IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES, PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, D/B/A PLANNED PARENTHOOD GREAT PLAINS, STEPHANIE HO, M.D., and THOMAS TVEDTEN, M.D., on behalf of themselves and their patients,

Plaintiffs,

v.

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas; LARRY JEGLEY, in his official capacity as Prosecuting Attorney of Pulaski County; MATT DURRETT, in his official capacity as Prosecuting Attorney of Washington County; SYLVIA D. SIMON, M.D., in her official capacity as Chairman of Arkansas State Medical Board; ROBERT BREVING JR., M.D., VERYL D. HODGES, D.O., JOHN H. SCRIBNER, M.D., OMAR T. ATIQ, M.D., RHYS L. BRANMAN, M.D., RODNEY GRIFFIN, M.D., MRS. MARIE HOLDER, BRIAN T. HYATT, M.D., MR. LARRY D. "BUDDY" LOVELL, TIMOTHY C. PADEN, M.D., DON R. PHILLIPS, M.D., WILLIAM L. RUTLEDGE, and M.D., DAVID L. STAGGS, M.D., in their official capacities as officers and members of the Arkansas State Medical Board, and NATHANIEL SMITH, M.D., M.P.H., in his official capacity as Director and State Health Officer of the Arkansas Department of Health,

Defendants.

FILED
U.S. DISTRICT COURT
EASTERN DISTRICT ARKANSAS
JUN 26 2019
JAMES W. McCORMACK, CLERK
By:
DEP CLERK

CIVIL ACTION
Case No. 4:19cv449-BRW

BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

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PRELIMINARY STATEMENT[1]

Plaintiffs seek emergency relief that will preserve the status quo—that is, their ability to continue providing safe, compassionate, quality, pre-viability abortion care to women in Arkansas, as they have done for decades. Two of the three laws that Plaintiffs are challenging blatantly flout long-standing, binding Supreme Court and Eighth Circuit precedent: the laws impermissibly ban pre-viability abortions outright (i) beginning at a wholly arbitrary point in pregnancy (18 weeks), and (ii) in cases where a physician has "knowledge" that a woman seeks abortion care because of a Down syndrome diagnosis, test result, or any other reason to believe the fetus has Down syndrome. The third challenged law places medically unjustified limitations on the category of clinicians who may perform abortions in the State, again in violation of Supreme Court and Eighth Circuit precedent. This law's enforcement would severely restrict the availability of abortions in the State, including by leaving women who are more than 10 weeks pregnant with no Arkansas abortion provider, and it would further no legitimate state interest. None of the challenged laws is constitutional, and without emergency relief from this Court before July 24, 2019, they will impose immediate and devastating restrictions on women's access to abortion care.

Plaintiffs Little Rock Family Planning Services ("LRFP") and Planned Parenthood of Arkansas & Eastern Oklahoma, d/b/a Planned Parenthood Great Plains ("PPAEO") operate the only three remaining abortion providers in the State. Plaintiff Dr. Stephanie Ho is a board-certified family-medicine doctor at PPAEO's Fayetteville clinic. Although she is a highly trained physician who has safely provided abortion care for nearly a decade, Dr. Ho will be prohibited from doing so under Arkansas's newly enacted and capricious requirement that

[1] Unless otherwise indicated, all emphasis is added and all internal citations and quotations are omitted.

anyone providing abortion care in the State be a board-certified or board-eligible obstetrician/gynecologist ("OBGYN"). Plaintiff Dr. Thomas Tvedten is a family-medicine doctor licensed to practice in Arkansas and is the part owner and Medical Director of LRFP. Although he is a highly trained physician who has safely provided abortion care for more than three decades, Dr. Tvedten will also be prohibited from doing so under Arkansas's new requirement—as will another provider of abortion care at LRFP, Dr. Thomas Horton.

In recent years, Arkansas has engaged in a targeted campaign against abortion care and the women who need it, enacting ***more than 25 laws*** aimed at obstructing and interfering with women's access to abortion care in this State, including at least 12 enacted in 2019 alone. The three restrictions that Plaintiffs are challenging here are the latest in the unrelenting campaign to deny women the health care they seek and to which they are constitutionally entitled:

- Act 493 of 2019 (the "18-Week Ban") bans abortions "where the pregnancy is determined to be greater than 18 weeks," as measured from the first day of a woman's last menstrual period ("LMP"),[2] even though viability is medically impossible at 18-weeks LMP, and for weeks thereafter, *see* Ex. 1;

- Act 619 of 2019 (the "Reason Ban") criminalizes any abortion, if the provider has "knowledge" that a woman's decision to terminate her pregnancy is based "solely" on a Down syndrome diagnosis, test result, or any other reason to believe the fetus as Down syndrome, *see* Ex. 2; and

- Act 700 of 2019 (the "OBGYN Requirement") requires all abortion providers to be board-certified or board-eligible OBGYNs, even though there is absolutely no medical justification for this arbitrary requirement and it would severely limit abortion access in the State, *see* Ex. 3.

The 18-Week Ban and the Reason Ban (together, the "Bans") fly in the face of more than four decades of unbroken Supreme Court precedent holding that a state may not ban abortion before the point of fetal viability. As the Supreme Court has repeatedly explained: "Before

[2] This statutory language is referenced in this brief as "after 18 weeks," which includes 18.1 weeks LMP and later stages of pregnancy.

viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *see also Roe v. Wade*, 410 U.S. 113 (1973). In fact, in reliance on *Roe*, the Eighth Circuit already invalidated an earlier Arkansas law that banned nearly all abortions starting at 12 weeks LMP, observing that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (quoting *Casey*, 505 U.S. at 879)). Ignoring this clear instruction, Arkansas seeks to run roughshod over controlling Supreme Court and Eighth Circuit precedent affirming *Roe*'s central holding.

The OBGYN Requirement is also unconstitutional under binding Supreme Court precedent because it confers ***no*** medical or safety benefit, and yet imposes an enormous burden on women's ability to access abortion. The Requirement serves no justifiable medical or health purpose because training, not specialty, is what determines a clinician's competence to provide safe abortion care. Leading medical organizations, including the American College of Obstetricians and Gynecologists, confirm as much, as does the fact that both non-OBGYN physicians and non-physician clinicians (such as midwives, nurse practitioners, and physician assistants) have safely and effectively provided compassionate abortion care across the country for decades. At the same time, the OBGYN Requirement would have a grave effect on women's health care in Arkansas. The three physicians who would be precluded from continuing to provide care have consistently provided ***nearly 90%*** of the abortions obtained in this State. Neither LRFP nor PPAEO has identified adequate replacements for their providers who are not board-certified or -eligible in OBGYN, despite numerous efforts to do so. The OBGYN Requirement would almost certainly force LRFP to close its doors, leaving Arkansas with ***no***

provider of abortions after 10 weeks LMP. But even if LRFP managed to stay open while providing only extremely limited care, the OBGYN Requirement would still prevent approximately 62% of the women who annually seek abortion care in Arkansas from obtaining in Arkansas the care that they otherwise would. These women would therefore be forced to attempt to obtain care outside the medical system, carry their pregnancies to term against their will, or travel ***hundreds of miles*** to different providers, embarking on a burdensome odyssey laden with economic and logistical obstacles that may be impossible to overcome or significantly delay care. As the Supreme Court recently reinforced in *Whole Woman's Health v. Hellerstedt* ("*WWH*"), laws (like the OBGYN Requirement) that significantly reduce the number of available abortion providers in a state, and force women to travel long distances to obtain abortion care yet have no offsetting health benefit unduly burden the right to access abortion care and cannot stand. *See* 136 S. Ct. 2292, 2309–18 (2016).

In short, together and individually, these three laws will unconstitutionally ban and burden the right to abortion. Plaintiffs therefore seek emergency injunctive relief to block the enforcement of these laws. In view of the immediate, irreparable harm that these laws would cause beginning on July 24, 2019, Plaintiffs respectfully request that the Court act on an expedited basis.

STATEMENT OF FACTS[3]

Background: Abortion In Arkansas Is Already Extremely Safe, And Is Available At Only Three Clinics

A. Abortion Practice and Safety.

There are two types of abortion procedures: medication and surgical. Medication abortion is a method of ending pregnancy by taking medications that cause the woman to undergo a process similar to an early miscarriage.[4] Despite its name, "surgical" abortion is not a typical surgical procedure, because it does not involve any incision.[5] Rather, it involves the use of suction and instruments to gently evacuate the contents of the uterus.[6]

Legal abortion is one of the safest medical procedures available in the United States.[7] In fact, it is significantly safer for a woman than carrying a pregnancy to term and giving birth.[8] And, as the Supreme Court recently affirmed, it is "safer than numerous procedures that take place outside hospitals," with complication rates that are far lower than the complication rate of other common medical procedures. *WWH*, 136 S. Ct. at 2315 (observing that childbirth's mortality rate is fourteen times that of abortion). In fact, abortions are safer than adult tonsillectomies and colonoscopies.[9] One recent, comprehensive report by the National Academies of Sciences, Engineering, and Medicine, which Congress established to provide objective advice on matters relating to science and technology, determined that the risks

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[3] This brief refers to "women," but the challenged statutes also inflict irreparable harm on members of transgender and gender non-binary communities who likewise need access to abortion services.
[4] Ho Decl. ¶ 15.
[5] Williams Decl. ¶14; Prine Decl. ¶ 11; Hopkins Decl. ¶ 25.
[6] Williams Decl. ¶14; Prine Decl. ¶ 11; Hopkins Decl. ¶ 25.
[7] *See, e.g.*, National Academy of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, S-8 (The National Academies Press 2018) ("National Academy Consensus Study Report"); Hopkins Decl. ¶ 21; Prine Decl. ¶ 17; Ho Decl. ¶16.
[8] National Academy Consensus Study Report at 11, 74–75; Hopkins Decl. ¶ 28; Prine Decl. ¶ 17; Ho Decl. ¶ 20.
[9] National Academy Consensus Study Report at 75; Hopkins Decl. ¶ 28.

associated with medication abortion are similar to those associated with over-the-counter anti-inflammatory drugs such as ibuprofen.[10] The same report also determined that the risks associated with surgical abortion are extremely low, with the risk of complications being in the 0–to–5% range.[11]

In addition to being extremely safe, legal abortion is also common: approximately one in four women in this country will have an abortion by age forty-five.[12] Women seek abortions for a multitude of diverse, complex, and interrelated reasons that are intimately linked to the individual woman's values and beliefs, culture and religion, health status and reproductive history, familial situation, educational and career goals, and resources and economic stability.[13] Some women have abortions because they conclude that it is not the right time to become a parent given their age, their desire to pursue their education or career, or their lack of the necessary financial resources, partner or familial support, or stability.[14] A majority of women having abortions in the United States already have at least one child;[15] as of 2017, approximately 65% of Arkansas abortion patients had one or more previous live births.[16] These women may already be struggling to provide for their existing children and may be concerned about their ability to make ends meet if they add another child to their family.[17]

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[10] National Academy Consensus Study Report at 79.
[11] National Academy Consensus Study Report at 60.
[12] Hopkins Decl. ¶ 21; *see also* News Release, Guttmacher Institute, Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates (Oct. 19, 2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.
[13] Hopkins Decl. ¶ 22; Williams Decl. ¶ 10.
[14] Hopkins Decl. ¶ 22; Williams Decl. ¶ 10.
[15] Hopkins Decl. ¶ 21; *see also* Guttmacher Institute, Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, (May 2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.
[16] *See* Arkansas Department of Health, Induced Abortions Data, 2017, Induced Abortions by Number of Previous Live Births, https://www.healthy.arkansas.gov/images/uploads/ pdf/2017_ITOP_Report.pdf.
[17] Hopkins Decl. ¶ 22; Ho Decl. ¶¶ 35-36; Williams Decl. ¶ 10.

