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

FREDERICK W. HOPKINS, M.D., M.P.H. *et al.*,	)	
	)	
Plaintiffs,	)	Case No. 4:17-cv-00404-KGB
	)	
v.	)	
	)	
LARRY JEGLEY *et al*.,	)	
	)	
Defendants.	)	

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

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INTRODUCTION

In 2017, the Arkansas legislature enacted the four abortion restrictions challenged in this case; namely, the D&E Ban;[1] the Medical Records Mandate;[2] the Local Disclosure Mandate;[3] and the Tissue Disposal Mandate.[4] These restrictions are part of the Arkansas legislature's targeted campaign to eliminate abortion access in the State. Indeed, the State has passed more than 25 abortion restrictions over the last several years, including restrictions—like the ones here—that are designed to push abortion out of reach or ban it outright. This Court preliminarily enjoined these four laws, holding they would have the effect of severely restricting, if not outright eliminating, the availability of abortion in Arkansas. *Hopkins v. Jegley*, 267 F. Supp. 3d 1024 (E.D. Ark. 2017).

The State appealed this Court's order, and the Eighth Circuit vacated the preliminary injunction and remanded this case to this Court with instructions to apply the undue burden test as set forth in Chief Justice Roberts's concurrence in *June Medical Services, LLC. v. Russo*, 140 S. Ct. 2103, 2133 (2020) (Roberts, C.J., concurring in the judgment).[5] *See Hopkins v. Jegley*, 968 F.3d 912, 914–16 (8th Cir. 2020). The Chief Justice's concurrence critiqued the *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), formulation of the undue burden test, which held

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[1] Act 45 codified at Ark. Code Ann. §§ 20-16-1801 to 1807 (H.B. 1032).

[2] Act 733 codified at Ark. Code Ann. §§ 20-16-1901 to 1910 (H.B. 1434).

[3] Act 1018 codified at Ark. Code Ann. § 12-18-108(a)(1) (H.B. 2024).

[4] Act 603 codified at Ark. Code Ann. §§ 20-17-801 to 802 (H.B. 1566).

[5] In this motion, citations to *June Medical Services* are citations to the Chief Justice's concurrence unless otherwise noted.

that a law is an undue burden if its burdens outweigh its benefits. According to Chief Justice Roberts, a law is an undue burden if it imposes a substantial obstacle in the path of a person seeking a pre-viability abortion or is not reasonably related to a legitimate state purpose. *June Med. Servs.*, 140 S. Ct. at 2138.

As this Court already held, and for the reasons set forth below, Plaintiffs are likely to succeed on the merits of their undue burden claims under the test the Eighth Circuit instructed this Court to apply, because the challenged laws impose a substantial obstacle in the path of people seeking abortion care *irrespective* of any potential benefits. *Hopkins*, 267 F. Supp. 3d at 1068, 1078, 1091, 1106. Additionally, the challenged laws are not reasonably related to any legitimate state interests. *Id*. at 1076, 1089, 1105. The Eighth Circuit's instruction that this Court also consider *Box v. Planned Parenthood of Indiana & Kentucky*, *Inc*., 139 S. Ct. 1780 (2019) (per curiam), *see Hopkins*, 968 F.3d at 916, does not affect this analysis. *Box* did not involve an undue burden claim.

Furthermore, the remand does not affect this Court's prior ruling that Plaintiffs are also likely to succeed on their claims that two of the laws (the Medical Records and Tissue Disposal Mandates) fail to give Plaintiffs fair notice of what is prohibited and are therefore unconstitutionally vague. *Id*. at 1084, 1110.

The other preliminary-injunction factors also decidedly weigh in Plaintiffs' favor. As this Court has already recognized, absent injunctive relief, the four laws will cause irreparable harm by wreaking havoc on abortion access, including by forcing patients to delay or forego abortion care and violating their constitutional rights. *Id*. at 1069, 1084–85, 1095, 1110. In contrast, Defendants will not face any harm, especially given that the law has been enjoined for more than three years. The threatened harm to Plaintiffs and their patients clearly outweighs any purported

harm alleged by Defendants. *Id*. at 1069, 1085, 1096, 1110. And it is in the public's interest to preserve the long-standing status quo and ensure the protection of constitutional rights while the Court considers the merits of the claims. *Id*. at 1069, 1085, 1096, 1110. Accordingly, this Court should grant Plaintiffs' motion.

FACTUAL BACKGROUND

I. BACKGROUND ON ABORTION IN THE U.S. AND IN ARKANSAS

Abortion is very safe in the United States, and is far safer than childbirth. December 10, 2020 Decl. of Mark D. Nichols, M.D., in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Nichols 2020 Decl.") (attached as Ex. 1) ¶¶ 8–9. The risk of mortality following childbirth is up to 14 times greater than that associated with abortion. Decl. of Mark D. Nichols, M.D., in Supp. of Pls.' Mot. For Prelim. Inj. or in the Alternative a TRO, Dkt. 4, filed June 20, 2017 ("Nichols June 2017 Decl.") ¶ 8. Although abortion is safer than pregnancy and birth, including in the second trimester, the risk of complications from an abortion increase with each week of delay. Nichols 2020 Decl. ¶¶ 9–10; Decl. of Willie J. Parker, M.D., M.P.H., M.Sc., in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Parker Decl.") (attached as Ex. 2) ¶ 20. Thus, once a person decides to have an abortion, care should be obtained as soon as possible. Parker Decl. ¶ 20.

Abortion is also very common. Approximately 30% of women have an abortion at some point in their lives. Nichols June 2017 Decl. ¶ 7. People seek abortion care for a variety of personal and medical reasons that are linked to their values and beliefs, health status, reproductive and familial circumstances, education and career goals, and resources and economic stability. Decl. of Lori Williams, M.S.N., A.P.R.N., in Supp. of Pls.' Second Mot. for Prelim. Inj. and/or TRO ("Williams Decl.") (attached as Ex. 3) ¶ 9; *see also* Parker Decl. ¶ 28. Some have abortions because they conclude it is not the right time to become a parent or to add to their family, or because of a need to care for the children they already have. Williams Decl. ¶ 9. Approximately two-thirds of

people obtaining abortion care already have children. Decl. of Shelia M. Katz, Ph.D., in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or a TRO ("Katz Decl.") (attached as Ex. 4) ¶ 31.[6]

Plaintiff LRFP is one of only two remaining abortion clinics in Arkansas and provides between 2,000 and 3,000 abortions per year. Williams Decl. ¶¶ 13, 28. LRFP has been providing abortion care, along with other reproductive health care, including miscarriage care, basic gynecological care, pap smears, STD testing, and contraceptive counseling and services, in Little Rock since 1973. *Id.* ¶ 8. LRFP provides medication abortion up to 10.0 weeks, as dated from the first day of the patient's last menstrual period (LMP), and abortion procedures up to 21.6 weeks LMP.[7] *Id.* ¶¶ 11, 26. The only other clinic in Arkansas currently providing abortion care is also in Little Rock and provides only medication abortion up to 10 weeks LMP. Williams Decl. ¶ 13; Parker Decl. ¶ 9. LRFP is therefore the only option for patients seeking abortion care after 10 weeks LMP. Williams Decl. ¶ 13; Parker Decl. ¶ 9.

People seek abortion care at different points during their reproductive years. Under Arkansas law, abortion patients under 18 who are unmarried, unemancipated, or who do not have parental consent for abortion must receive a bypass from a judge who determines whether the minor seeking care is either mature and well-informed enough to decide without a parent or that requiring parental consent is not in the minor's best interest. Ark. Code Ann. § 20-16-809

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[6] Ark. Ctr. of Health Stat., *Induced Abortion Report 2019*, at 12 (2020) https://www.healthy.arkansas.gov/images/uploads/pdf/Induced_Abortion_final_2019.pdf (in Arkansas, two-thirds of abortion patients had one or more previous live births).

[7] Pregnancy is typically dated from the first day of the patient's last menstrual period. The number of weeks appears before the decimal point and the number of days appear after the decimal point, so 10.0 weeks LMP means 10 weeks and zero days since the patient's last menstrual period. Parker Decl. ¶ 2 n.1.

(2016). In 2019, LRFP treated 53 patients under 17 years old, 51 of whom had parental consent and two of whom obtained a judicial bypass. Williams Decl. ¶ 57.

Like abortion patients across the country, LRFP abortion patients disproportionately have low incomes. *Id*. ¶ 18; Parker Decl. ¶ 19; Katz Decl. ¶ 31; Decl. of Lauren J. Ralph, Ph.D., M.P.H., in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Ralph Decl.") (attached as Ex. 5) ¶ 19. Approximately 60% of LRFP patients qualify for financial assistance to cover part of the costs of their abortion care, and those that do not receive financial assistance nevertheless struggle in gathering the resources to obtain abortion care. Williams Decl. ¶ 18; *see also* Decl. of Patient Jane Doe 2 in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Doe 2 Decl.") (attached as Ex. 6) Decl. ¶¶ 8–9 (patient who received aid describing travel and additional expenses incurred traveling 2.5 hours to LRFP to obtain abortion care). In addition to the cost of the abortion itself, patients must arrange for transportation for at least two, and in some cases three, trips to the clinic; for childcare, if they have children; and for time off from work for at least two, and, in some cases three, days.[8] Patients who are traveling from far away will also have to arrange for overnight lodging. Williams Decl. ¶¶ 20, 22. For patients already struggling to make ends meet, raising the funds to pay for these unexpected costs can make it even more difficult to maintain a minimally self-sufficient standard of living. Williams Decl. ¶¶ 18–22; Katz Decl. ¶ 38.

[8] In 2019, Arkansas increased the mandatory waiting period between State-mandated counseling and receiving abortion care from 48 hours to 72 hours. Thus, under Arkansas law, all patients must travel to the clinic to receive the State mandated in-person counseling, wait three days, then return to the clinic to receive care. Ark. Code Ann. § 20-16-1703. Those patients who require overnight dilation must make a third trip to complete their care. Williams Decl. ¶ 15; Parker Decl. ¶ 15.

The amount needed to maintain a minimally self-sufficient standard of living in Arkansas is almost twice the amount of the federal poverty guideline. Katz Decl. ¶ 27. In 2019, 17% of Arkansas population lived below the federal poverty threshold, which is $12,760 for a single person, with $4,480 added per year for each additional member of the household. *Id*. ¶¶ 17, 19. The poverty rate for women in the State was higher at 18.6%, and the poverty rates among people of color were even higher with 29.3% of Black or African American people, 22.6% of American Indian or Alaskan Native people, and 25.6% of Hispanic or Latino people living in poverty. *Id*. ¶¶ 19, 21.[9] People of color disproportionately seek abortion care and are thus disproportionately affected by abortion restrictions; for example, almost half of abortion patients are Black. *Id*. ¶ 31; *see also* Ralph Decl. ¶ 18.

In some cases, the additional time, expense, and lost income from the added travel restricts patients' ability to buy food or other necessities, jeopardizes their employment and the confidentiality of their pregnancy and abortion decision by forcing disclosure to an employer or an intimate partner, and imposes other significant burdens. Katz Decl. ¶ 36; *see also* Decl. of Patient Jane Doe 3 in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Doe 3 Decl.") (attached as Ex. 7) ¶¶ 11–12 (describing being forced to disclose her care to her employer in order to take time off to obtain care and subsequently losing her job due to her employer's opposition to abortion). Moreover, even if they are ultimately able to obtain an abortion, patients must often delay care to gather these resources and, as explained above, that delay increases the medical risks of the procedure and the cost of the procedure, which, in turn, can lead to further delay. Williams Decl. ¶¶ 19–23; Parker Decl. ¶ 20.

[9] *See also* U.S. Census Bureau, *Quick Facts: Arkansas*, https://www.census.gov/quickfacts/AR; Ark. Ctr. of Health Stat., *supra* note 6, at 6–7.

If patients are unable to obtain care at LRFP, there is no other in-state option for obtaining abortion care after 10 weeks LMP. Williams Decl. ¶ 25. The next-nearest clinic providing care after 10 weeks LMP is in Memphis, Tennessee, which provides care up to 19.6 weeks LMP and is 300 miles roundtrip from Little Rock and 600 miles roundtrip from Fayetteville, where many LRFP patients live. *Id*. The trip would require transportation and lodging costs, in addition to the costs of childcare, food, and/or the cost of the procedure itself. Katz Decl. ¶¶ 37–46; *see also* Doe 2 Decl. ¶¶ 8–9 (describing travel and expenses incurred traveling 2.5 hours to LRFP for an abortion). The total financial burden would add up to a significant amount of a person's monthly income, not to mention the cost of lost wages due to the time she would have to miss work. Katz Decl. ¶ 55. The next-closest clinics providing care up to 21.6 weeks LMP are in Granite City, Illinois, and Dallas, Texas, both of which are approximately 600–700 miles roundtrip from Little Rock. Williams Decl. ¶ 25. Forcing patients to travel out of state for abortion care will usually delay patients' access to care and thus increase medical risks and costs. *See* Williams Decl. ¶¶ 23, 25; Parker Decl. ¶ 20; Ralph Decl. ¶ 26.

To obtain the money required to access this time-sensitive care, patients with low incomes are likely to (i) make sacrifices in other areas such as not paying rent or utilities, drastically reducing their food budget, or forgoing other medical care; (ii) borrow money through a predatory loan service, incurring high interest rates; or (iii) borrow money from a partner, even if they are no longer together or the partner was abusive.[10] Katz Decl. ¶¶ 61–65. Some patients

[10] Indeed, recent research shows that policies that restrict abortion access result in women being at greater risk for domestic violence because they are "unable to terminate unwanted pregnancies, potentially keeping some women in physically violent relationships and putting women and their children at increased risk of violence and other negative health consequences." Katz Decl. ¶ 65 (quoting Sarah C.M. Roberts et al., *Risk of Violence From the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12 BMC Med. 144 (2014)).

will be unable to gather the resources to obtain care out of state and will be forced to either carry their pregnancies to term against their will or attempt to end their pregnancies without medical assistance, possibly using unsafe means. Parker Decl. ¶ 31; Williams Decl. ¶ 25; Ralph Decl. ¶¶ 40–41; *see also* Katz Decl. ¶ 67–68 (describing studies showing that distance negatively impacts abortion access and that the most common reasons women delayed abortion care were travel and procedure costs, having to get time off work, and finding childcare).

The COVID-19 public-health emergency has further exacerbated the burdens LRFP's patients experience accessing abortion care. People have lost their jobs or had their hours cut, making the financial hardship and logistical obstacles associated with abortion care even more daunting. Katz Decl. ¶ 60; Williams Decl. ¶ 24. Arranging for transportation and childcare, which already posed challenges for LRFP's patients, is even more difficult for patients who can no longer rely on family members, friends, or others during a time of recommended social distancing. Williams Decl. ¶ 24.

