Birmingham's 1,342 procedures in 2013. *See id.*

[3] Indeed, other than the tiny fraction of abortions performed in Alabama hospitals, WAWC and AWC are the only facilities in the entire state that provide such services. In the most recent year for which published statistics are available, all of the hospitals in Alabama combined to perform just 23 of the 8,080 abortions performed in the state—a figure that includes abortions performed before 15 weeks. *See* Second Johnson Decl. ¶ 9.

In recent years, Alabama has enacted a multitude of laws that make it difficult or impossible for Alabama's few remaining abortion providers to keep their doors open, and that otherwise obstruct a woman's ability to access abortion.[4] The laws now at issue before the Court are part and parcel of this campaign to obstruct abortion access.

II. THE CLINIC CLOSURE REQUIREMENT

The clinic closure requirement, which bars ADPH from issuing or renewing licenses to abortion clinics located within 2,000 feet of a K-8 public school, would shutter AWC and WAWC, each of which is located within 2,000 feet of at least one K-8 public school. *See* Second Gray Decl. ¶ 30; Second Johnson Decl. ¶ 26. Each clinic's current license is valid through December 31, 2016, and the process for renewing these licenses begins in October. *See* Second Gray Decl. ¶ 38; Second Johnson Decl. ¶ 44. If the law is not enjoined, WAWC and AWC would be forced to close on December 31, 2016, but would be forced to cease providing abortion services well before then. *See* Second Gray Decl. ¶¶ 37-40; Second Johnson Decl. ¶ 52.

[4] *See, e.g.*, Ala. Code § 26-23B-5 (2011 statute banning abortions after 20 weeks post-fertilization except to prevent the woman's death or "to avert serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions"); Ala. Code § 26-23C-3 (2012 statute banning insurance plans on the health exchange from providing coverage for nearly all abortions); Ala. Code § 26-23E-4(c) (2013 statute imposing staff-privileges requirement on physicians who provide abortions), *invalidated by PPSE III*, 33 F. Supp. 3d at 1377-79; Ala. Code § 26-23E-9 (2013 statutory requirement that abortion clinics meet ambulatory health care occupancy standards); Ala. Code § 26-23A-4(a) (2014 statute increasing the mandatory delay requirement for a woman in need of an abortion from 24 to 48 hours); Ala. Code § 26-21-4 (2014 statute requiring minor seeking a judicial bypass to parental consent requirement to appear before a judge who may, *inter alia*, appoint a guardian ad litem to represent the minor's fetus); *cf. Planned Parenthood Southeast, Inc. v. Bentley*, --- F. Supp. 3d ----, No. 2:15-cv-620–MHT, 2015 WL 6517875 (M.D. Ala. Oct. 28, 2015) (enjoining governor's 2015 decision to terminate PPSE's Medicaid provider agreement).

A. The History of the Clinics

As Mr. Johnson and Ms. Gray make clear in their declarations, if SB 205 forced AWC and WAWC to close, those closures would be permanent. *See* Second Gray Decl. ¶ 34; Second Johnson Decl. ¶¶ 10-25. The history of these clinics, and the state-imposed hurdles they have had to surmount, make clear why that is so.

Mr. Johnson first opened AWC in a facility on Madison Street in downtown Huntsville that housed the ob-gyn practice of the clinic's co-founder, Dr. Palmer. Second Johnson Decl. ¶ 11. Mr. Johnson and Dr. Palmer did not originally intend for the clinic to be located in that building, but after conducting a six-month search in which every prospective lessor refused to lease space upon learning that it would be used to operate an abortion clinic, Mr. Johnson and Dr. Palmer opened the clinic in the Madison Street building. *See id.* ¶ 12. The clinic operated in that location for over a decade. *See id.* ¶ 13. In 2013, however, the legislature enacted HB 57 (2013), which—in addition to imposing the staff-privileges requirement at issue in the *PPSE* litigation—mandated that abortion clinics meet certain enhanced ambulatory health care occupancy requirements and enhanced fire safety code standards. *Id.* Mr. Johnson hired an architect and submitted multiple rounds of plans to ADPH with proposals to bring the clinic into compliance with HB 57's facility requirements, but ADPH rejected each of those proposals, and Mr. Johnson and the architect ultimately determined that the clinic would have to relocate or shut down. *Id.*

Based on his prior unsuccessful attempt to lease a space for AWC, Mr. Johnson recognized that his only option was to purchase a new space that could comply with HB 57's facility requirements. *See id.* ¶ 14. At that time, Dr. Robinson White, one of the physicians at AWC, conducted her ob-gyn practice at a facility she leased on Sparkman Drive, which could be

modified to comply with HB 57's requirements. *Id.* ¶ 15; Declaration of Yashica Robinson White, M.D. ("Robinson White Decl."), attached hereto as Exhibit 4, at ¶¶ 10, 12. In 2014, Mr. Johnson purchased the Sparkman Drive facility so that abortion services would remain available in Alabama. However, to do this, he had to cash in his entire retirement savings, take out a $100,000 line of credit, refinance the mortgage on the Madison Street building and take all the equity out of it, and spend the maximum amount on each of his and Dr. Robinson White's credit cards. *See* Second Johnson Decl. ¶¶ 16-18; Robinson White Decl. ¶ 13.

Mr. Johnson surrendered AWC's clinic license for the Madison Street facility in June 2014, temporarily closing the clinic, and hoped to open at the Sparkman Drive location soon thereafter. *See* Second Johnson Decl. ¶ 19. He received express zoning authorization from the Huntsville Department of Urban Development to operate the clinic at the Sparkman Drive building in May 2014 and a building permit in July 2014. *See id.* ¶¶ 20-21. The plan to reopen AWC was hindered, however, when anti-abortion activists, led by Rev. James Henderson, filed a petition with the Huntsville Board of Zoning Adjustment (the "Zoning Board") seeking to block AWC from opening at its new location and, when the Zoning Board reaffirmed the authorization, unsuccessfully sued the Board to overturn its decision. *See id.* ¶ 22. During the pendency of these proceedings, ADPH refused to issue a license to AWC. *See id.* ¶ 23. It was not until October 2014 that Mr. Johnson was finally able to reopen AWC. *Id.* ¶ 24. As he states in his declaration:

> Today, I am hundreds of thousands of dollars in debt as a result of our efforts to comply with the last statute. There is no way I could afford to do the same thing all over again. And even if I could what would stop the state from passing some new law, at the behest of antiabortion activists, designed to shut down the next space I went hundreds of thousands of dollars deeper into debt to purchase? I cannot imagine a business that could survive a succession of laws and private efforts designed to shutter it, again and again, year after year.

Id. ¶ 25.

For similar reasons, if SB 205 forced WAWC to close, it would permanently shutter that clinic. *See* Second Gray Decl. ¶ 34. Ms. Gray and the co-founder of WAWC, Dr. Payne, purchased the clinic's space in 1993 when the landlord refused to renew the lease. *See id.* ¶ 31. To comply with HB 57's facility requirements in 2013, Ms. Gray spent more than $130,000 to meet the new specifications, yet when she had the building appraised in 2015, it was worth little more than its purchase price more than two decades earlier. *See id.* ¶¶ 32-33. Ms. Gray could not afford to purchase or build a new facility without depleting her retirement account or going into debt, and at this late stage of her career, she would not be able to recoup those losses. *See id.* ¶ 34. Moreover, like Mr. Johnson, even if Ms. Gray could afford to purchase a different building—which she cannot—she would not do so because the likelihood that the state would simply impose new, unforeseen requirements forcing the new space to shut down makes the prospect of purchasing a new building untenable. *See id.*

B. SB 205 and Anti-Abortion Protests

Rev. Henderson—the anti-abortion activist and protester who led the effort to revoke AWC's zoning authorization—made public statements confirming that his group drafted the clinic closure requirement. *See* Second Johnson Decl. ¶ 27. However, were it not for the presence of protesters, there would be nothing about WAWC or AWC to distinguish either clinic from any other outpatient medical provider to an outside observer. *See id.* ¶ 28; Second Gray Decl. ¶ 35. In fact, Rev. Henderson and the other protesters at AWC make concerted efforts to direct their protest activities at the school itself, not just the clinic. *See* Second Johnson Decl. ¶¶ 29-30.

Moreover, the record is clear that while enforcement of SB 205 would result in the closure of abortion clinics, it would not accomplish the State's purported objective of preventing public school students from witnessing anti-abortion protests.[5] The protesters in Huntsville do not confine their activities to abortion *clinics*, but also protest at the private *offices* of physicians who perform abortions. *See* Second Johnson Decl. ¶ 32. For example, long before AWC's current facility on Sparkman Drive was an abortion clinic, it was Dr. Robinson White's private ob-gyn practice, where she performed no abortions. *Id.* ¶ 33; Robinson White Decl. ¶¶ 10, 12-13. Yet just over two months after Dr. Robinson White opened her private office in that building, anti-abortion protesters started protesting outside. Robinson White Decl. ¶ 10; Second Johnson Decl. ¶ 34. Those protests continued as the building transitioned from an ob-gyn office to an abortion clinic. Robinson White Decl. ¶ 14; Second Johnson Decl. ¶ 36. Similarly, after AWC surrendered its license at its previous building on Madison Street, Dr. Robinson White relocated her ob-gyn practice to that building. Robinson White Decl. ¶ 13; Second Johnson Decl. ¶ 37. The protests at Madison Street continued even when the building transitioned from an abortion clinic to an ob-gyn office where no abortions are performed. Robinson White Decl. ¶ 14; Second Johnson Decl. ¶¶ 37-39. The Madison Street building is within 2,000 feet of a public middle school, and the closure of the abortion clinic there did not cause protest activity proximate to the school to cease. Robinson White Decl. ¶¶ 11, 14; Second Johnson Decl. ¶¶ 37-39.

If SB 205 were enforced and Mr. Johnson were forced to surrender AWC's license, Dr. Robinson White would revert to utilizing the Sparkman Drive space as an ob-gyn office, due in

[5] As explained *infra* at pp. 34-36, this objective is not a legally permissible basis for closing abortion clinics as a matter of law.

part to the fact that Mr. Johnson now owns that building and has sunk virtually all of his resources into it. Robinson White Decl. ¶ 16; Second Johnson Decl. ¶ 40. Although she would not be able to provide abortion services there at the clinic's current capacity, under ADPH regulations, she would be permitted to perform up to 100 office-based abortions there per year, and would do so, even though it would not come close to meeting the demand for such services. Robinson White Decl. ¶ 30; Second Johnson Decl. ¶ 41. Given that protesters in Huntsville target not just abortion clinics but the private offices of abortion providers—and indeed given that abortions will be performed at the Sparkman Drive space no matter what—SB 205 would not prevent protest activity from taking place at the Sparkman Drive facility. Robinson White Decl. ¶¶ 15-16; Second Johnson Decl. ¶ 42 (quoting Rev. Henderson, who promised to "go where the abortions are done").

WAWC would likewise be forced to close because it is within 2,000 feet of a public middle school. Second Gray Decl. ¶¶ 30, 34. However, students at the school can neither see nor hear protest activity taking place at and around WAWC because the clinic is separated from the school by an impassable, dense wooded area. *Id*. ¶ 35.

As detailed below, *see* Irreparable Harm at pp. 20-22, *infra*, the forced closure of WAWC and AWC—the only abortion clinics in Tuscaloosa and Huntsville, the sole clinics providing abortion services after approximately 15 weeks LMP, and the providers of well over half the abortions in Alabama—would inflict devastating and irreparable harm on women in need of abortion services.

III. THE D&E BAN

SB 363 bans physicians from performing a D&E, the safest and most common method of second-trimester abortion and the only method available to Alabama women on an outpatient

basis after approximately 15 weeks LMP. *See* Declaration of Anne Davis, M.D. ("Davis Decl."), attached hereto as Exhibit 5, at ¶ 7, 14; Second Declaration of Willie Parker, M.D. ("Second Parker Decl."), attached hereto as Exhibit 6, at ¶ 14; Robinson White Decl. ¶¶ 20, 22-25. Women seek abortions after the first trimester for the same reasons that women seek earlier procedures, including for personal, familial, and medical reasons. Davis Decl. ¶ 11; Second Parker Decl. ¶ 22; Second Johnson Decl. ¶ 55. In addition to those reasons, for many women seeking abortions after the first trimester, there may be additional considerations at play, including difficulties in making financial or logistical arrangements to access an abortion provider, delayed recognition of pregnancy, or the diagnosis of a genetic or anatomical abnormality after the first trimester. Robinson White Decl. ¶ 29; Davis Decl. ¶ 11; Second Parker Decl. ¶ 22; Second Henshaw Decl. ¶ 14; Second Johnson Decl. ¶¶ 55-56. While the vast majority of abortions performed at WAWC and AWC are first-trimester procedures, the clinics provide care for hundreds of women in need of second-trimester abortion services each year. *See* Second Johnson Decl. ¶¶ 54, 58; Second Gray Decl. ¶ 13.