While the vast majority of women who seek abortion care in Arkansas (as in the nation as a whole) do so in the first trimester, i.e., within the first 13 weeks LMP,[18] women also seek pre-viability abortions in the second trimester, including at and after 18 weeks LMP.[19] They do so for all the reasons described above, often coupled with decisional and logistical hurdles that result in delay. Some patients may experience several weeks of delay in accessing abortion care while they confirm their pregnancies, research their options, and decide to seek an abortion.[20] Other patients seek an abortion at or after 18 weeks LMP because they discover a fetal anomaly that could not have been detected or confirmed sooner.[21] In these circumstances, a woman may arrive at her decision to obtain an abortion only after having been referred to multiple specialists and subjected to significant testing, and having taken additional time for consultation to ensure that she is making the right decision for herself and her family.[22] Still other patients seek abortions at or after 18 weeks LMP because of one or more pregnancy-related health concerns or risks that only emerge (or worsen) at that point in time.[23]

The majority of women who obtain abortion care in the United States are poor or low income, and poverty is a significant problem in Arkansas, the country's fifth-poorest state.[24] Abortion patients, including LRFP's and PPAEO's, frequently suffer delay in locating a provider of abortion services; in struggling to obtain the funds to pay for the procedure, transportation to and from appointments, and child-care expenses; and in obtaining time off work to attend

[18] Williams Decl. ¶ 15; *see also Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1036 (E.D. Ark. 2017) ("*Jegley II*").
[19] Williams Decl. ¶ 21.
[20] Williams Decl. ¶ 25.
[21] Williams Decl. ¶ 10; Stuebe Decl. ¶ 27.
[22] Williams Decl. ¶¶ 29–30; Stuebe Decl. ¶ 28.
[23] Williams Decl. ¶¶ 25–26; Stuebe Decl. ¶ 10.
[24] Katz Decl. ¶ 13.

appointments.[25] Many women, particularly those who are low-income, fear losing their jobs (or sacrificing their privacy) by asking for time off.[26] Any delay is compounded by Arkansas's mandate that each patient make two trips to the clinic separated by at least 48—soon to be 72—hours before they can receive abortion care.[27] Although abortion is safer than carrying a pregnancy to term, delay in seeking abortion care increases the risks associated with the procedure.[28]

B. Arkansas Abortion Providers and Their Patients.

LRFP and PPAEO are the only two entities in Arkansas providing abortion care.[29]

LRFP

LRFP has operated a reproductive health-care clinic providing abortion services in Little Rock since 1973. It offers an array of women's health-care services, including procedures that are similar to abortion care for patients whose pregnancies end in miscarriage, as well as basic gynecological care, including pap smears, STD testing, and contraceptive counseling and services.[30] It currently provides medication abortion up to 10 weeks LMP and surgical abortion up to twenty-one weeks and six days ("21.6") LMP,[31] which is before any pregnancy can be viable.[32] While the vast majority of abortions provided at LRFP are first-trimester procedures,

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[25] Williams Decl. ¶ 25; Katz Decl. ¶¶ 38-48.
[26] Williams Decl. ¶ 24; Katz Decl. ¶ 39.
[27] On April 20, 2019, Arkansas enacted a new law requiring a 72-hour delay between a woman's consultation with a doctor concerning a possible abortion and any abortion procedure, except where it "will cause substantial and irreversible impairment of a major bodily function." 2019 Ark. Acts 801, *codified at* Ark. Code §§ 20-16-1109, -1703(b), -1706. This law goes into effect at the same time as the three laws challenged here—July 24, 2019.
[28] Hopkins Decl. ¶¶ 30–34; Williams Decl. ¶ 26; Ho Decl. ¶16.
[29] Williams Decl. ¶ 12; *see also Planned Parenthood Ark. & E. Okla. v. Jegley*, 2016 WL 6211310, at *2 (E.D. Ark. Mar. 14, 2016) ("*Jegley I*") ("Arkansas women are currently able to access abortion at three health centers in the State: two in Little Rock and one in Fayetteville."), *rev'd on other grounds*, 864 F.3d 953 (8th Cir. 2017) ("*Jegley III*").
[30] Williams Decl. ¶ 12.
[31] Williams Decl. ¶ 14; Prine Decl. ¶ 10-11; Hopkins Decl. ¶ 34.
[32] Hopkins Decl. ¶ 34.

the clinic also provides care for hundreds of women in need of second-trimester abortion services each year.[33] In 2018, LRFP provided 170 abortions after 18 weeks LMP.[34]

The great majority of LRFP's abortion services are provided by two clinicians: Dr. Thomas Tvedten and Dr. Thomas Horton. Dr. Tvedten is not an OBGYN and cannot become a board-certified or board-eligible OBGYN without the enormous outlay of time and expense required to restart medical training after decades of safely providing care to patients in Arkansas.[35] Dr. Horton completed his residency in OBGYN, but he is neither board-eligible nor board-certified, because he dedicated his practice to providing abortion care, and being a board-eligible or board-certified OBGYN is simply not necessary to provide that care. He too cannot become a board-eligible or board-certified OBGYN without taking significant time away from his patients and professional responsibilities, which he cannot do.[36] Together, Drs. Tvedten and Horton have provided 94% of the abortion care at LRFP over the past three years.[37] They receive assistance approximately once every other month from Dr. Fred Hopkins, a board-certified OBGYN who lives in California.[38] Dr. Hopkins is unable to increase his patient volume at LRFP because of significant, full-time professional obligations in California, including his role as an Associate Clinical Professor at Stanford University Medical School, where he trains post-residency Family Planning fellows.[39]

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[33] Williams Decl. ¶ 21.
[34] Williams Decl. ¶ 21.
[35] Tvedten Decl. ¶ 23.
[36] Horton Decl. ¶ 23.
[37] Horton Decl. ¶ 11-13.
[38] Hopkins Decl. ¶ 1.
[39] Hopkins Decl. ¶ 47.

PPAEO

PPAEO operates health centers in Little Rock and Fayetteville, and PPAEO or predecessor organizations have provided high-quality reproductive health care in Arkansas for more than 30 years.[40] PPAEO offers a number of health-care services, including well-woman exams, testing and treatment for sexually transmitted infections, provision of birth control and emergency contraception, HIV testing, pregnancy testing, screening for vaginal infections, human papillomavirus ("HPV") vaccinations, and transgender care.[41]

Since 2008, PPAEO has provided medication abortions to women up to 10 weeks LMP.[42] Dr. Ho, a board-certified family-medicine doctor, is the only physician providing care at PPAEO's Fayetteville clinic. As a family-medicine doctor, Dr. Ho is neither a board-certified OBGYN nor eligible for such certification.[43] She could not become such without abandoning her patients and practice to begin her medical training anew—which, as an established physician providing high-quality services for many years, she cannot do.[44]

PPAEO Little Rock employs two board-certified OBGYNs who provide medication abortions, Dr. Janet Cathey and Dr. Dudley Rodgers, neither of whom is able to travel to treat PPAEO Fayetteville's patients.[45]

LRFP's and PPAEO's Non-Directive Counseling

Before providing an abortion, LRFP and PPAEO provide non-directive patient counseling to each patient, during which they listen to, support, and provide information to the

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[40] Ho Decl. ¶ 9.
[41] Ho Decl. ¶ 9.
[42] Ho Decl. ¶ 3.
[43] Ho Decl. ¶ 7.
[44] National Academy Consensus Study Report at 117–18.
[45] Cathey Decl. ¶ 4.

patient, without directing her course of action.[46] That process is designed to ensure that patients are well informed with respect to all their options, including terminating the pregnancy, carrying to term and parenting, and carrying to term and placing the baby for adoption.[47] Although some of Plaintiffs' patients disclose information about the reasons they are seeking an abortion, Plaintiffs, following standard medical practice, do not require patients to disclose any or all of their reasons for seeking an abortion.[48]

The Challenged Laws and Their Impact

The 18-Week Ban

A. Act 493 (The 18-Week Ban)

The 18-Week Ban amends Arkansas Code Title 20, Chapter 16 to add an additional Subchapter 20 that bans abortion after 18 weeks LMP in almost all cases. *See* Act 493, § 20-16-2004(b). Specifically, the Ban prohibits a person from "intentionally or knowingly" performing, inducing, or attempting to perform or induce an abortion, if the probable gestational age is determined "to be greater than eighteen (18) weeks' gestation," as measured "from the first day of the last menstrual period of the pregnant woman." *Id.* § 20-16-2004(b); *id.* § 20-16-2003(9).

Act 493 includes only two limited exceptions: (1) in the case of a "medical emergency," narrowly defined as "a condition that, on the basis of the physician's good-faith clinical judgment, necessitates an abortion to preserve the life of the pregnant woman whose life is endangered by a physical [condition] . . . or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function," *Id.* § 20-16-2004(b); *id.* § 20-16-2003(6) (7); and (2) where the pregnancy is the result of rape or incest, as

[46] Williams Decl. ¶ 8; *see also* Ho Decl. ¶ 14.
[47] Williams Decl. ¶ 8; *see also* Ho Decl. ¶ 14.
[48] Williams Decl. ¶ 29; *see also* Ho Decl. ¶ 14.

defined by Arkansas code, *id.* § 20-16-2004(b).[49] The Ban contains no exception for the many cases where failure to perform an abortion risks serious harm to a woman's health (physical or mental) or well-being, without clearly rising to the level of causing "substantial and irreversible impairment of a major bodily function." *Id.*[50]

Violation of the 18-Week Ban constitutes a Class D felony, which is punishable by up to six years in prison and a fine of up to $10,000. *See id.* §§ 5-4-201, -401, 20-16-2006(a)(1). Any physician who violates the Ban is also subject to mandatory license suspension or revocation by the Arkansas State Medical Board. *See id.* § 20-16-2006(b)

B. The Impact of the 18-Week Ban

If the 18-Week Ban is permitted to take effect, almost all of LRFP's patients seeking pre-viability abortion services after 18 weeks LMP will be outright prohibited from obtaining the constitutionally protected health care they require. LRFP will provide abortion care to patients with pregnancies past 18 weeks LMP only if it can determine that one of the few, narrow legal exceptions applies.[51] Notably, these exceptions would not permit LRFP to provide care for a woman who suffers from medical complications or who faces health risks that do not constitute a "medical emergency," as defined as a threat of either death or "a ***serious*** risk of ***substantial and irreversible impairment*** of a major bodily function," Act 493, § 20-16-2004(b). Accordingly,

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[49] Pre-existing sections in Arkansas' Administrative Code require physicians performing abortions in cases of rape or incest who seek Medicaid reimbursement to (1) determine that the pregnancy is the result or rape or incest, (2) complete a certification form certifying that the pregnancy resulted from forcibly compelled sexual intercourse or incest as defined by the Arkansas code, (3) obtain the patient's or her guardian's signature on the certification form, (4) contact the Department of Human Services to obtain prior authorization for the abortion procedure as required in the Arkansas Medicaid Physician's Manual, (5) provide any additional information requested by the state agency, and (6) after the procedure, submit the claim and required documentation, including patient history and physical examination records, for payment. *See* Ark. Admin. Code 016.06.3-216.120 *see also id.* 016.06.36-261.260

[50] The 18-Week Ban also imposes new reporting mandates to ensure compliance. It requires physicians who provide abortions after 18 weeks LMP to file a report with the Department of Health, detailing the statutory justification for the abortion. *Id.* § 20-16-2003(c)(1)-(2).

[51] Williams Decl. ¶¶ 20, 22.

LRFP will be forced to turn away women even in cases where doing so is against its physicians' best medical judgment and will cause harm to the patient that falls short of the narrow medical emergency exception. The Ban would likewise require LRFP to refuse care to Arkansas women who receive at or around 18 weeks LMP the devastating news of a severe anomaly and make the deeply personal decision to terminate the pregnancy, based on their individual values, beliefs, and circumstances.[52]

The Reason Ban

A. Act 619 (The Reason Ban)

The Reason Ban amends Arkansas Code Title 20, Chapter 16 to add an additional Subchapter 20 that (among other things) prohibits a physician from intentionally performing or attempting to perform an abortion "with the knowledge" that a pregnant woman is seeking an abortion "solely on the basis" of: (1) a test "indicating" Down syndrome; (2) a prenatal diagnosis of Down syndrome; or (3) "[a]ny other reason to believe" the fetus has Down syndrome. Act 619, § 20-16-2003.[53]

The Ban exempts a physician from its rigid requirements in only a few narrow cases, including: (1) when an abortion is necessary to save the life or preserve the health of the pregnant woman, *id.* § 20-16-2002(1)(B)(i); and (2) when the pregnancy resulted from rape or

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[52] Stuebe Decl. ¶ 28.

[53] Act 619 defines "Down syndrome" as "a chromosome disorder associated with either: (A) An extra copy of the chromosome 21, in whole or in part; or (B) An effective trisomy for chromosome 21." *Id.* § 20-16-2002(2). The Reason Ban also mandates that the physician ask the pregnant woman if she is aware of any test results, prenatal diagnosis, or any other evidence that the fetus may have Down syndrome. *See* Act 619, § 20-16-2003(b)(1). If the woman answers in the affirmative, the physician must: (1) inform the woman that Arkansas law prohibits abortion solely on the basis of an indication, diagnosis or belief that the fetus has Down syndrome, *id.* § 20-16-2003(b)(2)(A), and (2) request the medical records of the pregnant woman relevant to determining whether she has previously obtained an abortion after she became aware of any indication that the fetus might have Down syndrome, *id.* § 20-16-2003(b)(2)(B). Moreover, the clinician "shall not perform an abortion until the physician spends at least fourteen (14) days to obtain the medical records." *Id.* § 20-16-2003(b)(3).

incest, *id.* § 20-16-2003(d).[54] Violation of the Ban constitutes a Class D felony, which is punishable by up to six years in prison and a fine of up to $10,000. Ark. Code Ann. §§ 5-4-201, -401; Act 619, § 20-16-2004. In addition, the Ban requires that the Arkansas State Medical Board revoke the license of a physician who violates its mandate, Act 619, § 20-16-2005(c), and makes that physician liable in a civil action for actual and punitive damages to "any woman who receives an abortion in violation of [the Ban]. . . , the parent or legal guardian of the woman if the woman is an [unemancipated] minor, or the legal guardian of the woman if the woman has been adjudicated incompetent," *id.* § 20-16-2004(b)(1)-(2).