Except in very limited circumstances, patients are entitled to decide whether and with whom their health information is shared. Parker Decl. ¶¶ 60, 68, 90–91. Confidentiality is an especially important concern for people seeking abortion care. *Id*. ¶¶ 59–61, 75, 91; Ralph Decl. ¶ 27. Individuals who have decided to end their pregnancy often fear reprisals—ranging from condemnation or harassment from their communities, schools, employers, and even other health care providers to violence by their intimate partners—if others find out about their decision. Williams Decl. ¶¶ 19, 43–44, 84–86; Parker Decl. ¶¶ 59, 61, 75, 91; Ralph Decl. ¶¶ 33–36; Katz ¶¶ 66, 73; *see also* Decl. of Patient Jane Doe 1 in Supp. of Pls.' Mot. for Second Prelim. Inj. and/or TRO ("Doe 1 Decl.") (attached as Ex. 8) ¶ 7; Doe 3 Decl. ¶¶ 13, 15. Minors have an especially strong interest in maintaining the privacy of their care and can be especially fearful about disclosure given their relative lack of economic independence. *See* Williams Decl. ¶ 70;

Parker Decl. ¶¶ 74, 92; Ralph Decl. ¶¶ 27–37, 42; *see also* Doe 3 Decl. ¶ 6. Thus, any threat to confidentiality can cause patients fear, delay their care, or deter them from accessing abortion altogether. Parker Decl. ¶ 75; Williams Decl. ¶¶ 44, 86; Doe 1 Decl. ¶ 7; Doe 3 Decl. ¶¶ 7–9; Ralph Decl. ¶¶ 27–42.

II. ABORTION PROVISION IN THE UNITED STATES AND ARKANSAS

In Arkansas, as in the nation as a whole, the vast majority of people who seek abortion care do so in the first trimester (up to approximately 14 weeks LMP). Parker Decl. ¶ 10. Approximately 88% of abortions in Arkansas take place in the first trimester. *Id*.

In the first trimester of pregnancy, there are two principal abortion methods: medication abortion and aspiration abortion. Nichols June 2017 Decl. ¶ 11; Parker Decl. ¶ 12. In a medication abortion, the patient takes two medications that together will induce a process similar to a miscarriage. The patient takes mifepristone on the first day, and misoprostol approximately 24–48 hours later in a location of the patient's choosing (usually at home), after which the patient expels the pregnancy tissue. Nichols June 2017 Decl. ¶ 12; Parker Decl. ¶ 12. In an aspiration abortion, which is provided throughout the first trimester, a clinician dilates the patient's cervix and inserts a small tube, or canula, into the patient's cervix and uses gentle suction to empty the contents of the uterus. Nichols June 2017 Decl. ¶ 13; Parker Decl. ¶ 12. LRFP is the only provider of aspiration abortion in Arkansas. Parker Decl. ¶ 12; Williams Decl. ¶ 13.

Dilation and evacuation ("D&E") is the principal method of abortion that is used throughout the second trimester and the only outpatient method that is used throughout the second trimester in Arkansas. Nichols June 2017 Decl. ¶ 16; Parker Decl. ¶ 13; *see also* Nichols June 2017 Decl. ¶ 19 (D&E "was a major innovation in abortion care because it is well suited to the out-patient, ambulatory setting"). National data suggest that D&E accounts for almost all

second-trimester abortion procedures in the United States; in 2019, D&E accounted for 100% of second-trimester abortion procedures reported in Arkansas. Parker Decl. ¶ 14; Nichols June 2017 Decl. ¶ 16. The only other abortion method that can be provided throughout the second trimester, induction of labor, is generally performed in a hospital; takes place over several hours or days; can entail more pain, discomfort, and distress for the patient; and is far more expensive than D&E. Parker Decl. ¶ 14; Nichols June 2017 Decl. ¶¶ 14–16.

During a D&E, a physician dilates the patient's cervix, and then, once the cervix is sufficiently dilated, evacuates the uterus using a combination of suction and instruments. Parker Decl. ¶ 13; Nichols June 2017 Decl. ¶¶ 17–18. The evacuation phase of the procedure typically takes under ten minutes. Parker Decl. ¶ 13; Nichols June 2017 Decl. ¶ 18. Because the physician dilates the cervix only enough to allow for the safe passage of instruments and removal of tissue, fetal tissue separates as it is removed through the cervix. Parker Decl. ¶ 13; Nichols June 2017 Decl. ¶ 18.

In Arkansas, the D&E procedure takes place over one or two days, depending on the medical needs of the patient. Parker Decl. ¶ 15; Williams Decl. ¶¶ 29–30. For a large majority of LRFP's second-trimester patients, a physician is able to safely dilate the cervix and evacuate the uterus on the same day by using manual dilators and medication. Parker Decl. ¶ 15; Williams Decl. ¶ 29. A small number of LRFP's second-trimester patients undergo overnight dilation, whereby physicians place osmotic dilators that expand slowly to gently achieve greater dilation over the course of several hours. Parker Decl. ¶ 15; Williams Decl. ¶ 29. Physicians evaluate patient history and circumstances and use their clinical judgment to determine the best dilation protocol for each individual patient. Parker Decl. ¶ 15; Williams Decl. ¶ 30. LRFP's physicians

typically begin the overnight-dilation protocol between 18 and 20 weeks LMP. Parker Decl. ¶ 15; Williams Decl. ¶ 30.

At LRFP, if a physician is using overnight dilation, the physician also typically attempts to induce fetal demise by injecting digoxin either directly into the fetus or, if such an injection is not possible, into the amniotic fluid when the physician begins dilation. Parker Decl. ¶ 16; *see also* Nichols 2020 Decl. ¶ 16. Digoxin can cause fetal demise over the course of 24 hours by causing the fetal heart rate to slow and eventually stop, but does not always cause demise. Parker Decl. ¶ 16; Nichols 2020 Decl. ¶¶ 16–17, 19. LRFP physicians attempt demise when using overnight dilation, where safe and appropriate, because it demonstrates compliance with federal and state partial birth abortion bans.[11] Parker Decl. ¶¶ 16–17; *see also* Nichols 2020 Decl. ¶ 16. If a patient requiring overnight dilation returns the next day and the digoxin injection has not caused fetal demise, the physician will still evacuate the patient's uterus on that same day. Parker Decl. ¶ 18. At this point, physicians will take steps with their forceps—such as compressing fetal parts—in order to attempt to cause demise and otherwise further demonstrate compliance with existing laws. *Id*.

III. THE D&E BAN

Act 45, codified at Ark. Code Ann. §§ 20-16-1801 to -1807, prohibits procedures that use instruments to separate fetal tissue. Because, as described above, a provider performing a D&E

[11] The federal "Partial Birth Abortion" ban, 18 U.S.C. § 1531, and its state analog, Ark. Code Ann. § 20-16-1203, prohibit a physician from intentionally performing a dilation and extraction ("D&X") procedure—a rarely used procedure, performed later in pregnancy, where the physician removes a certain portion of the fetus intact—unless fetal demise is induced before the procedure. *See Gonzales v. Carhart*, 550 U.S. 124, 132–33, 135, 164–65 (2007). While no physician at LRFP ever intends to perform a D&X procedure under any circumstances, attempting fetal demise starting at 18 to 20 weeks further demonstrates their compliance with this ban.

uses instruments to separate fetal tissue, the law prohibits D&E. Act 45 makes D&E a felony and subjects providers to criminal, professional, and civil penalties for performing the procedure. Although the law prohibits D&E where the fetus is "living," as this Court previously found, *Hopkins*, 267 F. Supp. 3d at 1059, under this Ban, there is no safe or reliable way to guarantee fetal demise in every case before evacuating the uterus using instruments, *see also* Nichols June 2017 Decl. ¶ 20; Parker Decl. ¶ 22. Thus, there is no way for Plaintiffs to continue to provide D&E without risking being subject to the penalties of this law.

As described below, the methods that Defendants propose physicians use to cause demise prior to D&E (injection of digoxin, injection of potassium chloride, and transection of the umbilical cord) are unreliable, experimental, and/or increase risk.[12] As such, under the Ban, a physician could not attempt to perform a D&E without jeopardizing patient care, exposing themselves to criminal liability, or both.

A. Digoxin.

Digoxin is a drug that is injected either transabdominally or transvaginally into the fetus or the amniotic sac. While LRFP providers attempt digoxin injections for certain patients in their current practice, digoxin is not appropriate for every patient and will not accomplish demise in every case. Parker Decl. ¶ 23a–d; Nichols 2020 Decl. ¶ 17. As an initial matter, digoxin injections are almost never performed prior to 18 weeks, which is when most D&Es are provided, and their use at this stage of pregnancy is unstudied. Nichols 2020 Decl. ¶ 18; Parker

[12] Indeed, the American Congress of Obstetricians and Gynecologists ("ACOG"), the preeminent medical organization in the field, has stated that there is no sound medical basis for requiring abortion providers to induce fetal demise prior to performing a D&E. Nichols June 2017 Decl. ¶ 22. According to ACOG: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester medical or surgical abortion." ACOG's statement is fully consistent with the medical literature. *Id.*

Decl. ¶ 23a. Physicians have no way of knowing the risks, complication rates or effectiveness of injections at this earlier stage of pregnancy. Rebuttal Decl. of Mark D. Nichols, M.D., in Supp. of Pls.' Mot for Prelim. Inj. or in the Alternative a TRO, Dkt. 32-1, filed July 20, 2017 ("Nichols July 2017 Decl.") ¶ 9; Parker Decl. ¶ 23a.

Even after 18 weeks, digoxin injections are contraindicated or otherwise inappropriate for some patients. Nichols 2020 Decl. ¶ 17; Parker Decl. ¶ 23c. Digoxin injections are also not 100% effective in causing fetal demise, even when successfully injected, and it is impossible to know at the time of the injection for which patients it will fail to cause fetal demise. Nichols 2020 Decl. ¶ 19; Parker Decl. ¶ 23d. In the case of a failure, where the patient's cervix will already be dilated, the standard of care is to complete the procedure as quickly as possible, but the D&E Ban would criminalize going forward without demise. Nichols 2020 Decl. ¶¶ 13, 15; Parker Decl. ¶ 23d. Because the law makes no exceptions for a failed demise attempt, any patient for whom the first injection failed to cause demise would have to undergo another demise procedure, like a second injection of digoxin, and wait for that procedure to cause fetal demise. However, repeat doses of digoxin are unstudied and physicians have no way of knowing the risks, complication rates or effectiveness of such injections. Nichols June 2017 Decl. ¶ 29; Parker Decl. ¶ 23d.

However, because even when successful digoxin takes up to 24 hours to work, requiring digoxin injections prior to all D&Es would require the majority of LRFP patients who normally have one-day procedures to undergo two-day procedures, in addition to the State-mandated visit to the clinic 72 hours already required before the first procedure day. Parker Decl. ¶ 23b; Williams Decl. ¶¶ 34–35. In effect, this would require every D&E patient to make at least three trips to the clinic. And, in cases where digoxin fails and the patient receives an experimental

second injection, patients would have to make still more trips to the clinic so the additional injection has time to work. Parker Decl. ¶ 23b.

In sum, in LRFP's current practice, physicians only attempt digoxin injections for patients undergoing overnight dilation, which physicians begin starting between 18 and 20 weeks, and when the physician determines that it is otherwise safe to do so. Parker Decl. ¶¶ 15–17; Williams Decl. ¶¶ 29–31; *see also* Nichols 2020 Decl. ¶¶ 7, 14. As explained above, in current practice, when digoxin fails, the procedure goes forward on the same day. Parker Decl. ¶ 18. Requiring LRFP's providers to use digoxin prior to every D&E would unnecessarily prolong the procedure (imposing significant financial and logistical burdens) and put patients at risk by subjecting them to injections that are medically inappropriate and/or experimental. Parker Decl. ¶ 23a–d; Nichols June 2017 Decl. ¶¶ 26, 29. Even then, there is no guarantee it will actually cause demise in every case, thereby exposing any physician who attempts to rely on it to significant criminal liability. Digoxin thus does not provide a safe or reliable workaround to the Ban.

B. Potassium Chloride.

Far less common than digoxin, injections of potassium chloride, or KCl, are used by some subspecialists to induce fetal demise through a transabdominal injection into the fetal heart; it will not cause fetal demise when injected into the amniotic fluid. Decl. of Katharine D. Wenstrom, M.D., in Supp. of Pls.' Second Mot. for Prelim. Inj. and/or TRO ("Wenstrom Decl.") (attached as Ex. 9) ¶ 7; Nichols June 2017 ¶ 31. KCl injections are generally used to perform selective terminations in a multi-fetal pregnancy. Wenstrom Decl. ¶ 9. Although KCl is effective if injected successfully, injections into the fetal heart require a very high degree of precision and skill. *Id*. ¶ 11. They are typically performed only by Maternal-Fetal Medicine ("MFM") specialists—OB/GYNs who have completed an additional, specialized fellowship with extensive and lengthy advanced training at one of few MFM programs in the country with a tertiary fetal

center. *Id*. ¶¶ 11–12. Even with that specialized training, KCl may be difficult or impossible to administer in some patients with common conditions such as obesity or uterine fibroids. *Id*. ¶ 23; Nichols June 2017 Decl. ¶ 31. It simply cannot be administered by the vast majority of abortion providers, including the providers at LRFP, who do not have, and cannot realistically get, that specialized training. Wenstrom Decl. ¶¶ 11–20; Parker Decl. ¶ 24. Moreover, use of KCl, particularly in untrained hands, involves serious risk including infection and maternal cardiac arrest. Wenstrom Decl. ¶ 22; Nichols June 2017 Decl. ¶ 31.

C. Transection of the Umbilical Cord.

Umbilical cord transection requires the clinician to rupture the amniotic membranes and insert an appropriate surgical instrument or suction into the uterus to grasp the umbilical cord, often probing the uterus in an attempt to find and grasp the cord. Nichols 2020 Decl. ¶ 20; Parker Decl. ¶ 25. If the clinician can grasp the cord, they will divide ("transect") it with gentle traction. Nichols 2020 Decl. ¶ 20; Parker Decl. ¶ 25. Once the cord is transected, demise will occur over the course of approximately ten minutes. Nichols 2020 Decl. ¶ 20. This procedure is not widely practiced, is barely researched, and cannot be performed for every patient. *Id*. ¶¶ 21–22.

Attempting umbilical cord transection can subject patients to significant health risks. *Id.*; Parker Decl. ¶ 25. Locating and transecting the cord may take additional time and additional passes into the uterus with instruments, both of which increase the risk of uterine perforation and other complications, and also increase the time the patient is bleeding and exposed to anesthesia. Nichols 2020 Decl. ¶ 21; Nichols July 2017 Decl. ¶ 15; Parker Decl. ¶ 25. The sole published study on cord transection reports on the experience of providers in a single setting and cannot be used to make conclusions about whether cord transection is safe because it does not reliably reflect the additional time or passes of instruments that were necessary to identify and transect

the cord. Nichols 2020 Decl. ¶ 22; Nichols June 2017 Decl. ¶ 34.[13] Moreover, under the D&E Ban, in attempting to transect the cord, physicians would have to ensure that they do not grasp fetal tissue instead of or in addition to the cord. Nichols 2020 Decl. ¶ 21; Parker Decl. ¶ 25. Grasping fetal tissue instead of or in addition to the cord before causing demise would violate the D&E Ban.

* * *

As the facts above show, under the D&E Ban, there is no safe or feasible way for providers to guarantee fetal demise in every case. The fetal-demise methods that Defendants propose are unavailable, unreliable, and/or experimental, and requiring demise in all cases would not only expose providers to criminal liability but would also expose patients to increased risks and/or multiple, unnecessary trips to the clinic.[14]

Physicians have an ethical obligation to take the best possible care of their patients. Nichols 2020 Decl. ¶ 23. Once the physician has started a D&E, the safest thing for the patient would be to complete the procedure as quickly as possible regardless of whether fetal demise has occurred. However, under the D&E Ban, completing the procedure would be unlawful without fetal demise, which cannot be guaranteed for any given patient. *Id*. ¶ 24, Parker Decl. ¶ 27. By

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[13] *See also W. Ala. Women's Ctr. v. Miller*, 299 F. Supp. 3d 1244, 1272 (M.D. Ala. 2017) (explaining that this lone study on cord transection is "flaw[ed]" and "raises more questions than it answers"), *aff'd*, 900 F.3d 1310 (11th Cir. 2018), *cert denied sub. nom. Harris v. W. Ala. Women's Ctr.*, 139 S. Ct. 2606 (2019).