In the first trimester of pregnancy, a surgical abortion is performed by dilating (or opening) the woman's cervix and using suction to empty the contents of the uterus. Davis Decl. ¶ 10. Starting early in the second trimester, it is not possible to perform an abortion using suction alone, and physicians performing outpatient abortions must use the D&E method to perform an abortion. *Id.* ¶ 12; *see also* Robinson White Decl. ¶ 22; Second Parker Decl. ¶ 12. A D&E has two steps: (1) sufficient dilation of the cervix to allow the safe passage of instruments, followed by (2) removal of the fetus and other contents of the uterus using instruments, often in conjunction with suction. Davis Decl. ¶¶ 12-13; Robinson White Decl. ¶ 20; Second Parker Decl. ¶ 12. Usually, disarticulation (separation) of fetal tissue occurs as the physician brings the

fetus through the cervix. Davis Decl. ¶ 13; Robinson White Decl. ¶ 20; Second Parker Decl. ¶ 12. This is why D&Es that do not involve fetal demise prior to the use of surgical instruments would violate SB 363, which—although it does not use recognized medical terminology—criminalizes the use of surgical instruments to cause disarticulation (or, in the ban's terms, "dismemberment") of a living fetus. *See* SB 363 § 2(3); *see also* Davis Decl. ¶ 13.

The development of the D&E procedure was a significant advance in safety over earlier methods of second-trimester abortion. Davis Decl. ¶¶ 14-17; Second Parker Decl. ¶¶ 14-15; *see also City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 435-36 (1983), *overruled in part on other grounds by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) ("Since [*Roe v. Wade* was decided], the safety of second-trimester abortions has increased dramatically. The principal reason is that the D & E procedure is now widely and successfully used for second-trimester abortions.") (footnotes omitted). Moreover, starting in the early second trimester, D&E is the only abortion procedure that can be performed on an outpatient, ambulatory basis. Davis Decl. ¶ 16; *see also City of Akron*, 462 U.S. at 436.

Given its impressive safety record and its availability in outpatient settings, D&E is by far the most prevalent method of second-trimester abortion, accounting for 95% of all second-trimester abortions nationally. Davis Decl. ¶¶ 7, 14. Today, the only alternative to D&E is an induction procedure, in which physicians use medication to induce labor and delivery of a non-viable fetus. *Id.* ¶ 16. In contrast to D&E, induction of labor must be performed at a facility, such as a hospital, with the capacity to admit patients for an extended stay, not an outpatient clinic like WAWC or AWC, and, as noted *supra*, hospital-based abortion services are all but unavailable in Alabama. *Id.*; *see also* Robinson White Decl. ¶ 24; Second Parker Decl. ¶¶ 14-15;

Henshaw Decl. ¶ 21. And unlike a D&E, which takes between 10-15 minutes to complete, an induction abortion takes anywhere from five hours to three days to complete, and is usually far more expensive than a D&E because it cannot be performed on an outpatient basis. Davis Decl. ¶ 16; Second Parker Decl. ¶ 15. In addition, inductions require women to go through labor, which is painful, psychologically challenging for some women (particularly those obtaining abortions after learning of a devastating fetal diagnosis), and medically contraindicated for some women (including those who have had previous cesarean deliveries). Robinson White Decl. ¶ 24; Second Parker Decl. ¶ 15; Davis Decl. ¶¶ 16-17.

If the D&E ban were to take effect, Plaintiffs would be forced to stop performing abortions at approximately 15 weeks LMP, after which point the physician-Plaintiffs cannot be certain that the use of suction alone would result in fetal demise before it is necessary to use instruments to complete an abortion. Robinson White Decl. ¶¶ 22, 25; Second Parker Decl. ¶ 16; *see also* SB 363 § 2(3) (prohibiting the performance of a "dismemberment abortion" on a "living" fetus). Under the ban, the only way a physician in Alabama could continue to provide outpatient abortions after approximately 15 weeks LMP would be to successfully induce fetal demise prior to starting the D&E procedure. *See* SB 363 § 2(3). But Plaintiffs, like the majority of abortion providers nationwide, do not perform additional, medically unnecessary procedures to induce fetal demise before performing a D&E. Robinson White Decl. ¶ 26; Second Parker Decl. ¶ 18; Davis Decl. ¶ 20, 29. Moreover, even if they did, these procedures are not guaranteed to be successful. Second Parker Decl. ¶ 20; *see also* Davis Decl. ¶ 24. Therefore, as detailed below, if the ban were to take effect, Plaintiffs would stop performing abortions at approximately 15 weeks. Robinson White Decl. ¶ 26; Second Parker Decl. ¶¶ 16, 26.

As an initial matter, as detailed in the declaration of Anne Davis, M.D., prior to 18 to 20 weeks LMP, it is not standard medical practice to induce fetal demise prior to a D&E. Davis Decl. ¶ 27. Thus, even if Plaintiffs were willing and able to take steps to attempt to induce fetal demise prior to performing a D&E—which they are not—SB 363 would impose a three-to-five-week abortion ban in the middle of the second trimester (from 15 to 18 or 20 weeks LMP). Davis Decl. ¶ 27. Beginning at around 18 to 20 weeks LMP, a minority of physicians do induce fetal demise prior to a D&E, typically via a transabdominal or transvaginal injection of a medication called digoxin. Davis Decl. ¶ 20. However, as the American College of Obstetricians and Gynecologists ("ACOG") has made clear, "'[n]o evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion.'" Davis Decl. ¶ 19 (quoting American College of Obstetricians and Gynecologists, *Practice Bulletin Number 135: Second Trimester Abortion*, 121 OBSTETRICS & GYNECOLOGY 1394 (2013)). Thus, even after 18 to 20 weeks, attempting to cause fetal demise forces a woman to submit to an additional, unnecessary medical procedure—one that has no proven medical benefit, but that does increase the complexity, risk, and pain related to the abortion procedure. Davis Decl. ¶¶ 21-26, 29.

Moreover, since digoxin takes up to 24 hours to be effective, forcing the physician to attempt to induce fetal demise before a D&E would turn all D&E procedures into two-day procedures, whereas the overwhelming majority of D&Es in Alabama are one-day procedures. Davis Decl. ¶ 22; Robinson White Decl. ¶ 20; Second Parker Decl. ¶¶ 13, 19. And even after 18 to 20 weeks, attempting to cause fetal demise is just that—an *attempt* that may not always be successful. Davis Decl. ¶ 24; Second Parker Decl. ¶ 20. The proper course of treatment in the event demise is unsuccessful would be to complete the abortion without additional delay.

Second Parker Decl. ¶ 20; Davis Decl. ¶¶ 24, 28. However, under SB 363, if a physician were to administer digoxin that did not result in fetal demise after 24 hours, SB 363 would compel him or her to attempt a second injection of digoxin, which is medically untested and thus contrary to the standard of care. Second Parker Decl. ¶ 20; Davis Decl. ¶ 28. Administering a second injection and waiting an undetermined amount of time for demise, rather than completing the abortion, would put a patient who is already dilated and whose uterus may have already started to contract at risk of infection or extramural delivery. Davis Decl. ¶ 28; Second Parker Decl. ¶ 20.

It is contrary to physician-Plaintiffs Dr. Parker's and Dr. Robinson White's medical judgment and ethics to subject their patients to unnecessary medical procedures that increase risk, but provide no benefit to the patient, and neither physician would act in contravention to his or her medical judgment and ethics if SB 363 were permitted to take effect. Robinson White Decl. ¶ 26; Second Parker Decl. ¶¶ 18, 26. Indeed, although Dr. Robinson White is a highly trained and experienced ob-gyn, she was not trained in the use of digoxin to cause fetal demise when she learned how to perform D&Es at the University of Alabama-Birmingham, and has never even performed such a procedure. Robinson White Decl. ¶ 26. Accordingly, if enforced, SB 363 would stop WAWC's and AWC's abortion practice beginning at approximately 15 weeks LMP. Robinson White Decl. ¶¶ 25-26; Second Parker Decl. ¶¶ 16, 26; Second Gray Decl. ¶ 41; Second Johnson Decl. ¶ 57. Because these are the only clinics providing abortions in Alabama at and after this point in pregnancy, SB 363 would effectively ban second-trimester abortions in Alabama. As set forth under Irreparable Harm, *infra* at pp. 20-22, the elimination of abortion services after 15 weeks LMP in Alabama would have devastating effects on women in need of abortion care.

IV. THE MEDICAL RECORDS REQUIREMENT

In the wake of this Court's TRO and Stay Order in this case, ADPH amended the regulation that had forced WAWC to close down. The amended regulation imposes a series of detailed provisions applicable only to an abortion clinic that is unable to satisfy the staff-privileges or covering physician requirements. *See* Ala. Admin. Code r. 420-5-1-.03(6)(c)(4). Among these provisions is the medical records requirement, which mandates that every "patient *shall receive* a copy of her medical record that pertains to the current abortion procedure prior to leaving the facility," *id.* (emphasis added). This provision applies irrespective of the patient's wishes. During the notice and comment period for the amended regulation, WAWC did not object to the vast majority of the new provisions. Second Gray Decl. ¶ 18. However, WAWC—along with, *inter alia*, every abortion provider in the state—filed comments highlighting the serious threat to patient confidentiality that the medical records requirement would impose and expressly urging ADPH to modify the requirement in a manner that respected a patient's desire not to receive an unwanted copy of her records. Second Gray Decl. ¶ 18; Second Johnson Decl. ¶ 6 n.2; Second Declaration of June Ayers ("Ayers Decl."), attached hereto as Exhibit 7, at ¶ 4 n.1; Declaration of Staci Fox ("Fox Decl."), attached hereto as Exhibit 8, at ¶ 3 n.1. Notwithstanding these comments, ADPH adopted the amended regulation as written.

Medical records at WAWC contain some of the most sensitive personal information imaginable. In addition to personally identifying information (*e.g.*, name, date of birth, social security number, contact information), the records reflect that the patient had an abortion; her mental health history; sexually transmitted infection status, including HIV status; substance abuse history; prior pregnancies, miscarriages and abortions; the names of any friends or physicians who referred the woman to the clinic, and other deeply private information. Second

Gray Decl. ¶ 22. Given the sensitivity of the information contained in medical records, WAWC makes substantial efforts to protect their confidentiality. *Id.* ¶¶ 21, 24, 25. The records are stored securely and in paper format only and cannot be easily accessed or transmitted; after approximately one year, the records are transferred to a locked storage facility to which only Ms. Gray has the key; and after four years, WAWC hires a shredding company to shred the records in Ms. Gray's presence, under her direct supervision. *Id.* ¶¶ 21, 24. When it is necessary to share information in a patient's medical record (for example, if a patient requests that information in the record be shared with another medical provider), WAWC offers to share only the limited portion of the record necessary for the requested purpose to minimize the unnecessary distribution of sensitive information. *Id.* ¶ 25.

No WAWC patient has ever requested a copy of her medical records at the time of her discharge. *Id.* ¶ 25. To the contrary, patients understandably desire to keep their abortion decision private and go to great lengths to do so, with some patients asking WAWC to not communicate with them via mail or telephone, or requesting that a prescription be called directly to the pharmacy so the patient does not have to take home a written copy of the prescription. *Id.* ¶¶ 26-27. Forcing patients to take records containing deeply sensitive, patient-identifying information, even over their objection, would jeopardize these efforts to preserve confidentiality. *Id.* ¶¶ 27-28.

The medical records requirement poses especially grave risks to WAWC's patients who have experienced, or are at risk of experiencing, domestic violence ("DV"). Declaration of Lenore Walker ("Walker Decl."), attached hereto as Exhibit 9, ¶¶ 17-28; *see also* Second Parker Decl. ¶ 6. As detailed in the declaration of Dr. Lenore Walker, domestic abusers subject women they abuse to relentless scrutiny, obsessively inspecting (among other things) the woman's

pocketbook, car, and even garbage. Walker Decl. ¶ 19. Women at risk of abuse must go to extreme lengths to avoid creating a paper trail of matters they hope to conceal from abusers, and indeed Dr. Walker has advised women at risk for DV who are seeking abortions to minimize the paperwork they take home from the abortion clinic. *Id.* ¶¶ 20-23. Forcing a woman at risk for DV to take with her a patient-identifying paper trail describing her abortion (and other sensitive facts) would seriously jeopardize her ability to conceal the abortion from her abuser. *Id.* ¶ 25. Moreover, unlike items like aftercare instructions that contain no patient-identifying information and can be discarded without being traceable, women cannot simply throw out medical records, which contain a host of patient-identifying information. Indeed, it would be particularly dangerous for women to discard the records in the garbage outside the clinic because anti-abortion protesters have rummaged through garbage outside the clinic in the past. Second Gray Decl. ¶ 28. As Dr. Walker attests from experience, when an abuser finds out that his partner had an abortion without his permission, it puts the woman in extreme danger of physical, sexual, and/or emotional abuse, and that danger is not confined to the woman herself. Walker Decl. ¶¶ 25-26. For example, in one especially tragic case, when an abuser learned that his partner had obtained an abortion without his knowledge, he beat their oldest child to death, exclaiming, "You killed one of my babies. I'll kill one of yours." Walker Decl. ¶ 25.