B. Down Syndrome

Down syndrome is a common name for a genetic anomaly that exists when an individual has an extra copy (full or partial) of the twenty-first chromosome.[55] The range of medical conditions and abilities can vary widely for people with Down syndrome, and they may require significantly more care than individuals born without this condition, sometimes through adulthood.[56] A variety of "screens" and more accurate diagnostic tests can help detect genetic, chromosomal, or structural anomalies like Down syndrome.[57] But no screens are available before 10 weeks LMP,[58] and most women do not receive a confirmed Down syndrome diagnosis until the second trimester.[59]

Women who receive a positive Down syndrome test result or diagnosis are typically referred by a high-risk OBGYN to a genetic counselor for significant counseling.[60] Counseling

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[54] *See supra* n.49.
[55] Stuebe Decl. ¶ 13.
[56] Stuebe Decl. ¶ 15.
[57] Stuebe Decl. ¶ 17.
[58] Stuebe Decl. ¶ 22.
[59] Stuebe Decl. ¶ 25.
[60] Stuebe Decl. ¶¶ 11, 19.

is intended to provide comprehensive, objective, and individualized counseling that addresses both the scientific aspect of any test result or diagnosis (e.g., their reliability) and the psychological effects of the result or diagnosis on the woman and any family members involved in her decision making.[61] A woman grappling with a Down syndrome diagnosis or another fetal anomaly is facing an extraordinarily complex decision that she should be able to make through self-reflection and discussion with anyone whom she chooses to involve in the process (such as her spouse, partner, friend, or family member).[62] It is critically important that women have the information and support they need to make this serious decision, and also the ability to terminate a pregnancy safely, if that is what they decide is best for them.[63]

C. The Impact of the Reason Ban

LRFP is aware that a small percentage of its patients seek abortions after receiving a fetal diagnosis or test indicating a fetal anomaly, including Down syndrome.[64] Although LRFP (consistent with best medical practices)[65] does not require its patients to disclose the reason or reasons they are seeking an abortion,[66] patients with an indication of a fetal anomaly sometimes mention this fact when they call to make an appointment, during the informed-consent and nondirective discussion, or to other physicians who refer patients to LRFP.[67] LRFP may also learn about the Down syndrome indication from the patient's medical records.[68]

If the Reason Ban is allowed to take effect, to avoid criminal penalties and adverse licensing and disciplinary sanctions, LRFP and its physicians and staff will cease providing

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[61] Stuebe Decl. ¶ 11.
[62] Stuebe Decl. ¶ 28.
[63] Stuebe Decl. ¶ 11.
[64] Williams Decl. ¶¶ 29–30; Tvedten Decl. ¶ 44.
[65] Williams Decl. ¶ 10; Tvedten Decl. ¶ 44.
[66] Williams Decl. ¶ 10.
[67] Williams Decl. ¶ 29.
[68] Williams Decl. ¶ 29.

abortions when they have "knowledge" that a woman is seeking an abortion "solely" on the basis of a test result, prenatal diagnosis, or other evidence indicating that the fetus has Down syndrome.

The OBGYN Requirement

A. Act 700 (The OBGYN Requirement)

Under current law, a "physician licensed to practice medicine in the State of Arkansas" may provide abortion care. See Ark. Code Ann. § 5-61-101(a). Act 700 amends Arkansas Code Title 20, Chapter 16 to add Section 605, which prohibits clinicians from providing abortions unless they are "a physician licensed to practice medicine in the state of Arkansas" who is "board-certified or board-eligible in obstetrics and gynecology." Act 700, § 20-16-605(a). A violation of this requirement is "a Class D felony," punishable by up to six years in prison and a fine of up to $10,000. *Id.* § 20-16-605(b); Ark. Code Ann. §§ 5-4-201, -401. It may also result in the revocation, suspension, or non-renewal of the physician's and/or facility's professional license(s). *See* Act 700, § 20-16-605(b).

B. The OBGYN Requirement Treats Abortion Differently Than Other Comparable Medical Procedures

Arkansas does not impose a limit like the OBGYN Requirement on any other comparable medical procedure. It does not require board-certification or board-eligibility (much less board-certification or -eligibility in a specific specialty) for administration of any other oral medication. Nor does Arkansas impose these requirements for outpatient procedures of comparable or greater medical risk, such as colonoscopies or tonsillectomies. Arkansas law contains no requirement of a particular specialty, board-certification, or board-eligibility for physicians offering pregnancy or birthing care at a birthing center, even though carrying to term, labor, and delivery pose significantly greater risk to women than abortion. *See supra* 5. And Arkansas law is bereft of

any such qualification requirements for providers of miscarriage management, even though that care is nearly identical to abortion care from a technical perspective.[69]

Moreover, abortion is already singled out as highly regulated in Arkansas. Under current Arkansas law:

- any woman seeking an abortion must be evaluated via a medical history, a physical examination, counseling, and laboratory tests, *see* Ark. Admin. Code. 007.05.2-8;
- facilities providing abortions must have various medical devices available to assist in the event of complications, *see id.*;
- abortion facilities must have a certain number of qualified personnel available to provide direct patient care, *id.* 007.05.2-7;
- Arkansas abortion facilities providing medication abortions must "have a signed contract with a physician who agrees to handle complications" and who has "active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug," Ark. Code § 20-16-1504(d)(1), (2); and
- Arkansas abortion facilities must satisfy a variety of ongoing obligations to educate staff about best practices and to assess their own services, Ark. Admin. Code 007.05.1-10, 2-5, 2-6(G), 2-7(D). 007.05.2-5.

[69] Prine Decl. ¶ 17; Tvedten Decl. ¶ 15; Horton Decl. ¶ 15.

In recent years, the State has engaged in a targeted campaign to restrict access to abortion care, enacting more than 25 laws regulating abortion access in this State,[70] including 12 enacted in 2019 alone.[71]

C. There is No Medical Justification for the OBGYN Requirement.

The three physicians who would have to stop providing abortion care at LRFP and PPAEO under the OBGYN Requirement are extremely well qualified and trained:

- Dr. Tvedten has been practicing medicine in Arkansas since the late 1970s.[72] He was first trained to provide abortion care more than 30 years ago by an experienced Arkansas abortion provider and family physician.[73] Dr. Tvedten has safely provided abortion care up to 21.6 weeks for more than 15 years,[74] and he has trained numerous

[70] *See, e.g.*, Ark. Act 234, § 19 (2018) (prohibiting expenditure of state funds for abortion referrals in public schools and for abortion services); Ark. Act 243, § 24 (2018) (same); Ark. Act 244, § 25 (2018) (same); Ark. Code Ann. §§ 20-16-1801-07 (2017) (banning most common method of second-trimester abortion); *id.* § 20-16-1801 (2017) (requiring physicians to delay a woman's abortion while they request and wait for a woman's medical records); *id.* § 20-16-108(a)(1) (2017) (requiring disclosure of abortion and preservation of fetal tissue for abortion patients under the age of 17); *id.* §§ 20-17-801-802 (2017) (imposing burdensome and confusing requirements regarding disposal of fetal tissue); *id.* § 20-9-302 (2017) (mandating the imposition of extreme penalties, such as license revocation, for violation of the many requirements imposed on abortion providers); *id.* §§ 20-16-801-817 (2015) (mandating parental consent for a minor's abortion); *id.* §§ 20-16-1504 (2015) (banning off-label use of abortion inducing drugs); *id.* (requiring medication-abortion providers have contract with physician with certain hospital admitting privileges); *id.* § 20-16-1703 (2015) (mandating 48-hour delay before an abortion and two, in-person trips to facility); *id.* § 20-16-1602 (2015) (banning public funding to any individual or entity that provides, counsels in favor of, or refers for abortion); *id.* §§ 20-16-1301-1307 (2013) (banning abortion at 12 weeks, requiring abdominal ultrasound to detect fetal cardiac activity, and mandating disclosure of cardiac activity if present) (ban at 12 weeks struck down by *Edwards v. Beck,* 786 F.3d 1113 (8th Cir. 2015)); *id.* §§ 20-16-1401-1410 (2013) (banning abortion after 20 weeks post-fertilization); *id.* § 23-79-156 (2013) (banning abortion coverage in state insurance exchange plans).

[71] In addition to the three laws challenged here: Ark. Code Ann. § 20-16-605 (2019) (imposing additional abortion-related reporting requirements on physicians and facilities); *id.* § 5-61-301-304 (2019) (asking Supreme Court to overturn *Roe v. Wade* and providing that, upon reversal, state law will prohibit abortions except to save the life of a pregnant woman); *id.* § 20-9-203(b)(1) (2019) (imposing additional requirements on abortion facilities); *id.* § 20-16-604, -811, -1109 (2019) (imposing additional reporting requirements and penalties on doctors providing abortions); *id.* § 20-16-1703, -1706 (2019) (extending waiting period between doctor providing required disclosures to woman seeking abortion and provision of abortion from 48 to 72 hours, and increasing information doctor must provide); *id.* § 20-16-1703(b)(9), -1704(b)(6) (2019) (imposing additional disclosure requirements on doctors providing abortion-inducing drugs); Ark. Act 877, § 23 (2019) (prohibiting expenditure of state funds for abortion referrals in public schools and for abortion services); Ark. Act 752, § 18 (2019) (same); Ark. Act 727, § 24 (2019) (same).

[72] Tvedten Decl. ¶ 1.

[73] Tvedten Decl. ¶ 5.

[74] Tvedten Decl. ¶ 7.

physicians to provide abortion care.[75]

- Dr. Horton has more than two decades of experience providing abortion care to thousands of women in Tennessee and Arkansas.[76] He completed four years of residency in OBGYN and passed the written examination for the American Board of Obstetrics and Gynecology in June 2002 and June 2013.[77]

- Dr. Ho completed her family-planning residency at the University of Arkansas in 2011 and has been providing medical care in the State since 2008.[78] During her residency, she was trained to provide surgical and medication abortion care by an experienced family-medicine physician who was on the faculty at the University of Colorado Health Sciences Center.[79]

Even though Drs. Tvedten, Horton, and Ho are eminently qualified to provide abortions, each will be prohibited from providing such care if the OBGYN Requirement goes into effect, simply because they are not, and cannot feasibly become, board-certified or board-eligible in OBGYN. *See supra* 9–10.

But board-certification or eligibility in OBGYN is not relevant to the safe provision of abortion care. Training, rather than specialty, determines competence to provide abortion care,[80] and a wide variety of clinicians can and do safely and routinely provide abortion services.[81] In fact, across the nation, roughly one third of abortion providers come from specialties other than OBGYN,[82] and medical schools and teaching hospitals around the country routinely use non-OBGYN faculty members to train residents and fellows in the provision of abortion care.[83] Indeed, abortion care is safely provided around the country up to at least 22 weeks LMP by non-

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[75] Tvedten Decl. ¶ 9.
[76] Horton Decl. ¶¶ 7–11.
[77] Horton Decl. ¶¶ 7–8, 22.
[78] Ho Decl. ¶¶ 1–2.
[79] Ho Decl. ¶ 3.
[80] Prine Decl. ¶ 18-20; Hopkins Decl. ¶¶ 35–37.
[81] Hopkins Decl. ¶¶ 36–38; *see* Ian M. Bennett et al., *Early Abortions in Family Medicine: Clinical Outcomes*, Annals of Family Medicine 7:527-533 (2009) (noting that among 2,550 women who sought abortions from family-medicine physicians in a study, 96.5% of medication abortions and 99.9% of surgical abortions were successful and led to no complications).
[82] Prine Decl. ¶ 20.
[83] Prine Decl. ¶ 20; Hopkins Decl. ¶¶ 35-37.

OBGYN providers.[84] Moreover, competence in abortion care is not a prerequisite for becoming a board-certified or eligible OBGYN.[85] OBGYN residents can opt out of any abortion training,[86] and many board-certified OBGYNs have never even observed an abortion.[87]

Prominent medical professional organizations agree that laws like the OBGYN Requirement are unjustified and unjustifiable. For example, the American College of Obstetricians and Gynecologists ("ACOG") has recognized that clinicians from many medical specialties can provide safe abortion care and that requiring board-certification in OBGYN is "medically unnecessary" and "designed to reduce access to abortion."[88] The President of the American College of Physicians has likewise opined that "[t]here is no evidence that these requirements improve patient safety; they just serve to reduce patient access to care."[89] Professional medical organizations and organizations such as the National Academies have also specifically endorsed the provision of abortion care by clinicians other than board-certified OBGYNs.[90]

There is no justification for requiring a clinician to be a board-certified or -eligible OBGYN to provide any abortion, but there is especially no justification for such a requirement as to medication abortion. Medication abortion involves the patient taking an initial medication in the clinic, and a second medication generally at home.[91] There is no need for a clinician to be a

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[84] Prine Decl. ¶ 20; Hopkins Decl. ¶¶ 35-37. Because LRFP provides abortion care only up to 21.6 weeks LMP, they have not included in this record evidence regarding the provision of abortion care after 22 weeks.
[85] Prine Decl. ¶ 21, n. 4; Hopkins Decl. ¶¶ 35-37.
[86] Prine Decl. ¶ 21, n. 4; Hopkins Decl. ¶ 38, n. 14.
[87] Prine Decl. ¶ 21, n. 4; Hopkins Decl. ¶ 38, n. 14.
[88] Prine Decl. ¶ 21, n. 4; Hopkins Decl. ¶ 38. n. 14
[89] *See* ACOG, Press Release (May 21, 2019), https://www.acog.org/About-ACOG/News-Room/News-Releases/2019/Amicus-Brief-in-June-Medical-Services-LLC-v-Gee?IsMobileSet=false.
[90] Prine Decl. ¶ 22, n. 5; *see also* Am. Academy of Family Physicians, Recommended Curriculum Guidelines for Family Medicine Residents: Women's Health and Gynecologic Care 9 (Aug. 2018); ACOG, Committee Op. No. 612 (Nov. 2014); National Academy Consensus Study Report at 163–165.
[91] Ho Decl. ¶ 15.

board-certified or -eligible OBGYN to prescribe these pills.[92] A variety of health-care professionals, including non-physicians, routinely prescribe medications to their patients for a variety of conditions—including medications that have significantly higher complication rates than medication abortion—and, in other states, regularly prescribe medication abortion.[93] Moreover, in Arkansas, medication-abortion providers are already required to have a contract with a back-up OBGYN provider. *See* Ark. Code Ann. § 20-16-1504 (2016) (requiring medication-abortion providers to contract with physician with certain hospital admitting privileges).

