IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, and on behalf of its patients and physicians, *et al*.,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	
	)	CASE NO. 13-CV-00862-LY
GREGORY ABBOTT, Attorney General of Texas, in his official capacity, *et al*.,	)	
Defendants.	)	

PLAINTIFFS' REPLY BRIEF IN FURTHER SUPPORT OF THEIR MOTION FOR PRELIMINARY AND PERMANENT INJUNCTION

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INTRODUCTION

The effect of the challenged provisions will be devastating for Texan women. Over 22,000 women each year will be denied access to abortion because of the admitting privileges requirement. One in three health centers that currently provide abortion will be forced to stop. Doctors will be forced to use a protocol for medication abortion that is less safe for their patients. Unable to muster any credible evidence to counter these facts, Defendants devote the majority of their brief to attacking Plaintiffs' standing and their proposed remedy, failing to acknowledge well-settled Supreme Court and Fifth Circuit precedent to the contrary. As to the merits, Defendants cannot successfully argue that denying 22,000 women the ability to obtain an abortion furthers women's health or that a substantial obstacle is not imposed. Nor can Defendants show that requiring women to follow a medication abortion protocol that is less safe and denies many others the ability to obtain a medication abortion at all, even for health indications, furthers women's health and is not a substantial obstacle. For all of these reasons, this Court should permanently enjoin the challenged provisions of the Act.

ARGUMENT

I. Plaintiffs Have Standing to Assert Third-Party Rights.

Defendants unconvincingly argue that Plaintiffs' lack third-party standing. Under a long line of Supreme Court and Fifth Circuit precedent, which Defendants ignore, Plaintiffs have standing to assert the rights of their patients and Plaintiff health centers can also raise the rights of their employees. Lastly, Plaintiffs can vindicate their patients' rights under 42 U.S.C. § 1983 and/or the Declaratory Judgment Act under decades of cases, and nothing in the text of either statute or the few cases that Defendants cite suggests the contrary.

A. Plaintiffs Have Third-Party Standing to Assert Claims on Behalf of Their Patients.

Defendants' argument that Plaintiffs lack standing to raise the rights of their patients flies in the face of four decades of Supreme Court precedent. The Supreme Court's recognition that medical providers can raise the rights of their patients seeking reproductive health services dates back to 1965 when the Court decided *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965). *Griswold* allowed the executive director and medical director of a reproductive health care clinic to raise the rights of married people with whom they had a confidential relationship. *See also Carey v. Pop. Servs. Int'l*, 431 U.S. 678, 683-84 (1977) (vendor of contraceptive devices had standing to assert rights of potential customers); *Eisenstadt v. Baird*, 405 U.S. 438, 446 (1971) (distributer of contraceptives had third-party standing to raise the rights of nonmarried individuals who sought contraceptives). In the context of abortion, the Supreme Court has explicitly recognized that an abortion provider has standing to challenge restrictions, and to assert claims on behalf of women seeking abortions. *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S 416, 440 n.30 (1983); *Bellotti v. Baird*, 443 U.S 622, 627 & n.5 (1979); *Singleton v. Wulff*, 428 U.S. 106, 117 (1976); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Doe v. Bolton*, 410 U.S. 179, 188 (1973). The Supreme Court has also repeatedly implicitly recognized the ability of physicians and health care centers to raise the rights of their patients. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914 (2000); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

The reasons for allowing third-party standing in this context are articulated in depth in *Singleton* where the Court concluded, under the flexible prudential prong of standing, that physicians who provide abortion should be able to raise the rights of their patients because: (1) physicians who provide abortions have a sufficiently close relationship with their patients and

are thus "uniquely qualified to litigate the constitutionality of the State's interference with" the abortion decision, and (2) there are several obstacles preventing women from bringing their own claims, including concerns about anonymity and potential mootness. 428 U.S. at 117-18.

Accordingly, under *Singleton*, Plaintiffs' patients face a hindrance to asserting their own rights as a matter of law. Defendants argue that women must be "unable" to assert their rights. Defs. Br. at 2. But *Singleton* already noted that such an argument goes too far. 428 U.S. at 116 n.6 (rejecting the notion that third-party standing is permissible only when such assertion by the third party would be practically impossible). Defendants further claim that, because some women choose to assert their own rights, women are not "hindered" from challenging abortion restrictions. But just because some women are willing to endure the possible risk of public exposure does not mean that other women would. And perhaps most importantly, *Singleton* recognized that from a prudential standpoint, it makes no difference whether the case is brought by a class representative, a woman whose claim has become moot, or a physician. *Id*. at 118 ("[I]f the assertion of the right is to be 'representative' to such an extent anyway, there seems little loss in terms of effective advocacy from allowing its assertion by a physician.").[1]

Similarly, Plaintiffs have a close relationship to their patients. As the *Singleton* Court held, "[a] woman cannot safely secure an abortion without the aid of a physician . . . the constitutionally protected abortion decision is one in which the physician is intimately involved." 428 U.S. at 117. Contrary to Defendants' claim, Defs. Br. at 3-4, there is no conflict between Plaintiffs and their patients' interests. In numerous cases involving various state interests, including an interest in protecting women's health, courts have allowed third-party standing. *See,*

[1] Defendants rely on *Kowalski v. Tesmer*, 543 U.S. 125 (2004), but the Court in that case explicitly noted that the line of reproductive health cases is one of the few examples where the Court allows third-party standing. *Id*. at 130 (citing *Doe* and *Griswold*).

e.g., *Akron*, 462 U.S. at 440 n.30 (challenge to, *inter alia*, parental consent law, holding explicitly that the physician plaintiff "has standing to raise the claims of his minor patients"); *Charles v. Carey*, 627 F.2d 772, 779-80 n.10 (7th Cir. 1980) (rejecting state's claim that abortion providers lacked standing because of conflict of interest with their patients in challenge to abortion-specific biased counseling law); *Karlin v. Foust*, 975 F. Supp. 1177, 1202 (W.D. Wis. 1997) (same), *aff'd on this holding*, 188 F.3d 446, 457 n.5 (7th Cir. 1999). Plaintiffs and their patients share a common interest in this case: the challenged provisions of HB 2 are detrimental to women's health as discussed *infra*.

Defendants attempt to discount the effect of *Singleton*, arguing that the plurality opinion is "unpersuasive," and "not law." Defs. Br. at 4-5. This argument is unavailing. First, even if *Singleton* had never been decided, *Doe*, *Danforth*, *Bellotti*, and *Akron* all stand for the proposition that abortion providers have standing to raise the rights of their patients.[2] But as to *Singleton*, Defendants misread the import of Justice Stevens's concurrence. Justice Stevens only wrote separately to make clear that physicians have standing to assert the rights of their patients *if*, as here, the physicians are also seeking to assert their own rights and have at least an economic interest at issue. 428 U.S. at 121-22 (Stevens, J., concurring). Defendants may disagree with *Singleton*'s analysis, but the decision (and its predecessors or progeny) bind this Court. *See Marks v. United States*, 430 U.S. 188, 193, 260 (1977) ("When a fragmented Court decides a case . . . 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds . . . .'" (citation omitted)).

[2] Despite this long line of Supreme Court precedent granting third-party standing to abortion providers, Defendants make the bizarre claim that *Roe v. Wade* would need to be overruled to grant physicians third-party standing. Defs. Br. at 8-9. This argument creates a false dichotomy between the capable-of-repetition-yet-evading review doctrine on the one hand, and third-party standing on the other. Obviously, the Supreme Court believes that the two doctrines can co-exist, and that challengers to abortion restrictions can *either* be women seeking abortion *or* their health care providers. *Compare Roe v. Wade*, 410 U.S. 113, 124-125 (1973) with *Doe v. Bolton*, 410 U.S. 179, 188 (1973).

Defendants also go to great lengths to discount *Okpalobi v. Foster*, 190 F.3d 337 (5th Cir. 1999) ("*Okpalobi I*"),[3] but they overlook other Fifth Circuit decisions explicitly holding that physicians and health care centers can raise the rights of their patients. *See Deerfield Medical Center v. City of Deerfield Beach*, 661 F.2d 328 (5th Cir. Unit B 1981); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873, 875 (5th Cir. 1975). In *Deerfield Medical Center*, the Fifth Circuit, citing *Singleton*, held that an abortion clinic that was denied a license could challenge the city commission's decision on constitutional grounds on its own behalf and on behalf of its potential patients. 661 F.2d at 333-34. Thus, the Fifth Circuit has recognized third-party standing in this precise context.

