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**Applications for admission pro hac vice forthcoming*
***Admitted pursuant to Ariz. Sup. Ct. R. 38(f)*

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Planned Parenthood Arizona, Inc.; Eric Reuss, M.D., M.P.H.; Paul A. Isaacson, M.D.; Desert Star Family Planning, LLC; DeShawn Taylor, M.D.,

Plaintiffs,

v.

Mark Brnovich, Arizona Attorney General, in his official capacity; Cara M. Christ, Director of the Arizona Department of Health Services, in

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION AND MEMORANDUM OF POINTS AND AUTHORITIES

Civil Action No. _____

her official capacity; Patricia E. McSorley, Executive Director of the Arizona Medical Board, in her official capacity; Richard T. Perry, M.D., Medical Board Chair, in his official capacity; James Gillard, M.D., Medical Board Vice Chair, in his official capacity; Jodi A. Bain, Medical Board Member, in her official capacity; Marc D. Berg, M.D., Medical Board Member, in his official capacity; Donna Brister, Medical Board Member, in her official capacity; R. Screven Farmer, M.D., Medical Board Member, in his official capacity; Gary R. Figge, M.D. Medical Board Member, in his official capacity; Robert E. Fromm, M.D., Medical Board Member, in his official capacity; Paul S. Gerding, Medical Board Member, in his official capacity; Lois Krahn, M.D., Medical Board Member, in her official capacity; Edward G. Paul, M.D., Medical Board Member, in his official capacity; Wanda J. Salter, Medical Board Member, in her official capacity; Jenna Jones, Executive Director of the Arizona Board of Osteopathic Examiners in Medicine and Surgery, in her official capacity; Scott Steingard, D.O., Board of Osteopathic Examiners in Medicine and Surgery President, in his official capacity; Douglas Cunningham, D.O., Board of Osteopathic Examiners in Medicine and Surgery Vice President, in his official capacity; Gary Erbstoesser, D.O., Board of Osteopathic Examiners in Medicine and Surgery Member, in his official capacity; Jerry G. Landau, Board of Osteopathic Examiners in Medicine and Surgery Member, in his official capacity; Martin B. Reiss, D.O., Board of Osteopathic Examiners in Medicine and Surgery Member, in his official capacity; Lew Riggs, Board of Osteopathic Examiners in Medicine and Surgery Member, in his official capacity; Vas Sabeeh, D.O., Board of Osteopathic Examiners in Medicine and Surgery Member, in his official capacity,

Defendants.

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

Plaintiffs Planned Parenthood Arizona, Inc. ("PPAZ"), Eric Reuss, M.D., M.P.H.; Paul A. Isaacson, M.D.; Desert Star Family Planning, LLC; and DeShawn Taylor, M.D., (collectively hereinafter "Plaintiffs"), by and through their attorneys, hereby move this Court pursuant to Rule 65 of the Federal Rules of Civil Procedure for a temporary restraining order and/or preliminary injunction, restraining Defendants from enforcing portions of S.B. 1318, 52nd Leg., 1st Reg. Sess. (AZ 2015) ("S.B. 1318") (to be codified at Ariz. Rev. Stat. §§ 36-2153(A)(2)(h), (i)) ("the Act"), which without order from this Court will become law on July 3, 2015. This Motion is supported by the following Memorandum of Points and Authorities.[1]

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

This case concerns a first-of-its kind law that would compel Plaintiffs—against their medical judgment and under threat of losing their licenses to practice medicine—to mislead their patients about the medical treatments available. The Act requires Plaintiffs to tell each patient seeking to have an abortion, orally and in a private meeting, that "it may be possible to reverse the effects of a medication abortion" if she changes her mind later, and that the state is providing information and assistance about doing so. The Act compels Plaintiffs to unwillingly convey this message to *every* patient, including those having a surgical abortion, even though no credible evidence exists that a medication

[1] Because this case involves important factual issues, Plaintiffs request that the Court set an evidentiary hearing on their application for preliminary injunction prior to July 3, 2015. In the (likely) case that a full hearing on the preliminary injunction cannot be set prior to that date, and/or Defendants will not agree to a temporary restraining order to allow the Parties an opportunity to fully prepare for a hearing, Plaintiffs request that the Court issue an order to show cause why a temporary restraining order should not issue, with a preliminary injunction hearing to be scheduled as soon thereafter as is convenient for the Court.

abortion (or any abortion) may be reversed, and even though the message encourages patients to begin a medication abortion before they are certain in their decision whether to have an abortion. The Act also compels Plaintiffs to steer patients toward an unproven, experimental practice that no major medical organization has recognized, and that the American College of Obstetricians and Gynecologists ("ACOG") opposes. Mandating that misleading, unscientific statements be given to and received by every patient seeking an abortion distorts the informed consent process and is harmful to patients.

The Act violates two separate fundamental rights. Because it compels Plaintiffs against their medical judgment and in violation of medical ethics to unwillingly discuss with their patients, "orally and in person," a state-mandated message that is not medically or scientifically supported, and that undermines the purpose of informed consent, the Act violates Arizona physicians' First Amendment right against compelled speech. The Act also violates Plaintiffs' patients' Fourteenth Amendment rights because it requires that they receive untruthful, misleading, and/or irrelevant information about abortion, which impedes rather than assists with their decision-making, and could expose them to unnecessary medical risk.

As is more fully explained below, a preliminary injunction is warranted because: 1) Plaintiffs are likely to succeed on their claims that the Act is unconstitutional; 2) Plaintiffs and their patients will suffer irreparable harm if the Act takes effect; 3) the balance of equities tips strongly in favor of Plaintiffs and their patients; and 4) the public interest will be served by an injunction. *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014) (citing *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)), *cert. denied*, 135 S. Ct. 870 (2014).

STATEMENT OF FACTS

A. Current Arizona Abortion Practice

Plaintiffs are Arizona health care providers who provide a full range of reproductive health services to women in Arizona, including abortions; pregnancy

diagnosis and counseling; contraceptive counseling; provision of all methods of contraception; HIV/AIDS testing and counseling; cancer screening; and testing, diagnosis, and treatment of sexually transmitted infections. Decl. of Bryan Howard ¶ 3, attached hereto as Exhibit 3 ("Howard Decl."); Decl. of Dr. Paul Isaacson ¶ 3, attached hereto as Exhibit 4 ("Isaacson Decl."); Decl. of Dr. Eric Reuss ¶ 3, attached hereto as Exhibit 5 ("Reuss Decl."). In providing care to their patients, Plaintiffs follow general principles of medical ethics, among the most fundamental of which is to provide patients with accurate information, in accordance with their medical judgment, training, and experience. Isaacson Decl. ¶¶ 4, 14; *see also* Howard Decl. ¶ 5; Reuss Decl. ¶ 5.