[14] Defendants also suggest that providers could perform aspiration procedures instead of D&E in the second trimester. *Hopkins*, 267 F. Supp. 3d at 1058 n.5. This is incorrect: suction cannot be relied upon to complete abortion procedures throughout the second trimester; even early in the second trimester, suction may be insufficient to complete a procedure. Starting as early as approximately 14 weeks LMP, in any given case, physicians may find it necessary to use instruments before demise has occurred to complete the procedure as quickly and safely as possible. Later in the second trimester, instruments will certainly be necessary to complete a procedure. Parker Decl. ¶ 26; Nichols July 2017 Decl. ¶ 5.

forcing physicians to either stop providing D&E altogether or risk criminal penalties and subject their patients to unnecessary procedures that are unstudied, potentially dangerous, and not in their patients' best interest, the D&E Ban makes ethical care impossible. Nichols 2020 Decl. ¶ 24; Parker Decl. ¶ 27.

D. Effect of the D&E Ban.

Because D&E is the only outpatient abortion procedure performed throughout the second trimester and accounts for 100% of second-trimester abortions reported in Arkansas, Parker Decl. ¶ 14, the D&E Ban effectively prohibits second-trimester abortion in Arkansas. Because there is no safe, feasible, or reliable way to guarantee fetal demise in every case, if the D&E Ban were to go into effect, providers in Arkansas would be unable to start any procedures, starting as early as approximately 14 weeks LMP, without putting themselves at risk of criminal penalties and without exposing their patients to experimental procedures, delay, and increased risks. *Id*. ¶ 27; Nichols 2020 Decl. ¶ 13.

Approximately 15–20% of abortions at LRFP occur during the second trimester. Williams Decl. ¶ 28. As with all patients seeking abortion care, LRFP's patients seek second-trimester abortion care for a variety of reasons. As described above, many of LRFP's patients have low incomes. *Id.* ¶ 18; Parker Decl. ¶ 19. It is common for patients to be delayed in obtaining care past the first trimester for financial reasons or due to the difficulty of arranging for transportation, childcare or time off work. Parker Decl. ¶ 28; Williams Decl. ¶ 21. Other patients may have medical reasons for seeking second-trimester abortion care. For example, they might have had difficulty recognizing the pregnancy or have only recently learned that continuing pregnancy posed a risk to their health. Parker Decl. ¶ 28.

If LRFP were to stop providing D&E procedures altogether, these patients would be forced to attempt to travel out of state to the next-nearest clinics providing second-trimester

abortion care. For some patients, that will require trips of 300–700 miles round trip. Katz Decl. ¶ 8; Williams Decl. ¶ 25. Nichols 2020 Decl. ¶ 12. As described above, because many LRFP's patient have low incomes, they will not be able to make that trip and will be forced to either carry their pregnancies to term or attempt to end their pregnancy without medical assistance, possibly by unsafe means. Those who might still be able to obtain care elsewhere will likely experience delay which, as described above, increases both medical risks and financial, logistical and emotional burdens on patients. Parker Decl. ¶ 30; Williams Decl. ¶ 33; Katz Decl. ¶ 66.

Even if providers were willing to attempt to cause fetal demise prior to every D&E procedure, adding such additional procedures to every patient's protocol would, as described above, subject patients to increased medical risks, and/or significant, if not insurmountable, financial and logistical barriers. For example, if providers were to attempt to cause demise with digoxin, providers would be experimenting on every patient before 18 weeks LMP; and *all* second-trimester abortion patients would be required to pay for and arrange for transportation and, if necessary, childcare for each of at least three trips to the clinic, and potentially for overnight lodging near the clinic, as well. Parker Decl. ¶ 23a–b; Williams Decl. ¶¶ 31, 34–35. Patients would also face higher procedure costs due to increased supplies and staff time needed to implement this new patient protocol. Williams Decl. ¶ 35. Because, as also described above, the majority of LRFP patients already struggle to gather the resources needed to obtain care, adding these additional logistical and financial barriers will, at minimum, force many patients to delay care, which itself increases medical risks; for some, it will push care out of reach completely. Parker Decl. ¶ 30; Williams Decl. ¶¶ 33–35.

IV. THE MEDICAL RECORDS MANDATE

A. The Challenged Statute.

The Medical Records Mandate provides that "[a]n abortion shall not be performed until" the physician "[r]equest[s] the medical records of the pregnant woman relating directly to [her] entire pregnancy history," and then spends "reasonable time and effort . . . to obtain" such records. Ark. Code Ann. § 20-16-1904(b)(2) (2018) (enacted as part of Act 722, H.B. 1434, and originally to be codified at Ark. Code Ann. § 20-16-1804(b)(2)). The statute fails to define what constitutes "reasonable time and effort" and fails to define the scope of "medical records relating directly to the entire pregnancy history" of the patient. It also fails to specify for what purpose the physician must collect the records and what actions, if any, the physician must take upon receiving any records. The Medical Records Mandate contains no exceptions, including none based on the patient's health, the gestational age of the pregnancy, or any other circumstances that would make medical records searches and their attendant delay especially harmful to the patient.

Violation of the Medical Records Mandate triggers severe penalties. A physician who "knowingly performs or attempts to perform an abortion" prohibited by the Medical Records Mandate is guilty of a Class A misdemeanor, punishable by up to one year in jail, a fine, or both. *Id*. § 20-16-1905 (2018); *see also id*. §§ 5-4-201 (2009), 5-4-401 (1983). A physician who undertakes a prohibited abortion "engage[s] in unprofessional conduct for which his or her license . . . shall be suspended or revoked." *Id*. § 20-16-1906(c) (2018). The Medical Records Mandate also provides for damages, *id*. § 20-16-1906(a)(l), and creates a cause of action for injunctive relief against a physician who knowingly violates the law, which may be brought by the Attorney General or by the patient's spouse, parent, guardian, or current or former licensed health care provider. *Id*. § 20-16-1906(d)(1).

In addition to the Medical Records Mandate, the legislature's same 2017 enactment, Act 722, separately provides that a physician "shall not intentionally perform . . . an abortion" knowing that the "woman is seeking the abortion solely on the basis of" the sex of the embryo or fetus, and requires the physician to ask each patient if she knows the sex. *Id*. § 20-16-1904(a), (b)(1). Plaintiffs do not challenge those provisions.

B. The Impact of the Medical Records Mandate.

The great majority of LRFP abortion patients have seen another health care provider or providers related to their current or a past pregnancy. Williams Decl. ¶ 48. Two-thirds of abortion patients have previously given birth at least once, often more than once. *Id*. ¶ 48; Katz Decl. ¶ 31. Of the other one-third, many have seen other health care providers related to the current pregnancy or to a pregnancy or pregnancies that were molar or ectopic or ended in miscarriage or abortion. Parker Decl. ¶¶ 33, 42; Decl. of Frederick W. Hopkins, M.D., M.P.H., in Supp. of Pls.' Mot. for Prelim. Inj. or in the Alternative a TRO, Dkt. 5 ("Hopkins Decl.") ¶¶ 31–32. For all of these patients, the Medical Records Mandate prohibits abortion unless and until Plaintiffs undertake a search for the "medical records relating directly to" the patient's "entire pregnancy history," however extensive a history that is. Ark. Code Ann. § 20-16-1904(b)(2).

Absent the Mandate, abortion providers seek medical records from other health care providers only in the tiny fraction of cases when there is a medical reason to do so. Williams Decl. ¶ 39; Parker Decl. ¶ 34; Nichols June 2017 Decl. ¶ 9. In those rare circumstances, the requests seek only limited information related to a particular patient's co-morbidity or a fetal diagnosis during the current pregnancy, to address medical issues typically raised by the patient herself. Parker Decl. ¶¶ 35–37; Williams Decl. ¶ 39. By contrast, seeking all medical records from all previous providers over each patient's "entire pregnancy history" is a sweeping search—and to no end. Such a sweeping search would not improve abortion health care. Parker

Decl. ¶ 37. Even in the few circumstances where requests for discrete records are currently made, physicians typically wait for records only if they can be obtained quickly, because any benefit from the records would otherwise be outweighed by the increased medical risks to the patient from delaying abortion. *Id*. ¶¶ 38–40; *see also* Hopkins Decl. ¶ 34.

The Medical Records Mandate does not serve any medical purpose but does impose unnecessary logistical hurdles, breach confidentiality, and create unjustified delay for patients. Parker Decl. ¶¶ 34–42, 58–62; Williams Decl. ¶¶ 40–50. Because the Mandate requires physicians to request the "medical records relating directly to" the patient's "entire pregnancy history," LRFP must first ask the patient to attempt to gather the names and current contact information of all relevant providers, potentially stretching back over a decade or more. Williams Decl. ¶¶ 47–48; Parker Decl. ¶ 33, 58. After marshaling this information, the patient would need to execute a separate records request for each of the past providers who may have records; LRFP would then need to transmit all of those requests. Williams Decl. ¶¶ 40, 49–50; Parker Decl. ¶ 61. To try to comply with the undefined terms of the statute, LRFP and its patients would have to err on the side of an expansive search. Parker Decl. ¶¶ 42–43, 62; Williams Decl. ¶¶ 46–47, 54. Indeed, a "medical record" that is "relat[ed] directly" to a patient's "entire pregnancy history" would seem to cover everything from hospital delivery records, to prenatal care from an obstetrician or primary care physician, to pregnancy-related care by a cardiologist, mental health professional, or any other specialist, to previous abortion, miscarriage or infertility care. Williams Decl. ¶ 47; Parker Decl. ¶ 33.

Each mandatory request for medically unnecessary records forces patients to disclose their care at LRFP, a well-known abortion provider, and enlists the LRFP physician in that breach of confidentiality. Williams Decl. ¶¶ 43–44; Parker Decl. ¶¶ 58–60. This is contrary to

medical ethics and the standard of care, which demand protection of the physician-patient relationship and prohibit forced disclosure of abortion care to other clinicians where there is no medical justification. Parker Decl. ¶ 60 & n.8. Confidentiality in the physician-patient relationship is an essential part of the provision of quality health care because it allows patients to fully articulate their needs or concerns. *Id.* Abortion patients routinely make clear to LRFP that they do not want their gynecologists, primary care physicians or other health care providers to know that they have sought an abortion. *Id*. ¶¶ 59–61; Williams Decl. ¶¶ 43–44. They fear judgment and adverse consequences from those health care providers and their community if their abortion is revealed, and are adamant that LRFP not disclose their abortion care to others. Parker Decl ¶ 59; Williams Decl. ¶ 44; Doe 1 Decl. ¶¶ 7–8. And patients' fears are rooted in reality: After LRFP made one records request to a physician in Arkansas, the physician's wife called the LRFP patient to press her not to have the abortion. Williams Decl. ¶ 44.

A second requirement in the Medical Records Mandate compounds the problems of the required blanket requests for records. The statute requires abortion providers to not only make sweeping requests for records over the patient's "entire pregnancy history," *but also* expend "reasonable time and effort" trying to obtain them before an abortion can legally be performed. Ark. Code Ann. § 20-16-1904(b)(2). But there is no definition of "reasonable time and effort" or any other standard given to allow providers to know when this requirement has been satisfied, such that abortion is permitted. Williams Decl. ¶¶ 45–46; Parker Decl. ¶¶ 41–42.

The Mandate's several required steps—identifying patients' past providers, executing and sending records requests, and spending "reasonable time and effort" to obtain those records—combine to create significant, indeterminate delays before any abortion can be provided for any patients who have seen any past providers. Parker Decl. ¶¶ 41–43, 62; Williams Decl. ¶¶ 46–50.

Requesting and attempting to obtain medical records from various providers spanning patients' "entire pregnancy history" could easily take weeks or months.[15] Parker Decl. ¶¶ 41–43; Williams Decl. ¶¶ 41–42, 46–50, 55. Even very limited records requests, unlike those seeking an entire pregnancy history, can take weeks. Parker Decl. ¶¶ 38–42; Williams Decl. ¶¶ 41–42, 46. Some requests remain unfulfilled. *See id.* Because providers can never be sure if they have fulfilled the requirements of the Medical Records Mandate, "LFRP and [its] physicians cannot know when an abortion can lawfully take place." Williams Decl. ¶ 46. This indeterminate delay will push patients outside the window when they can obtain the medication abortion they sought, from aspiration abortion to a D&E procedure, and from a one-day to a two-day procedure. *See id*. ¶ 23. Some patients may be delayed beyond the point at which they can access legal abortion in Arkansas. *See id*. ¶ 23. And as noted above, though abortion is very safe, each week of delay increases the risks. Nichols 2020 Decl. ¶¶ 9–10. Here, the process is uncertain, with delays stretching until past providers comply or the undefined "reasonable time and effort" is expended.

The Medical Records Mandate would also consume much LRFP staff time and impose financial costs for patients. Williams Decl. ¶¶ 48–50, 54–55; Parker Decl. ¶ 62. LRFP now requests only a limited part of 20–25 patients' medical records per year, but the Medical Records Mandate would force the clinic to annually undertake comprehensive searches aiming to cover thousands of patients' entire pregnancy histories. Williams Decl. ¶¶ 39, 47–48. This will likely trigger multiple records requests for the majority of those patients, and for many of these historical requests, fees may be required. *Id*. ¶ 48–50. The Arkansas Medical Board, for example, says that Arkansas medical providers can charge per-page copying fees for medical records and

[15] Federal law allows U.S. providers 30 days for their initial response to records requests; the actual medical records may follow later; and the patient's recourse for non-production of records involves review by government officials and/or litigation. 45 C.F.R. § 164.524(b).

separate fees for record retrieval from storage. *See* Ark. Code Ann. § 16-46-106 (2019).[16] Furthermore, the Medical Records Mandate does not limit the medical records search to providers within Arkansas. Wherever patients received care related to their past pregnancies or current pregnancy, the Mandate creates an obligation to try to obtain that full history. Accordingly, requesting and working to obtain records from other states and countries (including those where medical care is provided in languages other than English) will likely impose additional complications, higher costs, and even greater delay. Parker Decl. ¶ 42; Williams Decl. ¶ 46.

V. THE LOCAL DISCLOSURE MANDATE

A. The 2017 Amendment to Section 12-18-108 and Plaintiffs' As-Applied Challenge to It.

The Local Disclosure Mandate (enacted as Act 1018, H.B. 2024) amended an earlier law to significantly expand its reach. The earlier law applied to only the tiny number of abortion patients in Arkansas who are 13 years old and under.[17] *See* Dkt. No. 1, Ex. C1 & C2. It required physicians to report those patients' abortions to local law enforcement where they lived, freeze the tissue from their abortions, and turn that over to the police, labeled with the patients' names, for indefinite storage and potential DNA testing at the State crime laboratory. The new Mandate expands these requirements to all abortion patients 14–16 years old, including when there is no criminality or abuse involved. Ark. Code Ann. § 12-18-108(a)(1). Plaintiffs challenge the

[16] Arkansas State Medical Board, Access to Medical Records, https://www.armedicalboard.org/Professionals/pdf/act767.pdf.