No scientific evidence was ever presented in legislative session as a justification for the OBGYN Requirement. Indeed, sponsor State Senator Stubblefield admitted that he is aware of no medical safety problem that necessitated the OBGYN Requirement,[94] even though non-OBGYNs have provided abortion care in Arkansas for decades, *see supra* 8–10.

D. Impact of the OBGYN Requirement

1. LRFP and PPAEO Have No Feasible Means of Complying With The OBGYN Requirement.

As an initial matter, LRFP and PPAEO cannot feasibly replace Drs. Tvedten, Horton, and Ho. Both have worked diligently to do so, with no success. Neither Dr. Hopkins (at LRFP) nor Drs. Cathey and Rodgers (at PPAEO Little Rock) are able to increase the hours they spend at these health centers, given their substantial personal and professional commitments and

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[92] Prine Decl. ¶¶ 26–29.

[93] Hopkins Decl. ¶ 40.

[94] *See* S.B. 448 Hearing Testimony, http://sg001-harmony.sliq.net/00284/Harmony/en/PowerBrowser/PowerBrowserV2/20190314/-1/17022?viewMode=1#agenda_ (Sen. Elliott: "No I'm asking you is it—do you have some evidence that there has been a [medical safety] problem that you are fixing, is what I'm asking." Sen. Stubblefield: "Not that I'm aware of."); *see also id.* (Sen. Stubblefield: "And as far as how many more of these abortion bills will I bring? I'll tell every one of you how many more I'll bring. As long as we keep killing unborn children–innocent unborn children–I'll keep bringing abortion bills.").

limitations.[95] Accordingly, LRFP and PPAEO both began attempting to recruit board-certified or -eligible OBGYNs shortly after the OBGYN Requirement was signed into law.[96] LRFP and PPAEO each sent a letter to all identified OBGYNs in the State, explaining that the OBGYN Requirement had passed, articulating its impact, and soliciting interest in joining their respective staffs.[97] LRFP and PPAEO also attempted to identify board-certified or board-eligible OBGYNs through repeated professional-network outreach and word of mouth.[98]

To date, LRFP has received no responses to its letter, and its efforts to identify through professional networks a physician licensed to practice in Arkansas who could satisfy the requirement have been unsuccessful.[99] Through its extensive outreach efforts, PPAEO Fayetteville was able to secure the limited services of one board-certified OBGYN, Dr. Kathleen Paulson, who agreed to provide medication abortion one night a week on a volunteer basis for a three-hour window of time if the OBGYN Requirement goes into effect.[100] She is uncertain, however, for how long she will be able to continue to provide this limited volunteer service.[101]

This lack of response is no aberration: Because of Arkansas's long history of medically unnecessary abortion restrictions, this is not the first time that LRFP and PPAEO have been forced to engage in extensive efforts seeking physicians with specific, medically irrelevant qualifications to ensure they can keep providing abortion care or to attempt to expand access, and

[95] Hopkins Decl. ¶ 47; Cathey Decl. ¶ 4. Board-certified OBGYN Charlie Browne, who has occasionally provided services at LRFP during discrete periods of time many years ago, is also unable to commit to providing any care at LRFP beyond the one week he has agreed to work in July 2019, if the OBGYN Requirement takes effect. Browne Decl. ¶ 14.
[96] Williams Decl. ¶ 36; Ho Decl. ¶ 22.
[97] Williams Decl. ¶ 36; Ho Decl. ¶ 24.
[98] Williams Decl. ¶ 37; Ho Decl. ¶ 25.
[99] Williams Decl. ¶ 36.
[100] Ho Decl. ¶ 26; Paulson Decl. ¶ 4.
[101] Ho Decl. ¶ 26; Paulson Decl. ¶ 6.

received few responses.[102] Nor is the lack of response surprising. Abortion providers face bombings and death threats, and some have been murdered. Dr. Horton was the victim of a bomb threat that prompted a hospital evacuation.[103] So, too, was Dr. Tvedten.[104] Dr. Tvedten also faced anti-abortion activists distributing flyers on the grounds of his children's school that provided Dr. Tvedten's name, picture, and home address, and labeled him and his family as complicit in murder.[105] LRFP's Clinical Director suffered anti-abortion activists mailing her photograph and a letter impugning her as an abortion provider to 800 of her neighbors.[106] And one of the doctors who trained Dr. Hopkins to provide abortion care, Dr. George Tiller, was murdered by an anti-choice extremist in 2009 while he was attending church; he had previously been shot in both arms in 1993 by another anti-choice extremist.[107] Another provider and friend of Dr. Hopkins, Dr. Garson Romalis, was shot and nearly killed in 1994 and stabbed in 2000 by anti-abortion extremists.[108]

Even when they do not face violence, abortion providers face profound stigma and harassment. As reproduction-sociology expert Dr. Lori Freedman explains, "the intense stigmatization of abortion providers makes it difficult, and in some geographical areas impossible, to find and retain abortion providers."[109] The stigma and harassment abortion providers face is particularly strong in Arkansas and surrounding areas.[110] Anti-abortion activists crowd outside LRFP nearly every day that its doors are open to patients,[111] shouting at

[102] Williams Decl. ¶ 36; Ho Decl. ¶¶ 32.
[103] Horton Decl. ¶ 27.
[104] Tvedten Decl. ¶ 34.
[105] Tvedten Decl. ¶ 34.
[106] Williams Decl. ¶ 41.
[107] Hopkins Decl. ¶ 51.
[108] Hopkins Decl. ¶ 51.
[109] Freedman Decl. ¶ 4; *see also* Tvedten Decl. ¶ 29.
[110] Freedman Decl. ¶ 21; Horton Decl. ¶¶ 25-26.
[111] Williams Decl. ¶ 39; Horton Decl. ¶ 26; Tvedten Decl. ¶ 34.

the physicians and harassing the medical residents who arrive for training and report fear about driving to the clinic in their personal vehicles.[112] Dr. Tvedten reports past problems renewing leases for his clinic, faced with a landlord who refused to be associated with abortion care.[113] Dr. Freedman has further determined that many providers who would otherwise be willing to provide abortions do not do so because of the immense personal and professional stigmatization that would result.[114]

One way this stigma manifests is that working as an abortion provider can make it difficult (or impossible) to maintain or find a job in private practice.[115] For example, Dr. Horton was rejected from two jobs for which he applied in 2004 and 2005, after he informed his interviewers that he provided abortion care.[116] Dr. Ho faced similar incidents.[117] And in 2005, Dr. Horton was fired from a hospital job after he provided abortion care that one of his colleagues requested for a patient.[118] Dr. Tvedten reports that physicians in Arkansas who provide abortion care generally jeopardize their ability to retain positions or admitting privileges at hospitals.[119] In fact, Dr. Tvetden gave up his family practice in 1999 because he knew it would be extremely difficult, if not impossible, to attract potential partners and patients while he was continuing to provide abortion care in Arkansas.[120] And one of the Arkansas physicians who trained Dr. Tvedten to provide abortion care, Dr. James Guthrie, was forced to abandon his provision of abortion care because of the harassment he and his family practice partners faced at

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[112] Williams Decl. ¶ 39.
[113] Tvedten Decl. ¶ 32.
[114] Freedman Decl. ¶ 4.
[115] Horton Decl. ¶ 28.
[116] Horton Decl. ¶ 28.
[117] Ho Decl. ¶ 29.
[118] Horton Decl. ¶ 28.
[119] Tvedten Decl. ¶ 29.
[120] Tvedten Decl. ¶ 33.

their offices and homes, which negatively affected their ability to continue their family practice and attract patients, as well as Dr. Guthrie's ability to maintain positive, collaborative relationships with his practice partners.[121]

2. *The OBGYN Requirement Will Dramatically Reduce Access To Abortion Care In Arkansas, And Almost Certainly Eliminate Care Altogether For Women After 10 Weeks LMP.*

As detailed below, the OBGYN Requirement will result in (i) insufficient capacity to provide care to women seeking abortions in the State and the complete elimination or substantial reduction of surgical abortion care in Arkansas, and (ii) women either (a) foregoing their abortion care altogether and carrying a pregnancy to term against their will or seeking an abortion outside the medical system, or (b) attempting to overcome the substantial obstacles associated with pursuing abortion care from out-of-state providers at great risk to themselves and their families.

a. LRFP and PPAEO will have insufficient patient capacity under the OBGYN Requirement.

Based on data from the last three years, an average of 3,167 women have obtained abortions from Arkansas providers annually,[122] with ***nearly 90%*** of those abortions provided by Drs. Tvedten, Horton, and Ho, whom the OBGYN Requirement would force to cease providing care.[123] Approximately 70% of Arkansas abortion procedures over the last three years were surgical abortions at LRFP (2,212),[124] and nearly half (45%) of those patients terminated their pregnancies at or after 10 weeks LMP,[125] meaning that medication abortion was not an option for them, *see supra* 8–10.

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[121] Tvedten Decl. ¶ 30.
[122] Lindo Decl. ¶ 2.
[123] Lindo Decl. ¶ 14.
[124] Lindo Decl. ¶ 2.
[125] Lindo Decl. ¶ 2.

Based on this record, Texas A&M University Professor of Economics Dr. Jason Lindo has determined that under any of the scenarios likely to be triggered by the OBGYN Requirement, women's ability to access abortion care in Arkansas will be dramatically reduced.[126] Indeed, if the OBGYN Requirement takes effect, ***at least 62-70%*** of women who seek abortion care in Arkansas will be unable to obtain the same care in the State.[127] Said differently, at most 955-1,207 of the 3,167 women who currently obtain abortion care in Arkansas each year would be able to do so going forward.[128]

LRFP will almost certainly be forced to close because it will not be economically feasible to continue operating while providing no abortion services other than those provided by Dr. Hopkins three days every other month.[129] If LRFP closed, even if the remaining PPAEO providers continued providing medication abortions, ***zero*** surgical abortions would be available in Arkansas.[130] This scenario would therefore leave approximately 70% of the 3,167 women who would otherwise obtain abortion care in Arkansas unable to obtain the same care that they would, absent the OBGYN Requirement.[131] Although there would theoretically be sufficient capacity for women seeking medication abortion, it would be available for women in the Fayetteville area only during a single, three-hour window each week that may be logistically impossible for many women, *see supra* 22.[132]

If LRFP closes ***and*** Dr. Paulson is no longer able to provide medication abortions, PPAEO Little Rock will be the State's sole provider, where a maximum of 956 medication (i.e.,

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[126] Lindo Decl. ¶ 3.
[127] Lindo Decl. ¶ 2.
[128] Lindo Decl. ¶ 2.
[129] Williams Decl. ¶¶ 48–50.
[130] Lindo Decl. ¶ 30.
[131] Lindo Decl. ¶ 53.
[132] Lindo Decl. ¶ 54.

pre-10 week LMP) abortions could be provided annually.[133] Although PPAEO would thus theoretically have sufficient capacity to provide all the medication abortions sought in the State, women in and around Fayetteville who otherwise would have sought care at PPAEO Fayetteville would need to overcome a substantial travel distance—i.e., an approximately 380-mile round trip odyssey from Fayetteville to Little Rock—to receive care.[134] And 100% of Arkansas's 2,212 annual surgical abortion patients would still be left without the care that they would otherwise be able to seek in Arkansas, absent the OBGYN Requirement.[135] Thus, even under the highly unrealistic assumption that all medication-abortions patients could overcome the burdens associated with traveling to a distant provider, approximately 70% of the 3,167 women who would otherwise obtain abortion care in Arkansas would ***still*** be unable to do so.[136]

Even under the best-case scenario (i.e., LRFP somehow manages to continue operations and Dr. Paulson continues providing care at PPAEO Fayetteville), women's ability to access abortion in the State would be nearly as bleak. In that scenario, LRFP's annual capacity would be only approximately 252 women—***a mere 11.4%*** of the women who seek surgical abortion care in Arkansas each year.[137] Thus, even this overly optimistic scenario would leave approximately 62% of women unable to obtain in Arkansas the care that they otherwise would.[138]