Plaintiffs' patients seek abortions for a variety of medical, psychological, emotional, familial, economic, and personal reasons. Isaacson Decl. ¶ 11; Reuss Decl. ¶¶ 8-10. Approximately one in three women in the United States will have an abortion by age 45, and most who do so either already have children or are planning to raise a family when they are older, financially stable, and/or in a supportive relationship with a partner. Decl. of Dr. Courtney Schreiber ¶ 7, attached hereto as Exhibit 1 ("Schreiber Decl."). Generally, if an Arizona woman seeks an abortion through the first 9-10 weeks of pregnancy as measured from the first day of her last menstrual period ("LMP"), she can choose between a surgical procedure that takes place in a health center (surgical abortion) or a procedure using pills alone (medication abortion). *See* Howard Decl. ¶ 4; Isaacson Decl. ¶ 7; Reuss Decl. ¶ 11; *see also* Schreiber Decl. ¶ 10.

Plaintiffs offer their patients the most common form of medication abortion, an evidenced-based regimen of a combination of two prescription pills: mifepristone and misoprostol (the "mifepristone/misoprostol regimen" or "early medication abortion"). Howard Decl. ¶ 4; Isaacson Decl. ¶ 8; Reuss Decl. ¶ 11. Mifepristone, also known as "RU-486" or by its commercial name Mifeprex, works first by temporarily blocking the hormone progesterone, thereby causing the uterine lining to break down, and by increasing the efficacy of the second medication in the regimen, misoprostol. Schreiber

Decl. ¶¶ 12-13. Misoprostol causes the uterus to contract and expel its contents. *Id.* at ¶ 13. Under current practice, a patient takes mifepristone at her health care facility and up to 72 hours later, usually at home, she takes misoprostol. *Id*. The mifepristone/misoprostol regimen Plaintiffs administer has been endorsed by ACOG, and is supported by vast amounts of clinical data. Schreiber Decl. ¶ 10 & n.3.

Mifepristone is not considered effective enough to use as an abortifacient on its own because it would fail to terminate pregnancy a significant percentage of the time. Schreiber Decl. ¶¶ 13-14 (citing data suggesting failure rate of up to 46 percent in first 49 days, and stating that other data suggest this rate would increase for pregnancies past 49 days). But when mifepristone is combined with misoprostol under the regimen used by Plaintiffs, the process is extremely effective. *Id*. For this reason, to provide an early medication abortion, Plaintiffs administer the two drugs in combination. Howard Decl. ¶ 4; Isaacson Decl. ¶¶ 8-9; Reuss Decl. ¶ 11.

After 9-10 weeks of pregnancy, the only option for most women is to have a surgical abortion; however, for certain medical reasons, medications are sometimes used to induce a non-surgical abortion later in pregnancy. For example, sometimes misoprostol alone is used to induce abortion in a hospital setting; this is called an "induction." Schreiber Decl. ¶ 15; Reuss Decl. ¶ 12(a). Another abortion method sometimes performed later in pregnancy involves using a medication called digoxin to cause fetal demise before the surgical evacuation of the uterus. Schreiber Decl. ¶ 15. Under Arizona law,[2] inductions and abortions via digoxin are both "medication abortions" because medications alone cause the abortion.

As healthcare providers, Plaintiffs have an ethical and legal obligation to obtain informed consent before providing medical treatment, including abortion. As part of the informed consent process, Plaintiffs discuss with each patient relevant information to

[2] *See* Ariz. Rev. Stat. § 36-449.01 ("'Medication abortion' means the use of any medication, drug or other substance that is intended to cause or induce an abortion.").

assist her with her decision of whether to have an abortion. Howard Decl. ¶ 5; Isaacson Decl. ¶¶ 12-13; Reuss Decl. ¶ 13. The information includes a discussion of her options and alternatives (which include carrying the pregnancy to term, adoption, and abortion), the abortion procedures that are available to her, and the risks and benefits associated with each procedure available to her. Howard Decl. ¶ 5; Isaacson Decl. ¶ 12; Reuss Decl. ¶ 13. The goal of the informed consent process is for patients to have the information necessary so that they can make the right decision for themselves. Declaration of Steven Joffe, M.D., M.P.H., at ¶ 18, attached hereto as Exhibit 2 ("Joffe Decl."). *See also* Howard Decl. ¶ 5; Isaacson Decl. ¶ 4; Reuss Decl. ¶¶ 5, 13.

Plaintiffs advise each patient that the decision to have an abortion is hers alone to make, and not to start an abortion, medication or surgical, unless and until she is firm in her decision to terminate the pregnancy. Howard Decl. ¶ 6; Isaacson Decl. ¶ 25; Reuss Decl. ¶ 20. In particular, when providing the mifepristone/misoprostol medication abortion regimen, Plaintiffs counsel each patient to be certain in her decision to terminate her pregnancy before starting the regimen, mainly because although mifepristone is not considered an effective abortifacient on its own (as compared to the combined regimen), mifepristone alone will cause termination in a significant percentage of pregnancies. Howard Decl. ¶ 6; Isaacson Decl. ¶ 26; Reuss Decl. ¶ 20.

B. The Act and Existing Informed Consent Process in Arizona

Existing Arizona law states that an abortion shall not be performed or induced without the voluntary and informed consent of a patient. Ariz. Rev. Stat. § 36-2153(A). Consent is considered voluntary and informed only if a patient seeking an abortion first meets in person with a physician, at least 24 hours before her abortion, to receive certain information, including accurate medical information about a patient's individual pregnancy. *Id.* In addition, a patient must receive from a physician (or a health professional chosen to represent him or her) various statements about Arizona law and policy, including that the Arizona Department of Health Services ("ADHS") maintains a

website regarding abortion and that the patient has a right to review the website, *id.*—similar to the required information approved by the U.S. Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 882-84 (1992).

The Act challenged here would radically alter existing informed consent requirements by compelling Plaintiffs to tell women seeking an abortion, at least 24 hours beforehand, that "it may be possible to reverse the effects of a medication abortion if the woman changes her mind but that time is of the essence," and that "information on and assistance with reversing the effects of a medication abortion is available on the department of health services' website." S.B. 1318, § 4 (to be codified at Ariz. Rev. Stat. § 36-2153(A)(2)(h), (i)). By statute, physicians and clinics that fail to comply face loss of licensure, other disciplinary action, and liability to private parties. *See* Ariz. Rev. Stat. §§ 36-449.02, 36-449.03; 36-429, 36-430; 32-1857(C); 36-2153(I), (J).

The Act also directs ADHS to post on its website "information on the potential ability of qualified medical professionals to reverse a medication abortion, including information directing women where to obtain further information and assistance in locating a medical professional who can aid in the reversal of a medication abortion." S.B. 1318, § 4 (to be codified at Ariz. Rev. Stat. § 36-2153(C)(8)). To date, ADHS has not posted on its website the information required by the Act. *A Woman's Right to Know*, Arizona Department of Health Services (last visited June 2, 2015), http://azdhs.gov/phs/owch/informed-consent/right-to-know/index.htm. Indeed, soon after the Act was signed by Governor Ducey, Plaintiff PPAZ's President and CEO wrote to ADHS then-Interim Director Cory Nelson requesting information about what ADHS intends to post on its website in response to the Act's directive, and requested a response by May 22, 2015. Howard Decl. ¶ 10, Exhibit A. After receiving no response to its first letter, on May 22 Plaintiff PPAZ's President and CEO followed up again, this time with current ADHS Director Christ, to request the same information and a response by May 29. Howard Decl. ¶ 11, Exhibit B. On June 1, Plaintiff PPAZ's President and CEO

received a letter from ADHS Director Christ stating that, "[g]iven the impact of [S.B. 1318] the Department is still working through the requirements and vetting potential language," and that the information required under the Act would be posted by July 3, and possibly available sooner, by June 19. *Id.* ¶ 11, Exhibit C.[3]

C. Impact of the Act

The Act violates Plaintiffs' and their patients' rights, forces physicians to violate fundamental principles of medical ethics and thereby negatively impacts the physician-patient relationship, and puts patients at risk.

