UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients, *et al.*,	)	
Plaintiffs,	)	
v.	)	Case No. 3:12-CV-00436-DPJ-FKB
MARY CURRIER, M.D., M.P.H. in her official capacity as State Health Officer of the Mississippi Department of Health, *et al.*,	)	
Defendants.	)	

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

Earlier this year, the Court struck down as unconstitutional the admitting privileges requirement in HB 1390 ("the Act"). The Act's separate requirement that all physicians associated with an abortion facility be board-certified or board-eligible obstetrician-gynecologists (the "ob-gyn requirement") is now before the Court. This requirement too is unconstitutional. It imposes numerous burdens on Mississippi women who have made the decision to end a pregnancy with no corresponding benefit. Training, not specialty, determines competence in abortion care, and the State cannot point to a single credible piece of evidence that suggests otherwise. Instead, this restriction is merely another in a series of restrictions enacted to achieve the publicly stated goal of State officials to make Mississippi "abortion free."

The ob-gyn requirement is a solution in search of a problem. Mississippi is the only state to prohibit all medical professionals other than board-certified or board-eligible ob-gyns from performing abortions. In all other states, qualified physicians from other specialties (and non-

physicians in some states) have been safely providing abortion for years. Indeed, before the Act, Mississippi law permitted family medicine physicians (among others) to provide abortions.

This is not surprising because the ob-gyn requirement has no medical basis. As major medical organizations such as the American College of Obstetricians and Gynecologists (ACOG) have recognized, the evidence is overwhelming that a range of physicians and non-physician clinicians can safely provide both surgical and medication abortions.

The ob-gyn requirement also significantly limits access to abortion in Mississippi. Jackson Women's Health Organization ("the Clinic") is the last remaining abortion clinic in the state, which currently ranks the lowest in the country in abortion access. The ob-gyn requirement exacerbates this problem by restricting the pool of physicians who could provide safe abortion services in Mississippi. A law with absolutely no medical benefit that limits women's access to legal abortion cannot survive the undue burden standard under *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). Accordingly, the Court should declare the ob-gyn requirement unconstitutional and remove the burdens that it imposes on Mississippi women by enjoining its enforcement statewide.

STATEMENT OF UNDISPTUED MATERIAL FACTS AND PROCEDURAL BACKGROUND

I. The Clinic and Its Patients

The Clinic is the only licensed abortion facility in Mississippi and has been the only option for women seeking legal abortion in the state for over a decade. Decl. of Sacheen Carr-Ellis, M.D., M.P.H., in Supp. of Pls.' Mot. for Summ. J. ("Carr-Ellis Decl.") ¶ 14; Decl. of Shannon Brewer in Supp. of Pls.' Mot. for Summ. J. ("Brewer Decl.") ¶ 2. It provides abortion services up to 16 weeks from a woman's last menstrual period (lmp) and other reproductive health care services, including contraception. Brewer Decl. ¶ 2; Carr-Ellis Decl. ¶ 4.

Two types of abortion procedures are available at the Clinic: surgical (aspiration) abortion and medication abortion, which allows women to end a pregnancy by taking pills. *See id.*; *see also* Decl. of Willie J. Parker, M.D., M.P.H., M.Sc., in Supp. of Pls.' Mot. for Summ. J. ("Parker Decl.") ¶ 22. Approximately half of the Clinic's patients choose medication abortion. Carr-Ellis Decl. ¶ 14. Medication abortion, however, is only available to women until 10 weeks lmp, based on current evidence-based medical practice. *See id.* ¶ 4; Parker Decl. ¶ 22.