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[133] Lindo Decl. ¶ 55.
[134] Lindo Decl. ¶ 55.
[135] Lindo Decl. ¶ 55.
[136] Lindo Decl. ¶ 53.
[137] Lindo Decl. ¶ 56. Even assuming some surgical-abortion patients could obtain medication-abortion care because they are less than 10 weeks LMP, at least 42% of women in this scenario would *still* be unable to obtain *any* type of abortion care in Arkansas, given the capacity constraints of the medication-abortion providers in the State. *See* Lindo Decl. n.58.
[138] Lindo Decl. ¶ 50.

b. <u>The OBGYN Requirement will force women to either forego abortion care altogether or assume highly burdensome travel obligations.</u>

If the OBGYN Requirement takes effect, women seeking medication and surgical abortion in Arkansas would be forced to travel much greater distances to access the care they desire and need. For example, if LRFP were forced to cease or severely restrict its provision of abortion services, women in and around Little Rock who cannot obtain care at PPAEO Little Rock would be forced to travel either (i) approximately 380 miles round trip to PPAEO Fayetteville (assuming they are seeking medication abortion up to 10 weeks LMP and PPAEO Fayetteville can provide the requisite care, given Dr. Paulson's limited availability, *see supra* 22), or (ii) out of state, such as the approximately 300-mile round-trip journey to Memphis, Tennessee (the next-nearest provider from Little Rock).[139] Similarly, if PPAEO Fayetteville were forced to eliminate its provision of medication abortion because Dr. Paulson could not continue providing care, women in and around Fayetteville seeking medication abortions would be forced to travel either approximately 360 miles round trip to PPAEO Little Rock or to an out-of-state provider (such as the approximately 220-mile round-trip journey to Tulsa, Oklahoma).[140]

Increases in travel distance are associated with substantial impacts on women's ability to access care.[141] One recent peer-reviewed study determined that ***a mere 25-mile*** increase in travel distance can reduce abortion rates by 10%,[142] with those women forced to carry to term against their will. That is because traveling increased distances to access health-care services is associated with substantial economic, logistical, and emotional burdens.[143]

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[139] Lindo Decl. ¶ 59.
[140] Lindo Decl. ¶ 28.
[141] Lindo Decl. ¶ 28.
[142] Lindo Decl. ¶ 25.
[143] Williams Decl. ¶¶ 24–25; Katz Decl. ¶ 8; Lindo Decl. ¶¶ 23–29.

These burdens are particularly devastating to the poor and low-income women who comprise a large portion of LRFP's and PPAEO's patient populations.[144] Across the United States, most women who obtain abortion care are poor or low income,[145] and it is no different in Arkansas. Between 2016 and 2018, for example, 61% of PPAEO Fayetteville's medication-abortion patients were at or below 110% of the federal poverty level.[146] One third of LRFP's patient population receives financial assistance that is available only to women who are at or below 110% of the federal poverty guidelines.[147]

Consistent with that, poverty expert and University of Houston Professor Sheila Katz has determined that the OBGYN Requirement would impose significant logistical and financial obstacles that harm poor and low-income women seeking abortions in Arkansas.[148] Specifically, the OBGYN Requirement would prevent some women from obtaining an abortion; delay other women's access to that care; jeopardize women's confidentiality and employment; increase the risk that victims of domestic violence would experience physical violence or other abuse; and put women and their families at risk of deepening poverty, hunger, or eviction.[149] The financial burdens and logistical obstacles associated with increased travel may seem negligible to Americans in the middle or upper-middle class, but they can be insurmountable for many poor and low-income women.[150] For example, Dr. Katz determined that the nearly 400-mile roundtrip journey between the Fayetteville area and Little Rock would likely cost an Arkansas woman earning minimum wage ***approximately 25%*** of her monthly income.[151]

[144] Williams Decl. ¶ 23; Katz Decl. ¶¶ 27-31.
[145] Hopkins Decl. ¶ 21.
[146] Ho Decl. ¶ 35.
[147] Williams Decl. ¶ 23.
[148] Katz Decl. ¶ 8.
[149] Katz Decl. ¶ 8.
[150] Katz Decl. ¶¶ 30-31.
[151] Katz Decl. ¶¶ 44-45.

Moreover, the delay caused by these burdens would (i) increase the risks associated with the procedure itself; (ii) push a woman past the point at which medication abortion is an option; (iii) push a woman into the second trimester, requiring a different procedure; and (iv) push a woman past Arkansas's legal limit for abortion—whether the current limit at 21.6 weeks LMP, or the new limit the State seeks to impose after 18 weeks LMP.[152]

ARGUMENT

Plaintiffs are entitled to a temporary restraining order and/or a preliminary injunction because the Bans and the OBGYN Requirement directly contravene decades of binding Supreme Court precedent holding that a State may not ban abortion before the point of viability or impose an undue burden on a woman's access to abortion care. *See, e.g.*, *WWH*, 136 S. Ct. at 2309. If the Bans and the OBGYN Requirement take effect, abortion access in Arkansas will be substantially reduced, with care after 10 weeks LMP almost certainly eliminated, and Plaintiffs and their patients will be severely harmed. Plaintiffs ask this Court to block the enforcement of these unconstitutional and harmful statutes, and allow women to continue obtaining the safe and effective reproductive health care they seek, as they have done for decades.

I. APPLICABLE LEGAL STANDARD.

"The primary function of a preliminary injunction is to preserve the *status quo* until, upon final hearing, a court may grant full, effective relief." *Kan. City S. Transp. Co., Inc. v. Teamsters Local Union No. 41*, 126 F.3d 1059, 1066 (8th Cir. 1997). In deciding a preliminary-injunction motion, the district court considers four factors: the (1) probability that the movant will succeed on the merits; (2) threat of irreparable harm to the movant; (3) balance of equities; and (4) public interest. *See Grasso Enters., LLC* v. *Express Scripts, Inc.*, 809 F.3d 1033, 1035 n.2 (8th Cir.

[152] Williams Decl. ¶ 26; Hopkins Decl. ¶ 30.

2016). Courts in this Circuit use the same factors to evaluate the propriety of a temporary restraining order ("TRO"), but a TRO may issue without notice to the adverse party in certain circumstances. *See, e.g.*, Fed. R. Civ. Proc. 65(b); *Pyle v. Huskins*, 2011 WL 2435433, a *1 & n.1 (W.D. Ark. May 27, 2011). Plaintiffs meet the standards for a temporary restraining order and preliminary injunction, as explained further below.

II. PLAINTIFFS HAVE DEMONSTRATED A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS OF THEIR SUBSTANTIVE DUE PROCESS CLAIM.

As detailed below, Plaintiffs have demonstrated a substantial likelihood of success on the merits of their substantive due process claim with regard to both the Bans and the OBGYN Requirement. Emergency relief is accordingly warranted to preclude all three laws from taking effect.

A. LRFP Is Likely To Succeed on the Merits of Its Claim That The 18-Week Ban and Reason Ban Are Unconstitutional.

1. The Bans Are Unconstitutional Prohibitions On Pre-Viability Abortion Care.

LRFP has provided safe pre-viability abortion care up to 21.6 weeks LMP for decades, but the Reason Ban prohibits all abortions at ***any point*** in a woman's pregnancy, if the physician has "knowledge" that a woman is seeking an abortion solely because of a Down syndrome diagnosis, test result, or reason to believe the fetus has Down syndrome. *See supra* 11–16. The 18-Week Ban will eliminate care between 18.1 and 21.6 weeks LMP. *See supra id.*

The Supreme Court has repeatedly held that a state may not enact ***any*** pre-viability ban on abortion. In *Casey*, decided more than a quarter century ago, the Court reaffirmed the "central principle" of *Roe* that, "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion." 505 U.S. at 846, 871. Although *Casey* abandoned *Roe*'s trimester framework in favor of the "undue burden" test, under which a restriction on pre-

viability abortion is permitted as long as the law does not place a "substantial obstacle" in the path of a woman seeking abortion, the Court emphasized:

> Our adoption of the undue burden analysis does not disturb the central holding of *Roe v. Wade*, and we reaffirm that holding. Regardless of whether exceptions are made for particular circumstances, a State may not prohibit ***any woman*** from making the ultimate decision to terminate her pregnancy before viability.

505 U.S. at 879; *see also id.* at 846 ("*Roe*'s essential holding . . . is a recognition of the right of the woman to choose to have an abortion before viability"); *id.* at 871 (any state interest is "insufficient to justify a ban on abortions prior to viability even when it is subject to certain exceptions"). Most recently, in *WWH*, the Supreme Court reaffirmed that a ban on abortion "before . . . viability" is unconstitutional. 136 S. Ct. at 2300 (quoting *Casey*, 505 U.S. at 878). Moreover, the Supreme Court has expressly held that a state may not "proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus. ***Viability is the critical point.***" *Colautti v. Franklin*, 439 U.S. 379, 389 (1979).

Given this long line of unbroken precedent, attempts to ban abortion before viability have, unsurprisingly, been uniformly rejected by courts of appeals and district courts across the country. *See, e.g.*, *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 776 (8th Cir. 2015) (striking 6-week ban and observing plaintiffs' experts' statement that "viability occurs at about 24 weeks" aligns "with the [definition of viability] adopted by the Supreme Court"), *cert. denied*, 136 S. Ct. 981 (2016); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (striking 12-week ban on basis that it "prohibits women from making the ultimate decision to terminate a pregnancy at a point before viability"), *cert. denied*, 136 S. Ct. 895 (2016); *Isaacson v. Horne*, 716 F.3d 1213,

1217, 1231 (9th Cir. 2013) (striking 20-week ban on the basis that its prohibition on abortion in "the period between twenty weeks gestation and fetal viability" denied women "the ultimate decision to terminate their pregnancies prior to fetal viability"), *cert. denied*, 134 S. Ct. 905 (2014); *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201 (6th Cir. 1997) (striking ban on most common procedure used to provide abortion after 13 weeks), *cert. denied*, 523 U.S. 1036 (1998); *Jane L. v. Bangerter*, 102 F.3d 1112, 1114, 1117–18 (10th Cir. 1996) (striking 22-week ban), *cert. denied sub nom Leavitt v. Jane L.*, 520 U.S. 1274 (1997); *Sojourner T. v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992) (striking ban on all abortions with exceptions), *cert. denied*, 507 U.S. 972 (1993); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69 (9th Cir. 1992) (same), *cert. denied*, 506 U.S. 1011 (1992); *Jackson Women's Health Org. v. Currier*, 349 F. Supp. 3d 536, 540 (S.D. Miss. 2018) ("*JWHO II*") (striking 15-week ban because "15 weeks lmp is prior to viability"), *appeal docketed sub nom. Jackson Women's Health Org. v. Dobbs*, No. 18-60868 (5th Cir. Dec. 17, 2018); *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630–32 (M.D.N.C. 2019) (striking down 20-week ban); *Jackson Women's Health Org. v. Dobbs*, No. 3:18-CV-171-CWR-FKB, 2019 WL 2240532, at *2–3 (S.D. Miss. May 24, 2019) ("*JWHO III*") (preliminarily enjoining ban on abortion starting when cardiac activity is detectable); *EMW Women's Surgical Ctr. v. Meier*, 2019 WL 2076553 (W.D. Ky. May 10, 2019), *appeal docketed*, No. 19-5516 (6th Cir. May 15, 2019) (striking down 6-week ban).

Indeed, only four years ago, the Eighth Circuit affirmed two district court decisions striking pre-viability abortion bans. The Eight Circuit noted that such prohibitions, even when they contain limited exceptions, are *per se* unconstitutional under binding Supreme Court precedent. *See Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (noting that "[a]s an

intermediate court of appeals, this court is *bound* by the Supreme Court's decisions in *Casey* and the "assum[ption]" of *Casey*'s "principles" in *Gonzales*"); *MKB Mgmt.*, 795 F.3d at 771 (observing the law at issue "clearly prohibits pre-viability abortions . . . , thereby imposing an undue burden on women seeking to obtain an abortion," and acknowledging that the court is "bound by" *Roe* and *Casey*).

Because both Bans prevent physicians from performing abortions prior to viability, which occurs well after 18 weeks,[153] they are patently unconstitutional under the controlling authority described above, and emergency relief is warranted.

2. The Reason Ban Violates Women's Constitutional Rights.

The Reason Ban is also inconsistent with Supreme Court precedent because underlying the privacy right first recognized in *Roe* and reaffirmed in *Casey* and *WWH* is the principle that the woman—not the State—gets to decide whether and on what grounds to terminate a pre-viability pregnancy. Indeed, *Roe* explicitly held that it is the woman's ***decision*** that merits Fourteenth Amendment protection, and that she must be permitted to engage in consultation with her clinician to make that decision. *See Roe*, 410 U.S. at 153. Extending this understanding of the woman's decisional autonomy further, *Casey* explained that protection for the abortion right reflects the fact that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 505 U.S. at 851; *see also Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 987 (7th Cir. 2012) (noting that the abortion right is, in part, "a constitutionally protected interest 'in making certain kinds of important decisions' free from

[153] Hopkins Decl. ¶ 2; *see also Casey*, 505 U.S. at 860 (viability is weeks after 18 weeks).

governmental compulsion"). The State, in other words, may not demand that a woman provide the reasons for her decision to seek a pre-viability abortion or veto her decision before viability based on those reasons.