First, on its face, the Act requires Plaintiffs to tell their patients seeking an abortion, orally and in person, and in a private medical setting, that it "may be possible to reverse the effects of a medication abortion," and that assistance is available to do so. But no evidence exists that a medication abortion can be reversed—whether it is the most common type of medication abortion (the mifepristone/misoprostol regimen) or a medication abortion via induction or digoxin.[4] *See* Schreiber Decl. ¶¶ 16, 42. Indeed, no abortion may ever be reversed; the termination of a pregnancy is always final. Thus, the Act compels Plaintiffs to provide their patients with a state-mandated message that is not medically or scientifically supported, and that is not truthful. Schreiber Decl. ¶ 3; Joffe Decl. ¶¶ 23, 32. In so doing, the Act compels Plaintiffs to violate a fundamental obligation the physician has in the informed consent process, which is to provide patients with honest information. Joffe Decl. ¶¶ 20-23, 32.

Second, the Act forces Plaintiffs to steer their patients toward an experimental medical practice that is unsupported by any credible evidence. Joffe Decl. ¶¶ 32, 45-46.

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[3] This is an additional reason why a temporary restraining order is warranted: to preserve the status quo until Plaintiffs and this Court can consider the specific "information on and assistance with reversing the effects of a medication abortion" the Act would require Plaintiffs to refer their patients.

[4] Nor are Plaintiffs aware of any physicians purporting to reverse a medication abortion after a woman has taken the combined mifepristone/misoprostol regimen, or been given a medication abortion via digoxin or induction.

As the legislature considered and debated the Act, testimony was provided by an Arizona physician, who discussed an experimental practice proposed by a California physician named Dr. George Delgado. *Hearing on S.B. 1318 Before the H. Federalism and State's Rights Comm.*, 2015 Leg., 52nd Sess. (Ariz. 2015) (statement of Dr. Allan Sawyer at 6:15-21:03, *available at* http://azleg.granicus.com/MediaPlayer.php?view_id=13&clip_id=15544). This experimental practice involves giving women numerous injections of large doses of the hormone progesterone to "reverse" the effects of mifepristone, the first drug in the early medication abortion regimen provided by Plaintiffs. *See* Schreiber Decl. ¶¶ 17, 32. Thus, it is notable that even the proponents of this experimental practice do not claim to be able to reverse "the effects of a medication abortion"; the experimental practice relates solely to "reversing" the effects of mifepristone.

Plaintiffs object to being compelled, against their medical judgment, to tell every patient seeking an abortion that a medication abortion may be reversed based on an unproven theory about mifepristone reversal. Howard Decl. ¶¶ 12-13; Isaacson Decl. ¶¶ 17-20; Reuss Decl. ¶¶ 14-16; *see also* Schreiber Decl. ¶¶ 19, 39; Joffe Decl. ¶¶ 30-32. There are no clinical studies demonstrating that the experimental practice is safe or effective, Schreiber Decl. ¶¶ 16, 23-28, 33, nor has any major medical organization recognized it as such. To the contrary, ACOG opposes it because it has not been proven safe or effective. *See* Schreiber Decl. ¶ 20, Exhibit B. Instead of credible evidence, there exists one peer-reviewed article—a case series—of just seven patients who were administered progesterone experimentally years ago; four carried their pregnancies to term, two aborted, and one was lost to follow up. Schreiber Decl. ¶ 17, Exhibit C.

For several reasons, this case series is not evidence that the experimental practice does anything at all, or that it is safe. Case series, because of their anecdotal nature and lack of any scientific design, are especially vulnerable to selection bias and therefore do not support causal inferences. Joffe Decl. ¶ 29, Schreiber Decl. ¶ 22. In other words, case series are not evidence that the treatment they describe actually achieved the outcomes

that were observed. *Id*. Rather, physicians use case series to present observations that, at best, may merit future study. This case series is no different. Joffe Decl. ¶ 30. In fact, its data is questionable even for a case series. Schreiber Decl. ¶¶ 24 (explaining missing details and unrepresentative nature of patients observed). Indeed, Drs. Delgado and Davenport themselves acknowledged the need for clinical studies on their proposed protocol before it could become integrated into standard practice management.[5] Schreiber Decl. ¶ 31; Joffe Decl. ¶ 32. For all the foregoing reasons, even if the Act was meant to refer only to "mifepristone reversal," as opposed to "medication abortion reversal," it still would force Plaintiffs to convey to their patients a state-mandated message that is highly misleading because it is not based on any medical evidence.[6]

The state-mandated message compelled by the Act is also deeply misleading to patients, especially those that are eligible for or considering a medication abortion. It encourages patients to believe that there is evidence, endorsed by their physician and the state, that a medication abortion can be reversed, Joffe Decl. ¶ 28, and that assistance is available to do so, when this is not the case. And Plaintiffs must raise this (medically

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[5] According to public statements by physicians experimenting on women with progesterone, it appears they have now expanded their practice beyond the seven women reported in the case series, but are doing so outside the normal bounds of accepted medical research methods—i.e., without approval by an institutional review board, *see* Joffe Decl. ¶¶ 39-43; Schreiber Decl. ¶¶ 34-36, and with misleading, public statements about the efficacy of their protocol, *see* Schreiber Decl. ¶ 33. The misleading nature of their public statements also calls into question whether any subjects could give true informed consent before participating in the research.

[6] It is puzzling that the Arizona Legislature would now encourage women who choose medication abortion to seek out *unstudied*, off-label progesterone administration, notwithstanding that just a few years ago, it banned women from using an evidence-based, off-label protocol for medication abortion that has been proven safe and effective in peer-review studies involving hundreds of thousands of women. *See Humble*, 753 F.3d 905. Similarly strange is that in the findings to that same law, the Arizona Legislature stated a concern that women might suffer complications from "*failure* to complete the two-step dosage process." H.B. 2036, 50th Leg., 2nd Reg. Sess. (AZ 2012), § 9.A.13 (emphasis added). The Act does not explain the inconsistency inherent in now encouraging women to do just that.

unsupported) possibility of reversing a medication abortion during the informed consent process—the very time at which Plaintiffs are trying to impress on each patient that she must be certain about terminating a pregnancy. Howard Decl. ¶ 16; Isaacson Decl. ¶¶ 22, 24; Reuss Decl. ¶ 19. In this way, the Act undermines a critical message Plaintiffs to seek to convey to their patients during the informed consent process, and creates a risk that a patient may begin an abortion before she is ready. *See* Schreiber Decl. ¶¶ 45-47; Joffe Decl. ¶ 35; Howard Decl. ¶ 16; Reuss Decl. ¶ 20.