The evidence makes plain that no medical justification warrants exposing women to these risks. Legal abortion is among the safest procedures in contemporary medical practice. Davis Decl. ¶ 8; *accord W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1314. Yet neither in Alabama nor, to Plaintiffs' knowledge, in any other state, is *any* other provider of *any* form of outpatient medical services—including services far riskier than abortion, whether or not the provider has hospital privileges or a covering physician—required by law to give all patients copies of medical records

upon discharge in the absence of a patient request and even over a patient's objection. *See* Second Parker Decl. ¶¶ 4-5; Declaration of Stephen Hargarten, M.D. ("Hargarten Decl."), attached hereto as Exhibit 10, at ¶ 5.

The record shows that there is good reason for this uniformity: In the extremely rare case of a woman who seeks treatment at a hospital emergency department ("ED") after she has been discharged from the abortion clinic, a copy of her medical records as they existed at the time of her discharge would not help the ED physician to diagnose and treat her symptoms. Hargarten Decl. ¶¶ 5-13. As Dr. Stephen Hargarten, Chairman of the Department of Emergency Medicine at the Medical College of Wisconsin in Milwaukee, attests, in more than 35 years of ED practice, he cannot recall ever having seen a patient who was discharged from an outpatient medical facility, sought ED care related to that procedure, and brought a copy of his or her medical records from the outpatient facility to the ED. *Id.* ¶ 13. ED physicians are specially trained to examine, diagnose, treat, and/or admit patients to the care of the appropriate on-call physician without reference to preexisting medical records. *Id.* ¶¶ 6-10. An ED physician treating a woman complaining of symptoms potentially indicative of a complication from abortion would ask the same questions and perform the same examination (including diagnostic tests) to identify the cause of the woman's symptoms, irrespective of whether the woman had abortion clinic medical records from the time she was discharged. *Id.* ¶¶ 8-10. Indeed, an abortion patient's medical records are not complete at the time of discharge, as they lack, *inter alia*, test and laboratory results, including the pathology report required by Alabama law, which verifies that the woman had an intrauterine pregnancy and that the abortion was complete and which will not be available until 7-10 days following the procedure. Second Parker Decl. ¶ 7; Second Gray Decl. ¶ 23. Nor would a patient's medical records at the time of discharge contain some of the

most relevant information the ED physician needs—her symptoms since she left the clinic and what caused her to seek care at the ED. Hargarten Decl. ¶ 11. Once a woman's symptoms have been diagnosed, the woman's medical records would not aid in her treatment. *Id.* ¶ 12. In short, ED physicians neither expect nor need patients to present to the ED with copies of their medical records, and the requirement thus does not meaningfully further any interest in patient health.

V. IRREPARABLE HARM

Enforcement of the three requirements before the Court would inflict devastating and irreparable harm on women seeking abortion services.

As set forth in greater detail below, *see infra* Argument, Section I.A and I.B, the evidence shows that SB 205 and SB 363 would decimate abortion access by closing the highest-volume abortion clinics in the state (and the only clinics offering abortion services after approximately 15 weeks LMP) and/or by forcing Plaintiffs to cease providing abortions after 15 weeks LMP. Enforcement of either requirement—or both—would make it impossible for a substantial proportion of women to obtain an abortion in Alabama. Consistent with this Court's past findings, *see PPSE III*, 33 F. Supp. 3d at 1356, the accompanying expert declarations make clear that increasing the distance women must travel to obtain an abortion harms women by imposing financial and logistical barriers that prevent a significant proportion of affected women from obtaining a desired abortion at all and that delay others' access to care. *See* Second Henshaw Decl. ¶¶ 16-26; Second Declaration of Sheila M. Katz, Ph.D. ("Second Katz Decl."), attached hereto as Exhibit 11, at ¶¶ 16-37.

If SB 205 forced the Tuscaloosa and Huntsville clinics to close, the next-closest provider of abortion services through approximately 15 weeks LMP would be in Birmingham, which is approximately 60 miles from Tuscaloosa and 100 miles from Huntsville. Second Henshaw Decl.

¶ 18. As Dr. Henshaw's declaration explains, the statistical and epidemiological evidence establishes that increases in travel distance of this magnitude significantly impact abortion rates. *Id.* ¶¶ 6-8, 19.

Moreover, if SB 205 closed the Tuscaloosa and Huntsville clinics or if SB 363 banned their D&E practices, women in need of an abortion at and after approximately 15 weeks LMP would have no option but to travel to Atlanta, Georgia, which is over 200 miles from Tuscaloosa and 180 miles from Huntsville. *Id.* ¶ 18. As Dr. Henshaw explains, when a Texas law forced a comparable loss of second-trimester abortion services and a comparable increase in the travel distance necessary to obtain an abortion, the result was a nearly 70% decrease in the number of women able to access such services and thousands of women who were prevented from obtaining abortions at all. *See id.* ¶¶ 4-5, 20; *accord PPSE III*, 33 F. Supp. 3d at 1356. These burdens would fall most heavily on the low-income women who make up the vast majority of WAWC's and AWC's patients, many of whom do not have access to reliable transportation or the financial resources to travel to a distant city or state to obtain medical care, and also on those who are victims of domestic violence, who must overcome exceptional hurdles to obtain an abortion without their abusers' knowledge. *See* Second Gray Decl. ¶¶ 45; Second Johnson Decl. ¶¶ 45-51; Second Henshaw Decl. ¶¶ 23-24; Second Katz. Decl. ¶¶ 16-37; Walker Decl. ¶¶ 13-16; *accord PPSE III*, 33 F. Supp. 3d at 1356-57.

Additionally, even if all women were able to overcome these travel-related obstacles—which they cannot—the three remaining abortion clinics in Alabama would not have the capacity to fill the gap created by the loss of abortion services (including post-15-week services) in Tuscaloosa and Huntsville. In 2014, WAWC and AWC performed 5,833 of the state's 8,080 abortions. Second Johnson Decl. Ex. D. The estimated maximum capacity for the three

remaining clinics is just 4,500 abortions per year—and even reaching that figure would require a dramatic expansion of services that none of the three remaining clinics is presently positioned to undertake. Second Ayers Decl. ¶ 8 (RHS's maximum capacity is 1,800); Fox Decl. ¶ 5 (PPSE's maximum capacity for two clinics is 2,700 total). The closure of WAWC and AWC would mean that there would be thousands more women in need of abortion services than the three remaining clinics could accommodate. And the capacity of the remaining clinics to care for patients in need of abortion services after approximately 15 weeks LMP is simply nonexistent. *See* Second Ayers Decl. ¶¶ 2, 9; Fox Decl. ¶ 5. Additionally, as this Court has recognized, when legal abortion is unavailable or difficult to access, some women turn to illegal and unsafe methods to terminate unwanted pregnancies. Second Parker Decl. ¶ 24; *accord W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1311 (citing cases).

Finally, enforcement of the medical records requirement would irreparably harm WAWC's patients by requiring them to take a paper trail of their abortion that would make it harder for them to maintain their confidentiality. For women at risk of domestic violence, the requirement threatens not only their privacy, but also their physical and psychological safety and that of their loved ones. Walker Decl. ¶¶ 18-26.

ARGUMENT

Plaintiffs are entitled to a temporary restraining order and/or preliminary injunctive relief because (1) they are substantially likely to prevail on the merits of their claims; (2) a temporary restraining order and/or preliminary injunctive relief is necessary to prevent irreparable injury to Plaintiffs and their patients; (3) these injuries to Plaintiffs and their patients outweigh any harm to Defendants; and (4) entry of relief in Plaintiffs' favor is in the public interest. *See McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998); *Ingram v. Ault*, 50 F.3d

898, 900 (11th Cir. 1995) (per curiam) (same standard applies to requests for preliminary injunctive relief and temporary restraining orders).

I. PLAINTIFFS ARE LIKELY TO PREVAIL ON THE MERITS OF THEIR UNDUE BURDEN CLAIMS.

Plaintiffs are likely to prevail on their undue burden challenges to the clinic closure requirement, the D&E ban, and the medical records requirement. "[T]here 'exists' an 'undue burden' on a woman's right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the 'purpose or effect' of the provision 'is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'" *Whole Woman's Health v. Hellerstedt*, ___ S. Ct. ___, 2016 WL 3461560, at *5 (U.S. June 27, 2016). (quoting *Casey*, 505 U.S. at 878) (emphasis omitted). As the Supreme Court recently reiterated, the undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at *16; *accord Planned Parenthood Se., Inc. v. Strange* ("*PPSE II*"), 9 F. Supp. 3d 1272, 1287 (M.D. Ala. 2014). That is, "the court must determine whether, examining the regulation in its real-world context, the obstacle is more significant than is warranted by the State's justifications for the regulation." *PPSE II*, 9 F. Supp. 3d at 1287; *accord Whole Woman's Health*, 2016 WL 3461560, at *16-17. Not only must there be "a constitutionally acceptable" justification for regulating abortion, but the regulation may not be upheld unless the benefits of the justification outweigh the burdens it imposes. *Whole Woman's Health*, 2016 WL 3461560, at *17; *accord PPSE II*, 9 F. Supp. 3d at 1287-88. Application of this standard requires close judicial scrutiny of the evidence, because, as the Supreme Court has explained, it would be "wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable

where, for example, economic legislation is at issue." *Whole Woman's Health*, 2016 WL 3461560, at *16 (citing *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 491 (1955)).

Under this standard, there can be no question that Plaintiffs are substantially likely to prevail on the merits of their challenges to all three requirements.

A. The Clinic Closure Requirement Imposes an Undue Burden

If enforced, SB 205 would impose severe burdens on women in need of abortion services. The law would close the only abortion clinics in Huntsville and Tuscaloosa—two clinics that not only provide well over half the abortion services in Alabama, but are also the sole providers of abortion services after approximately 15 weeks LMP in the entire state. The forced closure of those clinics would have a devastating effect on women in need of abortion services.

1. *Effect of SB 205 on the Plaintiff Clinics*

Turning first to the effect SB 205 would have on the clinics, *see W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1308, by its terms the statute would bar ADPH from renewing the licenses for WAWC and AWC, each of which is located within 2,000 feet of at least one K-8 public school. *See* Second Gray Decl. ¶ 30; Second Johnson Decl. ¶ 26. The law would thus shutter these two clinics.

Moreover, as the record makes clear, these closures would be permanent. As set forth in detail in Mr. Johnson's declaration, just two years ago, Mr. Johnson was forced to purchase an entirely new facility when Alabama enacted HB 57 (2013), which imposed new costly ambulatory health care occupancy requirements—again, without any possibility of grandfathering—with which the facility he had operated for over a decade could not comply. Second Johnson Decl. ¶ 13. He is now hundreds of thousands of dollars in debt as a result of his efforts to comply with that statute and cannot afford to go even further into debt to purchase yet

another property. *Id.* ¶ 25. Similarly, Ms. Gray was forced to spend more than $100,000 to bring the Tuscaloosa clinic into compliance with HB 57, and yet when she had the facility appraised last year it was worth little more than what she had originally paid for it over twenty years ago. Second Gray Decl. ¶¶ 32-33. She cannot afford to purchase a new building in another location and bring it into compliance with HB 57's facility requirements without depleting her retirement or going into debt, which at this late stage of her career she cannot afford to do. *Id.* ¶ 34. Moreover, even if Mr. Johnson or Ms. Gray could afford to purchase a new facility that is more than 2,000 feet from a K-8 public school, which they cannot, neither would do so given the near-inevitability that Alabama would simply enact yet another statute imposing new requirements designed to shut down those facilities—just as the State did in enacting SB 205 just three years after HB 57. *Id.*; Second Johnson Decl. ¶ 25. As Mr. Johnson states, he "cannot close down, purchase a new building, and start from scratch again—no business could sustain itself under those circumstances." Second Johnson Decl. ¶ 3. Therefore, if SB 205 forces the clinics to close, those closures will be permanent.