Accordingly, two federal courts recently held unconstitutional bans very similar to the Reason Ban. Directly on point here, a federal district court in Ohio recently enjoined a law that prohibited abortions sought in whole or in part on the basis of a Down syndrome diagnosis. As that court explained, "[t]he interest protected by the Due Process Clause is a woman's right to choose to terminate her pregnancy pre-viability, and that right is categorical. ***The State cannot dictate what factors a woman is permitted to consider in making her choice***." *Preterm Cleveland v. Hines*, 294 F. Supp. 3d 746, 755 (S.D. Ohio 2018), *appeal argued* No. 18-3329 (6th Cir. Jan. 30, 2019). The Seventh Circuit similarly held unconstitutional a law prohibiting abortion if the sole reason for the woman's decision was the race or sex of the embryo/fetus, or a prenatal diagnosis of an anomaly. The court found that the law was clearly unconstitutional because "[t]he provisions prohibit abortions prior to viability if the abortion is sought for a particular purpose. These provisions are far greater than a substantial obstacle; they are absolute prohibitions on abortions prior to viability which the Supreme Court has clearly held cannot be imposed by the State." *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 888 F.3d 300, 306 (7th Cir. 2018), *cert. denied*, 139 S. Ct. 1780 (May 28, 2019).

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Thus, under binding precedent, both Bans on pre-viability abortions are inarguably unconstitutional, irrespective of any interest the State may assert to support them. *See Casey*, 505 U.S. at 846; *Roe*, 410 U.S. at 164–65. The narrow exceptions to the Bans do not change the constitutional analysis. *See, e.g., Casey*, 505 U.S. at 879 ("Regardless of whether exceptions are

made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability."); *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (same); *Isaacson*, 716 F.3d at 1227–28 (holding that "while a health exception is necessary to save an otherwise constitutional post-viability abortion ban from challenge, it cannot save an unconstitutional prohibition on the exercise of a woman's right to choose to terminate her pregnancy before viability").

B. Plaintiffs Are Likely To Succeed on the Merits of Their Claim That the OBGYN Requirement Is Unconstitutional Because It Substantially Burdens Women's Access to Abortion with No Countervailing Benefit.

Supreme Court precedent has long protected "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State." *Beck*, 786 F.3d at 1116–17 (quoting *Casey*, 505 U.S. at 846). As the Supreme Court recently reaffirmed, a law that does not outright ban abortion is also unconstitutional, "if the ***purpose or effect*** of the provision ***is to place a substantial obstacle*** in the path of a woman seeking an abortion before . . . viability." *WWH*, 136 S. Ct. at 2300 (emphasis in original). This undue burden standard "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer," and "a law may not be upheld unless the benefits of the justification outweigh the burdens it imposes." *Id.* at 2309; *accord Planned Parenthood of Greater Iowa, Inc. v. Atchison*, 126 F.3d 1042, 1049 (8th Cir. 1997) (explaining law cannot be upheld if it has been enacted for "no purpose other than to make abortions more difficult"); *Planned Parenthood v. Ariz., Inc. v. Humble*, 753 F.3d 905, 913 (9th Cir. 2014) ("W]e must weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests."); *Planned Parenthood of Wis., Inc.*

v. Van Hollen, 738 F.3d 786, 798 (7th Cir. 2013) ("The feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous.").

As detailed below, the OBGYN Requirement is unconstitutional, because it confers no benefit on patients, and at the same time enormously burdens a large fraction of women seeking abortion care in Arkansas.

1. The OBGYN Requirement Will Confer No Medical Benefit.

There is no conceivable state interest that would remotely justify the OBGYN Requirement. This is not surprising, given that abortion is one of the safest medical procedures available, with a recent National Academies Consensus Report confirming that it is safer than a colonoscopy or tonsillectomy, and comparing the side effects of medication abortion to those associated with ibuprofen. *See supra* 5–6. Consequently, "there [is] no significant health-related problem" the OBGYN Requirement "help[s] to cure"; nor is it "more effective than pre-existing [state] law" in furthering women's health. *WWH*, 136 S. Ct. at 2311, 2314.

In fact, the law's lead sponsor specifically conceded that there is no medical justification for the OBGYN Requirement. Asked whether there is "evidence that there has been a [medical safety] problem that you are fixing," the Senator sponsor conceded: "***Not that I'm aware of.***" When asked, "Why do you have this bill then?" he responded, "***I'm having this bill to prevent any further abortions.***"[154] This rationale is dispositive under Eighth Circuit authority: If a "requirement serves no purpose other than to make abortions more difficult, it strikes at the heart of a protected right, and is an unconstitutional burden on that right." *Atchison*, 126 F.3d at 1049; *see also Whole Woman's Health v. Hellerstedt*, 2017 WL 462400, at *8 (W.D. Tex. Jan. 1, 2017)

[154] S.B. 448 Floor Debate; *see also id.* (Sen. Elliott: To do what? Sen. Stubblefield: "To -- to protect women who are having abortions, by a doctor who is certified in obstetrics and gynecology. To make sure she has further protections").

(fact that certain Texas regulations applied to abortion but not miscarriage or ectopic pregnancy was "evidence [the State's] stated interest is a pretext for its true purpose, restricting abortions").

The OBGYN Requirement is at odds with current abortion-care practices throughout the country and Plaintiffs' decades of practice in Arkansas. Across the nation, trained and skilled clinicians who are not board-certified or -eligible OBGYNs routinely and safely provide abortions. *See supra* 19–21. In fact, roughly one third of clinicians who provide abortion in the United States are not OBGYNs, and non-OBGYNs routinely and safely provide care up to at least 22 weeks LMP. *See supra id.* And the evidence shows that they provide abortion safely and with a high degree of patient satisfaction. *See supra id.* Major medical organizations have opposed laws like the OBGYN Requirement as "medically unnecessary." *See supra* 21. Here in Arkansas, Drs. Tvedten, Horton, and Ho have provided safe and effective abortion care for decades. *See supra* 8–10.

In short, the OBGYN Requirement lacks a medical basis. And as the Supreme Court recently clarified, purported "health" regulations that lack a medical basis serve no state interest. *See WWH*, 136 S. Ct. at 2311–12 (summarizing evidence, including from ACOG, undermining State's rationale for abortion restrictions); *City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 435–37 (1983) (concluding "present medical knowledge" "convincingly undercut[]" state's justification for abortion restriction after examining standards of major medical organizations), *overruled in part on other grounds by Casey*, 505 U.S. 833; *Jegley II*, 267 F. Supp. 3d at 1076 ("the feebler the medical grounds … the likelier it is that any burden on abortion is disproportionate and therefore undue" (quoting *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 920 (7th Cir. 2015)).

Moreover, abortion is already singled out and highly regulated in the State. *See supra* 17–18 (detailing numerous regulations). Providers are required to have a certain number of qualified personnel available to provide direct patient care, and they must satisfy annual educational and continual process-refinement requirements. *See supra id.* Facilities providing abortions are also required to have various medical tools available to assist if complications arise (*see id.*), and an OBGYN back-up provider for medication abortion. *See id.* In *WWH*, the Supreme Court pointed to just such a back-up provider requirement—in addition to evidence that complications stemming from abortion procedures are exceptionally uncommon—in holding that Texas's admitting-privileges requirement provided no benefit compared to pre-existing law and thus unduly burdened a woman's right to have an abortion. 136 S. Ct. at 2310–11. The same is true here. There is simply no credible evidence that adding the OBGYN Requirement to these extensive pre-existing abortion regulations furthers any interest in women's health and safety. *See WWH*, 136 S. Ct. at 2314 (invalidating admitting-privileges requirement in part because Texas law "already contained numerous detailed [abortion] regulations"). In fact, the OBGYN Requirement functions to prohibit experienced physicians from providing care to patients, which compromises rather than protects these patients' health and safety.

2. The OBGYN Requirement Will Substantially Burden Care.

In *WWH*, the Supreme Court explained that the undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. at 2309. For the reasons set forth above, the requirement provides no benefits to women. And as required by the Eighth Circuit, the evidence shows that the requirement is likely to unduly burden a "large fraction" of the relevant women, and those

burdens "substantially outweigh[]" any health benefit. *Jegley III*, 864 F.3d at 960 n. 9. Thus, Plaintiffs are likely to prevail on the merits of their claim.

Numerous courts, including the Supreme Court, have specifically identified a range of burdens that courts should consider in evaluating abortion regulations that purport to serve women's health, including the capacity of remaining providers, increased travel distances, associated financial burdens, delay, and outright obstruction of care. *See, e.g., WWH*, 136 S. Ct. at 2302, 2313–14, 2318 (identifying "increased driving distances" to access abortion and "fewer doctors, longer waiting times, and increased crowding," and noting that these factors would "erect a particularly high barrier for poor, rural, or disadvantaged women"); *Jegley III*, 864 F.3d at 959–60 (instructing district court to consider "how many women would face increased travel distances," "the number of women who would forgo abortions," and "the number of women who would postpone their abortions" in conducting undue burden analysis); *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1326–27 (11th Cir. 2018) (affirming injunction where law would increase patients' medical risk and "increase the costs of travel and lodging for women who do not live near the plaintiff clinics," which "would be especially burdensome for low-income women, who comprise a large proportion of the plaintiffs' patients"); *Schimel*, 806 F.3d at 918 (affirming injunction of law that would delay women in obtaining abortions, causing some "to forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks"). Any analysis of a law's burdens should therefore include an examination of "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations." *Humble*, 753 F.3d at 915; *see Casey*, 505 U.S. at 887–94 (considering effect of domestic abuse on women seeking

abortions); *Van Hollen*, 738 F.3d at 796 (citing cumulative effect of different abortion regulations).

There can be no doubt that the OBGYN Requirement will operate as a substantial obstacle for a large fraction of women seeking abortions in Arkansas: ***At least 62-70%*** of women who seek abortion care in Arkansas on an annual basis will be prevented from obtaining the care that they would be able to obtain absent the OBGYN Requirement. These women will be forced to either carry to term against their will or attempt to terminate outside the State's health-care system, *see supra* 28–30. Many will be delayed in obtaining care, in light of the severe reduction in physician capacity resulting from the OBGYN Requirement. If these are not substantial obstacles, it is difficult to conceive what would be.[155]

a. LRFP and PPAEO have identified no feasible means of complying with the OBGYN Requirement.

Neither LRFP nor PPAEO have identified a remotely reliable means of sustained operation under the OBGYN Requirement. *See supra* 21–25. Despite extensive efforts—including contacting every licensed OBGYN in the State and outreach through professional networks, *see id.*—LRFP is unable to identify replacements for Drs. Tvedten and Horton, who together provide approximately ***94%*** of LRFP's abortion care. *See supra* 9. And while PPAEO has identified Dr. Paulson, she is available, as a volunteer, for an extremely limited period of

[155] As shocking as the 62-70% figure is, it understates the reality, because the relevant group is patients seeking an abortion who, but for the OBGYN Requirement, would obtain it from a physician who is not a board-eligible or board-certified OBGYN. In other words, the denominator should exclude patients who already receive care from board-certified OBGYNs (Drs. Cathey and Rodgers at PPAEO Little Rock and Dr. Hopkins at LRFP). *See WWH*, 136 S. Ct. at 2313 (in large fraction analysis, relevant group is women for whom the challenged requirement is a relevant—not an irrelevant—restriction). Dr. Lindo's analysis assumes all women seeking abortions in the State are impacted by the Requirement, and thus provides the most conservative estimate of its impact.

time, and it is uncertain whether and for how long she will be able to continue providing medication-abortion care at PPAEO Fayetteville. *See supra* 22.

This inability to hire board-certified or -eligible OBGYN providers is consistent with the enormous stigma, harassment, and safety risks that abortion providers face in Arkansas. *See supra* 22–25. Indeed, numerous courts have noted that it is often difficult to retain abortion providers because of the social opprobrium to which they are subject. *See, e.g.*, *Schimel*, 806 F.3d at 917 (noting "vilification, threats, and sometimes violence directed against abortion clinics and their personnel in states . . . in which there is intense opposition to abortion"); *Planned Parenthood Ark. & E. Okla. v. Jegley*, 2018 WL 3029104, at *11 (E.D. Ark. June 18, 2018) ("*Jegley IV*") (citing cases finding "that abortion providers face threats of physical violence and professional stigmatization"). As one district court judge put it: "A doctor who is considering performing abortions . . . learns that any degree of abortion practice comes at a cost of losing her standing within the local medical community, and possibly also risking her ability to maintain an independent practice seeing other patients." *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1349 (M.D. Ala. 2014). "[T]he stigma of abortion," the judge explained, is "particularly strong in small and mid-sized cities," where "an abortion doctor is more recognizable and easily singled out." *Id.* And "[b]eyond the professional consequences of providing abortion, potential abortion doctors must also consider the physical threats to them and their families." *Id.* at 1351. In short, the OBGYN Requirement further limits the number of doctors able to provide abortion care in Arkansas, which is already limited due in part to preexisting, significant pressure on doctors not to provide such care.

b. The OBGYN Requirement will cause a dramatic reduction in Arkansas clinic capacity.