The Act also requires Plaintiffs, against their medical judgment, to inform *all* of their patients seeking abortion that it may be possible to reverse the effects of a medication abortion, and that assistance is available to do so. This information, even if it were truthful (which it is not), is wholly irrelevant to many of Plaintiffs' patients who are not eligible for or do not want a medication abortion. This highlights another way in which the Act undermines the purpose of informed consent by distracting patients from the critical information that is necessary to an informed decision. *See* Joffe Decl. ¶ 36.

In all of these ways, the Act forces Plaintiffs, against their own professional, medical judgment, and in their own voice, to convey a message to their patients that is not based on medical evidence, violates the prevailing standard of care, is against their patients' best interests, and is untrue, misleading, and irrelevant. *See* Joffe Decl. ¶¶ 23, 33; Schreiber Decl. ¶¶ 3, 16-33, 39-47. As a result, the Act is harmful to women, to the physician-patient relationship and to the integrity of the medical profession, and it frustrates rather than supports the informed consent process. *See* Joffe Decl. ¶¶ 25, 32-34, 45-46; Schreiber Decl. ¶¶ 39, 41-45, 48.

ARGUMENT

I. PLAINTIFFS ARE ENTITLED TO A PRELIMINARY INJUNCTION AND, IF NECESSARY, A TEMPORARY RESTRAINING ORDER

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of

preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Humble*, 753 F.3d at 911 (quoting *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). When a court applies this standard, "the elements of the preliminary injunction test are balanced, so that a stronger showing of one element may offset a weaker showing of another." *Pimentel v. Dreyfus*, 670 F.3d 1096, 1105 (9th Cir. 2012) (quoting *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1131 (9th Cir. 2011)). "'[S]erious questions going to the merits' and a balance of hardships that tips sharply towards the plaintiff can support issuance of a preliminary injunction, so long as the plaintiff also shows that there is a likelihood of irreparable injury and that the injunction is in the public interest." *Humble*, 753 F.3d at 911 (quoting *Alliance for the Wild Rockies*, 632 F.3d at 1135). "[T]he purpose of a preliminary injunction is to preserve the status quo between the parties pending a resolution of a case on the merits." *McCormack v. Hiedeman*, 694 F.3d 1004, 1019 (9th Cir. 2012). As explained below, Plaintiffs meet this standard.

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS

Plaintiffs are highly likely to prevail on their First and Fourteenth Amendment claims. The Act infringes on Plaintiffs' First Amendment rights by compelling them to speak a state-mandated message to every patient about an experimental medical practice that has not been proven safe or effective, that violates the standard of care, and that is antithetical to ensuring informed consent. Accordingly, the Act must be reviewed under heightened scrutiny. The Act clearly fails this demanding test by compelling speech that is not tailored to further even a legitimate government interest. Moreover, the Act is separately unconstitutional under the Fourteenth Amendment, as it requires women seeking to exercise their right to choose abortion to receive information that is untruthful, misleading, and/or irrelevant.

A. The Act Violates Plaintiffs' First Amendment Rights Against Compelled Speech.

1. The Act must be subjected to heightened scrutiny.

The U.S. Supreme Court has long held that the First Amendment protects not only against government restrictions on speech, but also against speech compelled by the government. "Since *all* speech inherently involves choices of what to say and what to leave unsaid, one important manifestation of the principle of free speech is that one who chooses to speak may also decide what not to say." *Hurley v. Irish-Am. Gay, Lesbian & Bisexual Grp. of Bos.*, 515 U.S. 557, 573 (1995) (emphasis added) (internal quotation marks and citations omitted). Thus, "[t]he First Amendment mandates that we presume that speakers, not the government, know best both what they want to say and how to say it." *Riley v. Nat'l Fed'n of the Blind of N.C.*, 487 U.S. 781, 790-91 (1988).

In determining the appropriate level of scrutiny by which to review a challenged measure, the "lodestars . . . must be the nature of the speech taken as a whole and the effect of the compelled statement thereon." *Riley*, 487 U.S. at 796. "[R]ecogniz[ing] the core First Amendment values of the doctor-patient relationship," the Court of Appeals for the Ninth Circuit has reasoned that "professional speech may be entitled to 'the strongest protection our Constitution has to offer.'" *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002) (quoting *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 634 (1995)). Specifically, that court has held "that doctor-patient communications *about* medical treatment receive substantial First Amendment protection." *Pickup v. Brown*, 740 F.3d 1208, 1227-1231 (9th Cir. 2013) (emphasis in original), *cert. denied*, 134 S.Ct 2871 (2014), *and cert. denied sub nom. Welch v. Brown*, 134 S.Ct 2881 (2014). This is because "[a]n integral component of the practice of medicine is the communication between a doctor and a patient," which hinges on "confidence and trust" and a physician's ability "to speak frankly and openly to patients." *Conant*, 309 F.3d at 636 (quoting *Trammel v. United States*, 445 U.S. 40, 51 (1980)); *see also Conant*, 309 F.3d at 636 (noting that the Supreme Court in *Casey* recognized that physician speech is entitled to First Amendment protection because of the significance of the doctor-patient relationship).

In *Conant*, the court applied heightened scrutiny to enjoin a government policy restricting physicians from merely recommending (although not prescribing) medical marijuana to their patients. 309 F.3d at 637-39. The court compared this to a law requiring licensing of psychoanalysts, which it had previously held to be content-neutral as it "did not attempt to 'dictate' the content of what is said in therapy." *Id.* at 637 (discussing *Nat'l Ass'n for the Advancement of Psychoanalysis v. Cal. Bd. of Psychology*, 228 F.3d 1043, 1055-56 (9th Cir. 2000) ["*NAAP*"]). The medical marijuana speech regulation, by contrast, was a content- and viewpoint-based regulation because it applied only to "doctor-patient conversations about the medical use of marijuana," and "condemn[ed] expression of a particular viewpoint, *i.e.* that medical marijuana would likely help a specific patient." *Id*. at 637. The court explained that content-based restrictions on speech are "presumptively invalid," *id.* (quoting *R.A.V. v. City of St. Paul, Minn.*, 505 U.S. 377, 382 (1992)), and "when the government targets . . . particular views taken by speakers on a subject, the violation of the First Amendment is all the more blatant," *id.* (quoting *Rosenberger v. Rector*, 515 U.S. 819, 829 (1995)).

Elaborating on *Conant* and *NAAP*, the Ninth Circuit in *Pickup* considered more generally the First Amendment rights of state-regulated health care professionals (including physicians), explaining that:

> At one end of the continuum, where a professional is engaged in a public dialogue, First Amendment protection is at its greatest. . . . At the midpoint of the continuum, within the confines of a professional relationship, First Amendment protection of a professional's speech is somewhat diminished. . . . At the other end of the continuum . . . is the regulation of professional conduct, where the state's power is great, even though such regulation may have an incidental effect on speech.