Furthermore, as this Court has recognized, if Alabama abortion clinics are forced to close "it is most unlikely that . . . any new clinics [would] open in the foreseeable future," *PPSE III*, 33 F. Supp. 3d at 1348, and restrictions like SB 205 only make the emergence of new providers less likely, *see W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1311; *see also Whole Woman's Health*, 2016 WL 3461560, at *26 (burden of complying with abortion facility requirement meant that "more surgical centers will not soon fill the gap when licensed facilities are forced to close"). In *Deerfield Medical Center v. City of Deerfield Beach*, the court similarly made clear that restrictions on where abortion clinics can be located "will discourage any future efforts by other enterprises to locate an abortion clinic within the city limits." 661 F.2d 328, 336 (5th Cir.

1981).[6] Given that no abortion clinic has opened in Alabama since Mr. Johnson opened AWC in 2001, Second Johnson Decl. ¶ 7, and given the additional barriers to entry the State continues to erect, there can be no reasonable expectation that new clinics would take Plaintiffs' place if WAWC and AWC were forced to close.

2. *Effect of SB 205 on Women Seeking Abortions*

If permitted to go into effect, SB 205 would inflict severe, irreparable harm on women seeking abortions. This Court has twice addressed the effects that the closure of abortion clinics imposes on women in Alabama. *See W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1309-12; *PPSE III*, 33 F. Supp. 3d at 1355-63. In a state with only five abortion clinics, where no city has more than a single provider, laws that close any of these few clinics (1) prevent women who would have obtained abortions from obtaining them, delay others' access, and impose other harms; (2) strain the capacity of remaining providers to care for women in need of abortion services; and (3) increase the risk that women without access to legal abortion will take matters into their own hands and attempt a medically unsupervised self-abortion. *See W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1309-12; *accord Whole Woman's Health*, 2016 WL 3461560, at *20; *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015), *cert. denied*, No. 15-1200, 2016 WL 1161714 (U.S. June 28, 2016); *June Medical Services LLC v. Kliebert*, ___ F. Supp. 3d ___, 2016 WL 320942, at *52 (M.D. La. Jan. 26, 2016); *PPSE III*, 33 F. Supp. 3d at 1355-63.

If SB 205 were enforced, the magnitude of these harms would be extreme. It is not only the case that WAWC and AWC are the only abortion clinics in Huntsville and Tuscaloosa. *See*

[6] *Deerfield Medical Center* is binding precedent in the Eleventh Circuit. *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1318 n.11.

Second Johnson Decl. ¶ 7; Second Gray Decl. ¶ 11. In addition, other than brief periods when each clinic was temporarily forced to close, these two clinics have for years been the two highest-volume abortion providers in the state, providing well over half of the abortions in Alabama every year for which statistics are available. *See* Second Johnson Decl. Ex. D; Second Gray Decl. ¶ 12; *see also W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1310 ("until it closed, [WAWC] . . . provided the most abortions in Alabama by a substantial margin, performing more than 40% of the abortions in the State"). Moreover, AWC and WAWC are the only clinics in Alabama that provide abortion services after approximately 15 weeks LMP. *See* Second Johnson Decl. ¶ 9; Second Gray Decl. ¶ 13; *see also W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1310 (describing particularly severe obstacles that closure of WAWC imposed on women in need of mid-second-trimester abortions); *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 992-93 (W.D. Wis. 2015) (emphasizing particularly severe obstacles imposed by law that would close the state's only provider of abortions after 18.6 weeks LMP). The closure of the only abortion clinics in Huntsville and Tuscaloosa, the loss of the two highest-volume clinics in the state, and the elimination of any clinic offering abortion services after the earliest weeks of the second trimester would have a profoundly harmful effect on women seeking abortions in Alabama.

a. *Travel Burden*

First, the forced closure of WAWC and AWC would impose significant travel-related burdens on women that would cause an array of significant harms, including the outright prevention of women's ability to obtain an abortion. *See PPSE III*, 33 F. Supp. 3d at 1355-60. Today, women in and around Huntsville and Tuscaloosa are able to obtain abortion services without having to travel outside the city. If SB 205 were to take effect, however, a woman

seeking an abortion prior to 15 weeks LMP in Huntsville would be faced with the burden of traveling over 100 miles one-way to the next-closest abortion provider in Birmingham. *See* Second Henshaw Decl. ¶ 18. A woman in need of an abortion prior to 15 weeks LMP in Tuscaloosa would be required to travel nearly 60 miles to Birmingham to obtain the care she needs. *Id.* As the declaration of Dr. Stanley Henshaw—an expert in reproductive epidemiology—establishes, the statistical evidence is clear that when women are faced with comparable increases in travel distance to access an abortion, abortion rates decline markedly because the burdens of travel prevent many women from reaching a provider. *See id.* ¶ 19. Indeed, this Court has repeatedly reached the same conclusion in examining the exact travel burdens at issue here. *See W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1309 ("The court has previously discussed the serious impact of the 'first 50 miles' of travel on women seeking abortions, and that 'when a clinic closes, the largest effects are actually felt by women who, prior to the closure, needed to travel only short distances, less than 50 miles.'" (quoting *PPSE III*, 33 F. Supp. 3d at 1358-60)); *see also Whole Woman's Health*, 2016 WL 3461560, at *8 (in considering evidence of burdens imposed by clinic closures, citing evidence of increased number of women of reproductive age who would live "more than 50 miles from a clinic," along with those who would live at further distances from a clinic).

But these obstacles—substantial as they are—pale in comparison to the burdens SB 205 would impose on women who require abortion services after approximately 15 weeks LMP. Without WAWC and AWC, Alabama would not have a single abortion clinic offering abortion services after the earliest point in the second trimester. The next-closest provider of second-trimester abortion services is in Atlanta, Georgia—more than 400 miles round-trip from Tuscaloosa and nearly 400 miles round-trip from Huntsville. *See* Second Henshaw Decl. ¶ 19.

Forcing women in need of post-15-week abortions to leave the state to seek medical care is unduly burdensome as a matter of law. *See Schimel*, 806 F.3d at 918 (where statute would have closed Wisconsin's only clinic providing abortion services after 18.6 weeks, explaining that as a matter of law it was a "profoundly mistaken assumption" for the state to suggest that women may be able to access such care out of state) (citation omitted); *Jackson Women's Health Org. Inc. v. Amy*, 330 F. Supp. 2d 820, 827 (S.D. Miss. 2004) (a law that would result in the "complete unavailability of early second-trimester abortions in Mississippi serves as a substantial obstacle to a woman's choice whether to seek such an abortion"); *accord Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457-58 (5th Cir. 2014) (refusing to consider abortion clinics outside the state in conducting undue burden analysis), *cert. denied*, No. 14-997, 2016 WL 3496801 (U.S. June 28, 2016). And even if it were not *per se* unduly burdensome to force women to leave the state to access abortion services, the statistical evidence confirms the intuitively obvious proposition that for many women, traveling hundreds of miles to access abortion services is no option at all. *See* Second Henshaw Decl. ¶¶ 4-8, 19-20; *see also W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1309; *PPSE III*, 33 F. Supp. 3d at 1356.

The obstacles imposed by the forced closure of WAWC and AWC would be particularly severe due to the very high poverty rates among these clinics' patients. *See PPSE III*, 33 F. Supp. 3d at 1357 ("the court should consider the nature and circumstances of the women affected by the regulation") (quotation marks and citation omitted); *accord Whole Woman's Health*, 2016 WL 3461560, at *8 (crediting the district court's finding that Texas abortion restrictions "erect a particularly high barrier for poor, rural, or disadvantaged women") (quotation marks and citation omitted); *Schimel*, 806 F.3d at 919. The vast majority of WAWC's and AWC's patients are low-income, and for many low-income women, it is simply not possible to arrange for transportation

to and from another city or state to access an abortion, given the multitude of hurdles such travel poses. *See* Second Katz Decl. ¶¶ 16-37. As this Court has explained:

> [F]or women in poverty . . . going to another city to procure an abortion is particularly expensive and difficult. Poor women are less likely to own their own cars and are instead dependent on public transportation, asking friends and relatives for rides, or borrowing cars; they are less likely to have internet access; many already have children, but are unlikely to have regular sources of child care; and they are more likely to work on an hourly basis with an inflexible schedule and without any paid time off or to receive public benefits which require regular attendance at meetings or classes. A woman who does not own her own car may need to buy two inter-city bus tickets (one for the woman procuring the abortion, and one for a companion) in order to travel to another city. Without regular internet access, it is more difficult to locate an abortion clinic in another city or find an affordable hotel room. The additional time to travel for the city requires her to find and pay for child care or to miss one or several days of work . . . .

W. Ala. Women's Ctr., 120 F. Supp. 3d at 1309-10 (quoting *PPSE III*, 33 F. Supp. 3d at 1357); *see also* Second Katz Decl. ¶¶ 16-37.

And as prevalent as indigence is among abortion patients in general, low-income women are particularly likely to need second-trimester abortion services—the very services that would be all but eliminated in Alabama if SB 205 were enforced. *See* Second Henshaw Decl. ¶ 14. Indeed, Plaintiffs' first-hand experience echoes what the statistical research establishes—when WAWC was temporarily forced to close, low-income women expressly stated to clinic staff that they could not travel to another city to obtain an abortion. *See* Second Johnson Decl. ¶¶ 49-51. Those problems would only be compounded by the closure of two clinics rather than one.

Finally, as this Court has recognized, "increased travel distance causes delays for women who do secure abortions." *PPSE III*, 33 F. Supp. 3d at 1356; *accord* Second Henshaw Decl. ¶¶ 13-14, 25. But if SB 205 were enforced, women delayed beyond approximately 15 weeks LMP as a result of increased travel distance would be unable to obtain an abortion in Alabama at all—the law would simultaneously impose conditions that delay women's access to abortion and

eliminate access to the very second-trimester abortion services that women would need as a result of that delay. The inevitable effect would be that many women would be prevented from obtaining an abortion while, as discussed *infra*, others would resort to taking matters into their own hands.

b. *Capacity Constraints*

Even if—contrary to statistical evidence, historical experience, and common sense—all of WAWC's and AWC's patients could surmount these travel-related obstacles, the remaining providers in the state would not be able to accommodate such a substantial influx of patients. *See, e.g.*, *PPSE III*, 33 F. Supp. 3d at 1361 (a law that would "dramatically reduce the total capacity of providers to offer abortions in the State" imposes a substantial obstacle to women seeking abortions); *accord Whole Woman's Health*, 2016 WL 3461560, at *26 (it is a "commonsense inference that the dramatic decline in the number of available facilities will cause a shortfall in capacity"); *Schimel*, 806 F.3d at 917-18. Once again, while this burden would obstruct women seeking abortion services at any stage of pregnancy, it would be particularly devastating to women in need of abortions after approximately 15 weeks LMP, for whom capacity would all but vanish.

Apart from the period when it was closed in 2015, WAWC has long "provided the most abortions in Alabama by a substantial margin." *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1310; *see also* Second Gray Decl. ¶ 12. And aside from a period in 2014 when it was forced to close, AWC has been the second highest-volume abortion provider in Alabama. *See* Second Johnson Decl. Ex. D. For as long as ADPH has published statistics on the number of abortions performed by clinics in the state, there has not been a single year in which WAWC and AWC did not combine to perform more than half of the abortions in the State—a total of 5,833 out of 8,080 in

2014, 5,069 out of 8,485 in 2013, and 4,954 out of 9,076 in 2012. *See id.* The total maximum capacity of the three remaining clinics in the state is just 4,500 abortions—and even that figure is premised on a substantial expansion of services that none of the remaining clinics is presently in a position to provide. *See* Second Ayers Decl. ¶ 8; Fox Decl. ¶ 5. With over 8,000 abortions performed in Alabama in 2014, the forced closure of WAWC and AWC would leave grossly insufficient capacity in the state to meet the demand.