Women travel from all over Mississippi, and sometimes from other states, to obtain care at the Clinic. Brewer Decl. ¶ 13. Most of the Clinic's patients are low-income. *See id.*

Women seek abortions for a variety of medical, family, economic, and personal reasons. Parker Decl. ¶ 11. Most are mothers who decide they cannot parent another child at this time, and some are young women who do not feel ready to carry a pregnancy to term because they want to pursue educational or work opportunities. *See id.* Some face serious health issues that make it dangerous to continue a pregnancy, are coping with abusive relationships, are pregnant as a result of rape, sexual assault, or incest, or have received a diagnosis of a fetal anomaly. *Id.*

II. Abortion Is Safe

Legal abortion is one of the safest medical procedures in the United States. Decl. of Daniel A. Grossman, M.D., F.A.C.O.G., in Supp. of Pls.' Mot. for Summ. J. ("Grossman Decl.") ¶ 9. It is also one of the most common; by the age of 45, approximately 1 in 3 women in the United States will obtain an abortion. *See id.* ¶ 8.

Abortion is analogous to other outpatient gynecological and non-gynecological procedures performed by physicians of various specialties in terms of risks, invasiveness, instrumentation, and duration. *See id.* ¶ 14. First-trimester abortions are similar in these respects to endometrial biopsy, miscarriage management, and vasectomy. *Id.* Second-trimester abortions

are similar in these respects to hysteroscopy, sigmoidoscopy, and operative colonoscopy. *Id.*

Further, to effectively assess the risks associated with abortion, it is important to put them in context. *See id.* ¶ 10. Women who seek abortions are pregnant, and pregnancy itself carries risk. *See id.* In terms of the risk of maternal mortality, abortion is dramatically safer than continuing a pregnancy to term, and the risk is especially low prior to 16 weeks lmp, when the Clinic provides abortion services. Parker Decl. ¶ 13.

Specifically, the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication, such as infection, is more common among women having live births than among those having abortions. Grossman Decl. ¶ 11. A recent large study found that the prevalence of any complication of first-trimester surgical abortion performed by physicians was 0.89%; the prevalence of major complications requiring treatment at a hospital was 0.05%. *See id.* ¶ 12. In comparison, vasectomy, another minor surgical procedure frequently performed in a doctor's office, has a prevalence of complications of 2% and a prevalence of major complications requiring hospitalization of 0.4%. *Id.*

III. The Ob-Gyn Requirement Is Unique in Mississippi Law and Is the Most Extreme Law of Its Kind in the United States

The ob-gyn requirement in the Act, which was passed during the 2012 regular legislative session, specifies that "all physicians associated with [a licensed] abortion facility" "must be board certified or eligible in obstetrics and gynecology."[1] HB 1390, § 1, codified at Miss. Code Ann. § 41-75-1(f). Providing abortions in violation of the requirement subjects a facility and its

[1] On March 17, 2017, the Court permanently enjoined the admitting privileges requirement in the Act because it imposes an unconstitutional undue burden on a woman's right to abortion in Mississippi. Order, ECF No. 190.

medical staff to civil, disciplinary, and potentially even criminal penalties, including license revocation, misdemeanor liability, and fines of up to $1000 per day. Miss. Code Ann. §§ 41-75-25 (incorporating by reference § 41-7-209), 41-75-26(1).

The Act substantially narrowed the types of physicians who can provide abortion at an abortion facility. Under the previous law, a physician could provide abortion if he or she had either: (a) "completed a residency in family medicine, with strong rotation through OB/GYN, in a residency program approved by the accreditation counsel for graduate medical education;" (b) "completed a residency in obstetrics and gynecology in a residency program approved by the accreditation counsel for graduate medical education;" or (c) had "an M.D. or O.D. degree and at least one year of postgraduate training in a training facility with an approved residency program and an additional year of obstetrics/gynecology residency." Code Miss. R. 15-16-1:44.1(24).