Pickup, 740 F.3d at 1227-29 (emphasis omitted). The court further explained, "certainly . . . content- or viewpoint based regulation of communication *about* treatment must be closely scrutinized." *Id.* at 1231. Because the law at issue in *Pickup* banned a particular *treatment*, the court held that it was a regulation of conduct, falling at the less speech-

protective end of the spectrum. *Id.* at 1229; *see also Pickup*, 740 F.3d at 1226 (contrasting conduct regulation at issue in *NAAP*, which required psychoanalysts to meet licensing requirements, with the ban on the "mere[] discussion" of marijuana treatment at issue in *Conant*, which restricted speech).

Thus, as both *Pickup* and *Conant* make clear, a content- or viewpoint-based regulation of a physician's speech about medical treatment within the confines of a professional relationship falls in the middle of the continuum, triggering "heightened scrutiny." *Pickup*, 740 F.3d at 1231; *accord Conant*, 309 F.3d at 637-39; *see also Stuart v. Camnitz*, 774 F.3d 238, 248 (4th Cir. 2014) (applying *Pickup* and holding that state-compelled physician speech in the informed consent context "resides somewhere in the middle on that sliding scale" and must satisfy at least intermediate scrutiny to survive).

Here, there is no question that the challenged Act regulates speech, not conduct, as it "dictate[s] the content of what is said," *NAAP*, 228 F.3d at 1056, in "doctor-patient communications *about* medical treatment," *Pickup*, 740 F.3d at 1227, and is deserving of heightened scrutiny. *See also Conant*, 309 F.3d at 637-39; *see also Camnitz*, 774 F.3d at 246 (finding regulation to be "quintessential compelled speech" as it "forces physicians to say things they otherwise would not say"). This is undeniably the case considering "the nature of the speech taken as a whole" mandated by the Act, and the "effect of the compelled statement[s]," *Riley*, 487 U.S. at 796. Specifically, the Act mandates speech that directly and negatively alters the content of Plaintiffs' informed consent discussions with their patients in at least three ways:

First, Plaintiffs would never tell their patients, against their best medical judgment, that it "may be possible to reverse . . . a medication abortion," nor would they tell their patients that assistance is available to do so, when no medically accepted evidence exists that it is possible to reverse a medication abortion. Howard Decl. ¶¶ 12-16; Isaacson Decl. ¶¶ 17-19; Reuss Decl. ¶¶ 14-15, 19. Indeed, Plaintiffs would not communicate the mandated information even if the Act were clear that it were only

referring to mifepristone reversal, because no medically accepted evidence exists that it is possible to reverse the effects of mifepristone either.[7] *Id.*; *see additionally* Isaacson Decl. ¶¶ 20-22; Reuss Decl. ¶¶ 16-17.

Second, by forcing Plaintiffs to tell a patient that she may be able to reverse her medication abortion if she later changes her mind, the Act undermines and confuses Plaintiffs' critical message to the patient that she must be certain that she wants to terminate her pregnancy before beginning the medication abortion process. Howard Decl. ¶ 6; Isaacson Decl. ¶ 25; Reuss Decl. ¶ 20; Joffe Decl. ¶ 34; Schreiber Decl. ¶ 47.

Third, but for the Act, Plaintiffs would never tell those patients who are only eligible for or interested in a surgical abortion irrelevant information (even if it were medically supported) about a medication abortion. Howard Decl. ¶ 12; Isaacson Decl. ¶ 27; Reuss Decl. ¶ 18; *see also* Joffe Decl. ¶ 35 ("[I]rrelevant information distracts patients from the critical information that is necessary to an informed decision.").

Put simply, the Act forces Plaintiffs to communicate to their patients in a private medical setting, against their medical judgment, a state-mandated medical message that they otherwise would not give their patients because it is misleading and would violate medical ethics and undermine the goal of the informed consent process.

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[7] To be clear, but for the Act, Plaintiffs would not advise their patients that the state has information and assistance with reversing a medication abortion, because, again, no medically accepted evidence exists that it is possible to reverse a medication abortion. Also, while Plaintiffs do not know what this "assistance" will consist of since ADHS is still vetting the language they intend to post on their website, *see* Howard Decl. ¶¶ 10-11, Exhibits A-C, the only information about which they are aware is the website abortionpillreversal.com. That website not only has numerous false statements about the efficacy of the experimental protocol, Schreiber Decl. ¶ 33, but explains that the "Abortion Pill Reversal" program is part of an organization, Culture of Life Family Services, *About Our Team*, Abortion Pill Reversal (last visited June 1, 2015), www.abortionpillreversal.com/about-us.php, which is categorically opposed to abortion, as well as prescription birth control, *About Culture of Life Family Services*, Culture of Life Family Services (last visited June 1, 2015), www.colfs.org/about-culture-of-family-life-family.php. Plaintiffs, who believe in comprehensive women's health services, object to referring their patients to such an organization.

A law that "mandat[es] speech that a speaker would not otherwise make necessarily alters speech's content," and thus is "a content-based regulation of speech" deserving of particularly searching scrutiny. *Riley*, 487 U.S. at 795; *accord Conant*, 309 F.3d at 637 (content-based regulations of physician speech are "presumptively invalid" (quoting *R.A.V.*, 505 U.S. at 382)); *Camnitz*, 774 F.3d at 245 ("[A] content-based regulation of a medical professional's speech . . . must satisfy at least intermediate scrutiny to survive."); *King v. Governor of N.J.*, 767 F.3d 216, 235 (3d Cir. 2014), *cert. denied sub nom. King v. Christie,* No. 14-672, 2015 WL 1959131 (May 4, 2015) (same); *see also United States v. Alvarez*, 132 S. Ct. 2537, 2544 (2012) ("[C]ontent-based restrictions on speech have been permitted, as a general matter, only when confined to the few 'historic and traditional categories [of expression] long familiar to the bar.'" (quoting *United States v. Stevens*, 559 U.S. 460, 469 (2010)) (reviewing those categories)).

"[T]he violation of the First Amendment is all the more blatant" here because the Act is also impermissibly viewpoint-based. *Conant*, 309 F.3d at 637 (quoting *Rosenberger*, 515 U.S. at 829). The Act singles out informed consent discussions between physicians treating pregnant patients seeking abortions, and compels not only discussion about a particular subject, i.e. purported "medication abortion reversal," but also compels physicians to tell patients the government's viewpoint, i.e. "that it may be possible" to reverse a medication abortion if they change their mind later—even though no evidence exists that this is true, and Plaintiffs as well as the leading medical organization of providers of health care to women, ACOG, disagree with this message. *See id.* (finding a regulation viewpoint-based because it targeted a particular viewpoint, *i.e.*, that medical marijuana would likely help a specific patient); *see also NAAP*, 228 F.3d at 1055-56 (holding that "California's licensing scheme is content and viewpoint neutral; therefore it does not trigger strict scrutiny" because "California does not dictate the content of what is said in therapy"); *Frudden v. Pilling*, 742 F.3d 1199, 1207 (9th Cir. 2014) (policy requiring students to wear uniforms with motto was deserving of strict

scrutiny because it compelled students to disseminate a particular viewpoint); *Ward v. Polite*, 667 F.3d 727, 733 (6th Cir. 2012) ("the most aggressive form of viewpoint discrimination [is] compelling an individual 'to utter what is not in [her] mind'" (quoting *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 634 (1943))).