B. Plaintiffs Have Third-Party Standing to Assert Claims on Behalf of Their Physicians.

Plaintiff health centers have Article III injury. The challenged provisions will be codified in Chapter 171 of the Texas Health and Safety Code and if any of the health center's employees violate any provision of that chapter, the center faces loss of licensure. *See* 25 Tex. Admin. Code § 139.32(7). For the reasons stated above, the health centers have the ability to raise the rights of their patients. Defendants argue that certain claims (vagueness, procedural due process, and non-delegation) must be brought by an individual physician. Defs. Br. at 9. But three individual physicians are named in the complaint. As many courts have held, when one (or more) party has standing, there is no need to address the question of whether the other parties have standing. *See, e.g.*, *Doe*, 410 U.S. at 189 (refusing to determine standing of additional parties after finding that a woman seeking an abortion and a physician had standing).

[3] The Fifth Circuit did not vacate *Okpalobi I* on third-party standing grounds, and it remains persuasive authority on that point. *See, e.g.*, *Hosein v. Gonzales*, 452 F.3d 401, 404 (5th Cir. 2006) (citing *Okpalobi I*, 190 F.3d at 350).

Nevertheless, contrary to Defendants' claims, Defs. Br. at 9-10, the health centers have third-party standing to raise the rights of their physicians. Plaintiff health centers may raise the rights of their physicians because there is a close relationship between the health center and the physician, and the physicians will face obstacles to bringing their own suit. Indeed, the Fifth Circuit has held that employers may properly assert the rights of their employees where there is a congruence of interests. *See, e.g., Hang On, Inc. v. City of Arlington*, 65 F.3d 1248, 1252 (5th Cir. 1995). If the Act is enforced here, physicians will be unable to practice in their specialty and the health center will be forced to stop providing abortion. Moreover, for all of the reasons that Plaintiffs are unable to find doctors to provide abortion—that many fear harassment or stigma—physicians may be chilled from instituting a constitutional challenge against an abortion restriction. *See* Declaration of Andrea Ferrigno ("Ferrigno Decl."), Exh. C. in App. To Pls. Mot. For Prelim. Inj. ¶ 16 (Docket #9-5); Declaration of Darrel Jordan, M.D. ("Jordan Decl."), Exh. D in App. To Pls. Mot. For Prelim. Inj. ¶¶ 11-12 (Docket #9-6); Exh. F, Rebuttal Declaration of Amy Hagstrom-Miller ("Hagstrom-Miller Decl.") ¶¶ 12, 13, 15. Although three physicians are named in this suit, it does not mean that all physicians would be willing to bring suit in their own names. Indeed, the Court only needs to look at the docket in this case to see that doctors who provide abortion are the targets of harassment and intimidation. *See* Motion for Intervention of Mitchell Williams (Docket #39).

C. Plaintiffs May Assert Claims on Behalf of Their Patients Under § 1983 and the Declaratory Judgment Act.

Defendants' argument that Plaintiffs cannot bring third-party claims under Section 1983 or the Declaratory Judgment Act is contradicted by the plain language of those statutes, numerous cases, and principles of equity. Section 1983 states in relevant part: "Every person who . . . subjects . . . any . . . person . . . to the deprivation of any rights . . . secured by the

Constitution and laws, shall be liable to the party injured . . . ." 42 U.S.C. § 1983. The statute does not limit who may bring suit, but only describes to whom defendants may be liable. Here, Plaintiffs may bring a claim under § 1983 on behalf of their patients, who are the "injured" parties to whom defendants "shall be liable." Indeed, as discussed above, Plaintiffs – both health centers and physicians – will suffer injury as a result of Defendants' enforcement of the Act, and Plaintiffs' have third-party standing to raise the rights of their patients.[4]

Defendants' novel argument is also belied by numerous cases that have allowed plaintiffs to pursue actions under § 1983 and have allowed third-party standing. *See, e.g., Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977) (allowing corporation to challenge prohibition on distribution of contraceptives on behalf of potential customers); *Craig v. Boren*, 429 U.S. 190 (1976) (allowing vendors on behalf of male customers to challenge the constitutionality of a prohibition on sale of beer to males under age of twenty one); *Inclusive Communities Project, Inc. v. Tex. Dep't of Hous. & Cmty. Affairs*, No. 08-CV-0546, 2008 WL 5191935, at *7 (N.D. Tex. Dec. 11, 2008) (allowing non-profit organization to sue on behalf of its clients). Moreover, if Defendants were correct, it would mean there could be no third-party standing in the context of constitutional challenges. This is not (and cannot be) the state of the law.

Defendants are also mistaken that Plaintiffs cannot vindicate their patients' rights under the Declaratory Judgment Act, a proposition for which they cite no cases at all. That Act states that "any court of the United States . . . may declare the rights and other legal relations of any interested party seeking such declaration." 28 U.S.C. § 2201(a). Because a declaration of the

[4] None of the cases Defendants rely upon stand for the proposition that a party seeking prospective relief under Section 1983 must be denied third-party standing. Instead, most of the cases relate to whether there was sufficient allegation of injury to the plaintiff. For example, in *Rizzo v. Goode*, 423 U.S. 362 (1976), cited in Defs. Br. at 9, the Court considered standing principles because the plaintiffs were seeking a remedy based on a limited number alleged improper incidents. In *Coon v. Ledbetter*, 780 F.2d 1158 (5th Cir. 1976), the court held that a man's wife could not show a deprivation of her own constitutional rights by the sheriffs who shot her husband.

Act's unconstitutionality would affect their ability to provide constitutionally protected medical services, Plaintiffs are interested parties whose "rights and other legal relations" will be affected by the court's ruling. Moreover, as with § 1983, Defendants' assertion is contradicted by decades of legal precedent, including cases that involve abortion providers seeking declaratory relief on behalf of their patients. *See, e.g*., *Craig*, 429 U.S. 190; *Danforth*, 428 U.S. 52 (1976).

II. The Act's Severability Clause Does Not Prevent Plaintiffs From Mounting a Challenge to the Act or Preclude Invalidation of the Challenged Provisions.

Defendants argue that Plaintiffs cannot sue on behalf of their patients seeking abortions because the legislature intended that this Court "sever every discrete application of HB 2 to every individual woman." Defs. Br. at 13 (italics omitted). In making this argument, Defendants conflate the assessment of the merits with the proper remedy. To the extent it is relevant at all, the severability clause only comes into play when this Court is fashioning relief after it has determined that challenged provisions are unconstitutional. The severability clause does not have any impact on whether Plaintiffs can show that there is a constitutional violation. Defendants argue, in effect, that the legislature can use a severability clause to change the substance of a federal constitutional right as well as the remedy a federal court can provide for a constitutional violation. These arguments are plainly incorrect.

A. The Severability Clause Cannot Alter the Standard for Determining Whether an Abortion Restriction Violates the Constitution.

Defendants' argument that this Court, when examining the merits of Plaintiffs' constitutional claims, must look to the Act's severability clause must fail. Clearly, the Texas legislature cannot alter the substance of Plaintiffs' and their patient's constitutional rights. For example, the relevant constitutional standard governing the merits of Plaintiffs' undue burden claims was articulated in *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992), where

the Supreme Court held that, the plaintiffs had to demonstrate that an abortion restriction placed a substantial obstacle in the path of women seeking abortion. *Id*. at 895. The "substantial obstacle" inquiry is the assessment of the *merits* of that challenge. The *Casey* Court went on to say that if the plaintiffs prove a "substantial obstacle" in a "in a large fraction of the cases in which [the statute] is relevant," then the law will be wholly invalidated. *Id*. at 895. Thus, as discussed *infra*, the "large fraction" test relates only to the remedy once a constitutional violation has been found.[5] Therefore, regardless of the language of the Act's severability clause, this Court must examine the merits of the constitutional claim before reaching the question of the appropriate remedy.

B. The Severability Clause Does Not Determine the Remedy.

Defendants argue that the Act's severability clause limits the remedy available for a constitutional violation because it precludes total invalidation of the challenged provisions unless "there is no conceivable present or future patient for whom that requirement will not impose an 'undue burden.'" Defs. Br. at 15. But under *Casey*, if the plaintiff can show that the law is unconstitutional in a large fraction of cases, the law must be completely invalidated. Indeed, the Court rejected the state's argument that the law should be invalidated because it "imposed almost no burden at all for the vast majority of women seeking abortions. *Id*. at 894. The Court noted that the "analysis does not end with the one percent of women upon whom the statute operates; it begins there" and that the "proper focus of constitutional inquiry is the group for whom the law

[5] Similarly, the fact that Defendants repeatedly refer to Plaintiffs' case as a "facial challenge" does not have any bearing on the Court's assessment of the merits. As the Supreme Court has explained, "[t]he distinction between facial and as-applied challenges is not so well defined that it has some automatic effect or that it must always control the pleadings and disposition in every case involving a constitutional challenge." *Citizens United v. Fed. Election Comm'n*, 558 U.S. 310, 331 (2010) (citing *United States v. Treasury Emps*., 513 U.S. 454, 477-78 (1995). Rather, "it goes to the breadth of the remedy employed by the Court, not what must be pleaded in a complaint." *Id*.

is a restriction, not the group for whom the law is irrelevant." *Id*.[6] Here, the challenged provisions should be invalidated in their entirety both because they are medically unnecessary and because they place a substantial obstacle in the path of a large fraction of the women for whom they are relevant. *See infra* at Sections III.A & B.[7]

But even if a plaintiff cannot meet the large fraction test for total invalidation, if it has proved constitutional violations, the court must provide some relief. The decision in *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320 (2006), is instructive. There, the Court made clear that even when a challenged law has a severability clause, courts must still conduct an independent analysis of whether any part of the law can stand after a constitutional violation has been found. *See id.* at 330-31; *see also Geeslin v. State Farm Lloyds*, 255 S.W.3d 786, 798-800 (Tex. App.–Austin 2008, no pet.) (conducting independent analysis of whether severance was possible without rewriting statute).