[17] As this Court has noted, Arkansas criminal law makes a distinction between older individuals and those 13 years old and under: Statutory rape for victims 13 and under is a strict liability crime, although there are certain affirmative defenses depending on the age of the accused. *Hopkins*, 267 F. Supp. 3d at 1086 n.14 (citing statutes and case law).

Mandate's requirements as applied to those 14- to 16-year-old patients whose circumstances indicate no sign of sexual or other abuse and therefore are not covered by the reporting requirements of the Arkansas Child Maltreatment Act ("CMA") (the "Non-CMA Teenage Patients").[18] These patients come to LRFP rightfully expecting confidential health care, and not the involvement of local police or state investigators. *See* Parker Decl. ¶ 60 & n.8.

The Local Disclosure Mandate requires that the physician, for each Non-CMA Teenage Patient, "shall preserve . . . fetal tissue extracted during the abortion," Ark. Code Ann. § 12-18-108(a)(l), and that the physician or facility "shall contact the law enforcement agency in the jurisdiction where the child resides," *id.* § 12-18-108(a)(3). The local police, once contacted, are to pick up the tissue "for use as evidence" and deliver it to the state crime laboratory. *Id.* § 12-18-108(b)(3). The tissue can apparently be maintained indefinitely. Only if and when the laboratory receives a "letter of destruction" from "the respective investigating agency" will it dispose of the tissue. Ark. Admin. Code § 171.00.2(4) . The Local Disclosure Mandate applies only to physicians providing abortions, and not to treatment of teenagers for spontaneous miscarriage, removal of an ectopic pregnancy, or any other reproductive health care. Ark. Code Ann. § 12-18-103(2)(B); Ark. Admin. Code § 171.00.2 (Definitions).

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[18] The sexual activity of 14- to 16-year-olds does not constitute reportable "sexual abuse" when it takes place with a similar-age partner or that teenager's spouse (and not with a caretaker or involving forcible compulsion). For 14-year-olds, for example, consensual activity with partners 14 to 17 years old does not trigger reporting, *see* Ark. Code Ann. § 12-18-103(20)(B) (2019); for 15-year-olds, consensual activity with partners 14 to 19 years old does not trigger reporting, *see id.* § 12-18-103(20)(C). Likewise, such similar-age consensual sexual activity does not constitute criminal activity. *See id.* §§ 5-14-101 (2017), -103 (2017), -110 (2019), -124 (2019), -125 (2019), -126 (2019), -127 (2019). By age 16, Arkansas no longer regulates sexual partners by age, and abuse reporting or criminality arises only through use of force or when a caretaker or other person in a similar relationship of power is involved. *See id.* §§ 5-14-101 (2017), -103 (2017), -110 (2019), -124 (2019), -125 (2019), -126 (2019), -127 (2019).

Under the Local Disclosure Mandate's implementing rules, "[a]ll products of conception should be preserved," including the "fragments of fetal, or membrane tissue remaining in utero following" abortion. Ark. Admin. Code § 171.00.2(1) & Definitions. That tissue is to be saved in a container labeled with "the patient's name and date of birth" and the name of the physician. *Id.* § 171.00.2(2). The provider must use a "reporting instrument" called the "Fetal Tissue Submission Form" when conveying the tissue to the local police, and that form includes spaces for the name and address of the "victim," the name and address of her parent, and the name and date of birth of the "suspect." *Id.* § 171.00.2(3); Dkt. No. 1, Ex. C4 (form). But the sexual partner of each Non-CMA Teenage Patient at issue would typically be a partner of the same or similar age, Ralph Decl. ¶ 13, and would **not** be a criminal or abuse suspect, just as the abortion patient would not be a victim.

A physician's failure to comply with the Local Disclosure Mandate or any rule adopted to implement it "shall constitute unprofessional conduct under the Arkansas Medical Practices Act," Ark. Code Ann. § 12-18-108(c). It thus subjects the physician to license suspension or revocation and other disciplinary penalties. *Id.* § 17-95-409 (2019). LRFP also faces parallel licensure penalties, should it or its physicians violate the Mandate or its implementing rules. *See id*. § 20-9-302(b)(3) (2019).

LRFP and its physicians have complied with Arkansas Code Section 12-18-108 since it first passed in 2013 for the handful of patients each year who are 13 and under. In 2019, there were five such 13-and-under patients. Williams Decl. ¶ 57. When LRFP calls a local police department, as this statute requires it to do, to pick up the fetal tissue for a young patient living within that department's jurisdiction, the officer contacted is often unfamiliar with the statute and

confused as to why the police are involved, when no crime is being investigated. *Id*. ¶¶ 62–63. The frozen tissue may remain at LRFP for weeks or months after the abortion, and the clinic often has to follow up repeatedly to remind the police to retrieve it. *Id*. ¶¶ 63–64. In a few instances, the police have never come. *Id*. ¶¶ 64–65. Since the law's inception, LRFP has never been contacted about the use in any active crime investigation of any fetal tissue obtained under this law and stored at the State crime laboratory. *Id*. ¶ 69.

Now, under the expanded Local Disclosure Mandate, many more patients will be subject to this process of involving the local police, completing the Fetal Tissue Transmission Form, and asking them to carry the tissue to the crime lab. In 2019, for example, LRFP provided 53 patients under 17 years of age with abortion care. *Id*. ¶ 57. All but two of those patients had an involved parent; the other two secured a judicial bypass. *Id.*

B. The Local Disclosure Mandate's Impact on Non-CMA Teenage Patients.

If the Local Disclosure Mandate is allowed to take effect, Non-CMA Teenage Patients will suffer fear and loss of privacy; the Mandate will also cause delays in some teenagers' abortion care and cause some to forego abortion care altogether. *See* Williams Decl. ¶ 70; Parker Decl. ¶¶ 73, 75; Ralph Decl. ¶¶ 11, 37, 40–42; Doe 3 Decl. ¶ 9. Even as to those few 13-year-olds already subject to the law, neither the patients nor the parents who accompany them to LRFP can understand why local police must collect "evidence" when, for example, the family is well-acquainted with the patient's same-age boyfriend, they have no concerns about criminality, and all concerned want confidentiality. *See* Williams Decl. ¶¶ 68, 70–71. Once the requirements of the law are explained during pre-abortion counseling, patients fear negative judgments or worse from the mandatory exposure of their sexual activity and abortion to local law enforcement. *See id*. ¶¶ 68, 70. Arkansas police departments are often very small; sometimes they consist of only two officers. *Id.* ¶¶ 68, 70. In one instance, a patient's relative worked for the

local police department to whom LRFP had to disclose the abortion and who would have to retrieve the tissue. *Id.* ¶ 68. The patient and her parents were fearful of the consequences of the relative knowing about the patient's abortion care, but were forced to decide between the patient's abortion (and disclosing it to this relative) or forgoing care in Arkansas. *Id*. This decision caused the patient and her family stress and hesitation with reason: They are aware of anti-abortion sentiment among many, including law enforcement personnel. *Id.* ¶¶ 68, 70; *see also* Doe 3 Decl. ¶¶ 6–9; Ralph Decl. ¶¶ 37–39. Local police have lectured LRFP's clinic director and "preached anti-abortion rhetoric, including telling [her] that the clinic is taking a life." Williams Decl. ¶ 66.

The Local Disclosure Mandate will cause many Non-CMA Teenage Patients to not only fear local police departments' knowledge of intimate details of their lives, but also feel shame, humiliation, and distrust. *See* Parker Decl. ¶¶ 63–67, 71–78; Williams Decl. ¶¶ 68, 70–71; Ralph Decl. ¶¶ 11, 40–42; Hopkins Decl. ¶¶ 47–50; Doe 3 Decl. ¶¶ 7–8. Involvement of the police where there is no criminal activity is punitive to these patients and their loved ones. *See id.* Likewise, the officers' collection of the tissue from patients' abortions as "evidence" will seem arbitrary and evoke negative feelings and fears. *See id.* This lack of confidentiality would be disturbing to any medical patient. Parker Decl. ¶¶ 60, 63, 71–78; *see also* Hopkins Decl. ¶¶ 47–50. For teenagers, as for adults, the country's leading medical authorities emphasize that confidential, non-judgmental reproductive health care is vital to ensure that patients' needs are met and that they can share the intimate details of their lives with clinicians. Parker Decl. ¶ 60 & n.8 (collecting medical organizations' statements on the importance of confidential adolescent care); *see also* Ralph Decl. ¶ 28. The judgmental and stigmatizing actions required by this Mandate may push Non-CMA Teenage Patients away from health care services in general, and

cause them to withhold information when they do seek future care. Parker Decl. ¶¶ 60 & n.8, 74–75, 77; Ralph Decl. ¶¶ 11, 28, 42. In all these ways, the Local Disclosure Mandate will have both immediate and long-lasting negative ramifications for those Non-CMA Teenage Patients subject to it.

In particular, the Local Disclosure Mandate will cause some patients to delay returning to LRFP for their abortion care. Parker Decl. ¶ 75; Williams Decl. ¶ 70; Ralph Decl. ¶¶ 40–41. Some patients who are close to their seventeenth birthday will wait to age out of the requirement, but, as discussed *supra* at p.3, each week of delay increases the medical risk and cost. Ralph Decl. ¶¶ 40–41; Parker Decl. ¶ 75; Williams Decl. ¶ 70; Hopkins Decl. ¶¶ 49–50; Nichols 2020 Decl. ¶ 10. Other patients will search for ways around the law, trying to travel or find other sources of care; even if they eventually return to the clinic, they will suffer from the delay in accessing care. *See id.* A few patients might be able to travel out of state, after taking the time to marshal the resources and other support to do so. Ralph Decl. ¶ 41; Parker Decl. ¶ 75; Williams Decl. ¶¶ 68, 70. Jane Doe 3, for example, explains that if this law had been in effect when she received her abortion at age 16, she would have delayed her care and gone without food to try to raise money to travel out of state for the abortion. Doe 3 Decl. ¶¶ 7–8. She lived in a town of just 600 people, had family members in the police force, and would have been gravely concerned for her boyfriend's safety, in light of his family's anti-abortion views. *Id.* ¶¶ 3, 6–9. Other patients may attempt to accomplish abortion on their own, potentially using unsafe methods. Parker Decl. ¶ 75; Ralph Decl. ¶¶ 32, 41. And the Local Disclosure Mandate may force others to carry their pregnancies to term, despite their decision to have an abortion, because they cannot risk disclosure to local law enforcement. Parker Decl. ¶ 75; *see also* Hopkins Decl. ¶¶ 49–50. Those Non-CMA Teenage Patients who proceed with their abortion under the Local Disclosure

Mandate will be left indefinitely wondering what might happen with the transmission form, the labeled tissue container, or the tissue "evidence" taken by the local police. Parker Decl. ¶ 76.

Finally, the State defines "abortion," both generally and in the Local Disclosure Mandate's implementing rule, to include both medication abortion and procedural care. *See* Ark. Code Ann. § 12-18-103(2); Ark. Admin. Code § 171.00.2 (Definitions). In this litigation, however, the State has asserted that the Local Disclosure Mandate's reference to tissue "extracted," Ark. Code Ann. § 12-18-108(a)(1), means that only procedural abortions are subject to the law. *See, e.g.,* Dkt. No. 23, at 64. Plaintiffs cannot rely on that litigation position, given the statutory and regulatory language and the serious penalties for any violation, and would need a court order endorsing that view. If the definition of "abortion" controls, rather than the State's litigation position, the Local Disclosure Mandate bars medication abortions for all Non-CMA Teenage Patients and imposes that further significant interference with their right to access abortion.

VI. THE TISSUE DISPOSAL MANDATE

A. Prior Law Governing Tissue Disposal and Changes Made by the Tissue Disposal Mandate.

Current Arkansas law requires abortion providers to dispose of embryonic and fetal tissue generated from abortions in a manner consistent with how health care facilities treat tissue from other medical care. *See* Ark. Code Ann. § 20-17-802 (2017) (requiring abortion facilities' disposal of tissue "in a fashion similar to that in which other tissue is disposed"). For almost all procedural abortions, a service provider collects medical waste and embryonic or fetal tissue generated at LRFP and disposes of it. Williams Decl. ¶ 74. A few patients each year, however, choose to have the tissue cremated and those patients make arrangements with the cremation facility. *Id*. For some other patients, tissue is sent to pathology labs to test for certain medical

conditions or to determine the cause of fetal diagnoses and the likelihood of recurrence in future pregnancies. And, for some abortions, when a crime has been reported or the patient is 13 years old or under, tissue is collected and preserved as evidence for law enforcement. *Id*. ¶¶ 61, 77. People who have medication abortions end their pregnancies in a manner similar to miscarriage, and tissue is disposed of at home.[19] *Id*. ¶ 76.

The Tissue Disposal Mandate would change the law to require that all embryonic or fetal tissue from any abortion be disposed of in accordance with the Arkansas Final Disposition Rights Act of 2009 ("FDRA"), Ark. Code Ann. § 20-17-102 (2013). *See* Dkt. 1, Ex. D (removing "fetal tissue" from the definition of "[h]uman tissue"); Ark. Code. Ann. § 20-17-801(b)(1)(B) (requiring that a "dead fetus" be disposed in accordance with the FDRA); *id.* § 20-17-802(a) (2017) (requiring that a "physician or facility that performs an abortion shall ensure that fetal remains and all parts are disposed" of in accordance with the FDRA and Arkansas Code Section 20-17-801, which itself refers back to the FDRA). Under the Mandate, abortion providers face criminal penalties for failure to dispose of tissue in accordance with the FDRA. *See* Ark. Code Ann. § 20-17-802(f).

The FDRA primarily governs which family members have "[t]he right to control the disposition of the remains of a deceased person, the location, manner, and conditions of disposition." Ark. Code Ann. § 20-17-102(d)(1). Under the FDRA, if a decedent has not appointed anyone to control the final disposition of his or her remains, that right vests in

[19] Prior to the passage of the Tissue Disposal Mandate, Arkansas law generally permitted tissue that is passed at home, rather than at a medical facility, to be disposed of without being regulated as medical or pathological waste. *See generally* Ark. Code Ann. § 20-32-101 (1993) (governing disposal of commercial medical waste); *id.* § 20-32-101(5) (defining "medical waste," in relevant part, as limited to "waste from healthcare-related facilities"); *id.* § 20-32-101(5)(A) (defining "pathological waste").

individuals in the order the FDRA prescribes, including the decedent's spouse; child or children; parent or parents; and so on, including other family members, or, ultimately, a state government actor with the statutory obligation to arrange for the disposition of a decedent's remains. *See id.* § 20-17-102(d)(1). Under the FDRA, the right to control the disposition of the remains of a deceased person vests only in persons who are 18 years old or older. *Id.* § 20-17-102(d)(1). When the disposition right vests in the decedent's parents and one parent is "absent," the right vests solely in the remaining parent only after "reasonable efforts have been unsuccessful in locating the absent surviving parent." *Id.* § 20-17-102(d)(1)(E)(ii). The FDRA defines neither "absent" nor "reasonable efforts." *Id.* § 20-17-102.