Finally, the Act compels speech in several uniquely onerous respects that make heightened scrutiny all the more appropriate here, and that clearly distinguish the Act from the requirement upheld in *Planned Parenthood of Southeastern Pennsylvania v. Casey*. There, the Supreme Court upheld a statutory requirement that physicians inform patients about the nature of the procedure, the health risks of abortion and of childbirth, and the probable gestational age of the fetus. It also required that physicians (or health care professionals acting on their behalf) inform women of the availability of state-created materials that described the fetus and contained information about assistance with childbirth and parenting. 505 U.S. at 882-884. Thus, as to the first requirement, the statute only required a physician to inform the woman of standard, general informed consent information that the physician could convey in accordance with his/her medical judgment. And as to the second requirement, the statute only required physicians to *offer* to patients the state's own speech, in state-created pamphlets, and thus there was no question that the views in the pamphlets belonged to the government. *Id.* Moreover, the accuracy of the state's materials was not at issue. *Id.* Finally and importantly, the physician was exempted from complying with this requirement if the physician reasonably believed that the offer of the information would harm the patient. *Id.* at 883.

Here, however, the Act distorts the informed consent process by commanding that Plaintiffs make statements that are not medically or scientifically supported. Schreiber Decl. ¶ 3; Joffe Decl. ¶ 23. Moreover, the state-mandated message directly conflicts with and undermines the critical message Plaintiffs seek to convey to their patients: that they must be certain about whether to terminate their pregnancy before starting an abortion. Howard Decl. ¶ 6; Isaacson Decl. ¶ 25; Reuss Decl. ¶ 20; *see also* Joffe Decl. ¶ 2. And

Plaintiffs must, against their medical judgment and medical ethics, speak the state-mandated message, in their own voice, even though it will negatively interfere with the informed consent process, and is potentially harmful to patients. Schreiber Decl. ¶¶ 47-48; Joffe Decl. ¶¶ 23, 32. The Act thus "'alter[s] the traditional role' of medical professionals," *Conant*, 309 F.3d at 638 (quoting *Legal Servs. Corp. v. Velazquez*, 531 U.S. 544 (2001)), by compelling Plaintiffs to communicate information that is not medically or scientifically supported, and that is misleading to patients. The Act compels Plaintiffs to convey this information under *all* circumstances to *all* patients seeking abortions, no matter how irrelevant or inappropriate it is to an individual woman's circumstances, thereby "'prevent[ing] the physician from exercising his or her medical judgment.'" *Conant*, 309 F.3d at 638 (quoting *Casey*, 505 U.S. at 883-84).[8]

In each of these respects, the speech compelled by the Act is entirely inconsistent with the traditional understanding of informed consent and prevailing norms of medical practice. *See* Joffe Decl. ¶¶ 2, 33; *see also Conant*, 309 F.3d at 638 (heightened scrutiny is applicable to regulation of physician's speech that departs from the "traditional role of medical professionals" and undermines "the proper functioning of [the medical] system[]" (internal quotation and citation omitted); *Camnitz*, 774 F.3d at 247-55 (holding

[8] Two cases from other Circuits, *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 686 F.3d 889 (8th Cir. 2012) (en banc) and *Texas Medical Providers Performing Abortion Services v. Lakey*, 667 F.3d 570 (5th Cir. 2012), have misapplied *Casey*'s Fourteenth Amendment standard—that information required by law to be given to abortion patients must be "truthful, nonmisleading, and relevant"—to the plaintiffs' First Amendment claims. Those cases were wrongly decided. As the Fourth Circuit Court of Appeals held, *Casey* did not purport to create a new, exceptionally low standard of review of compelled speech merely because the topic of that speech is abortion. *See Camnitz*, 774 F.3d at 249 (holding that *Casey* "does not assert that physicians forfeit their First Amendment rights in the procedures surrounding abortions, nor does it announce the proper level of scrutiny to be applied to abortion regulations that compel speech to [an] extraordinary extent"). And, in any event, this Circuit's authority—most notably *Pickup, Conant,* and *NAAP*—control Plaintiffs' First Amendment claim here. Plaintiffs' Fourteenth Amendment claim, including the application of *Casey*'s "truthful, nomisleading, and relevant" standard, is discussed *infra* at Part II.B.

same where regulation imposed speech "requirements [that] look nothing like traditional informed consent"). Where, as here, a statute regulates a physician's speech about medical treatment in a manner that is incompatible with prevailing norms of medical practice, the law is clear that heightened scrutiny applies. *See, e.g.*, *Conant*, 309 F.3d at 638-39; *Pickup*, 740 P.3d at 1226; *accord Camnitz*, 774 F.3d at 250 (striking down a law mandating speech "beyond the extent permitted for reasonable regulation of the medical profession, . . . threatening harm to the patient's . . . health, interfering with the physician's professional judgment, and compromising the doctor-patient relationship").

Under clear precedent, the Act must be given "heightened" scrutiny, affording Plaintiffs substantial protection against government regulation of communications with their patients about treatment. A law like the Act challenged here, which is plainly antithetical to the purpose of the informed consent process, cannot withstand such review.

2. The Act does not survive heightened scrutiny.

Under heightened scrutiny, the government bears the burden of showing that the challenged law is constitutional. *See, e.g.*, *Alvarez*, 132 S. Ct. at 2544; *Bd. of Trustees of State Univ. of N.Y. v. Fox*, 492 U.S. 469, 480-81 (1989); *see also Conant*, 309 F.3d at 637-39. Thus, to sustain the burden the Act imposes on Plaintiffs' First Amendment rights, "the State must show at least that the statute directly advances a substantial governmental interest and that the measure is drawn to achieve that interest." *Sorrell v. IMS Health Inc.*, 131 S. Ct. 2653, 2667-68 (2011); *accord Conant*, 309 F.3d at 639 ("To survive First Amendment scrutiny, the government's policy must have the requisite narrow specificity." (internal quotation omitted)). The State cannot satisfy its burden.