[6] The Fifth Circuit has taken contradictory positions on the question of whether a plaintiff challenging an abortion restriction must meet the test from *United States v. Salerno* in order to obtain complete invalidation of the statute, 481 U.S. 739, 745 (1987) (requiring that there be "no set of circumstances" in which a statute could be applied constitutionally before wholly enjoining it), as opposed to in *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 925 (1992) (requiring facial invalidation where the restriction will be unconstitutional in a "large fraction" of individual cases). *See, e.g., Sojourner T. v. Edwards*, 974 F.2d 27, 30 (1992) (applying *Casey* standard to facial challenge to abortion statute); *Barnes v. Moore*, 970 F.2d 12, 14 n.2 (5th Cir. 1992) ("[W]e do not interpret *Casey* as having overruled, *sub silentio*, longstanding Supreme Court precedent governing challenges to the facial constitutionality of statutes."); *see also Causeway Medical Suite v. Ieyoub*, 109 F.3d 1096, 1102-04 (5th Cir. 1997), *cert. denied*, 118 S. Ct. 357 (1997) (declining the parties' request to reevaluate the position set forth in *Barnes* and "confront head-on the question of the standard of proof that should govern facial challenges in abortion cases"). Each of these cases was prior to the Supreme Court's recognition of the open question in *Gonzales v. Carhart*, 550 U.S. 124, 167-68 (2007). This Court should hold that the *Casey* standard governs, given that every other circuit court to consider the question has concluded it does. *See Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 195-96 (6th Cir. 1997), *cert. denied*, 118 S. Ct. 1347 (1998); *Jane L. v. Bangerter*, 102 F.3d 1112, 1116 (10th Cir. 1996), *cert. denied*, 117 S. Ct. 2453 (1997); *Planned Parenthood v. Miller*, 63 F.3d 1452, 1456-58 (8th Cir. 1995), *cert. denied*, 517 U.S. 1174 (1996); *Casey v. Planned Parenthood*, 14 F.3d 848, 863 n.21 (3d Cir. 1994)). *But see Richmond Medical Center For Women v. Herring*, 570 F.3d 165, 173-174 (4th Cir. 2009) (declining to address the question).

[7] Plaintiffs additionally bring a pre-enforcement, as-applied challenge to the medication abortion restrictions on the grounds that they prohibit the procedure for women beyond 49 days LMP for whom medication abortion is significantly safer than any alternatives. *See infra* at Section IV.A.3.

In *Ayotte*, the Court considered a challenge to a parental notification for abortion law for failing to include a medical emergency exception. *Ayotte*, 546 U.S. at 324. Although the law contained a severability clause, the Court denied the State's request to enjoin it only as applied to medical emergencies. *Id.* at 331-32. Instead, it remanded to the district court to determine if the legislature would have preferred no law at all to one with a medical emergency exception. *Id.* Thus, the explicit severability clause was not dispositive of the question of whether a partial injunction was the correct remedy.

Moreover, the factors considered by the *Ayotte* Court in determining the appropriate remedy counsel against the type of severability that Defendants seek here. In *Ayotte*, the Court considered as-applied injunctive relief because the Court had "long upheld state parental involvement statutes like the Act," and "only a few applications . . . would present a constitutional problem." *Id.* at 327, 331. Here, by contrast, Plaintiffs have shown that many applications of both provisions are unconstitutional.

The *Ayotte* Court further noted that its "ability to devise a judicial remedy that does not entail quintessentially legislative work often depends on how clearly we have already articulated the background constitutional rules at issue and how easily we can articulate the remedy." *Id.* at 329. In this case, there is no well-established federal law upholding the challenged provisions—to the contrary, these provisions have been struck down by other courts. *See infra* Sections III, IV. And Defendants identify *no* rule or principle by which the statute could be partially enjoined, and offer no logical or easily articulable remedy. They simply argue that the challenged provisions must be upheld with respect to each woman for whom they would not individually constitute an undue burden.

Perhaps they are suggesting that this Court should engage in a *seriatim* review of each individual woman's constitutional claim of undue burden, which, in practical terms, would mean that tens of thousands of women would have to come to court. Even if that were feasible, it would not remedy the constitutional violations. Would the court decide that if Jane Doe has to travel too far, her doctor does not need admitting privileges, but if Mary Roe lives near a provider, her doctor does? The reality is that if the law goes into effect, those physicians that cannot obtain admitting privileges will cease providing abortions, leaving no remedy for the unconstitutional applications.[8] This Court should therefore find that the admitting privileges requirement and the medication abortion restrictions are not severable as to each individual woman and enjoin them in their entirety.

III. The Admitting Privileges Requirement Is Unconstitutional.

In arguing that the admitting privileges requirement is unconstitutional, Plaintiffs make two separate arguments: first, that it is not medically necessary, and second, that regardless of whether it serves the state's interest in women's health, it imposes a substantial, and thus impermissible, obstacle in the path of women seeking abortions.[9] Defendants improperly conflate these arguments. As the Fifth Circuit has recognized, "[a]s long as *Casey* remains

[8] Defendants' proposal also goes against *Ayotte*'s admonition that courts should not "rewrit[e] state law to conform it to constitutional requirements even as [they] try to salvage it." 546 U.S. at 329 (internal quotations and citation omitted). For that reason, "in a murky constitutional context, or where line-drawing is inherently complex," crafting a partial remedy "may call for a far more serious invasion of the legislative domain than [courts] ought to undertake." *Id.* at 330. *See also Geeslin*, 255 S.W.3d at 799 (quoting *Randall v. Sorrell*, 548 U.S. 230, 262 (2006)).(Texas courts cannot sever parts of a law when doing so will require the court to "'write words into the statute, to leave gaping loopholes in the statute, or to foresee which of many different possible ways the legislature might respond to the constitutional objections.'").

[9] Plaintiffs have three other claims challenging the privileges requirement: vagueness, procedural due process, and unconstitutional delegation of government authority. As to the first claim, Defendants offer a limiting interpretation of the phrase "active admitting privileges" to mean just current and unexpired privileges. If Defendants will enter into a stipulated order with this clarifying interpretation, Plaintiffs would agree to dismiss their vagueness claim as to admitting privileges. As to the second claim, Defendants cite no cases in response to Plaintiffs' opening arguments and Plaintiffs therefore rely on their opening brief. The third claim is discussed *infra*.

authoritative, the constitutionality of an abortion regulation thus turns on an examination of the importance of the state's interest in the regulation *and* the severity of the burden that regulation imposes on the woman's right to seek an abortion." *Barnes v. Mississippi*, 992 F.2d 1335, 1339 (5th Cir. 1993) (emphasis added).

A. The Admitting Privileges Law is Medically Unnecessary.

Plaintiffs have established that the admitting privileges requirement cannot be upheld unless Defendants show that it actually advances the State's purported interest in women's health. *See* Pls. Br. at 2-3. It cannot be the case, as Defendants suggest, that this Court's review of Plaintiffs' patients' privacy rights amounts to something less than even rational basis review. While plaintiffs bear the burden of demonstrating a particular law presents an undue burden, it is the state that always bears the burden of demonstrating its interest in that law. The decision "whether to bear or beget a child" is one of those "fundamental[]" choices that is "central to the liberty protected by the Fourteenth Amendment." *Casey*, 505 U.S. at 851 (citation omitted). Therefore, this Court must be "something more than a rubber stamp of any rationale defendants now articulate," and must consider whether the state has truly demonstrated a genuine interest in women's health animates the law. *Planned Parenthood of Wis., Inc. v. Van Hollen*, No. 13-cv-465-wmc, 2013 WL 3989238, at *12 (W.D. Wis. Aug. 2, 2013). Defendants must show that a regulation that they claim advances women's health actually will do so. *See, e.g., Akron*, 462 U.S. at 430-31 (quoting *Roe*, 410 U.S. at 163) (State must show that regulation "reasonably relates to the preservation and protection of maternal health"). And, in evaluating whether a statute that purports to promote women's health actually does so, the courts evaluate whether the requirement "departs from accepted medical practice." *See, e.g., id.*, 462 U.S. at 434 (state may

not "adopt abortion regulations that depart from accepted medical practice.").[10] In considering whether defendants are likely to succeed in demonstrating a reasonable link between the admitting privileges requirement at issue here and maternal health, this court is bound "to review factual findings where constitutional rights are at stake." *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007). "'Uncritical deference' to legislative fact findings is 'inappropriate.'" *Id*. at 166. *Planned Parenthood of Wis.*, 2013 WL 3989238, at * 14 (quoting *Gonzales*, 550 U.S. at 166).