Under the OBGYN Requirement, a ***maximum*** of 955-1,207 women would be able to obtain in Arkansas the same abortion care that they would otherwise obtain absent the OBGYN Requirement—a range far short of the 3,167 women currently obtaining abortion care in Arkansas each year. *See supra* 26. Indeed, at least ***62-70%*** of the women who currently seek abortion care in Arkansas on an annual basis would no longer be able to obtain the same care, even if they were willing and able to travel the hundreds of miles roundtrip from Little Rock to Fayetteville or vice versa. *See id.*

LRFP will almost certainly close if the OBGYN Requirement takes effect because providing care only one week every-other month when Dr. Hopkins is available to travel to Arkansas is not economically practicable. *See id.* LRFP's closure would result in the complete elimination of surgical abortion care in the State, leaving ***all women more than 10 weeks LMP with no Arkansas provider***. *See id.* Women seeking medication abortions in Arkansas who would otherwise seek care in Fayetteville would be limited to obtaining care from Dr. Paulson—for as long as she can volunteer—one day a week during evening hours only. *See supra* 23. Even in a best-case scenario under the OBGYN Requirement, whereby LRFP manages to stay open and Dr. Paulson provides care longer term, the clinics' combined capacity will not come close to meeting patient need, leaving 62% of women unable to obtain the care they would otherwise seek. *See supra* 27–28.

Moreover, many of the women who would be prevented from visiting their nearest provider but could potentially receive care by making the roughly 380-mile round-trip journey from the Fayetteville area to Little Rock (or vice versa)—such as to obtain a medication abortion at PPAEO Little Rock when Fayetteville is closed—would be prevented or delayed in doing so.

Travel burdens would be exacerbated by the mandated 72-hour delay that would by then be in effect, *see supra* 8, requiring women to make a dauntingly long trip more than once or to make the funding and logistical arrangements necessary to stay overnight away from home for at least two nights. *See supra* 28–30. Thus, because of the difficulty of arranging logistics related to additional and substantial travel, many women would delay obtaining care. *See id.* Increased travel distances of ***only 25 miles*** have been shown to decrease access to abortion care altogether, i.e., prevent some women's abortions. *See supra* 28. And even delay alone can result in substantial harm, by rendering a woman ineligible for a medication abortion, or pushing her from having a first-trimester procedure to a potentially more complex and lengthy second-trimester procedure. *See supra* 30. While abortion is extremely safe, the risk associated with the procedure increase as the pregnancy progresses. *See supra* 8. Numerous courts, including this one, have recognized the legal harms associated with such delay. *See, e.g.*, *Van Hollen,* 738 F.3d at 796 (noting "[p]atients will be subjected to weeks of delay because of the sudden shortage of eligible doctors"); *Schimel*, 806 F.3d at 920 (explaining delay "compel[s] some women to defer abortion to the second trimester of their pregnancy—which the studies . . . find to be riskier than a first-trimester abortion"); *Humble*, 753 F.3d at 915-17 ("[D]elay in abortion increases health risks."); *Strange II*, 172 F. Supp. 3d 1275, 1289 (M.D. Ala. 2016) (same). Moreover, the delays and the increased travel required to obtain an abortion will burden all women seeking abortion care, but they will disproportionately affect poor and low-income Arkansas women, who comprise a substantial portion of LRFP's and PPAEO's abortion patient populations. *See supra* 8–9.

As numerous courts have recognized, such reduction of abortion services imposes serious burdens on the right to access abortion. *See WWH*, 136 S. Ct. at 2316–18 (inability of remaining

clinics to accommodate demand after surgical-center requirement shut down other clinics showed that requirement put a substantial obstacle in path of women seeking an abortion); *see id.* at 2313 (recognizing that "fewer doctors" means "longer waiting times," which together with "increased driving distances" and "the virtual absence of any health benefit," showed that abortion regulation unduly burdened access); *Jegley III*, 864 F.3d at 958 (recognizing clinic-capacity issues could burden women); *Schimel*, 806 F.3d at 920 (discussing burdens associated with law's "reduc[tion of] the number of doctors . . . allowed to perform abortions"); *Humble*, 753 F.3d at 915 (discussing "practical considerations, such as the frequency with which clinics can see patients").

The OBGYN Requirement's alarming capacity constraints and associated travel burdens within the State are dispositive, and this Court cannot properly consider the availability of out-of-state providers in assessing the Requirement's burdens. That is because, as one court of appeals has explained in the abortion context, "the proposition that the harm to a constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction . . . [is] a profoundly mistaken assumption." *Schimel*, 806 F.3d at 918; *see also Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350 (1938) ("[T]he obligation of the State to give the protection of equal laws can be performed only where its laws operate, that is, within its own jurisdiction . . . the burden of which cannot be cast by one State upon another, and no State can be excused from performance by what another State may do or fail to do."). ***"A state,"*** in other words, ***"cannot lean on its sovereign neighbors to provide protection of its citizens' federal constitutional rights,"*** *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014), including abortion rights. *See, e.g.*, *Planned Parenthood Ark. & E. Okla. v. Jegley*, 2018 WL 3816925, at *51 (E.D. Ark. July 2, 2018) ("*Jegley V*") ("[T]he Court declines to consider out-of-state

abortion providers in this [undue burden] analysis."); *EMW Women's Surgical Ctr., P.S.C. v. Glisson*, 2018 WL 6444391, at *27 (W.D. Ky. Sept. 28, 2018) (holding in abortion context that a state "simply cannot foist upon sister states its obligation to provide constitutional protections to its own citizens"); *W. Ala. Women's Ctr. v. Miller*, 299 F. Supp. 3d 1244, 1261 n.11 (M.D. Ala. 2017) ("[C]ourts have refused to allow out-of-jurisdiction access to cure within-jurisdiction restrictions.").

In fact, the rule that out-of-state abortion care cannot remedy the undue burden imposed by a state's regulations of abortion care undergirded the Supreme Court's recent decision in *WWH*. As noted above, that decision invalidated Texas laws that significantly reduced the number of available abortion providers in the State and forced women to travel longer distances for an abortion without any offsetting health benefit. 136 S. Ct. at 2309–18. The Court held that the laws imposed an undue burden on access to abortion, and did so without looking at access outside of the state. *Id.* at 2318; *see J.D. v. Azar*, -- F.3d --, 2019 WL 2479436, at *27 (D.C. Cir. June 14, 2019) (A "state could not ban abortions outright on the theory that pregnant women can just go elsewhere"). As the D.C. Circuit recently put it: "The undue-burden framework has never been thought to tolerate any burden on abortion the government imposes simply because women can leave the jurisdiction." *Id.*

But even if the Court could properly consider women's ability to access care outside Arkansas, the burdens associated with women doing so are likewise substantial. Out-of-state travel to next-nearest providers would require the same hundreds of miles of round-trip travel that women would face in attempting under the OBGYN Requirement to obtain in-State care. *See supra* 28–30. Indeed, Dr. Katz determined that for a woman earning minimum wage, the

costs associated with such travel would consume approximately 25% of her income. *See supra* 29.

Women seeking care between 19.6 and 21.6 weeks LMP would face even more obstacles, given the limited number of out-of-state clinics providing care at that point in pregnancy. For example, because Memphis, Tennessee clinics do not provide abortions after 19.6 weeks LMP, a woman in Little Rock would need to travel to either Dallas, Texas (a more than 600-mile round-trip journey) or Wichita, Kansas (approximately 900 miles round trip) to obtain this care.[156] *See WWH*, 136 S. Ct. at 2302, 2313 (considering "increased driving distances" in burden analysis); *Van Hollen*, 738 F.3d at 796 (characterizing hundreds of miles of travel as "nontrivial burden on the financially strapped and others who have difficulty traveling long distances to obtain an abortion, such as those who already have children," and that "[s]ome patients will be unable to afford the longer trips they'll have to make to obtain an abortion").

In short, it is beyond debate that the OBGYN Requirement will operate as a substantial obstacle for a large fraction of women seeking abortions in Arkansas, preventing at least 62-70% of women who seek abortion care in Arkansas on an annual basis from obtaining the care they seek. These women will be forced to either carry to term against their will, attempt to terminate outside the health-care system, or try to surmount the enormous hurdles to obtaining care out of state. Because all available evidence shows that the OBGYN Requirement unduly burdens access to the abortion care women are constitutionally entitled, Plaintiffs have shown that they are likely to succeed on their challenge to this Requirement and injunctive relief is warranted.

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[156] Lindo Decl. ¶¶ 20, 59, Appendix.

III. PLAINTIFFS HAVE DEMONSTRATED A SUBSTANTIAL LIKELIHOOD OF SUCCESS ON THE MERITS OF THEIR EQUAL PROTECTION CLAIM.

Because the OBGYN Requirement's differential treatment of abortion providers and patients seeking abortion procedures is not justified by any legitimate governmental interest (*see supra*), Plaintiffs also are likely to succeed on the merits of their claim that the OBGYN Requirement violates the Equal Protection Clause. In fact, the OBGYN Requirement's imposition of unnecessary restrictions on abortion providers and patients fails equal protection review under any level of scrutiny.

The Equal Protection Clause is "essentially a direction that all persons similarly situated should be treated alike." *Stevenson v. Blytheville Sch. Dist. #5*, 800 F.3d 955, 970 (8th Cir. 2015). "Generally, a law will survive . . . scrutiny if the distinction it makes rationally furthers a legitimate state purpose." *Zobel v. Williams*, 457 U.S. 55, 60 (1982). "The State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985). "Some particularly invidious distinctions are subject to more rigorous scrutiny." *Zobel*, 457 U.S. at 60.

Where government action discriminates on the basis of a fundamental right, such as the abortion right, equal-protection analysis requires strict scrutiny. *See Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 312 & n.3 (1976) (noting classifications burdening fundamental rights are reviewed under strict scrutiny); *Craigmiles v. Giles*, 312 F.3d 220, 223 (6th Cir. 2002) ("When a statute regulates certain 'fundamental rights' (*e.g.* voting or abortion) . . . the statute is subject to 'strict scrutiny.'"). As the Supreme Court recently noted in adjudicating the undue burden claim in *Whole Woman's Health*, 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." 136 S. Ct. at 2309–10. Such heightened equal protection review requires close tailoring to extremely weighty state interests. *See, e.g.*, *Grutter v. Bollinger*, 539 U.S. 306, 326 (2003).

The OBGYN Requirement cannot withstand any heightened equal protection scrutiny. It singles out abortion and abortion providers like Drs. Ho and Tvedten for unique regulation, even though it is extremely safe and remains so when performed by a range of clinicians. *See supra* 19–21. "[T]he differential treatment of abortion vis-à-vis medical procedures that are at least as dangerous as abortions and probably more so" undermines any potential justification for this Requirement. *Van Hollen*, 738 F.3d at 791 (preliminarily enjoining admitting privileges requirement). Arkansas imposes no similar requirement for comparable outpatient procedures, nor for other, more risky procedures, including pregnancy care, *see supra* 18–19; *Schimel*, 806 F.3d at 914 (reasoning State's "indifferen[ce] to complications of any other outpatient procedures, even when they are far more likely to produce complications that abortions" undermines its interest); *Van Hollen*, 738 F.3d at 790 (explaining that "[a]n issue of equal protection of the laws is lurking in this case" because "the state seems indifferent to complications from non-hospital procedures other than surgical abortion (especially other gynecological procedures), even when they are more likely to produce complications," such as colonoscopies). The OBGYN Requirement's application to medication abortion is particularly infirm because it bars all physicians except board-certified or -eligible OBGYNs from prescribing oral medication only when that medication is for an abortion. *See supra* 20–21.

The OBGYN Requirement cannot even withstand rational basis review. It treats abortion providers and patients "differently . . . than similarly situated persons." *Stevenson*, 800 F.3d at 970. No comparable procedure, nor the providers of any comparable procedure, are subject to

board-certification or -eligibility requirements. In particular, providers of delivery care are not required to be board-certified or -eligible, even though pregnancy and delivery are much riskier than abortion. Arkansas likewise places no similar restrictions on miscarriage treatment. This differential treatment violates Plaintiffs' and their patients' equal protection rights. *See Romer v. Evans*, 517 U.S. 620, 633 (1996) (holding that law that on its face imposes a "special disability" on one group alone violates equal protection).

Moreover, as detailed above, there is no legitimate state interest requiring the OBGYN Requirement. *See supra* 18–21. As the Supreme Court has explained, "if the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare . . . desire to harm a politically unpopular group cannot constitute a legitimate governmental interest." *Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973); *see also Cleburne*, 473 U.S. at 448 ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."); *Ranschburg v. Toan,* 709 F.2d 1207, 1211 (8th Cir. 1983) ("An intent to discriminate is not a legitimate state interest."); *see also Whole Woman's Health,* 2017 WL 462400, at *8 (fact that certain Texas regulations applied to abortion but not miscarriage or ectopic pregnancy was "evidence [the State's] stated interest is a pretext for its true purpose, restricting abortions").