As an initial matter, the Act does not satisfy heightened scrutiny because forcing doctors to make medically unsupported statements to patients against the doctor's medical judgment, and in violation of medical ethics, is not a legitimate means of advancing any state interest. As ACOG has determined and as the evidence herein makes plain, there is no credible evidence that a medication abortion—whether the

mifepristone/misoprostol regimen or a medication abortion via induction or digoxin—can be reversed. *See* Schreiber Decl. ¶¶ 16-33, 39, 42, Exhibit C; Joffe Decl. ¶ 26. Compelling physicians to communicate medically unsupported information to patients during the informed consent process—the very process that is meant to enable the patient to make an autonomous decision based on truthful, medically supported information, *see* Joffe Decl. ¶¶ 17-19—simply does not advance any permissible state interest. Indeed, "[a] doctor may not counsel a patient to rely on quack medicine." *Pickup*, 740 F.3d at 1228 (internal quotation marks and citation omitted). And, as the Ninth Circuit held in a comparable context, "the State has no legitimate reason to force retailers to affix false information on their products." *Video Software Dealers Ass'n v. Schwarzenegger*, 556 F.3d 950, 958 (9th Cir. 2009). That principle applies with even greater force here: forcing physicians to disregard their medical judgment and medical evidence to make scientifically unsupported statements to their patients during the informed consent process does not permissibly advance any constitutionally sufficient state interest. *Cf. Camnitz,* 774 F.3d at 253-54 ("It subverts the patient's expectations when the physician is compelled to deliver a state message bearing little connection to the search for professional services that led the patient to the doctor's door."); *Duncan v. Scottsdale Med. Imaging, Ltd.*, 205 Ariz. 306, 311 (Ariz. 2003) ("[W]e hold that if a patient's consent is obtained by a health care provider's fraud or misrepresentation, a cause of action for battery is appropriate." (citing 6 Am. Jur. 2d Assault and Battery § 127 (1999)).

For similar reasons, the Act unquestionably fails in its tailoring. Under the heightened scrutiny applicable here, it is the State's burden to prove, at minimum, that the Act's speech mandate is narrowly drawn to achieve a substantial government interest, and that there is a close "fit between the legislature's ends and the means chosen to accomplish those ends." *Sorrell*, 131 S. Ct. at 2668 (quotation marks and citation omitted). Compelling physicians to tell each patient a message that is not medically or

scientifically supported, and that is misleading, is clearly more extensive than necessary to further any state interest, and certainly does not advance an interest in informed medical decision-making. That is especially so when the Act forces physicians to act against their best medical judgment and in violation of the standard of care. *See Conant*, 309 F.3d at 638 (government marijuana policy was similarly unconstitutional as limitation struck down by Supreme Court in that it "'alter[s] the traditional role' of medical professionals by 'prohibit[ing] speech necessary to the proper functioning of those systems'" (quoting *Velazquez*, 531 U.S. 544 (2001))).

Indeed, not only is there an insufficiently close fit between the Act's speech mandate and any proper state interest, but the Act directly undermines women's ability to make an informed choice about abortion. For patients seeking an early medication abortion, the Act compels their trusted medical provider to *mis*inform their decision by making statements lacking scientific or medical support. *See* Schreiber Decl. ¶ 48; Joffe Decl. ¶ 23. And during the same time when the medical provider must communicate to the patient that she should be certain that she wants to terminate her pregnancy before the abortion begins, the Act again undermines the informed consent process by introducing the misleading prospect that reversal is possible, thereby creating the serious risk that a patient may begin an abortion before she is ready—again, contrary to the entire purpose of the informed consent process. *See* Joffe Decl. ¶ 34; Schreiber Decl. ¶¶ 45-47.

The Act also lacks "the requisite narrow specificity" the First Amendment requires, *Conant*, 309 F.3d at 629 (internal citation omitted), because it compels Plaintiffs to convey a state-mandated message that (even if it were medically supported) is wholly irrelevant to many women who are not even eligible for or are not interested in early medication abortion. Compelling physicians to make statements to surgical abortion patients about medication abortion reversal is the very opposite of the tailoring that the First Amendment requires—and indeed, providing irrelevant information distracts a patient from processing the critical information she needs to understand to make an

informed decision. *See* Joffe Decl. ¶ 35; Schreiber Decl. ¶ 41. Similarly, for patients seeking a medication abortion via induction or digoxin, the Act forces physicians to falsely state that such medication abortions can be reversed when no one even claims that is possible. *See* Schreiber Decl. ¶ 42. Once again, mandating speech that misinforms patients is the very opposite of the close means-ends fit that First Amendment requires.

The Act, thus, is a clear violation of Plaintiffs' First Amendment rights. "'If the First Amendment means anything, it means that regulating speech must be a last—not first—resort.'" *Conant*, 309 F.3d at 637 (quoting *Thompson v. W. States Med. Ctr.*, 535 U.S. 357, 373 (2002)). Therefore, the Act must be enjoined.

B. The Act Violates a Woman's Right to Choose Abortion.

The Act also violates Plaintiffs' patients' Fourteenth Amendment rights. Women have a fundamental liberty interest, protected by the Fourteenth Amendment, in deciding whether to continue a pre-viability pregnancy. *Casey*, 505 U.S. at 845-46. In the specific context of laws mandating the provision of information to women seeking an abortion, the Supreme Court has made clear that such a law is unconstitutional under the Fourteenth Amendment if the information the state compels providers to convey is false, misleading, or irrelevant. *See Casey*, 505 U.S. at 882; *see also Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 540 (9th Cir. 2004) (reasoning that it would be facially irrational to "require[] physicians to provide false or misleading information to women seeking abortions"). This is because "the means chosen by the State to further the interest in potential life *must be calculated to inform* the woman's free choice," *Casey*, 505 U.S. at 877 (emphasis added), and when the state injects false or misleading information into a woman's decision-making process, it does precisely the opposite.

As explained above, the Act requires Plaintiffs to provide untruthful and misleading information to every patient seeking an abortion because there is no evidence that a medication abortion may be reversed. *See supra* pp. 7-10. Specifically, the information mandated by the Act is untruthful and misleading for women seeking early

medication abortion because—as ACOG has emphasized—the notion of "medication abortion reversal" is not supported by the weight of scientific evidence. *See* Schreiber Decl. ¶¶ 16-33, Exhibit C. Moreover, the information mandated by the Act is untruthful and misleading for women seeking medication abortions via induction or digoxin, because there is no evidence—and not even a claim—that such abortions are reversible. *See* Schreiber Decl. ¶ 42. On this basis alone, the Act is unconstitutional under *Casey*.

The Act also violates *Casey* because it compels Plaintiffs to provide information that is wholly irrelevant to the significant share of women who are either ineligible for or uninterested in early medication abortion. Howard Decl. ¶12; Isaacson Decl. ¶ 27; Reuss Decl. ¶ 18, Schreiber Decl. ¶¶ 40-41; Joffe Decl. ¶ 35. *Cf. Planned Parenthood of Ind. v. Comm'r of Ind. Dep't of Health*, 794 F. Supp. 2d 892, 920 (S.D. Ind. 2011) (enjoining compelled physician statement as applied to patients for whom it was not relevant), *rev'd in part on other grounds*, 699 F.3d 962 (7th Cir. 2012). Forcing a physician to tell a woman who is to receive a surgical abortion that "it may be possible to reverse the effects of a medication abortion" plainly does not "inform the woman's free choice," *Casey*, 505 U.S. at 877. Instead, the forced communication of such irrelevant information can only serve to distract from the important—and relevant—informed consent information that medical providers seek to convey to their patients, Joffe Decl. ¶ 35, thereby impermissibly "hinder[ing]" the patient's decision-making, *Casey* at 877.