Defendants incorrectly claim that the *Casey* Court "jettisoned" these earlier cases. Defs. Br. at 27. While *Casey* overruled "those parts of *Danforth* and *Akron* which . . . are inconsistent with *Roe*'s statement that the State has a legitimate interest in promoting the life or the potential life of the unborn," 505 U.S. at 870, it was very careful not to overrule them in their entirety. *See id.* at 882-83 ("[W]e depart from the holdings of *Akron I* . . . *to the extent that* we permit a State to further its legitimate goal of protecting the life of the unborn") (emphasis added). *Casey*, in fact, applied the very standard articulated in those cases in upholding the recordkeeping and reporting requirements because that was the only portion of the Pennsylvania law that involved women's health rather than fetal life. *Id.* at 900-01.[11]

Defendants attempt to rely on both *Mazurek v. Armstrong*, 520 U.S. 968 (1997), and *Gonzales*, 550 U.S. at 124, but neither of these cases addresses the question here: whether a regulation bears the necessary relationship to women's health. *Mazurek* focused primarily on whether the challenged statute was passed with an impermissible motive. In *Gonzales*, having held that a ban on one seldom-used abortion method served state interests in promoting

[10] This sort of review is supported by the Fourth Circuit's decision in *Greenville Women's Clinic v. Commissioner*, 222 F.3d 157 (4th Cir. 2000), cited by Defendants, where the court upheld a regulation because, *inter alia*, it "largely track[ed]" the "standards and guidelines issued by the ACOG" and was reasonably directed at promoting women's health. *Id.* at 167.

[11] Defendants are correct that the *Casey* Court did not articulate whose burden it was to show this relationship, but because it did not overrule its prior precedent on this point, it is clear the burden rests with Defendants.

"potential life" and "protecting the integrity" of the medical profession, 550 U.S. at 158, the Court addressed whether the ban's lack of a health exception constituted an undue burden where there was medical disagreement about whether the ban itself would ever impose health risks. *Id.* at 129. Thus, *Gonzales* and *Mazurek* certainly did not overrule—and *Casey* supports—the holdings of *Akron* and *Danforth* that a State must demonstrate that a regulation that purports to advance women's health at least "reasonably relates" to that asserted interest. Defendants cannot meet this burden here. *See Planned Parenthood of Wis.*, 2013 WL 3989238, at * 1 ("[D]efendants are not likely to succeed in demonstrating that the admitting privileges requirement is reasonably related to maternal health"). First, they claim that the law "serves as a quality-control mechanism." Defs. Br. at 29. But this argument says *nothing* about why those privileges need to be at a hospital within 30 miles, which is one of the most burdensome parts of the Act. *See, e.g.*, Jordan Decl. ¶ 6 (explaining that some Texas providers have privileges, but not within 30 miles of all sites where they perform abortions). And as demonstrated by Plaintiffs, there are numerous reasons why physicians may not be able to get privileges at a particular hospital that have nothing to do with reputation or training. *See id.* ¶¶ 8-10, 12; Ferrigno Decl. ¶12; Hagstrom-Miller Decl. ¶ 14; Declaration of Angela Martinez, Exh. E in App. To Pls. Mot. For Prelim. Inj. (Docket #9-7) ("Martinez Decl.") ¶ 7.[12]

Second, Defendants claim that requiring privileges promotes women's health because it will ensure "continuity of care." Defs. Br. at 29. But a law actually directed at continuity of care would require "the physician who provided abortion services actually accompany his or her patient to the hospital, provide treatment of the patient at the hospital, or . . . facilitate the hand-

[12] The state relies on *Women's Health Ctr. of W. County Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989), as precedential support for its privileges law. However, the law at issue in *Women's Health Center* merely required that a doctor performing abortions had admitting privileges anywhere in the United States, not at a local hospital.

off of the patient to emergency doctors or other specialists." *Planned Parenthood of Wis.*, 2013 WL 3989238, at *10. The Act does none of these things. Nor are privileges necessary to ensure that women receive continuous care. Exh. A, Rebuttal Declaration of Paul M. Fine, M.D. ("Rebuttal Fine Decl.") ¶¶ 10-24; Exh. D, Rebuttal Declaration of Jennifer Carnell, M.D. ¶¶ 5-25.[13]

Notably, Defendants do not point to a single instance in which the health of a woman who had an abortion was compromised by the failure of her doctor to have admitting privileges at a local hospital. Plaintiffs have established—and Defendants do not contest—that much more serious procedures, including, for instance, those involving general anesthesia, are routinely performed outside of hospitals with no requirement that they physician have local privileges. Declaration of Paul Fine, M.D., Exh. B in App. To Pls. Mot. For Prelim. Inj. (Docket #9-2) ("Fine Decl.") ¶¶ 32-33; *see also Planned Parenthood of Wis.*, 2013 WL 3989238, at *10 (local admitting privileges not required "for *any* other clinic or outpatient procedure than abortion . . . not just by a governmental entity, but by any medical group or society").[14]

Defendants cite to three incidents from other states as "evidence" that this requirement is necessary. Defs. Br. at 30. Plaintiffs do not minimize those events, but Texas already has a substantial regulatory system in place to license and routinely inspect abortion providers. *See generally* Tex. Health & Safety Code Ann. tit. 4, §§ 245.001-.024 (licensing of abortion

[13] Defendants also suggest that admitting privileges are necessary because not all hospitals have OB-GYNs on call. Defs. Br. at 30, Love Decl. ¶ 7, Thorp Decl. ¶ 41. They seem to overlook the fact that the law itself requires admitting privileges at a hospital *with an OB-GYN department. See* Tex. HB 2 at Section 2. Whether the lack of OB-GYN services at hospitals is a national problem says nothing about the availability of OB-GYNs at hospitals in Texas, and certainly not those *with* an OB-GYN department. *See* Rebuttal Fine Decl. ¶ 24.

[14] To justify its differential treatment of abortion, Defendants rely on the statement from *Harris v. McRae* that "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of [fetal] life." 448 U.S. 297, 325 (1980). But the *Harris* Court made that statement in the context of a government funding restriction that purportedly served the government's interest in preserving fetal life, not the woman's health. *Id*. Where a state ostensibly acts to protect women's health, that action must actually be related to women's health, and not related to the state's antipathy to abortion.

facilities); *see also* Rebuttal Fine Decl. ¶ 10. Indeed, Texas law *already requires* that physicians who work at an abortion facility "*have admitting privileges or have a working arrangement with a physician(s) who has admitting privileges at a local hospital* in order to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a) (emphasis added). This meets the standard for "continuity of care" advanced by Defendants' only local physician. Love Decl. ¶ 13 ("A responsible surgeon who abides by the standard of care will have admitting privileges *or a relationship with a surgeon who does*.") (emphasis added)).[15]

B. The Admitting Privileges Law Has the Effect of Imposing an Undue Burden on Plaintiffs' Patients.

Defendants present no credible evidence to dispute the fact that the admitting privileges requirement will cause one-third of the facilities that perform abortions to stop performing abortions entirely on October 29 and others to significantly reduce their capacity.[16] Instead, Defendants reiterate their arguments about their view of Plaintiffs' burden, facial challenges, and the Act's severability clause. But, under these facts, there is no question that the admitting privileges requirement is unconstitutional. *See* Pls. Br. at 7.

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[15] In addition, abortion facilities must have a written protocol for emergency management and the transfer of patients to a hospital. And the unchallenged provisions of HB 2 require that Plaintiffs provide their patients with "a telephone number by which the pregnant woman may reach the physician, or other health care personnel . . . 24 hours a day to request assistance for any complications that arise from the performance or induction of the abortion . . . and . . . the name and telephone number of the nearest hospital to the home of the pregnant woman at which an emergency arising from the abortion would be treated." Tex. Health & Safety Code Ann. § 171.0031.