When the supply of abortion services cannot meet demand, the result is a waiting list at abortion clinics that delays access to care and increases the need for later abortions. *See*, *e.g.*, *Schimel*, 806 F.3d at 918; *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1311. But the remaining clinics do not even provide abortions past approximately 15 weeks LMP. SB 205 would thus precipitate a dire need for later abortion services while at the same time all but banning them. With the exception of women who feel constrained to attempt to take matters into their own hands, *see infra*, the inevitable result of these capacity constraints will be to prevent women from obtaining the abortion care they require.

c. *Medically Unsupervised Self-Abortion*

Finally, the dangers posed by travel- and capacity-related obstacles to abortion access are "compounded by the threat that women who desperately seek to exercise their ability to decide whether to have a child would take unsafe measures to end their pregnancies." *PPSE III*, 33 F. Supp. 3d at 1363; *accord Whole Woman's Health*, 2016 WL 3461560, at *29 (Ginsburg, J., concurring) ("When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux*, at great risk to their health and safety."); *June Med. Servs.*, 2016 WL 320942, at *39 (finding that "restricted access to abortion doctors and clinics would result in delays in care, causing a higher

risk of complications, as well as a likely increase in self-performed, unlicensed and unsafe abortions"); *Van Hollen*, 94 F. Supp. 3d at 979 n.31 ("[E]pidemiological data indicate an inverse relationship between the availability of legal abortion and resorting to illegal abortion associated with remarkable increased risks of death or morbidity, which includes septic abortion, uterine infection, pelvic abscess, loss of uterus and/or ovaries and infertility.") (internal citations omitted). Indeed, as this Court recognized, when WAWC was temporarily forced to close in 2015, the evidence demonstrated that this risk was far from hypothetical:

> The plaintiffs submit evidence that the remaining providers already are witnessing the manifestation of that risk. One woman showed up to the Center after it had closed and threatened to take measures into her own hands because she was unable to travel the distance to another clinic. Similarly, the Huntsville clinic has received at least two calls per month from women who, after explaining that they plan to attempt to terminate the pregnancy on their own because they cannot travel to Huntsville, have sought advice as to what pills they can take to self-induce abortion.

W. Ala. Women's Ctr., 120 F. Supp. 3d at 1311-12; *accord* Second Johnson Decl. ¶¶ 49-51; Second Gray Decl. ¶ 47; Robinson White Decl. ¶ 27 (describing women who have attempted to self-induce abortion by, *inter alia*, throwing themselves down stairs and asking others to beat them).

If the risk of self-abortion was borne out during the period when WAWC was closed but AWC remained open, the scale of harm would only be magnified if both clinics closed. Faced with substantially increased travel distance to access legal abortion services, insufficient capacity among the three remaining clinics, and the total loss of outpatient abortion services after approximately 15 weeks LMP, many women will have no choice but to take matters into their own hands. *See PPSE III*, 33 F. Supp. 3d at 1363.

3. *State Justifications*

SB 205 contains no statement of legislative purpose and no findings of fact, but its sponsors sought to justify it on the extraordinary basis that abortion clinics should be closed to protect children from seeing anti-abortion protests. *See* Second Johnson Decl. Ex. A (statement of House sponsor Rep. Ed Henry), Ex. B (statement Senate sponsor Sen. Sanford). Neither the Supreme Court nor, to Plaintiffs' knowledge, any other court has ever so much as suggested that a state may invoke third-party bystanders' perception of *anti-abortion protesters'* activities outside of abortion clinics *as a reason to close abortion clinics*. And with good reason: If states were permitted to restrict abortion access because abortion *opponents'* activities might be witnessed by third parties, that would give those who oppose the fundamental right to abortion a heckler's veto over its exercise. *See, e.g.*, *Roe v. Crawford*, 514 F.3d 789, 796 (8th Cir. 2008) ("If the State . . . banned abortion in general, on the basis of concerns about societal disruption due to protests at the clinics, the [heckler's veto] principle would no doubt apply and the government would be required to take steps to ensure access, rather than enacting a ban."); *Deerfield Med. Ctr.*, 661 F.2d at 337-38; *Planned Parenthood of N. New England v. City of Manchester*, No. CIV. 01-64-M, 2001 WL 531537, at *3 (D.N.H. Apr. 27, 2001) (holding zoning board's denial of permit to an abortion clinic unlawful because government "acquiescence in public opposition [to abortion] . . . is . . . impermissible").

By the logic underlying SB 205, when anti-Semitic protesters target a synagogue, a state can respond by forcing the *synagogue* to close or move on the sole basis that bystanders (including students) might witness the anti-Semitic protests—an unheard-of result that would give those opposed to the exercise of a constitutional right veto power over the congregants' religious exercise. Such a rule would give perverse incentives to opponents of abortion (or other

fundamental rights). And lest there be any doubt that these perverse incentives are directly at play here, the record shows (1) that the very anti-abortion group responsible for protests at the Huntsville clinic publicly acknowledged that it drafted the clinic closure requirement, *see* Second Johnson Decl. ¶ 27; and (2) that the protesters at the Huntsville clinic make concerted efforts to target the school itself—thus intentionally exacerbating the "problem" the bill they drafted purports to "solve"—by, *inter alia*, protesting at the time when students arrive even though that is well before the time when the clinic opens, *see id.* ¶¶ 29-30.

Indeed, courts have consistently found efforts to restrict the operation of abortion clinics under similar rationales unconstitutional. Most relevant is the binding decision in *Deerfield Medical Center v. City of Deerfield Beach*, in which the court addressed a city's decision to deny an abortion clinic's license application in a business-zoned district. 661 F.2d at 337. The city sought to justify the denial on the basis that the clinic would "pose a threat to the health and welfare of the citizens of the area," *specifically* invoking the fact that "children would be walking past the facility on the way to school." *Id.* at 337-38 n.16 (quotation marks omitted). The court held that this was an inadequate justification for restricting women's right of access to abortion, explaining that the city's asserted rationale would "permit arbitrary governmental action aimed at the suppression of protected activity solely because the residents of the community disapproved of the nature of the activity or were offended by it." *Id.* at 337-38 (quotation marks, brackets, and citation omitted). Other courts faced with comparable government actions have ruled identically. *See Planned Parenthood of N. New England*, 2001 WL 531537, at *3 (holding that zoning board's denial of permit to abortion clinic was unconstitutional because "opposition to abortion . . . cannot serve as a lawful basis for denying a variance or making other zoning decisions"); *West Side Women's Servs., Inc. v. City of Cleveland*, 573 F. Supp. 504, 523 (N.D.

Ohio 1983) ("A municipality has no legitimate interest in shielding certain members of a community from constitutionally-protected activities which they find offensive on personal, moral, or even religious grounds."); *cf. Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 868 (8th Cir. 1977) ("There is no judicial authority allowing a municipality, by imposing special restrictive zoning requirements on first trimester abortion clinics, to do indirectly that which it can not do directly by medical regulation."); *accord City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 448-50 (1985).

Thus, the governmental interests purportedly underlying SB 205 are insufficient to warrant a restriction on abortion—and certainly one as burdensome as this statute—as a matter of law. *See Whole Woman's Health*, 2016 WL 3461560, at *17 (requiring a "constitutionally acceptable objective" to justify an abortion restriction); *PPSE II*, 9 F. Supp. 3d at 1284 ("'[T]he Court must not only determine the legitimacy and strength of each of [the government's] interests; it also must consider the extent to which those interests make it necessary to burden the plaintiff's rights.'") (quoting *Anderson v. Celebrezze*, 460 U.S. 780, 789 (1983)). Just as a state has no valid interest in giving a husband "an effective veto" over his wife's abortion decision, *Casey*, 505 U.S. at 897, the State does not have a valid interest in giving anti-abortion activists "an effective veto" over abortion access by invoking bystanders' potential observation of *abortion opponents'* activities as a basis for shuttering the *clinics*. *See Crawford*, 514 F.3d at 796; *Deerfield Med. Ctr.*, 661 F.2d at 337-38; *see also Whole Woman's Health*, 2016 WL 3461560, at *28 ("[W]e now use viability as the relevant point at which a State may begin limiting women's access to abortion for reasons unrelated to maternal health.").

But even if the purported state interest animating SB 205 were not invalid as a matter of law, that interest cannot justify the burdens imposed by SB 205 for a separate reason: As a

factual matter, enforcement of the statute would not achieve the State's asserted interest (invalid as it is) in preventing students from witnessing anti-abortion protests in either Huntsville or Tuscaloosa. *See PPSE II*, 9 F. Supp. 3d at 1287 ("[T]he more severe the obstacle a regulation creates, the more robust the government's justification must be, *both in terms of how much benefit the regulation provides towards achieving the State's interests and in terms of how realistic it is the regulation will actually achieve that benefit.*") (emphasis added); *accord Whole Woman's Health*, 2016 WL 3461560, at *22-23 (invalidating abortion restriction that failed to further state's asserted interest).

In Huntsville, enforcement of SB 205 would force AWC to cease operating an abortion clinic at its Sparkman Drive facility, but it would not eliminate antiabortion protests at that facility (or elsewhere in the city). This is because in Huntsville (and in Alabama more generally, *see W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1308), abortion opponents do not confine their protests to abortion *clinics*, but also protest at the *private offices* of physicians who perform abortions. *See* Second Johnson Decl. ¶ 32; Robinson White Decl. ¶¶ 10, 14-16. In particular, before the Sparkman Drive facility was an abortion clinic, it was Dr. Robinson White's private ob-gyn office, where she did not provide abortions. Second Johnson Decl. ¶ 33; Robinson White Decl. ¶ 10. Approximately two months after she opened her private practice in that building, anti-abortion activists began protesting there, notwithstanding the fact that it was not an abortion clinic. Those very same protests have persisted to the present day, even as the space transitioned from an ob-gyn office to an abortion clinic. Second Johnson Decl. ¶¶ 34-36; Robinson White Decl. ¶¶ 10, 14-15. And when AWC moved to the Sparkman Drive facility in 2014, Dr. Robinson White relocated her private ob-gyn practice to AWC's prior space on Madison Street (which is within 2,000 feet of Huntsville Junior High School), and the anti-abortion protests at

the Madison Street facility continued unabated, *even after it had ceased operating as an abortion clinic* and only housed Dr. Robinson White's ob-gyn practice. Second Johnson Decl. ¶¶ 37-39; Robinson White Decl. ¶¶ 14-16. In other words, the closure of the abortion clinic at that location did not cause anti-abortion activity within 2,000 feet of the school there to cease—there is no clinic on Madison Street, but anti-abortion protests (within 2,000 feet of a school) persist there to this day. Second Johnson Decl. ¶ 39; Robinson White Decl. ¶¶ 14-17.

If SB 205 were enforced, Mr. Johnson would be unable to renew AWC's license as an abortion clinic, but he would continue to own the Sparkman Drive building, into which he has sunk virtually all his of assets. Second Johnson Decl. ¶ 40. Under those circumstances, Dr. Robinson White would utilize both the Sparkman Drive and Madison Street facilities as ob-gyn offices, and would perform abortions at both offices—although she would be barred from performing ten or more procedures per month or 100 or more procedures per year, under Ala. Admin. Code r. 420-5-1-.01(2)(e) (2016).[7] Robinson White Decl. ¶¶ 16, 30. As Rev. Henderson, the leader of the anti-abortion protesters in Huntsville, stated after the passage of SB 205, "we go where the abortions are done." Second Johnson Decl. ¶ 42. Abortions would be "done" (albeit at a far reduced rate) in the exact same place where they are performed today if SB 205 were enforced, and protests would continue to take place—just as they have at the Madison Street location since it ceased operating as an abortion clinic. Second Johnson Decl. ¶¶ 40-42; Robinson White Decl. ¶¶ 14-17. Thus, enforcement of SB 205 would do nothing to stop anti-abortion protests from occurring within 2,000 feet of schools at either the Sparkman Drive

[7] Because she believes that access to abortion is essential, Dr. Robinson White would provide what limited abortion services she can in an office-based setting if SB 205 forced the clinic to close—but providing ten procedures per month (but no more than 100 procedures per year) would not come close to filling the gap left by AWC's closure. Robinson White Decl. ¶¶ 16, 30.

or Madison Street locations. *See PPSE III*, 33 F. Supp. 3d at 1378-79 (finding abortion restriction that imposed a substantial burden and that did little-to-nothing to further the asserted state interest unconstitutional); *accord Whole Woman's Health*, 2016 WL 3461560, at *22-23 (same); *Karlin v. Foust*, 188 F.3d 446, 489 n.16 (7th Cir. 1999) (striking requirement that doctor informs abortion patients with lethal fetal anomalies about the "father's child support obligations and the availability of state childrearing assistance serves no legitimate state interest").

Nor would enforcement of SB 205 in Tuscaloosa do anything to further the State's purported interest. Although WAWC is located within 2,000 feet of Tuscaloosa Magnet Elementary School, the clinic is separated from the school by a large and impassable wooded area of tall trees. *See* Second Gray Decl. ¶ 35. It is impossible to see or hear protesters from the school. *See id.* To the extent that the State has an interest in preventing students from seeing anti-abortion protesters, enforcement of SB 205 would do nothing to further that interest because the protests are not detectable from the school.

In sum, the substantial obstacles imposed by SB 205 are far "more severe than warranted by the State's justifications" for the law, *PPSE III*, 33 F. Supp. 3d at 1377, because (1) the State has no valid interest in closing abortion clinics to prevent bystanders (including students) from being exposed to anti-abortion protesters' activities, and (2) in any event, enforcement of SB 205 would do nothing to accomplish the State's legally invalid purpose. This Court has held that "[a]t some point, the obstacles on the right to obtain an abortion will become so significant that the State cannot justify them at all." *PPSE II*, 9 F. Supp. 3d at 1288. If ever there were an example of such a restriction, SB 205 is it.