Individuals with disposition rights may "dispose of the remains in any manner that is consistent with existing laws, rules, and practices for disposing of human remains, including . . . cremat[ion]." *Id.* § 20-17-102(i). Where there is a dispute among people who share equal disposition rights, the circuit court for the county decides to whom to award the disposition right. *See id.* § 20-17-102(e)(2). A person may forfeit their right in certain circumstances, with the right passing to the next qualifying person. Forfeiture occurs where, for instance, a person fails to exercise their disposition right with "within two (2) days of notification of the death of the decedent," or "within five (5) days of the decedent's death, whichever is earlier." *See id.* § 20-17-102(e)(1)(B).

B. The Impact of the Tissue Disposal Mandate.

Importing the FDRA's scheme for assigning rights to decide how to dispose of a deceased family member's body into the abortion context, for which it was never intended, imposes burdensome and confusing requirements that threaten Plaintiffs' ability to continue providing abortion care. Should the Mandate take effect, Plaintiffs would no longer be able to provide abortion care confidentially, without disclosing patients' abortions to other individuals,

or ensure compliance with all of its vague requirements. Parker Decl. ¶ 88; Williams Decl. ¶¶ 78, 80. They would accordingly be forced to stop providing abortion care, or risk serious penalties for continuing to provide care. Parker Decl. ¶ 88; Williams Decl. ¶ 79.

The Mandate equates a patient and her sexual partner with the "parents" of tissue from the patient's abortion and assigns them shared rights to make decisions about how the tissue from her abortion should be disposed. *See* Ark. Code Ann. § 20-17-102(d)(1)(E) (requiring unspecified "reasonable efforts" be made to locate the "absent" parent prior to disposition). Minors have no rights under the Mandate. *Id*. § 20-17-102(d)(1). Instead, each minor's sexual partner would control disposition if he is at least 18; if he is also a minor, then her parent(s) *and* his parent(s) (as the "grandparents" of the tissue) would control. *See id.* § 20-17-102(d)(1)(G).

The Mandate thus compels intervention into confidential pregnancy care by a patient's partner or spouse, even if that person is no longer in her life, is abusive, or is a perpetrator of sexual assault. Williams Decl. ¶¶ 84–85. Decl. of Jane Doe 5, in Supp. of Pls.' Mot. for a Second Prelim. Inj. and/or TRO ("Doe 5 Decl.") ¶ 6 (attached as Ex. 11). For minors, the Mandate circumvents the State's constitutionally mandated judicial bypass process, through which a minor can exercise her constitutional right *not* to involve her parent in her abortion decision and instead obtain judicial authorization for the abortion. *See* Ark. Code Ann. § 20-16-809 (providing for judicial bypass and requiring proceedings to be confidential). The Mandate also potentially expands the adults who may be involved to four "grandparents" of the embryo or fetus. Williams Decl. ¶ 80. These forced disclosures violate physicians' ethical obligations to provide confidential care to patients and to not cause harm, and they can threaten patient safety. Parker Decl. ¶¶ 89–93. The notification requirements alone are enough to deter patients from

abortion care altogether, just as if the State had banned it outright. *See* Williams Decl. ¶ 85; Parker Decl. ¶¶ 91–92; Doe 5 Decl. ¶ 6.

Moreover, the Mandate requires abortion providers to "ensure" compliance with the FDRA but does not explain how to accomplish this. *See* Ark. Code Ann. § 20-17-802(a). The Mandate leaves key terms undefined and imposes criminal penalties for any violation by abortion providers.[20] Plaintiffs must notify each member of a class of decision-makers, must "use[] reasonable efforts to notify" those class members it cannot locate, and must ensure that any dispute between these class members is resolved by a vote of the class members or a proceeding before the circuit court. *See* Ark. Code Ann. § 20-17-102(d), (e). But the Mandate does not specify what constitutes "reasonable efforts," or how to confirm that the proper person has been notified. Parker Decl. ¶ 96; Williams Decl. ¶ 83. Additionally, the Mandate does not explain what it means for a patient's sexual partner to be "absent," nor what efforts a provider must take to confirm their absence. Parker Decl. ¶ 96. And those with disposition rights may request disposition "in any manner that is consistent with existing laws, rules, and practices for disposing of human remains," leaving Plaintiffs uncertain as to how to comply, especially if there is a dispute among those with shared disposition rights. *See* Ark. Code Ann. § 20-17-102(d)(2) , (e)(2) , (i) . It is also unclear whether at-home disposal of tissue following a

[20] The FDRA's safe harbors do not apply to abortion providers. Ark. Code Ann. § 20-17-102(f)(2) (providing that a "funeral establishment, cemetery, or crematory shall have the right to rely on" a signed funeral service contract or authorization, and "shall have the authority to carry out the instructions of the person or persons whom the funeral home, cemetery, or crematory reasonably believes holds the right of disposition").

medication abortion is permitted under the FDRA, further threatening Plaintiffs' ability to continue to provide this care.[21]

Complicating matters further, Plaintiffs cannot provide abortion care without knowing *before* they begin that care that tissue can be disposed of lawfully. Williams Decl. ¶ 79. As a practical matter, attempting to comply with the Mandate's myriad requirements makes abortion impossible to access: Plaintiffs simply cannot set up systems sufficient and timely enough to ensure compliance with all the Mandate's requirements before they provide abortion care. *Id*. ¶¶ 78–79.[22] Accordingly, even if the Mandate's notification requirements did not effectively bar abortion care, attempting to notify the proper people and comply with the Mandate's numerous other provisions would delay abortion care. That delay would force people to remain pregnant and experience the symptoms and risks of pregnancy; it would increase the risks associated with abortion care; and it would eventually deprive some people of access to abortion in Arkansas altogether by pushing them past the legal limit. *See id*. ¶ 23. And, if Plaintiffs provided care despite uncertainty of their compliance with the Mandate's many provisions—none of which were intended or defined for abortion care—Plaintiffs would risk criminal penalties.

As this Court has already observed, Defendants' suggestions for how the FDRA operates in the abortion context are divorced from its text and reality. *See Hopkins*, 267 F. Supp. 3d at

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[21] The Department of Health issued a regulation purporting to exempt medication abortion care from the Mandate. *See* Williams Decl. ¶ 76. But it is not clear on what basis the Department issued that regulation, nor why tissue from a medication abortion would be treated differently than tissue from procedural abortions. *See* Parker Decl. ¶ 95; Williams Decl. ¶ 76.

[22] Even if Plaintiffs could comply with the Mandate by searching for and notifying individuals—and adhering to the FDRA's myriad other requirements—*after* they provided abortion care, notifying others that patients' obtained abortion care would raise the same practical and confidentiality concerns, as Plaintiffs could no longer guarantee patients' access to confidential care. *See* Parker Decl. ¶ 99; Williams Decl. ¶ 86.

1099–1101. For instance, Defendants have indicated Plaintiffs could comply with the Mandate by preserving tissue for five days, during which time they would wait for any individuals' disposition rights to expire. *See id.* at 1099. If Defendants mean to suggest Plaintiffs could do nothing during that time, Defendants ignore the FDRA's emphasis on making efforts to notify individuals with disposition rights, Ark. Code Ann. § 20-17-102(d)(1)(E), (d)(3)(A), and undermine any claim that the Mandate serves a legitimate purpose.

ARGUMENT

"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. v. Teamsters Local Union No. 41*, 126 F.3d 1059, 1066 (8th Cir. 1997) (citation omitted). In deciding a preliminary injunction motion, the district court considers four factors: (1) the probability that the movant will succeed on the merits; (2) the threat of irreparable harm to the movant; (3) the balance of equities; and (4) the public interest. *Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033, 1036 n.2 (8th Cir. 2016) (citing *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981)). This Court applies the same standard for both preliminary injunction and temporary restraining order requests. *See Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-cv-00784-KGB, 2018 WL 3029104, at *8 (E.D. Ark. June 18, 2018). For the reasons set forth below, Plaintiffs satisfy this standard and are entitled to a preliminary injunction or temporary restraining order as to each of the challenged restrictions.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR CLAIMS.

Plaintiffs are likely to succeed on the merits of their undue burden claims because, as this Court previously found, the challenged laws impose a substantial obstacle in the path of people seeking abortion, irrespective of any purported benefits. The Eighth Circuit did not disturb these

findings or even suggest they are clearly erroneous; rather, with respect to the undue burden claims, the Eighth Circuit remanded to this Court solely to apply the test as articulated by Chief Justice Roberts in his *June Medical Services* concurrence.[23]

Under the Chief Justice's concurrence, abortion restrictions are unconstitutional if they are not "reasonably related" to a "legitimate purpose," or if they impose "a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *June Med. Servs.*, 140 S. Ct. at 2138. Importantly, the concurrence did not alter what constitutes a "substantial obstacle." Instead, the Chief Justice affirmed that laws impose a "substantial obstacle" when they have the effect of "likely [] preven[ting] a significant number of women from obtaining an abortion," *id.* at 2137 (quoting *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 893 (1992)), as well as when they subject people seeking abortions to delay, increased travel, and/or increased medical risks, *id.* at 2140 (citing *Whole Woman's Health*, 136 S. Ct. at 2313). Applying this test, the Chief Justice joined the plurality to strike down the Louisiana law at issue in *June Medical Services* because it imposed a substantial obstacle by, *inter alia*, creating longer wait times for appointments, increasing travel distances, and increasing medical risks for patients. *Id*. In particular, the Chief Justice recognized that these obstacles must be considered on top of the obstacles that people already faced accessing abortion in Louisiana, including affording or arranging childcare. *Id.*

Accordingly, based on this Court's previous findings that the laws impose a substantial obstacle in the path of people seeking abortion care, and the additional evidence submitted in

[23] Plaintiffs preserve their argument, discussed in their petition for rehearing en banc, *Hopkins v. Jegley*, No. 17-2879, Entry ID 4947895 (8th Cir. Aug. 21, 2020), that the Chief Justice's concurrence does not eliminate the requirement that courts must weigh the benefits of an abortion restriction with the law's burdens.

support of the instant motion, Plaintiffs are likely to succeed on the merits of their undue burden claims. As this Court has already found, and as discussed further below, the extensive record evidence demonstrates that each of the challenged laws imposes a substantial obstacle in the path of people seeking pre-viability abortions. *See, e.g.*, 267 F. Supp. 3d at 1068 (D&E Ban); *id.* at 1078 (Medical Records Mandate); *id.* at 1091 (Local Disclosure Mandate); *id.* at 1106 (Tissue Disposal Mandate). As this Court also already found, because the evidence demonstrates that each of the laws to which patients brought a facial challenge imposes a substantial obstacle for a large fraction of those patients to whom it is relevant, each one of those laws is facially invalid. *See e.g.*, *id.* at 1068 (D&E Ban); *id.* at 1078 (Medical Records Mandate); *id.* at 1105 (Tissue Disposal Mandate). In addition, for at least three of the four laws challenged this Court also found there was no reasonable relationship to any proffered state purpose. *See, e.g.*, *id*. at 1076 (Medical Records Mandate); *id*. at 1089 (Local Disclosure Mandate); *id*. at 1105 (Tissue Disposal Mandate). Plaintiffs' additional evidentiary submissions, and additional arguments made below, bolster this Court's prior holdings that, on each of those grounds, the challenged laws impose an undue burden.

On remand, the Eighth Circuit also instructed this Court to consider the holding in *Box v. Planned Parenthood of Indiana and Kentucky*, 139 S. Ct. 1780 (2019) (per curiam). *See Hopkins*, 968 F.3d at 916. The *Box* Court emphasized that, because the plaintiffs there had only brought the rational basis claim against a fetal tissue disposal law, "[t]his case . . . does not implicate our cases applying the undue burden test to abortion regulations," and "expresses no view on the merits of those challenges." 139 S. Ct. at 1782; *see also id.* at 1781 (the challengers in *Box* "never argued that Indiana's law creates an undue burden on a woman's right to obtain an

abortion"). Because Plaintiffs have brought undue burden claims, not rational basis claims, *Box* is inapplicable here.

Finally, since *June Medical Services* involved only substantive due process privacy claims, and *Box* involved only a rational basis claim, the Eighth Circuit's remand does not impact the other grounds upon which this Court found Plaintiffs likely to succeed, including the unconstitutional vagueness of at least two of the challenged laws (Medical Records Mandate and Tissue Disposal Mandate). Plaintiffs are still likely to succeed on the merits of those vagueness claims as well.

A. Plaintiffs Are Likely to Succeed on Their Claim that the D&E Ban Is Unconstitutional Because It Creates an Undue Burden on Patients' Right to Obtain Abortion.

As set forth below, a ban on D&E, the predominant abortion procedure used throughout the second trimester—and the only outpatient second-trimester abortion procedure available in Arkansas—is unconstitutional under decades of unwavering Supreme Court precedent. The reason is straightforward: A ban on the "usual" second-trimester method "imposes an undue burden, as a *facial* matter, because its restrictions on second-trimester abortions are too broad." *Gonzales*, 550 U.S. at 135, 150; *see also Stenberg v. Carhart*, 530 U.S. 914, 930 (2000); *Carhart v. Stenberg*, 192 F.3d 1142, 1145–46 (8th Cir. 1999). Additionally, as this Court correctly found, *Hopkins*, 267 F. Supp. 3d at 1068, the D&E Ban is likely unconstitutional because the evidence shows its enforcement would impose a substantial obstacle on patients seeking second-trimester abortion in Arkansas. Thus, regardless of whether the Chief Justice's concurrence in *June Medical Services* altered the *Whole Woman's Health* balancing test, the D&E Ban cannot stand: Even if this Court considers only the burdens imposed by the D&E Ban, Plaintiffs are likely to

succeed on the merits of their claim that the D&E Ban is unconstitutional.[24] Accordingly, "[t]he State cannot win the factual battle[,] [n]or the legal one." *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1325 (11th Cir. 2018) (striking virtually identical D&E ban in Alabama), *cert. denied*, *Harris v. W. Ala. Women's Ctr.*, 139 S. Ct. 2606 (2019).

1. A Ban on D&E is Unconstitutional.

The Supreme Court has consistently affirmed the longstanding rule that a ban on the dominant second-trimester method is unconstitutional. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 77–79 (1976) (holding unconstitutional a law barring then "most commonly used" method of second-trimester abortion); *Stenberg*, 530 U.S. at 945–46 (holding unconstitutional a law banning D&X that was written so broadly as to also ban D&E, "the most commonly used method for providing previability second trimester abortions"); *Gonzales*, 550 U.S. at 165 (upholding narrowly written D&X ban that did not "construct a substantial obstacle to the abortion right" because the "commonly used and generally accepted method," D&E, remained available). In preserving access to the most common second-trimester abortion method, the Supreme Court has rejected arguments that would "force[] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed," or through methods "used only on an experimental basis." *Danforth*, 428 U.S. at 77–79. Significantly, where a challenged statute effectively prohibited performing D&E on a "living fetus," but did not apply where fetal demise had already occurred, the Court's analysis was unchanged—even where the Court was aware of fetal-demise procedures, it did not change the

[24] Though, for the purposes of this brief, Plaintiffs focus on the substantial obstacle prong of the Chief Justice's test, Plaintiffs do not concede that the D&E Ban is reasonably related to a legitimate state purpose. *See June Medical Servs.*, 140 S. Ct. at 2138 (it is a "threshold requirement" of the governing standard that abortion laws be reasonably related to a legitimate state purpose).

outcome. *See, e.g.*, *Stenberg*, 530 U.S. at 922, 925 (law prohibiting D&E struck down despite discussion of digoxin and KCl). Simply put, in more than four decades of abortion jurisprudence, the Supreme Court has upheld only one ban on a rarely-used abortion procedure (D&X), and it did so only after confirming that the usual second-trimester method (D&E) remained available. *Gonzales*, 550 U.S. at 164–65.