[16] Defendants argue that the expert testimony of Dr. Joseph Potter "does not satisfy the standards of Federal Rule of Evidence 702 or *Daubert v. Merrell Dow Pharm., Inc*.," and "should not be given any weight by this court." Defs. Br. at 33, 35. Potter's testimony clearly satisfies *Daubert*'s reliability standard. His report employs statistical methods that are the standard method of analysis in his field. *See, e.g., Skidmore v. Precision Printing & Pkg., Inc*., 188 F.3d 606, 618 (5th Cir. 1999) (finding testimony reliable where the expert "testified to his experience, to the criteria by which he diagnosed [patient] and to standard methods of diagnosis in his field"); *City of Tuscaloosa v. Harcros Chemicals, Inc.*, 158 F.3d 548, 566 (11th Cir. 1998) (finding testimony reliable where the expert's data compilations were "the products of simple arithmetic and algebra and of multiple regression analysis, a methodology that is well-established as reliable"). In addition, while Potter's recent findings through the Texas Policy Evaluation Project ("TxPEP") are too current to have completed the publication process, TxPEP's initial findings were published in a peer-reviewed article in the *New England Journal of Medicine*. *See* Exh. B, Rebuttal Declaration of Dr. Joseph E. Potter ¶6.

Since they do not really dispute the dramatic effect that the admitting privileges requirement would have, they are left claiming that the effect is only speculative and cannot support relief because some physicians may secure privileges in the future and some new providers may open. Br. at 34. This argument suffers from at least three flaws. First, it ignores the substantial evidence that the difficulty in attaining privileges for Plaintiffs' doctors and/or hiring doctors with admitting privileges already is systemic. *See, e.g,* Ferrigno Decl. ¶¶ 9-15; Jordan Decl. ¶ 7-13; Hagstrom-Miller Decl. ¶ 14; Martinez Decl. ¶ 7-9. Second, it ignores the reality that a clinic that must stop offering abortions will not be able to magically start offering those services again two months later if applications are approved. Hagstrom-Miller Decl. ¶ 20. Third, and most importantly, it ignores that as of October 29, without relief from this Court, one-third of Texas providers will have to stop performing abortions and many others will have to dramatically reduce that care. Whether that situation lasts for a week, a month, or a year, during that time, *one-third of the women seeking abortions in Texas will have their constitutional rights denied.* This injury is not speculative; this injury will happen a week from Tuesday. "[A] court's proper focus must be on the practical impact of the challenged regulation and whether it will have the likely effect of preventing a significant number of women for whom the regulation is relevant from obtaining abortions." *Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999). When doctors "stop performing abortions for non-speculative fear of prosecution, it [] create[s] an 'undue burden' and irreparable harm." *Jackson Women's v. Currier*, 878 F. Supp. 2d 714, 718 (S.D. Miss. 2012).

Defendants also question Plaintiffs' proof that (1) they have been diligently pursuing admitting privileges for their doctors; and (2) admitting privileges have been difficult to obtain, for reasons unrelated to the quality of the physicians. Defs. Br. at 31-32. It would not be feasible

to provide evidence detailing each of Plaintiffs' physicians' privileges attempts, particularly when some have applied to ten or twenty hospitals. Plaintiffs instead highlight some of the common problems they have experienced. For example, the Ferrigno Declaration details the efforts that Plaintiff Whole Woman's Health has made—contacting hospitals, obtaining applications, and completing those applications. Ferrigno Decl. ¶¶ 9-16. Despite those efforts, to date, none of the physicians at three of their five licensed facilities that perform abortions—in Fort Worth, McAllen, and San Antonio – have privileges. Ferrigno Decl. ¶ 7. Darrell Jordan and Angela Martinez describe similar difficulties in Waco, Fort Worth, Austin, and Lubbock. Jordan Decl. ¶¶ 7-13; Martinez Decl. ¶¶ 7-8.

Defendants also argue that even if the admitting privileges requirement will stop one-third of abortion providers from providing abortions that this does not represent an "undue burden." First, they claim that under *Casey* and *Mazurek*, the admitting privileges requirement is "*per se*" constitutional. Defs. Br. at 21. This assertion borders on the frivolous. As discussed above, *Mazurek* is not a case about *effects* but instead about *legislative purpose*. There was no question by the time the case reached the Supreme Court as to whether the restriction in that case actually had imposed a substantial obstacle on a woman's right to seek an abortion. *Mazurek*, 520 U.S. at 971 (citing with approval district court's conclusion that "[t]here exists insufficient evidence in the record to support the conclusion [that] the requirement that a licensed physician perform an abortion would amount, 'in practical terms, to a substantial obstacle to a woman seeking an abortion.'"). More importantly, *Casey* and *Mazurek* make clear that the question of whether a law has the effect of imposing an undue burden is one of fact that will turn on the record in a particular case. *See id.* at 971-72; *see also Casey* at 884-85 ("*Since there is no evidence on this record* that requiring a doctor to give the information . . . would amount . . . . to

a substantial obstacle . . . ., we conclude that it is not an undue burden.") (emphasis added)); *Karlin*, 188 F.3d at 484-85 ("Plaintiffs are not precluded from challenging a waiting period provision nearly identical in all respects to the one upheld in *Casey*," because "[s]tates differ in the number of physicians who perform abortions, the number of abortion facilities, the distances women must travel in order to reach an abortion facility, and the average income of women seeking abortions."). If Plaintiffs are able to demonstrate that based on the facts in this case, as they have, that the privileges requirement imposes an undue burden, it is invalid.

Relatedly, Defendants assert that travel distances themselves can never constitute an undue burden, based on the refusal of the *Casey* Court to find the distances in that case an undue burden. But as explained above, the determination in *Casey* was not a per se decision that travel cannot constitute an undue burden. And, here, the facts are not the same. Texas is five times as big, more than twice as wide, and more than four times as long as Pennsylvania. If the admitting privileges requirement goes into effect, it will eliminate abortion care in Waco, Killeen, Lubbock, Harlingen, McAllen, and Fort Worth, leaving no provider west of San Antonio except one in El Paso. Pls. Br. at 8. It will force two of the state's six providers of abortions at 16 weeks or greater to stop providing abortion care and force a third to dramatically reduce that care. *Id*. This will result in more women having to travel extremely long distances. For instance, the only clinic in Lubbock, the closest clinic for women in the South Plains and Panhandle regions, will have to stop offering abortions and women in that region will have to travel approximately 350 miles each way to access services. Women in Amarillo, instead of travelling 124 miles each way, will now have to travel 438 miles each way. This is not a case where those women will have to drive an extra 30 minutes or an hour to get to a nearby city, *cf., Women's Medical Prof. Corp*, 438 F.3d at 605-606, but one where they will have to spend two days travelling back and forth

As numerous courts have recognized, this is an undue burden. *See Planned Parenthood of Wis.*, 2013 WL 3989238, at *16-*17 (relying in part on increased travel burdens in finding Wisconsin's admitting privileges requirement to be an undue burden); *Planned Parenthood Se.*, 2013 WL 3287109, at *4-*5 (same with respect to Alabama); *Jackson Women's Health Org.* 2013 WL 16424365, at *4-*5 (same with respect to Mississippi). This Court should do the same.

C. The Admitting Privileges Requirement Is an Unconstitutional Delegation of Authority to Hospitals

The admitting privileges requirement grants hospitals broad discretion to determine whether a physician will be able to provide abortions, for reasons that may be wholly unrelated to the safety of that care. This violates century-old principles of due process that: 1) states may not authorize private parties to act against third-party liberty or property interests in ways that the state itself could not act; and 2) in order for a delegation of governmental authority to be constitutional, states must retain the ability to review private parties' exercise of governmental discretion. *See, e.g., Wash. ex. rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116 (1928) (striking down law preventing certain uses of land unless consented to in writing by two-thirds of the property owners in the immediate vicinity); *Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1374 (E.D. Mich. 1981), *aff'd on other grounds*, 743 F.2d 352 (6th Cir. 1984) (law requiring abortion clinics to have a transfer or emergency backup agreement with a physician who had staff privileges at a local hospital "violate[d] due process concepts because [it] delegate[d] a licensing function to private entitles without standards to guide their discretion."); *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158 (E.D. N.C. 1974) (striking down written transfer agreement or admitting privileges requirement for abortion providers because "the state . . . placed no limits on the hospital's decision to grant or withhold a transfer agreement, or even to ignore a request for one."). *Cf. Women's Med. Ctr. Of Nw.*

Houston v. Bell, 248 F.3d 411 (5th Cir. 2001) ("Especially in the context of abortion, a constitutionally protected right that has been a traditional target of hostility, standardless laws and regulations . . . open the door to potentially arbitrary and discriminatory enforcement."). Simply put, the State cannot do *indirectly* – by delegating governmental authority to a private, non-state actor – that which it cannot do directly.[17] Accordingly, delegation of state authority to a private party is constitutional *only* if it is accompanied by criteria to constrain the private party's discretion or the state retains some final decision-making authority over the decision. In the Act, Texas has done neither.