The Act also fails the *Casey* standard because it does not serve a valid state interest at all, let alone to a degree that justifies the burden it imposes on women seeking an abortion. *See Humble*, 753 F.3d at 913 ("[W]e must . . . ask[] whether and to what extent the challenged regulation actually advances the state's interests. If a burden significantly exceeds what is necessary to advance the state's interests, it is 'undue.'" (citation omitted)). *See also Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) (same); *Planned Parenthood Southeast, Inc. v. Strange*, 33 F. Supp. 3d 1330, 1340-41 (M.D. Ala. 2014) (same), *supplemented by* 33 F. Supp. 3d 1381,

and amended by 2014 WL 5426891. Critically, the first part of this inquiry requires a real-world look at "whether *and to what extent* the challenged regulation *actually* advances the state's interests." *Humble*, 753 F.3d at 913 (emphasis added). As demonstrated by the evidence here, the Act fails to further any proper state interest because it forces patients to receive information that is false, misleading, and or irrelevant (thus hindering their ability to make a well-informed decision); and, for early medication abortion patients, confuses the physician's critical message that the patient must be certain that she wants to terminate her pregnancy before beginning the medication abortion process. Schreiber Decl. ¶ 47; Joffe Decl. ¶ 34. *See Eden*, 379 F.3d at 540 (laws that require abortion patients to receive false and/or misleading information are irrational on their face, and plainly unconstitutional).

Not only does the Act fail to serve any conceivable state interest, but it also burdens women by misleading them, interfering with their decision-making process, and violating the trust they place in their physician. See *supra* pp. 7-10. *Cf. Humble*, 753 F.3d at 915 (holding that undue burden analysis includes consideration of whether a challenged law would "usurp[] . . . providers' ability to exercise medical judgment" (quoting *Eden*, 379 F.3d at 543)); *Casey*, 505 U.S. at 884 (finding it significant that the informed consent statute "does not prevent the physician from exercising his or her medical judgment"). In these ways, the Act is unlike any informed consent law ever sanctioned and must be enjoined.

III. PLAINTIFFS ARE LIKELY TO SUFFER IRREPARABLE HARM ABSENT PRELIMINARY RELIEF

Absent a temporary injunction, Plaintiffs and their patients will suffer irreparable harm. It is well established that "the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Humble*, 753 F.3d at 911 (quoting *Melendres v. Arpario*, 695 F.3d 990, 1002 (9th Cir. 2012) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976))); *accord Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1138 (9th Cir. 2009); *see also Women's*

Med. Ctr. of Nw. Houston v. Bell, 248 F.3d 411, 422 (5th Cir. 2001) (affirming district court's finding of irreparable harm based on threat to women's constitutional right to abortion). Moreover, "[a] 'colorable First Amendment claim' is 'irreparable injury sufficient to merit the grant of relief.'" *Doe v. Harris*, 772 F.3d 563, 583 (9th Cir. 2014) (quoting *Warsoldier v. Woodford*, 418 F.3d 989, 1001 (9th Cir. 2005)).

In addition to the threatened violation of constitutional rights, the Act inhibits informed decision-making, and threatens to harm the physician-patient relationship and the integrity of the medical profession. Joffe Decl. ¶ 46; Howard Decl. ¶¶ 14-18; Isaacson Decl. ¶¶ 22-23. The Act also threatens to steer women toward an experimental medical practice that has not been proven safe or effective, Joffe Decl. ¶¶ 32, 45, and that is opposed by the nation's leading women's medical organization, ACOG, Schreiber Decl. ¶ 20; Joffe Decl. ¶ 26.[9]

IV. THE BALANCE OF HARMS STRONGLY FAVORS PLAINTIFFS AND THE PUBLIC INTEREST IS SERVED BY AN INJUNCTION

The balance of equities also weighs heavily in favor of an injunction. As set forth above, Plaintiffs and their patients will suffer serious harm if the law takes effect, whereas Defendants only stand to lose the ability temporarily to enforce a law that does not serve any state interest, and which is likely to be held unconstitutional. Indeed, where a law threatens the loss of First Amendment rights, "[t]he 'balancing of equities that is undertaken in a conventional equity case is out of place in dealing with rights so important as the . . . rights of expression to be.'" *Galassini v. Town of Fountain Hills, Ariz.*, No. CV-11-02097-PHX-JAT, 2011 WL 5244960, at *6 (D. Ariz. Nov. 3, 2011)

[9] The threat of the Act's onerous penalties, including license revocation, too constitutes irreparable harm. *See, e.g.*, *A Choice for Women v. Butterworth*, 54 F. Supp. 2d 1148, 1158 (S.D. Fla. 1998) (stating that because clinics faced potential prosecution for offering abortions, there was irreparable injury); *Planned Parenthood of Cent. N.J. v. Verniero*, 41 F. Supp. 2d 478, 504 (D.N.J. 1998) (finding irreparable injury, in part, because Planned Parenthood faced heavy fines for noncompliance with abortion regulation), *aff'd sub nom Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127 (3d Cir. 2000).

(quoting *Shondel v. McDermott*, 775 F.2d 859, 869 (7th Cir. 1985)). *See also Doe v. Harris*, 772 F.3d at 583 (granting preliminary injunction after showing of irreparable injury by threatened loss of First Amendment rights).

Finally, granting an injunction in this case will serve the public interest. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Melandres*, 695 F.3d 990 at 1002 (punctuation and citations omitted) (reviewing cases). *See also Harris*, 772 F.3d at 583 (courts "have consistently recognized the significant public interest in upholding First Amendment principles.") (citation and internal punctuation omitted). It is also in the public interest to protect the integrity of the medical profession and the ability of physicians to act in the best interests of their patients and of those patients to receive truthful, relevant information.

CONCLUSION

For all of the foregoing reasons, Plaintiffs' motion for a preliminary injunction and, if necessary, their request for a temporary restraining order should be granted. Defendants should be enjoined from enforcing the Act pending the final determination of Plaintiffs' claims.[10]

[10] Because Plaintiffs and their patients face a loss of constitutional rights, and Defendants are not faced with any monetary injury if a preliminary injunction is issued, no bond should be required under Fed. R. Civ. P. 65(c). *See, e.g.*, *Galassini*, 2011 WL 5244960, at *7; *United Food & Commercial Workers Local 99 v. Brewer*, 817 F. Supp. 2d 1118, 1128 (D. Ariz. 2011); *see also Diaz v. Brewer*, 656 F.3d 1008, 1015 (9th Cir. 2011) (affirming district court's waiver of bond in constitutional rights case, and noting that under Rule 65(c) "[t]he district court retains discretion as to the amount of security required, *if any*.") (emphasis in original) (internal punctuation and citations omitted)).

Dated: June 4th, 2015

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**Applications for admission pro hac vice forthcoming*
***Admitted pursuant to Ariz. Sup. Ct. R. 38(f)*

CERTIFICATE OF SERVICE

I hereby certify that on the 4th day of June, 2015, I electronically transmitted the attached document to the Clerk's Office using the CM/ECF system for filing.

s/Lawrence J. Rosenfeld