Courts have consistently applied these decisions to hold that bans on D&E are unconstitutional.[25] Applying this precedent, the Eighth Circuit has repeatedly recognized that because "[t]he D&E procedure is the most common procedure for second-trimester abortion," "[i]f [this] procedure is barred by" a law, "an undue burden is created for a woman seeking a second trimester abortion[.]" *Little Rock Family Planning Servs., P.A. v. Jegley*, 192 F.3d 794, 797–98 (8th Cir. 1999); *accord Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 388 (8th Cir. 1999); *Stenberg*, 192 F.3d at 1145–46.

Under this dispositive precedent, the D&E Ban is unconstitutional. Act 45 bans D&E—the method used for 100% of abortions reported in Arkansas at or after 14 weeks LMP and the only outpatient abortion method that can be used throughout the second trimester in Arkansas.[26] *See supra* at p.10. As there is no doubt that D&E is "the usual abortion method in [the second] trimester," *Gonzales*, 550 U.S. at 135, it cannot be prohibited, irrespective of the availability of

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[25] *EMW Women's Surgical Ctr. v. Friedlander*, 960 F.3d 785, 799 (6th Cir. 2020); *Hope Clinic v. Ryan*, 249 F.3d 603, 604–05 (7th Cir. 2001) (per curiam); *Causeway Med. Suite v. Foster*, 221 F.3d 811, 812 (5th Cir. 2000); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 145–46 (3d Cir. 2000); *Bernard v. Individual Members of the Ind. Med. Licensing Bd.*, 392 F. Supp. 3d 935, 961–62 (S.D. Ind. 2019).

[26] As this Court and multiple other courts have found, induction is not an appropriate substitute for a D&E because of the significant time, cost, pain, discomfort, and risks associated with the procedure. *Hopkins*, 267 F. Supp. 3d at 1068; *see also Bernard*, 392 F. Supp. 3d at 939; *Planned Parenthood Sw. Ohio Region v. Yost*, 375 F. Supp. 3d 848, 856 (S.D. Ohio 2019).

separate, invasive procedures to attempt to circumvent the Ban. As the Chief Justice recently reaffirmed, courts have a responsibility to "treat like cases alike," *June Med. Servs.*, 140 S. Ct. at 2134, and the Eighth Circuit has held that this Court must apply the Chief Justice's concurrence to this case. Here, that requires this Court to find that Plaintiffs are likely to succeed on their claim that the D&E Ban unconstitutional.

2. The D&E Ban Imposes a Substantial Obstacle on Patients Seeking Abortion Care.

Plaintiffs are also likely to succeed on their claim that the D&E Ban is unconstitutional because, as the evidence demonstrates, the State's so-called "workarounds" to the Ban cannot guarantee demise in every case, and thus the only way for physicians to protect themselves from criminal liability would be to stop providing abortions altogether, starting as early as 14 weeks LMP. That physicians can attempt demise for some patients in the later weeks of the second trimester does not change that a physician, knowing such an attempt could fail, would risk prosecution in beginning any D&E for any patient. Just as the Supreme Court held in *Danforth* that the state cannot ban the most common second-trimester abortion method simply by pointing to purported "alternatives" that were not actually available, Arkansas cannot ban D&E by proposing physicians expose themselves to criminal liability and perform experimental, unfeasible, and/or risk-enhancing additional procedures on patients. *See Danforth,* 428 U.S. at 77-79.[27]

[27] Indeed, fetal demise procedures are not *alternative* procedures at all; they are *additional* procedures. Where, as here, providers attempt additional demise procedures for only a small number of patients for whom they determine it is safe and medically appropriate to do so, requiring that all patients seeking second-trimester abortion care undergo this procedure "by nature expose[s] patients to additional risks and burdens." *Friedlander*, 960 F.3d at 798; *see also e.g. Danforth*, 428 U.S. at 78–79 (invalidating abortion restriction that "force[d] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the

Even if providers were willing to risk liability and attempt such procedures for every second-trimester abortion patient, the D&E Ban would still impose an undue burden. There is no medical evidence that Defendants' proposed demise procedures are safe, feasible, or available in the early weeks of the second trimester, when most D&Es occur. *See supra* at pp.12–17. At a minimum, to require patients to undergo these additional procedures would transform one-day abortion procedures into two-day procedures, imposing significant and increased financial and logistical burdens on patients. *See supra* at pp.17–19. And Defendants' proposed methods are either unstudied, unfeasible, and/or unreliable and expose patients to increased risks and/or additional financial and logistical burdens, which could prevent some patients from being able to obtain care at all. *See supra* at pp.12–17. These burdens are not only amply supported by the evidence described above, but also have been confirmed by every fact-finder to consider comparable evidence, including this Court. *See Glossip v. Gross*, 576 U.S. 863, 882 (2015) (court review is "more deferential" when "multiple trial courts have reached the same finding, and multiple appellate courts have affirmed those findings").[28] Thus, because patients who undergo fetal demise procedures "are exposed to the medical risks, uncertain consequences, potential unavailability and time and emotional burden that procedure entails," *Friedlander*, 960

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method outlawed"); *Williamson*, 900 F.3d at 1326 (noting the state's concession that fetal demise procedures "would always impose some increased health risks on women").

[28] *Hopkins*, 267 F. Supp. 3d at 1067–68; *see also, e.g., Bernard*, 392 F. Supp. 3d at 963; *EMW Women's Surgical Ctr. v. Meier*, 373 F. Supp. 3d 807, 819, 820, 822 (W.D. Ky 2018), *aff'd sub. nom. EMW Women's Surgical Ctr. v. Friedlander*, 960 F.3d 785 (6th Cir. 2020); *Miller*, 299 F. Supp. 3d at 1286, 1273, 1275, 1278–79, *aff'd sub. nom*., *Williamson*, 900 F.3d at 1327*, cert. denied sub. nom. Harris v. W. Ala. Women's Ctr.*, 139 S. Ct. 2606 (2019); *Planned Parenthood of Cent. N.J. v. Verniero*, 41 F. Supp. 2d 478, 500 (D.N.J. 1998), *aff'd sub. nom.*, *Farmer*, 220 F.3d 127; *Evans v. Kelley*, 977 F. Supp. 1283, 1318 (E.D. Mich. 1997); *see also Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 467–68 (Kan. 2019) (sustaining trial court findings).

F.3d at 810, requiring all patients to undergo fetal demise procedures prior to a D&E—and preventing providers from safely completing the procedure unless demise is successful—imposes a substantial obstacle on all patients seeking second-trimester abortion in Arkansas.

Because it is readily apparent that all patients seeking a D&E will be burdened by the D&E Ban, Plaintiffs are likely to succeed on their claim that the D&E Ban is facially invalid. *See Casey,* 505 U.S. at 895 (a law is facially invalid when it presents a substantial obstacle in a large fraction of cases in which it is relevant). As this Court has already concluded, the D&E Ban is "only relevant for Arkansas women who elected to have the standard D&E." *Hopkins*, 267 F. Supp. 3d at 1067. As shown above, if the D&E Ban were enforced, 100% of patients seeking D&Es in Arkansas would face a substantial obstacle to obtaining abortion care: The D&E Ban would force Plaintiffs either to (i) stop providing D&E altogether or (ii) expose every D&E patient to unnecessary medical risks, uncertainty, and emotional, financial, and logistical burdens by forcing all such patients to undergo demise procedures and preventing providers from safely completing a D&E if demise fails. Indeed, because there is no failsafe way to achieve demise in every case, and because it is not possible to know beforehand in which instances demise will fail, absent relief from this Court, every D&E patient would face these risks. Accordingly, it remains true that "if the D&E [Ban] takes effect a large fraction of Arkansas women who select abortion throughout the second trimester would experience a substantial obstacle to abortion. *Id*. at 1068.[29]

[29] Alternatively, as this Court previously recognized, even if the Court considers this law to be a substantial obstacle for only those patients who would not otherwise undergo a fetal demise procedure, a large fraction of patients would face a substantial obstacle to care. *See Hopkins*, 267 F. Supp. 3d & n.9. For example, at LRFP, all D&E patients between 14.0 and 17.6 and half of patients between 18.0 and 20.0 receive care in one day without an additional demise procedure. Williams Decl. ¶ 29. If the D&E ban had been in effect, over 80% of second-trimester patients in

In sum, enforcement of the D&E Ban would force physicians to choose between exposing themselves to criminal liability and exposing their patients to significant medical, financial and logistical burdens, *see id.* at 1061, or stopping provision of second-trimester abortions altogether. Thus, as this Court already found, even considering "only the effects of the provisions," Plaintiffs have shown they are likely to succeed on the merits. *Id.* at 1064.

B. Plaintiffs Will Likely Succeed in Showing that the Medical Records Mandate Is Unconstitutional.

1. The Medical Records Mandate Is Likely Unconstitutionally Vague.

This Court previously found Plaintiffs "likely to succeed on [the] claim that the Medical Records Mandate is unconstitutionally vague." *Id*. at 1084. The Medical Records Mandate remains just as vague today as it was when this Court rendered its earlier decision. Thus, the statute's exceedingly unclear requirements still call for a preliminary injunction while Plaintiffs litigate the final merits of their challenges. *See id.* at 1080–84.

As this Court has explained, the vagueness of the Medical Records Mandate "lies in its terminology used to outline" what the statute requires before an abortion can lawfully proceed. *Id.* at 1084. There are at least three areas of impermissible vagueness: What "records relate[] directly to a woman's entire pregnancy history"? What constitutes "reasonable time and effort"? And what, if anything, is the physician to do if records are obtained? *See id.* at 1080–84 (internal quotation marks omitted). Without specified boundaries, and with terms that are "subjective in nature," the Court found that "the Medical Records Mandate fails to provide fair notice and could potentially result in arbitrary enforcement." *Id.* at 1082. The statute's lack of clarity violates essential due process protections. *See id.* at 1080–84; *Johnson v. United States*, 576 U.S.

2019 (294 of the 357) who would not have otherwise had an additional procedure would have been required to undergo a fetal demise procedure with all the burdens that entails or be denied care altogether. *See* Ark. Ctr. of Health Stat., *supra* n. 6, at 8.

591, 595–96 (2015) (fair notice of the conduct punished and clear standards to prevent arbitrary enforcement are the well-recognized "first essential of due process") (internal quotation marks omitted)); *Grayned v. City of Rockford*, 408 U.S. 104, 113 (1972) (highlighting the due process problems with a "completely subjective standard"). That is just as true now as when this Court issued its prior preliminary-injunction decision.

In fact, an even higher level of clarity is required here than in many other civil cases because the Medical Records Mandate imposes criminal penalties, as well as severe civil licensing ones, and affects the exercise of a fundamental liberty right. *See Vill. of Hoffman Estates v. Flipside*, *Hoffman Estates, Inc.*, 455 U.S. 489, 499 (1982) (describing a strict test when a law "threatens to inhibit the exercise of constitutionally protected rights" and when it imposes "prohibitory and stigmatizing" civil penalties); *District of Columbia v. City of St. Louis*, 795 F.2d 652, 654 (8th Cir. 1986) (a "strict test of specificity" applies when a statute carries criminal penalties). Vague requirements without discernable standards impermissibly allow prosecutors or other enforcers "to pursue their personal predilections." *Kolender v. Lawson*, 461 U.S. 352, 357–58, 362 (1983). These serious dangers remain and the Court again should act to prevent this standardless bar to abortion from taking effect as the case proceeds.

2. The Medical Records Mandate Also Likely Fails Both Prongs of the Undue Burden Standard.

The Medical Records Mandate (1) is not reasonably related to a legitimate state purpose and (2) imposes a substantial obstacle in the path of women seeking abortions before viability. On both those grounds, it creates an undue burden under the standard the Eighth Circuit has now instructed this Court to apply. *See* 968 F.3d at 915 (describing Roberts, C.J., approach). Either ground alone is sufficient to show likelihood of success on Plaintiffs' claim that the Medical Records Mandate violates patients' liberty rights. *See id*.

a. This Required Search for Abortion Patients' Historical Medical Records Is Not Reasonably Related to a Legitimate State Purpose.

As described above, the Medical Records Mandate requires LRFP to undertake an expansive search for medical records for abortion patients' prior pregnancy-related care, and bars abortion until LRFP has devoted "reasonable time and effort" to that search—but then does not direct the abortion provider to review or use any patient records obtained. Indeed, the Mandate does not specify that the provider do anything if and when records are received, and is not reasonably related to any legitimate state purpose. The Court's prior conclusion remains correct: The Medical Records Mandate "appear[s] to serve no proper state purpose." 267 F. Supp. 3d at 1076.

The legislature passed the Medical Records Mandate along with separate statutory provisions that prohibit abortion decisions solely based on the sex of the fetus or embryo, but the legislation does not in any way connect the voluminous historical records search it requires to the sex-selection prohibition. Furthermore, there is no reasonable relationship between the sweeping Medical Records Mandate and preventing abortions based on the sex of the fetus. Parker Decl. ¶¶ 46–56. Medical records from prior pregnancies, or even from the current pregnancy, cannot establish an abortion patient's personal reason or reasons for ultimately deciding to have an abortion. *Id.* Indeed, most records will not even include any reference to the sex of the fetus for the current or prior pregnancies. *Id*. ¶ 51. And even if records did include a notation of sex, any past medical record-keeping still reveals nothing about the patient's present decision. *Id*. ¶¶ 51–56. The legislature's separate sex-selection ban stands on its own. But that prohibition provides no reasonable grounding for the Medical Records Mandate.

The State has just as unreasonably suggested that the Medical Records Mandate might improve medical care. *See* 267 F. Supp. 3d at 1077. Historical records of a patient's "entire

pregnancy history," however, are not needed for and do not aid abortion practice. Parker Decl. ¶¶ 34, 37. This Court rightly rejected as an "unsupported statement by defense counsel" the contention that "a patient is always more likely to receive better care when her physician has greater knowledge of her health history." 267 F. Supp. 3d at 1077 (internal quotation marks omitted). Instead, the breach of confidentiality, added cost, and delay caused by this pointless, blanket medical records search will harm patients if allowed to take effect, as discussed further below. Parker Decl. ¶¶ 55–62; Williams Decl. ¶¶ 40–55. The delay required for comprehensive records requests and the "time and effort" spent seeking their production pushes patients later in pregnancy and directly clashes with the legislature's stated purpose of avoiding the risks of later abortion.[30] Contrary to the State's assertion, the Mandate is not reasonably related to any interest in advancing patient health. Plaintiffs, therefore, will continue to succeed in showing that the Medical Records Mandate advances no proper purpose, 267 F. Supp. 3d at 1076, and is likely unconstitutional under the first prong of the undue burden test.

b. Plaintiffs Are Likely to Succeed in Showing that the Mandate Imposes a Substantial Obstacle to Care.