The Act imposes *no* standards on hospitals with respect to the admitting privileges process. Although under existing law hospitals in Texas must consistently apply whatever criteria they have in place for assessing privilege applications, they have broad discretion to set those criteria in the first instance.[18] Indisputably, Texas hospitals are free to adopt requirements that bear no relation whatsoever to the provision of safe abortion care. For instance, it is common for privileges to be extended only to those physicians who admit a minimum number of patients each year. *See* Ferrigno Decl. ¶ 11, Jordan Decl. ¶ 8. This requirement alone will prevent many

[17] Defendants' opposition brief misconstrues the crux of Plaintiffs' unlawful delegation claim by suggesting that Plaintiffs' challenge the admitting privilege requirement solely on the grounds that it transfers authority to private actors, that is, hospitals. *See* Defs. Br. at 38. The admitting privileges requirement is unconstitutional not because it delegates authority to private actors alone, but because it does so without ensuring that the private actors' discretion is properly constrained and subject to adequate review. Accordingly, several of the cases on which Defendants rely – *Currin v. Wallace*, 306 U.S. 1 (1939) and *United States v. Rock Royal Co-Operative*, 307 U.S. 533, 577 (1939) – are inapposite as they only support the undisputed proposition that, in some instances, delegation of government authority to private actors is constitutional.

[18] Texas law authorizes hospitals to develop their own rules for reviewing privilege applications so long as those rules, *inter alia*, are: "determined on a reasonable basis, such as the professional and ethical qualifications of the physician," Tex. Occ. Code § 151.051(a)(1); "based on reasonable standards," *id.* at § 151.051(a)(2); "applied without irrelevant considerations," *id.* at § 151.051(a)(3); "supported by sufficient evidence," *id.* at §151.051(a)(4); are not "arbitrary and capricious," *id.* at § 151.051(a)(5); do not "differentiate solely on the basis of the academic medical degree held by the affected physician," *id.* at § 151.051(a); or "den[y] membership or privileges on any ground that is otherwise prohibited by law," Tex. Health & Safety Code Ann. § 241.101(f). A physician may challenge a hospital's consideration of his or her application. *See* Tex. Health & Safety Code Ann. § 241.101(c) (incorporating the due process requirements set forth in 42 U.S.C. § 11101 *et seq*.)

of Plaintiffs' physicians from providing abortions because few, if any, of their patients require hospitalization. This is precisely the sort of arbitrary result that the nondelegation doctrine guards against: Since it would be unconstitutional for Texas to bar Plaintiffs from providing abortion solely because their physicians do not send a minimum number of patients to the hospital each year, it is equally impermissible for the state to delegate such an irrational power to a private entity.[19] *See Tucson Women's Clinic v. Eden*, 379 F.3d 531, 556 (9th Cir. 2004) (explaining that nondelegation doctrine prohibits State from delegating to a third party the power to prohibit abortion providers from providing abortions based on criteria that would be illegitimate for the state to act on itself); *Hallmark Clinic*, 380 F. Supp. 2d at 1158-59 ("The state cannot grant hospitals power it does not have itself.").

Moreover, the Act vests hospitals with largely unreviewable veto power over physicians' practices. This is the *sine qua none* of unconstitutional delegation and is sufficient in and of itself to render the admitting privileges requirement unconstitutional. *See, e.g.*, *Roberge*, 278 U.S. at 121-22 (finding violation of due process where "[t]here is not provision for review under the ordinance; [the private property owners'] failure to give consent is final"); *cf. Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 610 (6th Cir. 2006) (holding nondelegation doctrine inapplicable where state had ability to waive hospital transfer agreement requirement thus 'prevent[ing] the hospitals from having an unconstitutional third-party vet over [abortion clinic's] license"). Here, the delegation of state authority is particularly suspect because it is "legislative delegation in its most obnoxious form[,] for it is not even delegation to an official or

[19] Apart from admission requirements, the Ferrigno, Martinez, and Jordan declarations identify a range of requirements unrelated to a physician's capacity to provide quality outpatient abortion care. For instance, hospitals within thirty miles of Plaintiffs' clinics require that physicians, *inter alia*: live within a certain distance of the hospital, Ferrigno Decl. ¶ 11, Martinez Decl. ¶ 7, Jordan Decl. ¶ 8; perform a set number of deliveries and/or major OB/GYN surgeries, Ferrigno Decl. ¶ 12; or, teach and do regular rounds at the hospital, Martinez Decl. ¶ 7.

an official body, presumptively disinterested, but to private persons whose interests may be and often are adverse to the interests of others in the same business." *Carter v. Carter Coal*, 298 U.S. 238, 311 (1936); *see also Reizen*, 508 F. Supp. at 1375 ("The defect lies in the delegation of unguided power to a private entity, whose self-interest could color its decision to assist licensure of a competitor."). While hospitals likely do not view abortion providers as competition *per se*, they may well have interests adverse to those of the clinics, such as an institutional objection to abortion or simply an interest in *not* being associated with abortion. *See, e.g.*, *Jackson Women's Health Org.*, 2013 WL 1624365, at *4 (hospitals rejected the plaintiffs' applications "out of hand" simply because they found abortions "anathema to the[ir] policies"); *Pro-Choice Miss. v. Thompson*, No. 3:96-596, at *21 (S.D. Miss. Sept. 28, 1996) ("[A]s a practical matter, local pressure can and will be brought upon hospitals to deny these written transfer agreement to abortion providers. . . . [T]he hospitals then would have third-party vetoes over whether the abortion providers can obtain a license from the State of Mississippi.").

IV. The Medication Abortion Restrictions are Unconstitutional.

Defendants incorrectly argue that no disputed facts need be resolved in order to uphold the medication abortion restrictions. But Defendants bear the burden of proving that those restrictions actually advance the State's asserted interest in women's health, and they have not done that. Moreover, the Supreme Court has never upheld a ban like this –on a safe, early, and common method of abortion—and its cases suggest that such a ban is an undue burden. Finally, Plaintiffs are entitled to relief because these restrictions are both particularly harmful to women with certain medical conditions and impermissibly vague.

A. The Medication Abortion Restrictions Violate Women's Due Process Rights.

1. Defendants Have Failed to Show That the Medication Abortion Restrictions Advance Women's Health

Not only have Defendants failed to meet their burden to show that the medication abortion restrictions protect women's health, but Plaintiffs (who do not bear the burden of proof on this issue) have shown that these restrictions will *harm* women by imposing requirements that radically depart from widely accepted medical practice. *See* Pls. Br. at 14-15. The Act bans medication abortion entirely for some women (even those who for whom it is significantly safer) and forces those women who can still have one to use a less effective procedure with greater potential for side effects. *Id*. at 15. Most significantly, by requiring women to return to the facility to ingest the misoprostol, the Act creates the medically untenable situation of women beginning to bleed and cramp on their way home from the clinic. *Id.*

Defendants' claim that medication abortions are more dangerous than surgical procedures, Defs. Br. at 41, is based largely on the declaration of Dr. Donna Harrison,[20] who asserts that medication abortion has a high rate of complications, that the most commonly used evidence-based regimen (200 mg of oral mifepristone followed by 800 µg of buccal misoprostol) is not safe, and that women with conditions that make surgical abortion more risky, should not have medication abortions because, in the event that a surgical procedure is needed, it will be more difficult. Her opinions are unsupported and illogical, and should not be credited.[21] They are based on studies which are small, out of date, for which the protocols used for the medication abortions were not identified, and/or which present misleading information about the risks of

[20] Defendants' other "evidence" on this issue is a declaration from Abby Johnson who is not a medical professional at all. *See* Rebuttal Fine Decl. ¶ 39.

[21] A North Dakota judge, after observing Dr. Harrison testify and be cross examined on virtually identical opinions that she provides here, recently found: "Dr. Harrison's opinions lack scientific support, tend to be based on unsubstantiated concerns, and are generally at odds with solid medical evidence. To the extent she referenced published studies during her testimony, Dr. Harrison tended to present the results in an exaggerated or distorted manner." *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205, Mem. Opinion and Order for Perm. Inj. at 14 (Index of Caselaw Relied Upon in Plaintiffs' Motion for Preliminary Injunction no. 7).

medication abortion. *See* Suppl. Fine Decl. ¶¶ 25-29, 31.