B. The D&E Ban Imposes an Undue Burden

SB 363 bans the safest and most common second-trimester abortion method—D&E—and the only method that can be performed on an outpatient basis. As such, SB 363 bans outpatient abortion in Alabama after approximately 15 weeks LMP.

Four decades of unwavering U.S. Supreme Court precedent squarely hold that it is unconstitutional to ban the most common second-trimester abortion method. *See Gonzales v. Carhart*, 550 U.S. 124 (2007); *Stenberg v. Carhart*, 530 U.S. 914, 945-46 (2000); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 77-79 (1976). By banning D&E, which is the safest and most common method of second-trimester abortion, SB 363 is in direct conflict with this precedent. Therefore, Plaintiffs are extremely likely to prevail on their challenge to the D&E ban.

In *Danforth*, the Supreme Court held that a Missouri law banning the most commonly used method of second-trimester abortion at that time—saline amniocentesis—was unconstitutional. 428 U.S. at 77-79. In overturning the lower court's opinion upholding the ban, the Court focused on several factors, including "the prevalence . . . of the use of saline amniocentesis as an accepted medical procedure in this country," which the Court found to range from 68 to 80% of all second-trimester abortions in the United States. *Id.* at 77. The Court also considered that there were severe limitations on the availability of alternatives to saline amniocentesis, including that one such alternative was used only on an experimental basis, and that the state could offer no evidence that alternatives were available in Missouri. *Id.* Finally, the Court recognized that, "as a practical matter, [the ban] forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Id.* at 79.

Next, in *Stenberg*, the first abortion method ban case considered by the Supreme Court after *Casey*, the Supreme Court struck down a Nebraska law banning the so-called "partial-birth abortion" procedure (dilation and extraction or "D&X") precisely because it was so broadly written that it also banned D&E procedures, which the Court recognized as the most common abortion procedure in the second trimester. 530 U.S. at 945-46. As such, the Court held that the law imposed an undue burden on a woman's right to abortion and was unconstitutional. *Id.*

Since *Stenberg*, federal courts—including this Court—have consistently struck laws banning the D&E procedure. *See, e.g.*, *Summit Med. Assocs., P.C. v. Siegelman*, 130 F. Supp. 2d 1307, 1314-15 (M.D. Ala. 2001) ("'By proscribing the most commonly used method for previability second trimester abortions [, that is, D&E], . . . the statute creates a substantial obstacle to a woman seeking an abortion, . . . and therefore imposes an undue burden.") (quoting *Stenberg*, 530 U.S. at 951 (O'Connor, J., concurring)); *see also Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323 (6th Cir. 2007) (affirming district court decision that law prohibiting D&E created an unconstitutional burden on a woman's right to abortion), *cert. denied*, 552 U.S. 1096 (2008); *Hope Clinic v. Ryan*, 249 F.3d 603 (7th Cir. 2001) (per curiam) (holding unconstitutional under *Stenberg* state laws prohibiting D&E); *Eubanks v. Stengel*, 224 F.3d 576 (6th Cir. 2000) (per curiam) (affirming under *Stenberg* district court decision that law prohibiting D&E created an unconstitutional burden on a woman's right to abortion); *Causeway Med. Suite v. Foster*, 221 F.3d 811 (5th Cir. 2000) (same); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127 (3d Cir. 2000) (same); *A Choice for Women v. Butterworth*, 2000 WL 34403086 (S.D. Fla. 2000) (permanently enjoining law prohibiting D&E); *Daniel v. Underwood*, 102 F. Supp.2d 680 (S.D. W. Va. 2000) (same); accord *Women's Med. Prof'l Corp. v. Taft*, 353

F.3d 436 (6th Cir. 2003) (upholding state ban on D&X because it explicitly exempted D&E); *R.I. Med. Soc'y v. Whitehouse*, 239 F.3d 104 (1st Cir. 2001) (per curiam).

Most recently, in *Gonzales*, the Supreme Court affirmed that the state may not ban the D&E procedure. The Court in *Gonzales* interpreted a federal ban on so-called "partial birth abortions" to ban *only* D&X procedures, not the standard D&E procedure, and held that the constitutionality of the federal ban rested on the continued availability of the "prototypical" D&E. 550 U.S. at 153, 164, 166-67. In so holding, the Court both distinguished and affirmed the continued vitality of *Danforth*. The statute at issue in *Danforth* was unconstitutional, the Court explained, because it banned the then-dominant second-trimester abortion method. By contrast, the ban at issue in *Gonzales* did not impose a substantial obstacle in the path of a woman seeking abortion because it allowed for the continued availability of a "commonly used and generally accepted method"—that is, the D&E method now banned by SB 363. *Gonzales*, 550 U.S. at 165. The Court likewise both distinguished and affirmed *Stenberg*, explaining that the statute at issue in that case was unconstitutional because it banned both D&X and standard D&E, whereas the law at issue in *Gonzales* did not ban standard D&E—the most common method of second-trimester abortion. *Id.* at 165-66.

Here, SB 363 bans the most commonly used method of second-trimester abortion—standard or "prototypical" D&E—and is therefore unconstitutional under *Danforth*, *Stenberg*, and *Gonzales*. *See also Northland Family Planning Clinic, Inc.*, 487 F.3d at 336-37 (recognizing that "*Gonzales* left undisturbed the holding from *Stenberg* that a prohibition on D&E amounts to an undue burden on a woman's right to terminate her pregnancy"); *PPSE II*, 9 F. Supp. 3d at 1288-89 (court must consider the availability of abortion services in assessing how great an obstacle a regulation presents). As such, SB 363 is unconstitutional and must be enjoined.

That SB 363 does not appear to ban D&E if the physician attempts to induce fetal demise prior to starting the D&E procedure—and is successful in doing so—cannot save the ban from invalidation. To begin with, forcing physicians to induce fetal demise prior to starting the procedure would compel a woman to submit to an additional, unnecessary medical procedure—one that has no proven medical benefit, but does increase the complexity, risk, and pain related to the abortion procedure. *See supra* at pp. 13-15. As a result, no clinics in Alabama attempt to cause fetal demise prior to beginning a D&E. *See Danforth* 428 U.S. at 77-79. Just as it was unconstitutional in *Danforth* for the state to ban the most common method of second-trimester abortion where so-called "alternatives" were not actually available in the state, the D&E ban cannot be upheld on the basis of similarly unavailable alternatives. *See id*. Moreover, as explained *supra* at p. 14, for several weeks in the second trimester, there are no tested and/or reliable methods for causing fetal demise, and therefore there can be no question that SB 363 is an outright ban on abortion in the state during that several week period. And, even at the point in the second trimester when an attempt to induce fetal demise would not require doctors to subject patients to untested procedures, the procedure still is not always successful. *See supra* at pp. 14-15. If the physician's attempt to induce demise is not successful, his or her only option would be to put the patient's health at risk by delaying the abortion and attempting to perform additional, possibly even experimental, procedures on the patient in an attempt to complete the abortion, or to perform the D&E in violation of the ban. *See id.*; *see also Danforth* 428 U.S. at 77-79.

Given that medical interventions to induce fetal demise are not practiced in Alabama, are not available throughout the second trimester, would increase the pain and risk of the abortion procedure with no medical benefit, are not always successful, and could force some patients to submit to untested and experimental procedures, there can be no argument that such

interventions render SB 363's ban constitutional. *See PPSE II*, 9 F. Supp. 3d at 1289 (under *Casey*, an impermissible obstacle "refers to the whole array of harms that a regulation may impose on women seeking abortions," such as "risks to the woman's health; additional cost or time; an intrusion of the women's physical person . . . emotional trauma; and delay" (internal citations omitted)). Indeed, such an argument would turn *Gonzales* on its head. In *Gonzales*, the Supreme Court upheld a federal law banning a minority abortion method precisely because the safest and most common abortion method—standard D&E—remained available throughout the second trimester. The state cannot now go after the D&E method itself based on a converse rationale—that a minority variation of D&E, which poses some risk without any medical benefit, is sometimes available. The D&E ban runs afoul of decades of settled precedent and must be enjoined. *See Gonzales*, 550 U.S. at 124; *Stenberg*, 530 U.S. at 945-46; *Danforth*, 428 U.S. at 77-79.

C. The Medical Records Requirement Imposes an Undue Burden

Under the Amended Regulation, a clinic that is unable to comply with the staff-privileges and/or covering physician requirement is required to ensure that every "patient *shall receive* a copy of her medical record that pertains to the current abortion procedure prior to leaving the facility." Ala. Admin. Code 420-5-1-.03(6)(c)(4) (2016) (emphasis added). As this Court explained in *PPSE II*, the right to abortion protects not only access to abortion, but also the right to an abortion without "exposure of private or confidential information" or "humiliation or emotional trauma." 9 F. Supp. 3d at 1289 (citing *Casey*, 505 U.S. at 900, 886). In determining whether an abortion regulation would impose such harms, "context matters." *Id.* at 1285. That is, "the circumstances of women affected by an abortion regulation, including those circumstances which are not directly caused by the regulation, must be considered in determining

the size of the obstacle." *Id.* at 1285 (citing *Casey*, 505 U.S. at 887-898; *see also Whole Woman's Health*, 2016 WL 3461560, at *8 (reviewing evidence of the particularly burdensome impact of restrictions on "poor, rural, or disadvantaged women") (quotation marks and citation omitted); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 915 (9th Cir. 2014). Here, the medical records requirement jeopardizes the privacy and wellbeing of women seeking abortions at WAWC, while doing little to nothing to further any state interest. Plaintiffs are therefore likely to succeed on the merits of their claim that it imposes an undue burden on women's right to abortion.

1. *The Medical Records Requirement Will Jeopardize the Privacy and, in Some Cases, Well-Being and Safety of WAWC's Patients*

A patient's medical record at WAWC reflects not only the woman's decision to have an abortion, but also her address, social security number, race, mental health history, sexually transmitted infections, HIV status, medications, and prior pregnancies, miscarriages, and abortions, among other highly sensitive information. Second Gray Decl. ¶ 22. By requiring WAWC to duplicate a patient's medical record and give it to her, even over a patient's express objection, the medical records requirement will threaten women's privacy and confidentiality. In addition, for women who are in abusive relationships, the requirement would jeopardize their well-being and safety, and could even place their loved ones at risk.

As this Court has recognized, "the pervasive anti-abortion sentiment among many in Alabama" means that "disclosures [of a woman's decision to have an abortion] may present risks to women's . . . safety." *PPSE III*, 33 F. Supp. 3d at 1357; *see also Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 553 (9th Cir. 2004) (abortion patients' medical information is "obviously very sensitive"); *Margaret S. v. Edwards*, 488 F. Supp. 181, 204 (E.D. La. 1980) ("One of the most personal matters that can be disclosed is the fact that a woman is seeking an abortion."). It

should therefore be unsurprising that both women seeking abortions and abortion providers take significant steps to protect a woman's confidentiality. For example, all patients at WAWC are assigned an identification number (*e.g.*, Patient #1) and are referred to by this number, rather than their actual name, when in the presence of other patients or over the telephone. Second Gray Decl. ¶ 21. WAWC also places the patient's medical file backwards in the examination room door so that no one walking down the hall can see the patient's name. *Id.* And with respect to a patient's medical record, in the rare event that a patient requests a copy of her record for either herself or another physician, WAWC will offer to send only the portion necessary for the requested purpose, which may not be the entire medical record. *Id.* ¶ 25. All patient medical records are stored securely, and when it comes time to destroy old patient records, the clinic hires a professional shredding company to shred the patient records box by box under the direct supervision of WAWC's director. *Id.* ¶¶ 21, 24.

WAWC's patients likewise take concerted steps to protect their confidentiality. For instance, many of WAWC's patients pay for their abortions in cash in order to avoid having an electronic credit card record of their abortion at WAWC. *Id.* ¶ 26. They are often reluctant to provide a phone number or address and ask that the clinic not contact them via telephone or mail. *Id.* Some patients wish to obtain an abortion without their partner's knowledge and will schedule appointments when they know their partner will not be at home, and some are forced to cancel their appointments at the last minute because of an unexpected change in their partner's work schedule. *Id.* ¶ 27. Patients likewise often tell the clinic staff that they do not want to take anything home from the clinic, in order to avoid the risk that a third party will find any paperwork indicating they had an abortion, and the clinic staff tries to accommodate this by minimizing the patient-identifying information a patient takes with her when she leaves the

clinic. *Id.* ¶ 26. For example, when the clinic provides patients with a "work excuse letter" for missed work, the letters do not have the clinic's name, but only a physician's signature. *Id.* Similarly, if a patient does not want to leave the clinic with a prescription for pain medication and antibiotics (which all patients are provided), the clinic will call the prescription directly into the woman's pharmacy. *Id.* This way, the patient will not leave the clinic with any documents with patient-identifying information. Finally, the staff at WAWC must often reassure their patients that they use paper, not electronic, records that cannot be easily duplicated or disseminated. *Id.* In other words, patients prefer that their medical record remain under the security and control of the clinic, and fear that duplication could lead to disclosure.