In addition, Plaintiffs are likely to succeed on the merits of the second prong of the undue burden test, namely that the Medical Record Mandate imposes a substantial obstacle in the path of people seeking abortion. As elaborated below, the Mandate fails to exempt patients with serious health complications who urgently need abortion care; delays care indefinitely and for

[30] The legislative findings for Act 722, which included the Medical Records Mandate, say that "[i]t is undisputed that abortion risks to maternal health increase as gestation increases." *Id.* § 20-16-1902(a)(2)(A). The legislature found, for example, that a "woman is thirty-five (35) times more likely to die from an abortion performed at twenty (20) weeks' gestation than she would have had the abortion[] been performed in the first trimester[.]" *Id.* § 20-16-1902(a)(2)(C). A stated purpose of the Act is to protect patients from the increased medical risks in later abortions. *Id.* § 20-16-1902(b)(2).

some may prevent any abortion in Arkansas; breaches patients' confidentiality, further deterring their care; and imposes enormous logistical hurdles and added costs.

By its plain terms, the Medical Records Mandate operates as a ban on abortion unless and until its requirements are satisfied. Ark. Code Ann. § 20-16-1904(b)(2). As the Court previously found, the Mandate contains no health exception. 267 F. Supp. 3d at 1074–75. It would require even very sick women to attempt to collect contact information for their past pregnancy health care providers, sign records requests for each, and allow the abortion provider at least some time and effort to gather those records for no purpose, before an abortion could proceed. All the while, the patient's health could be deteriorating. This result is not only nonsensical but also prohibited by numerous Supreme Court precedents, which have made clear that "a State may not restrict access to abortions that are "'necessary, in appropriate medical judgment, for the preservation of'" the patient's health. *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 327 (2006).

In addition, even for patients who are not acutely ill, the Medical Records Mandate's indeterminate delay will push patients further into their pregnancies, which increases medical risks and limits the type of care that they can obtain. Williams Decl. ¶¶ 23, 40–55; Parker Decl. ¶¶ 41–44, 62. This delay will mean that many patients will no longer be eligible for a medication abortion, leaving a procedure as their only option, if they are able to access abortion at all. *Id.* The Mandate will also push patients from aspiration abortion to a D&E procedure, and from a one-day to a two-day procedure. *Id.* Each week of delay increases patients' medical risks. Nichols 2020 Decl. ¶ 10; *supra* at p.3. The delays imposed by the Mandate will also increase the costs to patients, including the cost of the procedure; will make navigating care more difficult; and will, for some, increase the number of clinic visits. Williams Decl. ¶¶ 40–55; *see generally*

Katz Decl. ¶¶ 66–70. The Mandate will push some patients completely past the gestational limit for abortion in Arkansas. Parker Decl. ¶¶ 41–44, 47, 62; Williams Decl. ¶¶ 23, 42–55; *see also* Hopkins Decl. ¶ 37. Indeed, the Mandate contains no exception that would allow a physician to avoid taking "time and effort" to obtain records when patients seek care on the cusp of losing their ability to obtain an abortion in Arkansas. These harmful patient delays constitute a substantial obstacle to exercise of patients' constitutional rights. *See, e.g.*, *June Med. Servs.*, 140 S. Ct. at 2140 (relying on longer wait times, diminished capacity to provide care, and the associated increased medical risks in finding a substantial obstacle); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 920 (7th Cir. 2015).

Furthermore, because neither the physician nor the patient can know when the Medical Records Mandate's requirements will, if ever, be satisfied, scheduling appointments and completing care is even more untenable. It is well-established that such open-ended roadblocks to abortion care impose unconstitutional obstacles. *See, e.g.*, *Bellotti v. Baird*, 443 U.S. 622, 644 (1979) (holding that judicial-bypass process for minor "must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained"); *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1110 (5th Cir. 1997) (striking down judicial bypass statute that lacked time limits and noting that "[s]uch an open-ended bypass procedure has never been approved"), *overruled on other grounds by Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001).

The Mandate's lack of a health exception and its open-ended delays plainly impose substantial obstacles. These are compounded by the fact that this Mandate will breach patients' confidentiality by revealing to other past or current health care providers that the patient is seeking an abortion. Violation of patients' confidentiality "further interfere[s] with a woman's

right to decide to end a pregnancy. *Bellotti*, 443 U.S. at 655." 267 F. Supp. 3d at 1076; *see also* Parker Decl. ¶¶ 57–62; Williams Decl. ¶¶ 43–44. It may dissuade patients from continuing with their care. *Id.*; *see also* Ralph Decl. ¶ 40.

Moreover, the administrative and logistical challenges that the Medical Records Mandate imposes will themselves impede care by inundating LRFP with medical-records-processing tasks for thousands of patients and making the permitted timing of any abortion care wildly uncertain; an abortion provider's ability to care for patients with extensive pregnancy histories or many prior providers scattered in various locations may be especially compromised. LRFP will have to pay for additional staff at the same time as its procedures become more sporadic and unpredictable. Williams Decl. ¶¶ 48–50, 54–55. This will significantly diminish its resources for patient care. *Id.*; *see also Whole Woman's Health,* 136 S. Ct. at 2317 ("common sense" that multiple demands on clinic resources will add "significant costs"); *Casey*, 505 U.S. at 901 ("at some point increased cost" could alone "become a substantial obstacle"). Taken together or separately, the obstacles imposed by the Mandate will be severe.

The State has previously contended the Medical Records Mandate applies only to patients who tell LRFP physicians that they know the sex of the fetus. The Court, however, has found "no ambiguity in the language" that would support that construction and has held that the required records search applies to all patients. 267 F. Supp. 3d at 1072. Regardless, the State's proposed reading only more starkly highlights the Mandate's illogic and serious burdens: The few patients who know the sex of the fetus are almost invariably later in pregnancy, and delay at that more advanced gestational age seriously adds to patients' medical risks and severely diminishes patients' ability to access care. *Id.* at 1071, 1074; Parker Decl. ¶¶ 47–50; Nichols 2020 Decl. ¶¶ 9–10. As the Court has explained, time is especially of the essence for patients far enough

along in pregnancy to know the sex of the fetus,[31] and taking time to search for their past medical records significantly increases, rather than diminishes, patient risk. 267 F. Supp. 3d at 1073–74.

Under either reading of the Medical Records Mandate, it creates substantial obstacles to abortion care for all affected patients that render it likely unconstitutional. As this Court has summarized, compliance with the Medical Records Mandate presents substantial obstacles for at least a "large fraction" of affected women by "increasing delays, very possibly putting abortion care out of reach for women late in pregnancy, increasing health risks to women as gestational age advances, increasing costs associated with compliance, and implicating privacy concerns." 267 F. Supp. 3d at 1078. The Mandate's indeterminate delays, lack of any specified actions for physicians once they obtain any records, and other vague requirements prohibit specific calculations of its precise effects. *Id.* But it is clear that, for whatever group of patients to which the Mandate applies, it breaches confidentiality and imposes uncertain delays for each one, among other harms, thereby erecting constitutionally unacceptable barriers to abortion access. Accordingly, Plaintiffs are likely to succeed on their claim that the Medical Records Mandate imposes an undue burden on patients and should be enjoined.

C. Plaintiffs Will Likely Succeed in Showing that the Local Disclosure Mandate Fails Both Prongs of the Undue Burden Standard As Applied to Non-CMA Teenage Patients.

[31] The record evidence shows that Arkansas abortion patients do not usually know the sex of the embryo or fetus. Parker Decl. ¶¶ 47–50; Williams Decl. ¶ 53. While cutting-edge testing capability may be able to determine sex fairly early in a pregnancy, that testing is not common among patients who seek abortion. *Id.*; *see also* 267 F. Supp. 3d at 1079. As this Court has noted, ultrasound examinations occur for patients seeking an abortion to determine the pregnancy's gestational age, but those exams do not necessarily employ the same high-resolution ultrasound used for ongoing prenatal care and do not typically result in the patient being advised of the sex of the fetus, if it can be seen. Parker Decl. ¶¶ 48–50; Williams Decl. ¶ 53. Before 14 weeks LMP, ultrasound cannot identify the sex of the fetus or embryo. Parker Decl. ¶ 48.

This Court has already examined the workings of the Local Disclosure Mandate in depth. *See* 267 F. Supp. 3d at 1086–92. Under the Eighth Circuit's recent instructions regarding the undue burden test and the expanded record before the Court today,[32] Plaintiffs remain likely to succeed in showing that this law, as applied to Non-CMA Teenage Patients, violates those patients' rights to access abortion. First, the Local Disclosure Mandate is not reasonably related to any legitimate state purpose because it discloses each patient's abortion to local police and takes "evidence" from them when there is no basis for such law enforcement involvement. Second, the law's condemnation of these patients' histories as somehow criminal and its breach of their confidentiality, along with the fear and distress the Mandate instills, creates substantial obstacles for teenage patients, delaying their abortion care or dissuading them from accessing it at all in Arkansas. Either of these two showings is independently sufficient to establish that the Mandate fails the undue burden test that the Eighth Circuit instructed this Court to apply.

1. The Local Disclosure Mandate Lacks a Legitimate State Purpose for Non-CMA Teenage Patients.

As the Court previously found, "the Local Disclosure Mandate serves no valid state purpose as applied to Non-CMA Teenage Patients." 267 F. Supp. 3d 1089. The Court emphasized that for those teenagers, "[t]here exists no state interest in addressing child abuse and criminal conduct" because there is no indication of any abuse under the CMA's exhaustive criteria. *Id.* at 1089–90. "There is no mandatory reporting required, and there is no role for local law enforcement or the Arkansas State Crime Laboratory under those circumstances." *Id.* at 1089. As this Court recognized, when the legislature established this scheme for patients 13 and

[32] On this renewed motion for a preliminary injunction against the Local Disclosure Mandate, Plaintiffs rely on Count VI (undue burden in violation of Fourteenth Amendment rights), but do not rely upon the Fourteenth Amendment informational privacy claim (Count VIII), reserving it for the merits stage of the case.

under, it "explicitly contemplated that its application was co-extensive with mandatory reporting." *Id.* at 1089. When the Local Disclosure Mandate "greatly expanded[ed] the reach of this section"—to "non-criminal, non-reportable activity that is affirmatively constitutionally protected: abortions sought by Non-CMA Teenage Patients after sexual activity under circumstances indicating no form of sexual abuse"—it did so without legitimate justification. *Id.*; *see also id.* at 1092 (the Local Disclosure Mandate "lacks any justifying state purpose as applied to Non-CMA Teenage Patients"). Therefore, even if the obstacles it posed were not substantial (which they are), "the Local Disclosure Mandate would still fail constitutional review." *Id.* at 1092.

2. The Local Disclosure Mandate Erects Substantial Obstacles to These Teenagers' Abortion Care.

The Court also correctly found that the Local Disclosure Mandate erects numerous "substantial obstacles" for the Non-CMA Teenage Patients. 267 F. Supp. 3d at 1091. Those include:

> [P]reventing or delaying abortion care for these Non-CMA Teenage Patients by confusing them with discussions of evidence, suspects, and investigations as those terms are used in the Local Disclosure Mandate when those terms do not apply to them; humiliating them by disclosing very private facts about their sexual activity and reproductive choices in writing to local community members; and making them fearful of the reaction by local law enforcement in their home jurisdiction if they proceed with the care they seek and their abortion is therefore disclosed.

Id. at 1091–92. The Court also concluded that "if the mandate prohibits medication abortion," that is another substantial obstacle barring access to abortion care. *Id.* at 1091.

The Local Disclosure Mandate violates the long-established principle that anonymity for abortion patients, including minors, must be preserved. *See generally Lambert v. Wicklund*, 520 U.S. 292, 295 (1997) (if an abortion statute requires parental consent, a judicial bypass that "ensure[s] the minor's anonymity" is required to satisfy constitutional requirements); *Casey*, 505

U.S. at 894 (recognizing the undue burden of spousal notification for married women who seek an abortion without disclosure; a "significant number of women . . . are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion"); *Thornburgh v. Am. Coll. of Ob. & Gyn.*, 476 U.S. 747, 766–67 (1986) (emphasizing that a "woman and her physician will necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known" to third parties), *overruled in part on other grounds*, *Casey*, 505 U.S. at 881.

Forcing each of these teenage patients "to divulge to a stranger" that she has chosen to undergo an abortion—here, to a powerful local authority figure that ordinarily deals with criminal conduct—"humiliates and degrades her as a human being." *Planned Parenthood Minn., S. Dakota, N. Dakota v. Daugaard,* 799 F. Supp. 2d 1048, 1060 (D.S.D. 2011); *see also* Ralph Decl. ¶¶ 34–39, 42. Moreover, as this Court has recognized, "[w]hile officers will presumably treat such information as confidential, once the information is known by local community members and written on required documents, there are risks to these young women's privacy, which can engender fear on the part of these young women." 267 F. Supp. 3d at 1088; *see also* Ralph Decl. ¶¶ 37, 42. The Local Disclosure Mandate singles out these teenagers' abortions to make that one type of health care accessible only if a patient accepts ongoing fear of exposure of her sexual activity, her sexual partner, or her health care choice and crime lab retention of her "evidence."

The Mandate's condemnation and shaming of the Non-CMA Teenage Patients, and the confusion and fear it instills, will drive those patients away from abortion care in Arkansas. Ralph Decl. ¶¶ 40–41. The stigma imposed by the Mandate will delay teenagers' abortion care and make it medically riskier and costlier, if they are able to obtain the abortion at all. Parker

Decl. ¶¶ 63–67, 71–78; Williams Decl. ¶¶ 68, 70–71; Ralph Decl. ¶¶ 40–41; Hopkins Decl. ¶¶ 47–50; Doe 3 Decl. ¶¶ 7–8. As discussed *supra* at p.30, some teenagers will wait weeks to age out of the law's application while others will not succeed in accessing abortion, unless they are able to raise the resources to, and navigate the complications of, travel out of state. For all the reasons this Court earlier recognized, if allowed to take effect for Non-CMA Teenage Patients, this law will erect multiple substantial obstacles to abortion access. 267 F. Supp. 3d at 1087–92; *see also, e.g., June Med. Servs.*, 140 S. Ct. at 2140 (relying on delayed care and increased medical risks in finding a substantial obstacle).

D. Plaintiffs Are Likely to Succeed on Their Claims that the Tissue Disposal Mandate Is Unconstitutionally Vague and Imposes an Undue Burden.

1. The Tissue Disposal Mandate Is Unconstitutionally Vague.

This Court has already found Plaintiff Hopkins was "likely to succeed on his claim that the Tissue Disposal Mandate is vague such that it unconstitutionally deprives Dr. Hopkins of his due process rights," because it "fails to provide Dr. Hopkins or enforcement authorities with 'fair notice of conduct that is forbidden or required.'" *Hopkins*, 267 F. Supp. 3d at 1110 (quoting *Fed. Commc'ns Comm'n v. Fox Television Stations, Inc*., 567 U.S. 239, 253 (2012)). That is still true today, and Plaintiffs remain likely to succeed on their claim that the Mandate is unconstitutionally vague.

As this Court concluded, the Tissue Disposal Mandate lacks clarity by failing to define key terms and imposes an "unclear . . . scope of the obligations" on Plaintiffs who would be required to comply with the FDRA in the abortion context. *Id.* at 1108–10. The Mandate does not explain what constitutes "reasonable efforts" to locate "absent" family members to inform them about their disposition rights. *Id.* at 1110. It is unclear how Plaintiffs should confirm the identity of individuals who must be informed of their rights under the Mandate, when Plaintiffs

must make notification efforts, what to do if there is a dispute among those with disposition rights, or how to comply with the FDRA's myriad other requirements, which, when imported into the abortion context, simply do not make sense.[33] Absent clarity, and "[g]iven the potential liability for violating [the Tissue Disposal Mandate], plaintiff cannot make good faith efforts to comply and hope for the best." *Id*. at 1109 (internal quotation marks omitted).