Plaintiffs, on the other hand, rely on large recent U.S. studies using the regimen most commonly used today. One of those studies, which involved more than 230,000 women, showed a rate of clinically significant adverse events of 0.16 percent and a rate of blood loss requiring transfusion of just 0.05 percent (compared to Dr. Harrison's reported incidence of hemorrhage of 15.6 percent). This study also showed an ongoing pregnancy in only 0.5 percent (compared to Dr. Harrison's figure of 18.3 percent). Suppl. Fine Decl. ¶ 12. A second study shows that the evidence-based regimen used at Planned Parenthood health centers nationwide and in Texas results in surgery following medication abortion in less than 2 percent of cases (compared to Dr. Harrison's figure of 6 percent). *Id.* In short, Plaintiffs have provided overwhelming evidence of the safety—and superiority—of the regimens that the Act bans.

Defendants' belief that the Act's ban on using alternative, evidence-based regimens will prevent deaths from serious infections is similarly misplaced. While Dr. Harrison correctly states that there have been eight such deaths in the United States following a mifepristone medication abortion, she does not acknowledge that an estimated more than 1.75 million women have chosen that procedure, yielding an extremely low fatality rate of 0.0005 percent. Rebuttal Fine Decl. ¶ 34; Exh. C, Declaration of James Trussell, Ph.D. ("Trussell Decl.") ¶ 4. While none of these eight women followed the regimen on the Mifeprex label, none would be expected to as the deaths were so rare and that regimen is used so infrequently. Rebuttal Fine Decl. ¶ 35. The FDA, which has studied these deaths, has concluded that it "do[es] not know whether using Mifeprex and misoprostol caused these deaths" at all. *Id.* Moreover, concerned about these deaths, providers changed their practices and have now provided this Court with up-to-the minute research, involving nearly a million women, showing that a regimen substantially identical to the

one used most often today—and banned by the Act—has resulted in *no* deaths. *Id.* ¶ 37; Trussell Decl. ¶¶ 7-10.[22]

Finally, Dr. Harrison's opinions regarding women for whom medication abortion is significantly safer than surgical procedures are cruel. It is her opinion that women for whom surgical abortion is contraindicated should be denied a medication abortion because of the exceedingly small chance (0.5-2%) that they might need follow up surgery. Harrison Decl. ¶¶ 10-12; Rebuttal Fine ¶ 38.

2. The Medication Abortion Restrictions Are an Undue Burden.

Defendants' opposition to Plaintiffs' undue burden claim obfuscates Plaintiffs' actual claim. Plaintiffs do not allege a "constitutional right to self-abort" or that requiring a physician to administer misoprostol alone imposes an undue burden. *See* Defs. Br. at 38. Plaintiffs claim that the medication abortion restrictions impose an undue burden in two ways: (1) for women with gestational ages past 49 days LMP, they ban entirely a safe, common method of terminating an early pregnancy using medication alone; and (2) for women with gestational ages through 49 days LMP, the burdens of the restrictions that Texas has placed on medication abortion (with their extra trips and costs) are undue.

As to Plaintiffs' first claim, Defendants maintain, relying on *Gonzales*, that they can ban medication abortion as long as surgical abortion remains available. Defs. Br. at 39-40. But *Gonzales* did not give the State the blanket authority that Defendants seek to assert. Rather, the Court recognized that a ban on a method of abortion may survive so long as "reasonable

[22] Defendants also assert that the medication abortion restrictions are necessary to ensure "medical supervision" during the four to six hour period following ingestion of misoprostol – "the most painful and difficult part of a medical abortion." Defs. Br. at 41 (citing Harrison Decl. ¶¶ 30-32). But Dr. Harrison's statement the Mifeprex FPL "assumes" that the patient will remain at the health center for an observation period (Harrison Decl. ¶ 30) is not true. None of the FPL documents require an observation period. Rebuttal Fine Decl. ¶ 33.

alternative procedures" remain. 550 U.S. at 163. In upholding the so-called partial birth abortion ban, the *Gonzales* Court was comparing apples to apples—the D & E procedure and what the Court described as a "variation" of that procedure. *Id*. at 136. Here, surgical procedures are not a comparable alternative to medication abortion. Fine Decl. at ¶¶ 6-11, 50-54.

Defendants seek to foreclose Plaintiffs' claim by arguing that medication abortions make up only 26% of the abortions performed in Texas, and therefore, Plaintiffs have failed to establish that medication abortions are common enough that they cannot be prohibited. Defs. Br. at 40. But the relevant inquiry looks at the alternative procedures available at the same period of pregnancy as the prohibited method. *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 78 (1976) (striking down prohibition on the most commonly used method "after the first trimester"); *Stenberg v. Carhart*, 530 U.S. 914, 938-39 (2000) (striking down prohibition on most commonly used method during the second trimester). Plaintiffs have shown, and Defendants have not contested, that approximately half of the women eligible for medication abortions select that option. Fine Decl. ¶ 49. No Supreme Court case has ever upheld a ban on a method used by so many women and certainly one that does not leave a comparable method.

For a woman with a pregnancy through 49 days LMP, under the Act, she must make four separate trips to the health center, over an approximately two-week period, which will greatly increase her costs and her ability to access the procedure. Defendants simply dismiss this evidence because a 24-hour delay was upheld in *Casey*. Defs. Br. at 42. Neither *Casey*, nor any decision since, suggests that because one extra trip may be permissible (if justified by a valid State interest), additional trips (now amounting to four, some of which have no legitimate justification) are necessarily valid. Indeed, *Casey* itself cautions that "at some point increased cost could become a substantial obstacle." 505 U.S. at 901. Defendants have chosen not to rebut

Plaintiffs' evidence that it will be difficult for some and impossible for other women to make the additional trip to the health center, due to cost, child care responsibilities and work. Fine Decl. ¶ 70. In fact, to the extent they address them, Defendants look at each additional burden in isolation from the others, even though the totality of the burdens created by the restrictions are undue.

Defendants are also incorrect in asserting that *Mazurek* renders the medication abortion restrictions "constitutional *per se*" and thus wholly insulated from challenge. Defs. Br. at 39. As discussed *supra*, the *Mazurek* Court upheld a physician-only law because that plaintiff failed to present "sufficient evidence" that the law in fact posed a substantial obstacle to women seeking abortions. 520 U.S. at 971-72. Separately, the Court rejected a challenge that the law had an impermissible purpose, holding that Plaintiffs could not prevail on that claim just by showing that physician's assistants can safely provide abortions *Id.* at 974. The decision does not create or even suggest the *per se* constitutional rule asserted by Defendants.

Finally, Defendants rely on the Sixth Circuit's decision in *Planned Parenthood Southwest Ohio Region v. DeWine*, 696 F.3d 490 (6th Cir. 2012), which held that an Ohio law that requires mifepristone to be prescribed according to the FPL did not impose an undue burden. Plaintiffs maintain that holding was in error. However, even if it were not, the factual differences between the cases, which Defendants dismiss as "legally immaterial," Defs. Br. at 44 are highly relevant here. First, the factual record in *DeWine* is from 2004 when providers' experience with mifepristone was much more limited and different regimens were being used. That court, therefore, had none of the evidence about the safety of the alternative regimen used today that Plaintiffs have provided here. Moreover, the differing facts about the burdens placed on Plaintiffs' patients in Texas (which is 268,580 square miles and many women have to travel very

long distances to access abortion) versus Ohio (which is 44,825 square miles or 1/6th the size of Texas) do matter. *See, e.g., Tucson Woman's Clinic*, 379 F.3d at 541 ("*Casey* made clear that the 'substantial obstacle' standard for determining when a law poses an undue burden on the right to abortion is record-dependent.") (citing *Casey*, 505 U.S. at 901)).

Plaintiffs urge this Court instead to consider the two other cases considering laws similar to HB 2's medication abortion restrictions, both of which had a more full and up-to-date factual record. *Okla. Coal. for Reprod. Justice v. Cline*, 292 P.3d 27 (Okla. 2012), *cert. granted*, 133 S. Ct. 2887 (2013); *MKB Management Corp. v. Burdick*, No. 09-2011-CV-02205 (N. D. Dist. Ct. July 15, 2013). Like those courts, this Court should declare the medication abortions restrictions unconstitutional.

3. The Medication Abortion Restrictions Impermissibly Threaten Women's Health

Plaintiffs have shown that for women with certain medical conditions, medication abortion has significant safety advantages. Pls. Br. at 18. As discussed in Section IV.A.1, *supra*, Defendants' attempt to rebut this evidence is unavailing. Under longstanding precedent that prohibits the State from restricting access to abortions necessary to preserve the life or health of the pregnant woman, the medication abortion restrictions are invalid "as applied to those women for whom a medication abortion is necessary, in appropriate medical judgment, to protect their lives or health." *Ayotte*, 546 U.S. at 327-28; see also *Casey*, 505 U.S. at 879.