It is beyond dispute that the OBGYN Requirement's differential treatment of abortion providers and procedures is not "rationally related to a legitimate government objective." *Stevenson,* 800 F.3d at 970. As detailed above, there is no plausible safety or health rationale for the Requirement, nor does it serve any other legitimate state interest. *See supra*. There is thus no reason to subject abortion providers and procedures to more stringent requirements than comparable (and riskier) procedures given that abortion is a particularly safe procedure with low

complication rates. *See WWH*, 136 S. Ct. at 2315 (finding no legitimate safety reason for singling out abortion facilities for differential treatment because "abortions taking place in an abortion facility are safe—indeed safer than numerous procedures that take place outside hospitals"); *see also, e.g.*, *Schimel*, 806 F.3d at 912 ("[C]omplications from an abortion are both rare and rarely dangerous."); *Jegley IV*, 2018 WL 3029104, at *44 ("[A]s established by the Supreme Court, abortion in the first and second trimester is a safe procedure."); *Jegley V*, 2018 WL 3816925, at *45 (same); *June Med. Servs. LLC v. Kliebert*, 2017 WL 1505596, at *30 (M.D. La. Apr. 26, 2017) ("Abortion is one of the safest medical procedures in the United States."); *Strange*, 33 F. Supp. 3d at 1364 (abortions are "extraordinarily safe"). And, as noted, Arkansas law already extensively regulates abortion providers and facilities. *See supra* 17–18.

While rational basis review does not "require a perfect or exact fit between the means used and the ends sought," *Walker v. Hartford Life & Accident Ins. Co.*, 831 F.3d 968, 978–79 (8th Cir. 2016), it is "not toothless," *Kansas City Taxi Cab Drivers Ass'n, LLC v. City of Kansas City, Mo.*, 742 F.3d 807, 810 (8th Cir. 2013). Instead, equal protection review requires, at a minimum, that a statute's discriminatory line-drawing be rationally related to a legitimate state need. Here, there is simply no plausible policy reason for the differential treatment. Rather, the OBGYN Requirement only advances "negative attitudes" toward abortion. *Cleburne*, 473 U.S. at 448.

Numerous courts have preliminarily enjoined government action targeting abortion providers and patients for dissimilar treatment on the grounds that such action likely violates the Equal Protection Clause. *See, e.g.*, *Planned Parenthood of Greater Ohio v. Hodges*, 188 F. Supp. 3d 684, 693–94 (S.D. Ohio 2016) (granting preliminary injunction and finding plaintiffs likely to succeed on equal protection challenge to state funding law that singled out abortion for

different treatment); *Planned Parenthood of Kan. Lyskowski*, 2015 WL 9463198 (W.D. Mo. Dec. 28, 2015) (granting preliminary injunction upon finding plaintiff likely to succeed on claim that state agency violated Equal Protection Clause by treating abortion facility more harshly than others in ambulatory-surgical-center licensing process); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r Ind. State Dep't of Health*, 984 F. Supp. 2d 912, 921-25 (S.D. Ind. 2013) (granting preliminary injunction and finding plaintiffs likely to succeed on equal protection challenge to requirement that abortion clinics, but not physician's offices, meet physical plant requirements). This Court should reach the same conclusion here.

IV. THE PLAINTIFFS AND THEIR PATIENTS WILL SUFFER IRREPARABLE HARM IF THE NEW LAWS TAKE EFFECT.

In the absence of injunctive relief preventing the Bans and the OBGYN Requirement from taking effect, Plaintiffs and their patients will suffer irreparable harm.

The new laws will inflict irreparable, tangible injuries on Plaintiffs' patients by forcing them to delay access to abortion care or remain pregnant against their will. *See, e.g., supra* 25–30. Either scenario will impose irreparably medical harm on Plaintiffs' patients: delay increases the risks of abortion, *see supra* 8, and carrying to term is far more dangerous for a woman than abortion, *see supra* 5. Plaintiffs' patients who can no longer obtain an abortion in Arkansas will have to travel out of state for the care they seek. *See supra* 28–30. Such travel will delay their care, which increases risks; it will also increase the cost of accessing care, including transportation, childcare and lost-wages, and impose mental and emotional stress associated with prolonging an undesired pregnancy. *See id.* Some women may also be forced to compromise their privacy and the confidentiality of their pregnancy and abortion decision in order to obtain time off work, transportation or child care. *See id.* As numerous courts have found, each of these harms is irreparable. *See, e.g.*, *Van Hollen*, 738 F.3d at 796 (irreparable harm where

abortion restriction would impose undue travel burden and increased health risks, which could "result in the progression of a pregnancy to a stage at which an abortion would be less safe"); *Harris v. Bd. of Supervisors, L.A. Cty.*, 366 F.3d 754, 766 (9th Cir. 2004) (irreparable harm where individuals would experience complications, pain, and other adverse effects due to delayed medical treatment); *Roe v. Crawford*, 396 F. Supp. 2d 1041, 1044 (W.D. Mo. 2005) (finding irreparable injury where delay in abortion might increase "medical, financial, and psychological risks"), *stay of preliminary injunction denied*, 546 U.S. 959 (2005).

Other women will simply be unable to travel out of state for an abortion as a result of logistical obstacles, including the inability to take time off work or to raise the requisite funds for the procedure, transportation and associated costs. *See supra* 28–30. These women will therefore be forced either to seek care outside the clinical setting, such as self-induced abortion, or to carry to term and give birth against their will. The irreparable harm that follows from this outright denial of a woman's "choice altogether is apparent." *Roe*, 410 U.S. at 153. As the Supreme Court has explained:

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it.

Id.; *see also Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. 1981) (infringement on a woman's constitutional right to have an abortion "mandates" a finding of irreparable injury because "once an infringement has occurred it cannot be undone by monetary relief").

Plaintiffs will also suffer irreparable harm to their professional reputations, if they are forced to cease providing desired medical services and compassionate and nonjudgmental health care, and are precluded from acting, based on their good-faith medical judgment, in the best interests of their patients. *See Planned Parenthood of Minn.*, 558 F.2d at 867 ("Planned Parenthood's goodwill was imperiled by the prospect of having to interrupt its services."); *United Healthcare Ins. Co. v. Advance PCS*, 316 F.3d 737, 741 (8th Cir. 2002) ("Loss of intangible assets such as reputation and goodwill can constitute irreparable injury.").

Moreover, LRFP's business operations will also be irreparably harmed because, in the absence of injunctive relief, it will be forced to limit services and hours or close altogether. *See Planned Parenthood Gulf Coast, Inc. v. Kliebert*, 141 F. Supp. 3d 604, 652 (M.D. La. 2015) (noting in irreparable harm analysis that "if the Agreements are terminated, [the provider plaintiff] would suffer significant financial loss and might have no choice but to close" one of its facilities); *see also Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health,* 699 F.3d 962, 980 (7th Cir. 2012) (upholding district court's finding that laying off workers, closing clinics, and stopping service to patients is irreparable harm).

And in any event, "[i]t is well-settled that the inability to exercise a constitutional right constitutes irreparable harm." *Jegley II*, 267 F. Supp. 3d at 1068, 1084, 1095, 1110 (citing Eighth Circuit precedent); *see also Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) (plaintiffs' showing of interference "with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury"); *M.B. v. Corsi*, 2018 WL 5504178, at *5 (W.D. Mo. Oct. 29, 2018) ("A threat to a constitutional right is generally presumed to constitute irreparable harm."); *Hughbanks v. Dooley*, 788 F. Supp. 2d 988, 998 (D.S.D. 2011) ("[W]hen an alleged constitutional right is involved, most courts hold

that no further showing of irreparable injury is necessary." (quoting 11A Charles Alan Wright et al., *Federal Practice & Procedure* § 2948.1 (2d ed. 1995))); *see also Am. Civil Liberties Union of Ky. v. McCreary Cty.*, 354 F.3d 438, 445 (6th Cir. 2003) ("[I]f it is found that a constitutional right is being threatened or impaired, *a finding of irreparable injury is mandated*." (emphasis added) (citing *Elrod v. Burns*, 427 U.S. 347, 373 (1976))). Indeed, this presumption of irreparable harm applies with particular force where, as here, the threatened or impaired constitutional right is a woman's fundamental right to abortion, as "the abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences," *Bellotti v. Baird*, 443 U.S. 622, 643 (1979); *see also, e.g., Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 795–96 (7th Cir. 2013).

V. THE BALANCE OF HARMS TIPS DECIDEDLY IN PLAINTIFFS' FAVOR.

A request for preliminary relief also considers "whether the balance of equities so favors the movant that justice requires the court to intervene to preserve the status quo until the merits are determined." *Dataphase Sys., Inc.* v. *CL Sys., Inc.,* 640 F.2d 109, 113 (8th Cir. 1981). Here, Plaintiffs and their patients unquestionably face far greater irreparable harm if the challenged requirements take effect, than Defendants face if the laws' enforcement is enjoined, which would merely maintain the status quo—that is, the availability of safe and effective abortion care. As discussed above, the new laws would deny women their constitutional right, and "effectively force[] [some women] against their will to remain pregnant until they give birth." *Planned Parenthood Minn., N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011). By contrast, the State will suffer no harm from the non-enforcement of laws that are plainly unconstitutional under decades of Supreme Court precedent. *See Chamber of Commerce*

of U.S. v. Edmondson, 594 F.3d 742, 771 (10th Cir. 2010) (defendant "does not have an interest in enforcing a law that is likely constitutionally infirm"). The balance of harms thus weighs decisively in Plaintiffs' favor.

VI. A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION SERVES THE PUBLIC INTEREST.

Enjoining the challenged requirements and allowing women to continue accessing safe care would also serve the public interest. As the Eighth Circuit has made clear, "whether the grant of a preliminary injunction furthers the public interest . . . is largely dependent on the likelihood of success on the merits because the protection of constitutional rights is always in the public interest." *Planned Parenthood Minn., N. Dakota, S. Dakota v. Rounds*, 530 F.3d 724, 752 (8th Cir. 2008). In other words, it is axiomatic that the public interest is served by upholding the Constitution and preventing the enforcement of unconstitutional laws. *See, e.g., Traditionalist Am. Knights of the Ku Klux Klan v. City of Desloge, Mo.*, 914 F. Supp. 2d 1041, 1052 (E.D. Mo. 2012) ("'It is always in the public interest to protect constitutional rights,' and the public interest is served by preventing the likely unconstitutional enforcement of [an Act] while [the] case is considered on the merits." (quoting *Phelps-Roper v. Nixon*, 545 F.3d 685, 690 (8th Cir. 2008))), *overruled on other grounds by Phelps-Roper v. City of Manchester, Mo.*, 697 F.3d 678 (8th Cir. 2008); *Planned Parenthood of Minn.*, 799 F. Supp. 2d at 1077; *Doctor John's, Inc. v. City of Sioux City, Iowa*, 305 F. Supp. 2d 1022, 1042 (N.D. Iowa 2004). Because the new laws are clearly unconstitutional (*see supra* Part II–III), an injunction would serve the public interest.

VII. A BOND IS NOT NECESSARY IN THIS CASE.

The Court should waive the bond requirement of Rule 65(b) of the Federal Rules of Civil Procedure. It is well established that whether to require a bond rests in the discretion of the trial court and that factual contexts such as the one here support a finding that no bond is necessary.

Where plaintiffs are "serving a public interest in acting to protect important constitutional rights related to abortion," and the governmental defendants "will not be harmed by the order to preserve the status quo," courts have exercised their discretion to waive the security requirement. *Jegley II*, 267 F. Supp. 3d 1024, 1111 (E.D. Ark. 2017), *amended*, No. 4:17-CV-00404-KGB, 2017 WL 6946638 (E.D. Ark. Aug. 2, 2017); *see also Comprehensive Health of Planned Parenthood Great Plains v. Williams*, 263 F. Supp. 3d 729 (W.D. Mo. 2017), *vacated and remanded on other grounds, sub nom. Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750 (8th Cir. 2018); *Evenstad v. City of W. St. Paul*, 306 F. Supp. 3d 1086, 1102 (D. Minn. 2018) (waiving bond requirement where plaintiff was "seek[ing] to vindicate an important constitutional right").

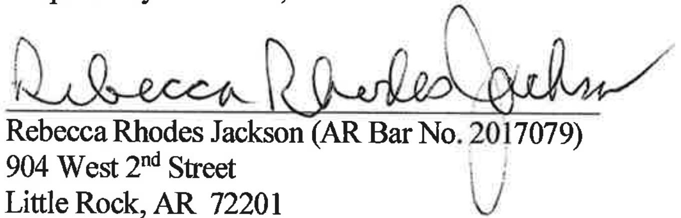
Plaintiffs, the last remaining abortion providers in Arkansas, are dedicated to serving their patients, including many poor and low-income women, and are seeking to vindicate and protect their constitutional rights. A bond would impose unnecessary strain on them, particularly where the State faces no prospect of monetary damages in this case. See *Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs,* 826 F.3d 1030, 1043 (8th Cir. 2016) (affirming district court's waiver of bond requirement "based on its evaluation of public interest"); *Ranchers Cattlemen Action Legal Fund v. U.S. Dep't of Agric.*, 566 F. Supp. 2d 995, 1008 (D.S.D. 2008) (individual ranchers attempting to vindicate public interest not required to post bond). Because Defendants will be unharmed by merely maintaining the status quo so that Plaintiffs can continue to provide safe and compassionate abortion care to their patients, the Court should waive the bond requirement.

CONCLUSION

For the foregoing reasons, the Court should grant Plaintiffs' Motion for Temporary Restraining Order and/or Preliminary Injunction, and enjoin Defendants, their employees, agents, and successors in office from enforcing the Bans and the OBGYN Requirement during the pendency of this litigation.

Dated: June 26, 2019

Respectfully submitted,



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** Motion for admission pro hac vice forthcoming*