By requiring that every woman receive a copy of her record related to the abortion, this unprecedented requirement, if allowed to take effect, would jeopardize WAWC's patients' confidentiality. Without the same means or resources that the clinic employs to securely store or dispose of their medical records, WAWC's patients will be at greater risk of having their medical record discovered by third parties. *Id.* ¶¶ 24, 28. These risks are heightened, in both degree and kind, for some of WAWC's most vulnerable patients: those who are victims of domestic violence. For these women, the threat to privacy caused by the medical records requirement would seriously jeopardize their well-being and safety, and that of their loved ones.

Women who are in abusive relationships often experience escalated violence during pregnancy. Walker Decl. ¶ 11. Moreover, carrying a pregnancy to term can tie the woman to her abuser and make it much harder for her (and any children she may already have) to leave the abusive relationship. *Id.* ¶ 12. Therefore, an abortion can be vitally important to the safety of an abused woman and her children and to their future. It is thus crucial that an abused woman who

has decided to have an abortion be able to obtain one without her abuser's knowledge. *Id.* ¶¶ 10-12.

The medical records requirement endangers abused women by substantially increasing the likelihood that an abuser will learn of the abortion against the woman's wishes. As detailed in the declaration of Dr. Lenore Walker, abusers are intrusive and extremely controlling, and because of this obsessive need for control, closely monitor their victims' activities. Critically, this monitoring includes regularly rifling through the woman's belongings, including her purse, files, car, and even garbage, to find notes, receipts, or anything else that may reveal her activities, private communications, or relationships. *Id.* ¶ 19. Therefore, when a woman has an abortion without her abuser's knowledge, it is crucial that she minimize any paper trail of her abortion that her abuser might find. *Id.* ¶¶ 18-23. But the medical records requirement prevents the woman from doing that and, if allowed to take effect, would place abused women and their children in extreme danger. When an abusive man learns that his partner has had an abortion without his knowledge, the woman is almost certain to face severe repercussions, including being beaten or raped. *Id.* ¶ 25. Similarly, abusers have used this information against abused women in custody disputes to suggest that the woman is an unfit mother. *Id.* ¶ 26. In the most extreme instances, abusers who found out about an abortion have committed murder. *Id.* ¶ 25 (describing client whose abusive partner killed their child after the partner found out that the woman had had an abortion).

While the repercussions of a breach of confidentiality are the most severe for abused women, the medical records requirement poses risks to all women who seek abortions at WAWC. Abortion patients face unique hostility from those who would use their decision to shame and harass them. Anti-abortion protestors, who are routinely outside the clinic with a

camera, often try to identify patients who have obtained abortions at WAWC by, for example, posting online their photos as they enter and exit the clinic. Second Gray Decl. ¶ 28. Protesters have even rummaged through WAWC's garbage looking for information about the clinic and its patients. *Id.*

Indeed, it is precisely because of this risk that WAWC, like other healthcare providers, does not simply discard patient health records or documents containing patient identifying information into the garbage, but instead shreds them or otherwise renders them unreadable "to limit incidental, and avoid prohibited, uses and disclosures" of patient information. *HIPAA for Professionals*, UNITED STATES DEP'T OF HEALTH & HUMAN SERVS., (Feb. 18, 2009), http://www.hhs.gov/hipaa/for-professionals/faq/576/may-a-covered-entity-dispose-of-information-in-dumpsters/index.html; Second Gray Decl. ¶ 24. Therefore, the notion that a patient could simply discard the copy of her medical records if she decides she does not want them is no answer. When considering the impact of the medical records requirement in the "context" of "the lived experience of the actual women who will be affected," it is thus clear that it will jeopardize women's privacy, confidentiality, and safety. *PPSE II*, 9 F. Supp. 3d at 1292.

2. *The Medical Records Requirement Is Unjustified*

As the evidence makes clear, the threat to patient privacy and well-being posed by the medical records requirement is not justified by the state's purported interest in patient health. *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1312. Indeed, requiring a woman to receive a copy of her medical record related to the abortion in the extremely unlikely case that she will subsequently present to a hospital emergency department ("ED") following her discharge would not affect, let alone enhance, the care she receives in the ED in any meaningful way.

As a threshold matter, it is important to recognize how extraordinarily unusual—indeed, *sui generis*—the medical records requirement is. *See id.* (when considering the justification for an abortion regulation, court considers, *inter alia*, "the means the regulation employs"). Neither Alabama nor, to Plaintiffs' knowledge, any other state requires any other provider of outpatient care to give patients their entire medical record upon discharge in the absence of a patient's request (and even over a patient's objection). Hargarten Decl. ¶¶ 5, 13; Second Parker Decl. ¶¶ 4-5. This is true even in the case of outpatient medical providers who perform procedures that entail greater risks than abortion. *Cf. Schimel*, 806 F.3d at 914 ("Wisconsin appears to be indifferent to complications of any other outpatient procedures, even when they are far more likely to produce complications than abortions are."). Indeed, Alabama does not even require all outpatient abortion providers to satisfy the medical records requirement. Ala. Admin. Code r. 420-5-1-.03(6) (2016). Women who obtain abortions from physicians with staff privileges at a local hospital or from clinics with a covering physician with such privileges are just as likely to present at an ED following their procedure, and yet they will not have their medical records with them. The fact that their doctor or the covering physician had privileges would not change this, as the woman is still likely to be treated by a doctor at the hospital who did not perform the abortion. *See PPSE III*, 33 F. Supp. 3d at 1372 (explaining that the "country-doctor" model where doctor who performed abortion would treat any subsequent complications is not used in Alabama); *see also W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1315 (in discussing weak justifications for covering physician requirement, observing that in the event of a complication requiring hospital-based care, "there is no guarantee that the covering physician will arrive at the hospital before the patient or before she is treated by the emergency-room doctor; will be any more knowledgeable about the patient than the hospital staff; or will be any more qualified to

treat her"). If there were any medical justification for the medical records requirement—which there is not—then *all* patients receiving any form of outpatient medical care, not just women who obtain abortions from doctors without admitting privileges or at clinics without a covering physician, would be required to receive a copy of their medical record upon discharge. *See Whole Woman's Health*, 2016 WL 3461560, at *23 (rejecting patient health rationale for law that singled out abortion for burdens not imposed on other surgical procedures).

Unsurprisingly, given that no other provider of outpatient medical services in Alabama or elsewhere is forced to give all patients unwanted copies of their medical records at the moment of discharge, the evidence makes clear that the medical records requirement is medically unjustified. The "likelihood of the anticipated benefit" from the medical records requirement is exceedingly slim. *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1312. The chance that a woman will suffer a complication requiring hospital-based treatment is "vanishingly rare" in the case of first-trimester abortions, *PPSE III*, 33 F. Supp. 3d at 1364 ("[c]omplications that require hospitalization occur in only 0.05 to 0.3% of early-term abortions"), and still exceedingly rare for second-trimester abortions, Davis Decl. ¶ 14 (major complications occur in less than 1% of D&E abortions). *See also Whole Woman's Health*, 2016 WL 3461560, at *17-18 (crediting similar evidence concerning the extremely low complication rate for abortion). It is therefore extremely unlikely that a patient who has been discharged from WAWC would suffer a complication at home that will need to be treated in the ED. Indeed, in most instances, complications or concerns that arise after the woman leaves the clinic can be addressed over the phone or during a follow-up visit to the clinic. *See PPSE III*, 33 F. Supp. 3d at 1366 ("most complications that arise after a patient has been discharged are best treated with over-the-phone

instructions, prescription medication from a pharmacy, or a follow-up visit to the abortion clinic.") (emphasis omitted).

Moreover, the "extent of the anticipated benefit" from the medical records requirement is exceedingly small. *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1312; *accord Whole Woman's Health*, 2016 WL 3461560, at *18-19. Simply put, in those rare instances when a woman presents to the ED following discharge from the clinic, the patient's medical record would not materially affect how an ED physician would evaluate, diagnose, or treat the woman's condition. Hargarten Decl. ¶¶ 5-13. This is true for three principal reasons. First, ED physicians are trained to evaluate, diagnose, and treat patients, including those suffering complications following an outpatient procedure, without relying upon a patient's outpatient medical records. *Id.* ¶¶ 8-13. When a patient who has gone home from an outpatient procedure later presents to the ED, the ED physician will take the patient's history and ask what procedure she had and the symptoms following her discharge that prompted her to present to the ED, and other background questions. *Id.* ¶ 8. An ED physician would ask these questions regardless of whether the patient also had her medical record from the abortion.[8] *Id.* In addition to asking the patient questions, the ED physician would run a standardized course of evaluation and diagnosis. *Id.* ¶ 9. When any woman of reproductive age comes to the ED complaining of abdominal pain or vaginal bleeding, the ED physicians will run a series of rapid diagnostic tests (including a pregnancy test and an ultrasound) to determine if her condition was the result of the abortion, as opposed to an intervening cause. *Id.* ¶¶ 9-10. This would also occur regardless of whether the patient had her medical record with her. *Id.* ¶ 10.

[8] Of course, if, for some reason, the ED physician treating a woman for an abortion complication requested the patient's medical record, WAWC would provide them immediately. Second Gray Decl. ¶ 25.

Second, not only are ED physicians trained to evaluate and diagnose a patient without her medical records from recent outpatient treatment, but it is extremely unlikely that anything in the records at the time of the woman's discharge from an abortion clinic would be pertinent to the diagnosis. *Id.* ¶ 11. As Dr. Hargarten explains, this is because the most common complications that would cause a woman to present to the ED after discharge would not have been known to the clinic or would have arisen after discharge, and would therefore not be reflected in the medical records. For example, if a woman presented to the ED because of excessive bleeding caused by an incomplete abortion, there would be nothing in the woman's medical record to aid in the ED physician's evaluation because that information would not be reflected in the medical record at the time of discharge. *Id.* The same would be true if the woman presented to the ED because of a missed ectopic pregnancy or an infection. *Id.*; Second Gray Decl. ¶ 23 (stating that medical record at time of patient's discharge will lack pathology report, which confirms that the pregnancy was intrauterine and not ectopic, and that all products of conception were removed during the procedure).

Finally, if the ED physician determined that the woman's symptoms were due to an abortion, nothing in the patient's medical record at the time of her discharge would aid in treating the patient. Hargarten Decl. ¶ 12; *see also PPSE III*, 33 F. Supp. at 1364 ("Doctors at [emergency rooms] are trained to provide care for all abortion complications."). Often, a woman who has had an abortion and presented to the ED merely requires reassurance that her bleeding and discomfort are normal and to be expected. *PPSE III*, 33 F. Supp. 3d at 1366 ("[E]ven when hospital care is unnecessary, patients will sometimes seek emergency-room treatment without first contacting the provider. Indeed, in some such cases, the woman may not be suffering from any complication at all, but may simply need reassurance."). In other cases the woman's

condition is identical to that of a woman who suffered a miscarriage and she would be treated in the same manner. Hargarten Decl. ¶ 7. And again, nothing in the woman's medical record from the time of her discharge from the abortion clinic would inform the woman's treatment. *Id.* ¶ 12.

* * * *

For all of these reasons, the medical records requirement imposes a severe obstacle to a woman's right to choose abortion by jeopardizing the privacy of women seeking abortions, particularly those in abusive relationships, which is not sufficiently justified by the requirement's benefits, of which there are all but none. Plaintiffs are therefore likely to succeed on their claim that it imposes an undue burden on women's right to abortion.

II. ALL THREE REQUIREMENTS WOULD IRREPARABLY HARM PLAINTIFFS AND THEIR PATIENTS.

Plaintiffs readily satisfy the second requirement for injunctive relief: Enforcement of the challenged laws against Plaintiffs will inflict irreparable harm on Plaintiffs and their patients for which there is no adequate remedy at law.