Defendants respond that, despite this precedent, Plaintiffs are not entitled to any relief because they have brought a facial challenge which is foreclosed by *Gonzales*. Defs. Br. at 42-43. But that is not true. On this claim, Plaintiffs are doing exactly what the *Gonzales* Court instructed: they have brought a pre-enforcement, as-applied challenge and shown "that in discrete and well-defined instances a particular condition has or is likely to occur in which the

procedure prohibited by the Act must be used." *Gonzales*, 550 U.S. at 167. In such a case, they are entitled to relief as applied to those circumstances. *Ayotte*, 546 U.S. at 967 ("[w]hen a statute restricting access to abortion may be applied in a manner that harms women's health," the question is not whether a remedy is available, but the scope of that remedy); . *see also DeWine*, 696 F.3d at 494 (noting that "a preliminary injunction is in place to cover the Act's failure to make an exception for circumstances involving the health and life of the mother"); *see also Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 511-12 (6th Cir. 2006).

Defendants' belief that "state officials will assuredly not punish" a physician who violates the Act if he or she provides a medication abortion to a woman whose life or health is endangered by pregnancy and for whom "a surgical abortion is impossible because of a medical condition," Defs. Br. at 43, is not an adequate remedy. *Cf. Stenberg*, 530 U.S. at 940 (cautioning against accepting "as 'authoritative' an Attorney General's interpretation of state law when 'the Attorney General does not bind the state courts or local law enforcement authorities'"). Not only is Defendants' statement not binding but it also misstates the applicable law in two significant respects. First, the Court's consideration of the circumstances under which a woman must have access to an otherwise prohibited medical procedure are not limited to conditions arising solely from the pregnancy. *Id*. at 945-46. Second, a surgical abortion need not be "impossible." The relevant precedent clearly holds that the State may not impose "significant health risks" on women seeking abortions. *See Gonzales*, 550 U.S. at 161 ("The prohibition in the Act would be unconstitutional, under precedents we here assume to be controlling, if it 'subject[ed] [women] to significant health risks.'") (quoting *Ayotte*, 546 U.S. at 327-28 (citing *Casey*, 505 U.S. at 879)). Because the Act fails this test as applied to those women for whom a medication abortion is necessary, in appropriate medical judgment, to protect their lives or health, Plaintiffs are

entitled to that narrow relief.

B. The Medication Abortion Restrictions Violate Plaintiffs' Due Process Rights Because They Are Impermissibly Vague

Defendants make no attempt to explain what the Act means when it allows physicians to follow the "dosage amounts" in the ACOG guidelines. Reading "dosage amount" to mean only the amount of the medications provided to the patient in the ACOG recommendation, without reference to the route of administration, leads to the absurd result that the Legislature intended to allow physicians to deviate from the FPL only with an untested protocol with no evidentiary support. Nevertheless, Defendants stand by this absurdity, Defs. Br. at 45, advocating that women should have an untested regimen while at the same time professing that the medication abortion restrictions are necessary to protect women's health.

Defendants further respond that even if the provision is vague, the only option for this Court is to sever it, leaving compliance with the FPL protocol Plaintiffs' only option. Defs. Br. at 45. This is incorrect. As they note in response to the vagueness claim regarding "active" admitting privileges, "federal courts must construe state statutes to avoid constitutional problems." Defs. Br. at 37 (citing *Ohio v. Akron Cntr. for Reprod. Health*, 497 U.S. 502, 514 (1990)). Here, the Court should consider the reasonable construction that, in order to give effect to the provision, the phrase "dosage amount," should be construed to encompass the full regimen that goes with the dosage amounts in the ACOG guidelines. If that construction cannot be reached, the medication abortion provisions must be declared unconstitutionally vague.

V. Defendants' Request to Dismiss the Attorney General Should Be Denied.

The Attorney General is a proper defendant. He is the State's chief law officer. Tex. Const. art. IV, §22 ("The Attorney General... shall ... from time to time, in the name of the State, take such action in the courts as may be proper and necessary to prevent any private corporation

from exercising any power ... not authorized by law [and] ... perform such other duties as may be required by law."); *Agey v. Am. Liberty Pipe Line Co.*, 172 S.W.2d 972, 974 (Tex. 1943) ("The Attorney General is the chief law officer of the State, and it is incumbent upon him to institute in the proper courts proceedings to enforce or protect any right of the public that is violated."). He may sue to enjoin unlawful conduct that would harm a public interest. *State v. Sw. Bell Tel. Co*., 526 S.W.2d 526, 531 (Tex. 1975); *see also State v. Paris Ry. Co.*, 55 Tex. 76, 1881 WL 9744, at *3 (Tex. 1881) (suit to enjoin railway company from acting unlawfully); *Bachynsk v. State*, 747 S.W.2d 847, 870 & n.9 (Tex. App.–Dallas 1988, writ denied) (suit against doctor and clinics for prescribing drug not approved by FDA).

Plaintiffs disagree that the Act is in the public interest, but the Attorney General would certainly invoke his constitutional power to enjoin abortion providers if they violated the Act.[23] Also, the Act contemplates his. Tex. Health & Safety Code § 171.064(a) (authorizing penalty under Tex. Occ. Code ch. 165); Tex. Occ. Code § 165.101(a) (attorney general "may institute an action for a civil penalty[.]"). Thus, the Attorney General is a proper defendant: he would be involved in enforcement of the Act. *See Ex parte Young*, 209 U.S. 123, 157 (1908).

CONCLUSION

For the foregoing reasons as well as those in Plaintiffs' opening brief, their witnesses declarations, and the testimony to be presented at trial, this Court should declare unconstitutional the Act's admitting privileges requirement and restrictions on medication abortion and permanently enjoin them.

[23] In fact, the Attorney General has relied on these same authorities in another case to argue he had authority to enforce a statute that did not expressly grant him enforcement power. *See* Brief of Amicus Curiae the State of Texas in *Brown v. de la Cruz*, 156 S.W.3d 560 (Tex. 2004), *available at* 2004 WL 825118, at *5-7.

Dated: October 18, 2013

Respectfully submitted,

/s/R. James George, Jr.

R. James George, Jr.
Texas State Bar No. 07810000
Elizabeth von Kreisler
Texas State Bar No. 24047273
Rico Reyes
Texas State Bar No. 24032999
George Brothers Kincaid & Horton LLP
1100 Norwood Tower
114 West 7th Street
Austin, TX 78701
(512) 495-1400
(512) 499-0094 (facsimile)
jgeorge@gbkh.com
evonkreisler@gbkh.com
rreyes@gbkh.com

Attorneys for all Plaintiffs

Janet Crepps
Esha Bhandari
Jennifer Sokoler
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(864) 962-8519 (Janet Crepps)
(917) 637-3600 (Bhandari & Sokoler)
jcrepps@reprorights.org
ebhandari@reprorights.org
jsokoler@reprorights.org

Attorneys for Plaintiffs Whole Woman's Health, Austin Women's Health Center, Killeen Women's Health Center, Southwestern Women's Surgery Center, West Side Clinic, Inc., Alan Braid, M.D., Lamar Robinson, M.D., and Pamela J. Richter, D.O.

Helene T. Krasnoff
Alice Clapman
Planned Parenthood Federation of America
1110 Vermont Avenue, N.W., Suite 300
Washington, D.C. 20005
(202) 973-4800
helene.krasnoff@ppfa.org
alice.clapman@ppfa.org

Attorneys for Planned Parenthood Plaintiffs

Brigitte Amiri
Renée Paradis
American Civil Liberties Union Foundation
Reproductive Freedom Project
125 Broad Street, 18th Floor
New York, NY 10004
(212) 519-7897
bamiri@aclu.org
rparadis@aclu.org

Rebecca L. Robertson
Texas Bar No. 00794542
American Civil Liberties Union of Texas
1500 McGowen Street, Suite 250
Houston, TX 77004
(713) 942-8146
rrobertson@aclutx.org

Attorneys for Plaintiffs Routh Street Women's Clinic, Houston Women's Clinic, and Southwestern Women's Surgery Center

CERTIFICATE OF SERVICE

I certify that on this 18th day of October, 2013, I electronically filed a copy of the above document with the Clerk of Court using the CM/ECF system, which will send notification to the following counsel of record.

Jonathan F. Mitchell
Solicitor General
Arthur C. D'Andrea
Assistant Solicitor General
Michael P. Murphy
Assistant Solicitor General
Beth Klusmann
Assistant Solicitor General
Philip A. Lionberger
Assistant Attorney General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
Attorneys for Gregory Abbott, David Lakey, M.D., Mari Robinson

/*s/ R. James George, Jr.*
R. JAMES GEORGE, JR.