As with the Medical Records Mandate, the Tissue Disposal Mandate's vagueness violates fundamental due process guarantees, which require clarity so that those bound by the law know what is expected of them. *See id*. at 1110; *see also supra* at pp.46–47. This is especially true here, where criminal penalties may be imposed and fundamental rights are implicated. *See supra* at pp.46–47. None of Defendants' attempts to re-write the FDRA to make it fit the abortion context provide certainty or clarity. *See Hopkins*, 267 F. Supp. 3d at 1099–1101. For example, the FDRA's civil provisions—located in the public health and welfare code and aimed at providing legal certainty and protection against liability to decedents, next of kin, funeral homes, and crematoria, *see, e.g.*, Ark. Code Ann. § 20-17-102(d)(1), (f)(2)—do not translate to Plaintiffs' provision of time-sensitive, confidential abortion care. Instead, the Mandate's vague legal requirements leave Plaintiffs to "guess at [their] meaning" and open them up to "arbitrary and discriminatory . . . enforcement." *United States v. Mabie*, 663 F.3d 322, 333 (8th Cir. 2011).

2. The Tissue Disposal Mandate Is Unconstitutional Because It Imposes an Undue Burden on Patients' Right to Abortion.

Plaintiffs also remain likely to succeed on their claim that the Tissue Disposal Mandate imposes an undue burden on patients' right to abortion under the standard the Eighth Circuit

[33] The Mandate's application to medication abortion is also unclear. *Hopkins*, 267 F. Supp. 3d. at 1110. Although the Department issued a regulation purporting to exempt medication from the Mandate's scope, the legal basis for that exemption was and remains unclear. *See id*. at 1110–11.

instructed this Court to apply. The Mandate imposes a substantial obstacle in the path of pregnant people seeking pre-viability abortion care and is not reasonably related to a legitimate state purpose. It is unconstitutional on both grounds, and either ground alone is sufficient to show Plaintiffs are likely to succeed on their undue burden claim.

a. The Tissue Disposal Mandate Imposes a Substantial Obstacle on Patients' Right to Abortion.

As this Court has already concluded, the Mandate imposes a substantial obstacle to pre-viability abortion care because it effectively requires disclosure of each patient's abortion to others—to a minor patient's parents and the parents of her sexual partner, and for adult patients, to their sexual partners—so that those individuals are aware of their rights related to the tissue. *Hopkins*, 267 F. Supp. 3d. at 1099. There are no exceptions; the Mandate requires Plaintiffs to make "reasonable efforts" to locate the patient's sexual partner if "absent," and emphasizes the importance of making efforts to notify others who have shared disposition rights. *See* Ark. Code Ann. § 20-17-102(d)(1)(E), (d)(3)(A).

By mandating notification to individuals whom a patient has a constitutionally protected right *not* to involve in her abortion care, the Mandate directly contradicts Supreme Court precedent and imposes a substantial obstacle. 267 F. Supp. 3d. at 1099, 1101 (collecting cases); *see also, e.g.*, *Casey*, 505 U.S. at 894 (rejecting spousal-notification requirement as substantial obstacle); *Bellotti*, 443 U.S. at 639–40 (requiring confidential judicial bypass for parental notification requirement); *Danforth*, 428 U.S. at 69 (rejecting spousal-consent requirement because "the State may not constitutionally require the consent of the spouse . . . as a condition for abortion . . . ."). In *June Medical Services*, the Chief Justice reiterated these key holdings, on which this Court previously relied in concluding that the notification requirements likely imposed a substantial obstacle. 140 S. Ct. at 2137 ("Without a judicial bypass, parental consent

laws impose a substantial obstacle to a minor's ability to obtain an abortion and therefore constitute an undue burden."); *id.* (spousal-notification law unconstitutional (citing *Casey*, 505 U.S. 893)). Accordingly, the Mandate's search-and-notification requirements alone render it a substantial obstacle under longstanding and recently reaffirmed precedent.

This Court also concluded that the Tissue Disposal Mandate would impose a substantial obstacle because it would force Plaintiffs to, at a minimum, cease providing abortion procedures. *Hopkins*, 267 F. Supp. 3d. at 1102, 1107–08. If the Mandate applies to medication abortion as well, Plaintiffs would be unable to provide any abortion care, as there is no way to "ensure" that tissue disposed of at each patient's home is disposed of in accordance with the FDRA, as the Mandate requires. Williams Decl. ¶ 76. The Mandate puts Plaintiffs in an impossible situation: attempting to comply would violate their professional ethical obligations, breach patient confidentiality, risk patient safety, and expose Plaintiffs to criminal penalties if they failed to fulfill the Mandate's vague requirements. Parker Decl. ¶ 88; Williams Decl. ¶¶ 78–79. As this Court recognized, Plaintiffs would thus be forced to stop providing abortion care if the Mandate goes into effect. Parker Decl. ¶ 100; Williams Decl. ¶ 79. Even if Plaintiffs were somehow able to continue to provide care while complying with the Mandate and their ethical obligations, Plaintiffs would be forced to delay abortion care to search for and notify the proper people, and ensure that the Mandate's many other requirements are met. *Hopkins*, 267 F. Supp. 3d. at 1108; Williams Decl. ¶ 78.[34] These obstacles are substantial; indeed, they are the same types of

[34] Moreover, even if Plaintiffs could conceivably search for and notify individuals after a patient's abortion, the constitutional violations that result from violating patient confidentiality and threatening patient safety by disclosing a patient's abortion to others would remain. *See supra* at 9. And given the complexities of trying to apply the FDRA in the abortion context, this is plainly a more theoretical than real possibility, since providers could not start abortions with

obstacles the Chief Justice discussed in concluding that the Louisiana law at issue in *June Medical Services* was unconstitutional. 140 S. Ct. at 2140.

b. The Mandate Is Not Reasonably Related to a Legitimate State Interest.

The Mandate is unconstitutional for the additional reason that it is "not reasonably related" to a legitimate state interest. *See June Med. Servs.*, 140 S. Ct. at 2138. The legislature made no findings related to the Tissue Disposal Mandate, and thus this Court "does not have an explanation from the legislature of the purpose of the law." *Hopkins*, 267 F. Supp. 3d at 1098. This Court has already concluded that, even if the interests Defendants stated the Mandate furthered were legitimate, the Mandate did not "advance[]" those interests. *Id*. at 1105. This Court was not "convinced that importing the FDRA's" requirements advance a "health goal," nor did it find that the Mandate furthered the state's interest in potential life, given that the Mandate applies after an abortion. *Id*. This remains true today and supports the conclusion that the Mandate is not "reasonably related" to a state interest.

Any interest the State has in disposition of pregnancy tissue in a medically appropriate way is served by current law. *See supra* at pp.31–32; *Whole Woman's Health*, 136 S. Ct. at 2311, 2314 (finding that new restriction "helped to cure," no significant problem, nor was it "more effective than pre-existing [state] law" in advancing state's asserted interest). Importing the FDRA's search-and-notice requirements into the abortion context advances no public health goal, and certainly does not advance any patient health goal, because delay and other negative effects threaten patients' health and wellbeing. *See* Williams Decl. ¶ 23; Parker Decl. ¶¶ 89–93, 97. Similarly, importing the FDRA scheme into abortion care violates, rather than furthers, any

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any discernable means of "ensuring" compliance with the Mandate after care occurred and thus could not risk starting that care in the face of the Mandate.

medical ethical goal, because notification threatens patient safety and breaches Plaintiffs' confidential relationship with their patients. *See* Parker Decl. ¶¶ 89–93. No interest in potential life can support the Mandate, because it applies to disposal of post-abortion pregnancy tissue, when there is no "potential life." *See Whole Woman's Health v. Hellerstedt*, No. A-16-CA-1300-SS, 2017 WL 462400, at *2 (W.D. Tex. Jan. 27, 2017) ("Unlike the legitimate state interests recognized by the Supreme Court, [Texas's] professed interest regulates a time when there is no potential life."). And, to the extent Defendants suggest the Mandate does not require Plaintiffs to make any efforts to notify individuals about their disposition rights, or to do anything but preserve tissue for a certain period of time, the Mandate serves no purpose whatsoever, much less a legitimate state purpose. *See* Defs.' Br. in Opp. to Pls. Mot. for Prelim. Inj. at 73 (July 11, 2017), Dkt. No. 23.

The Eighth Circuit's instruction that, on remand, this Court consider *Box*, does not alter this conclusion. First, Plaintiffs have brought an undue burden claim against the Mandate, and the challengers in *Box* brought a rational basis claim. In articulating the "threshold requirement" that an abortion restriction must be "reasonably related" to a legitimate state goal, the Chief Justice did not depart from the longstanding principle that the undue burden standard is not merely rational basis scrutiny, but a form of heighted review. *See June Med. Servs.*, 140 S. Ct. at 2138 ("*Casey* discussed benefits in considering the threshold requirement that the State have a 'legitimate purpose' and that the law be 'reasonably related to that goal.'" (citations omitted)); *Casey*, 505 U.S. at 877 (requiring lower courts to assess whether legislation was a "permissible means of serving" the State's "legitimate" purpose); *see supra* at p.38. Second, the Tissue Disposal Mandate is different than the law at issue in *Box*: while the law challenged in *Box* dictated the acceptable methods of tissue disposition after abortion, the Mandate here dictates

who has rights to make disposition decisions, through an elaborate scheme that strikes at the heart of a person's ability to access confidential abortion care. *See* Ark. Code Ann. §§ 20-17-802(a), 20-17-102(d)(1) (describing order in which individuals have the "right to control the disposition of the remains"). The Supreme Court's analysis of what was "rational" in *Box* simply has no bearing here.

The Tissue Disposal Mandate is thus unconstitutional because it both fails the Chief Justice's "threshold requirement" and poses a substantial obstacle to patients' right to access to abortion.

c. The Mandate is Facially Unconstitutional.

As this Court previously concluded, the Mandate imposes a substantial obstacle on a large fraction of patients for whom it is relevant and is therefore facially unconstitutional. *Hopkins*, 267 F. Supp. 3d at 1105. Whether the Court construes the Mandate to apply to people seeking any abortion care or only procedural abortions, this "end result will not" change. *Id*. Like the spousal-notification requirement in *Casey*, the search-and-notice requirements here "will mean that in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle." *Id*. at 1106 (quoting *Casey*, 505 U.S. at 895). Because the Mandate forces disclosure of each patient's abortion regardless of the patient's wishes, "the numerator equals the denominator." *Id*. Accordingly, even "[a]ccepting defendants' argument regarding scope," the Mandate "would still impose . . . impermissible notification requirements," and impose an "undue burden for a large fraction of women" impacted by it. *Id*. at 1107. And, "even if the notification requirements are not alone sufficient to constitute an undue burden," forcing Plaintiffs to stop providing certain abortion care, or risk criminal penalties and attempt to comply with the Mandate's many and vague requirements—and in turn breach patient confidentiality, delay care, and risk patients' safety—would impose a substantial obstacle on a large fraction of

patients. *See id*. at 1107–08. Plaintiffs are therefore likely to succeed on their claim that the Mandate imposes a substantial obstacle on a large fraction of patients and is facially invalid.

II. THE CHALLENGED LAWS WOULD IMPOSE IRREPARABLE HARM

This Court has already concluded in its prior preliminary-injunction order that if these laws took effect, they would impose irreparable harm on Plaintiffs and their patients. *Id*. at 1069; *id*. at 1073–74, 1084–85; *id*. at 1093, 1095–96; *id*. at 1110. As this Court held, "[i]t is well-established that the inability to exercise a constitutional right constitutes irreparable harm." *Id*. at 1069, 1084, 1095, 1110; *see also Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury." (citations omitted)); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)).

Moreover, enforcement of the laws would wreak havoc on abortion access by banning, delaying, or discouraging abortion for the vast majority of people who seek access in Arkansas. 267 F. Supp. 3d at 1069 (D&E Ban would prohibit the only method of second-trimester abortion); *id*. at 1073–74, 1084–85 (Medical Records Mandate would to lead to denial of abortion care or delayed abortion access); *id*. at 1093, 1095–96 (Local Disclosure Mandate would discourage minors from obtaining an abortion and unnecessarily disclose intensely private information to local police); *id*. at 1110 (Tissue Disposal Mandate would impose a substantial obstacle in the path of people seeking abortion). Additionally, the vagueness in the Medical Records Mandate and the Tissue Disposal Mandate fail to give Plaintiffs notice as to how to comply with these laws and continue providing care, in violation of their due process rights, and threatens them with substantial penalties. *Id*. at 1084–85, 1110.

III. THE BALANCE OF THE EQUITIES WEIGHS HEAVILY 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.*, 640 F.2d at 113. As this Court held in its prior preliminary injunction, the balance of harm clearly tips in Plaintiffs' favor: if the laws take effect, the vast majority of abortions would be halted, while on the other hand, "likely unconstitutional law[s]" will not go into effect; indeed, the threatened harm to Plaintiffs and their patients "clearly outweighs" any potential harm a proposed injunction may cause the State. 267 F. Supp. 3d. at 1069, 1085, 1096, 1110. This is especially true where this Court has held that the three of the four laws do not serve the State's legitimate interests. *Id*. at 1076, 1089, 1105. Furthermore, the challenged laws have been enjoined for three years, and Defendants can point to no harm to the State that has occurred in this time.

IV. INJUNCTIVE RELIEF IS IN THE PUBLIC INTEREST

Finally, the interests of Plaintiffs and their patients are aligned with those of the general public. In a case involving constitutional claims, the public interest factor considered on a motion for a preliminary injunction "is largely dependent on the likelihood of success on the merits because the protection of constitutional rights is always in the public interest." *Edwards*, 946 F. Supp. 2d at 850 (citing *Phelps-Roper v. Nixon*, 509 F.3d 480, 485 (8th Cir. 2007)). This Court held in its prior preliminary injunction order that it is in the public interest is to "preserve the *status quo*." 267 F. Supp. 3d. at 1069, 1085, 1096, 1110. The same is true here: absent a preliminary injunction, abortion access will be severely curtailed, and it is in the public interest to maintain the status quo until this Court can adjudicate Plaintiffs' motion for a preliminary injunction.

V. A BOND IS NOT NECESSARY IN THIS CASE

The Court should waive the Federal Rule of Civil Procedure 65(c) bond requirement. Although that rule typically requires the posting of security when a preliminary injunction issues, it is well-established that whether to require a bond rests in the discretion of the trial court and that factual contexts like this one support a finding that no bond is necessary. Where "plaintiffs are serving a public interest" in acting to protect constitutional rights related to abortion, and the governmental defendants "will not be harmed by the order" to preserve the status quo, it is "customary" to not require security. *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, 263 F. Supp. 3d 729, 739 (W.D. Mo. 2017), *vacated on other grounds sub nom. Comprehensive Health of Planned Parenthood Great Plains v. Hawley*, 903 F.3d 750 (8th Cir. 2018). Plaintiffs are health care providers dedicated to serving patients, including many low-income people, at one of the last two abortion clinics in Arkansas, and 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. US. 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).

CONCLUSION

For all of the forgoing reasons, this Court should grant Plaintiffs' motion for a second preliminary injunction and/or TRO.

Dated: December 21, 2020

Respectfully submitted,

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** Motion for admission pro hac vice granted*