First and foremost, as this Court has repeatedly held, the threatened enforcement of laws that violate "the constitutionally protected privacy interests of Alabama women" constitutes irreparable harm. *W. Ala. Women's Ctr.*, 120 F. Supp. at 1318; *see also Planned Parenthood Se., Inc. v. Bentley* ("*PPSE I*"), 951 F. Supp. 2d 1280, 1289 (M.D. Ala. 2013); *Touchston v. McDermott*, 234 F.3d 1133, 1159 n.4 (11th Cir. 2000) ("[W]e have presumed irreparable harm to a plaintiff when certain core rights are violated" and "cannot be undone through monetary remedies."); *Ne. Fla. Chapter of Associated Gen. Contractors v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990) ("[A]n on-going violation [of the constitutional right to privacy] constitutes irreparable injury" because "invasions of privacy, because of their intangible nature,

could not be compensated for by monetary damages; in other words, plaintiffs could not be made whole.") (internal citations omitted), *overruled on other grounds by* 508 U.S. 656 (1993); *Women's Medical Ctr. of Nw. Houston v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001) (affirming district court's finding of irreparable harm based on threat to women's constitutional right to privacy); *Deerfield Med. Ctr.*, 661 F.2d at 338 (finding of irreparable injury is mandated where constitutional right to privacy is being threatened or impaired). As set forth *supra* at pp. 23-54 enforcement of any and all of the challenged laws would impose an undue burden on Plaintiffs' patients' constitutionally protected right to have an abortion.

Second, absent injunctive relief against the clinic closure requirement, Ms. Gray and Mr. Johnson will be forced to lay off their staff and permanently close clinics that have provided critical health care services to tens of thousands of women for decades. *See* Second Gray Decl. ¶ 30; Second Johnson Decl. ¶ 52. As this Court has already held, this in and of itself constitutes irreparable harm. *W. Ala. Women's Ctr.*, 120 F. Supp. at 1318; *see also PPSE I*, 951 F. Supp. 2d at 1289 (finding irreparable harm where statute would force clinic owner to "close her business altogether"); *ABC Charters, Inc. v. Bronson*, 591 F. Supp. 2d 1272, 1307 (S.D. Fla. 2008) (finding irreparable harm where plaintiffs would "be forced to close their businesses," thus depriving plaintiffs of sole source of income and means of retirement); *Mid–Fla Coin Exchange v. Griffin*, 529 F. Supp. 1006, 1030 (M.D. Fla. 1981) (finding irreparable harm where plaintiffs' "businesses face virtual extinction if they are forced to comply with the legislation").

Moreover, the evidence also shows that enforcement of either the clinic closure requirement or the D&E ban—or both—would "decrease the access to abortion for many Alabama women and deny it altogether for others." *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1318; *see supra* at pp. 20-22. This too would cause irreparable, non-speculative harms to

Plaintiffs' patients. *Id.*; *accord Whole Woman's Health*, 2016 WL 3461560, at *26 (discussing burdens imposed by reduced abortion access). Last year, based on virtually identical evidence, this Court found that the closure of WAWC alone had a profoundly negative effect on Alabama women. *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1311-12. If both WAWC *and* AWC were forced to close, the evidence laid out above shows that these harms will be significantly compounded: women would be prevented and/or delayed from obtaining an abortion. Moreover, even if all women had the financial and logistical resources to travel to one of the few remaining clinics in Alabama—which the evidence clearly demonstrates that they do not—the remaining clinics lack the capacity to make up for the loss in services. *See supra* at pp. 21-22. As this Court has already found, these physical, financial, and psychological harms will fall most heavily on the low-income women who make up the vast majority of WAWC's and AWC's patients, many of whom do not have access to reliable transportation or the financial resources to travel to a distant city or state to obtain medical care. *PPSE III*, 33 F. Supp. 3d at 1356-57.

As was also the case last year, the impact on Plaintiffs' second-trimester patients will be even more acute. The evidence shows that women seek abortion in the second trimester for a number of reasons, including difficulties in making financial or logistical arrangements to access an abortion provider, delayed recognition of pregnancy, or the diagnosis of a genetic or anatomical abnormality after the first trimester. *See supra* at pp. 10-11. AWC and WAWC are the only clinics in Alabama providing abortions after approximately 15 weeks LMP. As such, enforcement of either the clinic closure requirement or the D&E ban would not just make it more difficult to obtain an abortion in Alabama—it would essentially limit in-state abortion services to the first trimester.

Injunctive relief against the clinic closure requirement and the D&E ban is therefore necessary to protect the safety and wellbeing of Plaintiffs' patients.[9] *W. Ala. Women's Ctr.*, 120 F. Supp. 3d at 1318; *see also PPSE I*, 951 F. Supp. 2d at 1289 (finding irreparable harm where "women who carry unwanted pregnancies to term are at increased risk of death and childbirth complications" and delay in seeking abortion "also carries an heightened risk of medical complication"); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 795-96 (7th Cir. 2013); *Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment).

Finally, injunctive relief against the medical records requirement is necessary to protect the privacy of Plaintiff WAWC's patients' personal medical decisions, and to protect them from stigma, harassment, or worse. *Supra* at pp. 16-18; *see also PPSE II*, 9 F. Supp. at 1289. As the evidence makes plain, by forcing clinics to turn over medical records to abortion patients, even over their patients' objections, the medical records requirement jeopardizes the confidentiality of Plaintiffs' patients' abortion decision, as well as a host of other sensitive information that is contained within a patient's medical record. *Supra* at pp. 16-18. This poses especially grave

[9] The record makes clear that although Plaintiffs' clinic licenses are valid until December 31, 2016, the irreparable harm of the clinic closure requirement would be felt well before then. *See* Second Gray Decl. ¶¶ 38-40; Second Johnson Decl. ¶ 52. Because WAWC sees patients for follow-up care three to four weeks after the abortion, without injunctive relief, WAWC would have to stop performing abortions in November. *See* Second Gray Decl. ¶ 38. (Because Dr. Robinson White would be able to continue to see patients at her private ob-gyn office, AWC patients would not be in the same position.) Moreover, Plaintiffs rightfully fear that members of their staff would leave to find other jobs with the threat of imminent closure (and resultant unemployment) hanging over their heads. *See id.* ¶¶ 39-40; Second Johnson Decl. ¶ 52. Indeed, Ms. Gray lost one of her best employees when her clinic was temporarily closed in 2015 as a result of the uncertainty over whether the clinic would be able to reopen. *See* Second Gray Decl. ¶ 39.

risks to WAWC's patients who have experienced, or are at risk of experiencing, domestic violence. Indeed, courts have long recognized that, if a woman is unable to keep the fact of her abortion secret from an abusive partner, that partner may exercise an "arsenal of physical, economic, and psychological abuse . . . to penalize [a woman] for exercising her constitutionally bestowed right" to abortion. *Planned Parenthood of Southeast Pa. v. Casey*, 947 F.2d 682, 712 (3d Cir. 1991), *judgment aff'd in part, rev'd in part*, 505 U.S. 833 (1992). The testimony of Dr. Walker above leaves no doubt about how severe, even deadly, these repercussions can be. *Supra* at pp. 17-18. Certainly, "[n]o remedy at law could adequately compensate [Plaintiffs' patients] for any physical, psychological, or emotional trauma they might suffer at the hands of one obtaining this personal information." *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1069 (6th Cir. 1998); *accord Am. Coll. of Obstetricians & Gynecologists v. Thornburgh*, 737 F.2d 283, 297 (3d Cir. 1984) (enjoining judicial bypass statute until promulgation of rules ensuring, *inter alia*, confidentiality). As such, injunctive relief is required here.

III. THE BALANCE OF EQUITIES WEIGHS HEAVILY IN PLAINTIFFS' FAVOR.

As compared to the extensive and irreparable harm that will befall Plaintiffs and their patients if any of the challenged laws are permitted to take effect, the relief Plaintiffs seek would impose only minimal harm on Defendants because Plaintiffs ask merely for the *status quo* to be maintained while significant questions about these laws' constitutionality are adjudicated. This is precisely the purpose of a preliminary injunction or TRO. *See Klay v. United Healthgroup, Inc.*, 376 F.3d 1092, 1101 n.13 (11th Cir. 2004) ("[T]he textbook definition of a preliminary injunction [is that it is] issued to preserve the status quo and prevent allegedly irreparable injury until the court ha[s] the opportunity to decide whether to issue a permanent injunction."). There can be no harm to Defendants from maintaining the *status quo*. Given that preventing women

from being able to obtain an abortion is not a legitimate governmental interest, *see PPSE II*, 9 F. Supp. 3d at 1298, any interests the state may assert in defending the clinic closure requirement and D&E ban simply cannot outweigh the concrete and irreparable harm that would result from closing WAWC and AWC or banning abortion after approximately 15 weeks LMP in Alabama. *See supra* at pp. 20-22. Likewise, the relationship between the medical records requirement and the state's interest in protecting women's health is tenuous, at best. Whatever theoretical benefits the medical records requirement might hold, these too cannot outweigh the concrete and irreparable harm that would result from enforcement of this requirement. Thus, the equities tip sharply in favor of granting a preliminary injunction and/or TRO while the constitutionality of these laws is decided. *See Scott v. Roberts*, 612 F.3d 1279, 1297 (11th Cir. 2010); *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006).

IV. INJUNCTIVE RELIEF IS IN THE PUBLIC INTEREST.

Finally, the interests of Plaintiffs and the general public are aligned in favor of granting temporary injunctive relief in this case. The public interest is not served by permitting the state to enforce unconstitutional statutes and regulations. *See Scott*, 612 F.3d at 1297; *KH Outdoor*, 458 F.3d at 1272. Particularly where civil rights are at stake, an injunction *serves* the public interest because the injunction "would protect the public interest by protecting those rights to which it too is entitled." *Nat'l Abortion Fed'n v. Metro. Atlanta Rapid Transit Auth.*, 112 F. Supp. 2d 1320, 1328 (N.D. Ga. 2000). Furthermore, without an injunction, access to abortion in Alabama would be drastically reduced and women's privacy would be jeopardized. *See supra* at pp. 20-22. Ensuring continued access to constitutionally protected health care services on a confidential basis is undoubtedly in the public interest. Thus, Plaintiffs satisfy the fourth and final requirement for injunctive relief.

V. A BOND IS NOT NECESSARY IN THIS CASE.

The Court should waive the Federal Rule of Civil Procedure 65(c) bond requirement. As the Eleventh Circuit held in *Bell S. Telecomm., Inc. v. MCIMetro Access Transmission Servs., LLC*, "it is well-established that 'the amount of security required by the rule is a matter within the discretion of the trial court . . . [, and] the court may elect to require no security at all.'" 425 F.3d 964, 971 (11th Cir. 2005) (quoting *City of Atlanta v. Metro. Atlanta Rapid Transit Auth.*, 636 F.2d 1084, 1094 (5th Cir. Unit B 1981)). The Court should use its discretion to waive the bond requirement in this case, as the temporary restraining order and/or preliminary injunction will not result in a monetary loss for Defendants. Moreover, Plaintiffs are healthcare providers dedicated to serving women in low-income and underserved communities, and a bond would strain the providers' already-limited resources.

CONCLUSION

For all of the foregoing reasons, the Court should grant Plaintiffs' motion for a temporary restraining order and/or preliminary injunctive relief in its entirety.

Date: July 6, 2016

Respectfully submitted,

s/ Andrew Beck
Andrew Beck*
New York State Bar No. 4740114
Alexa Kolbi-Molinas*
New York State Bar No. 4477519
Jennifer Lee*
New York State Bar No. 4876272
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004
abeck@aclu.org
akolbi-molinas@aclu.org
jlee@aclu.org

(212) 549-2633

Randall C. Marshall
ASB-3023-A56M
ACLU FOUNDATION OF ALABAMA, INC.
P.O. Box 6179
Montgomery, AL 36106-0179
rmarshall@aclualabama.org
(334) 265-2754

Attorneys for Plaintiffs

** Admitted pro hac vice*

CERTIFICATE OF SERVICE

I, Andrew Beck, do hereby certify that a true and correct copy of the foregoing will be filed with the Clerk of Court using the CM/ECF system, which will serve a copy of the same upon the following counsel of record, on this 6th day of July, 2016:

P. Brian Hale
Bethany L. Bolger
Carol R. Gerard
Alabama Department of Public Health
P.O. Box 303017
Montgomery, AL 36130

I further certify that a true and correct copy of the foregoing will be served upon the following by hand delivery this same day:

Luther Strange
Attorney General of Alabama
501 Washington Avenue
Montgomery, Alabama 36104

Lyn Head
District Attorney for Tuscaloosa County
714 Greensboro Avenue
Tuscaloosa, Alabama 35401

Robert L. Broussard
District Attorney for Madison County
100 North Side Square
Huntsville, Alabama 35801

H. Joseph Falgout, M.D.
Alabama Board of Medical Examiners
848 Washington Avenue
Montgomery, Alabama 36104

James E. West, M.D.
Medical Licensure Commission of Alabama
848 Washington Avenue
Montgomery, Alabama 36104

s/ Andrew Beck
Andrew Beck
New York State Bar No. 4740114
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004
abeck@aclu.org
(212) 549-2633