Before the Act became law, State officials openly admitted it was designed to "end abortion in Mississippi." *See, e.g.*, Roslyn Anderson, *Gov. Bryant signs abortion bill*, MS News NOW, April 16, 2012, http://www.msnewsnow.com/story/17461039/gov-bryant-to-sign-abortion-bill; *see also* Decl. of Julie Rikelman in Supp. of Pls.' Mot. for Summ. J. ("Rikelman Decl.") Ex. A (news article reporting multiple statements by state officials). After it passed, officials touted the Act as the beginning of their efforts to make Mississippi "abortion free." *See* jecarter4, *GOP State Rep – We have literally stopped abortion in Mississippi*, YouTube (May 11, 2012), https://www.youtube.com/watch?v=IsM4n8DeSi0 (speech by State Representative Lester "Bubba" Carpenter stating that to end abortion "you have to start somewhere, and [H.B. 1390] is what we decided to do"). In their statements, officials specifically noted the Act's likely negative impact on the Clinic. *See id.* (discussing limits that Act would impose on Clinic).

Mississippi does not impose a limit like the ob-gyn requirement on comparable medical

procedures. First, there is nothing in Mississippi law even resembling the ob-gyn requirement for prescribing any other oral medication. Second, there is no requirement that physicians providing office-based surgery other than abortion be board certified or eligible in one type of specialty versus another. Code Miss. R. 30-17-2635:2.4-2.6 (providing requirements for office-based surgery). Third, Mississippi law requires neither a particular specialty nor board certification/eligibility for physicians offering pregnancy and birthing care at a birthing center. *See generally* Code Miss. R. 15-16-1:43.2-43.9. Birthing centers provide care for the labor and delivery process,[2] which poses more risk to women than a pre-viability abortion. *See supra* at Part II. Nevertheless, regulations enumerate only three requirements for a birthing center physician: that he or she "(a) [s]hall currently be licensed by the Mississippi Board of Medical Licensure as M.D. or D.O.; (b) [s]hall have at least one year of experience in obstetrics and be trained and annually certified in adult and infant CPR and infant resuscitation; [and] (c) [s]hall have good mental and physical health." Code Miss. R. 15-16-1:43.2.4.

Finally, the ob-gyn requirement only applies to physicians "associated with an abortion facility." Miss. Code Ann. § 41-75-1(f). Thus, there are no restrictions on physicians in private medical practices who are legally permitted to provide fewer than 100 abortions per year without being licensed as an abortion facility, *id*. § 41-75-1(f)(i); these physicians can provide abortions even if they are not board-certified or board-eligible ob-gyns.

The ob-gyn requirement is the most extreme law of its kind in the United States. No other state prohibits all medical professionals other than board-certified or board-eligible ob-

[2] Birthing centers provide "those [surgical services] normally performed during uncomplicated childbirth[,]" including circumcisions of male infants, as well as episiotomy and repair, but not cesarean sections or "operative obstetrics." Code Miss. R. 15-16-1:43.2.4. Additionally, regulations permit "[s]ystemic analgesia" and "local anesthesia for prudential block and episiotomy repair" but not "[g]eneral and conductive anesthesia." *Id.*

gyns from providing any abortion services. Indeed, some states permit non-physicians, such as physician assistants, to provide abortions. *See, e.g.,* Mont. Code Ann. § 50-20-109(1)(a). But even states with legal restrictions on which types of physicians can provide abortions have laws that are less restrictive than the ob-gyn requirement. *See, e.g.*, S.C. Code Ann. Regs. 61-12.309 (requiring board certification or candidacy for board certification in obstetrics and gynecology, general surgery, *or* family practice and only for physicians performing abortion *after* 14 weeks). In short, the ob-gyn requirement is an extreme outlier when compared to the regulatory landscape in the rest of the country.

IV. There is No Medical Justification for the Ob-Gyn Requirement[3]

There is no medical basis for the ob-gyn requirement. Decl. of Linda W. Prine, M.D., in Supp. of Pls.' Mot. for Summ. J. ("Prine Decl.") ¶¶ 7, 22; Parker Decl. ¶ 19; Grossman Decl. ¶ 6. Training, not specialty, determines competence in abortion care, which is why a wide variety of clinicians can safely provide abortion services. Prine Decl. ¶ 14; Parker Decl. ¶ 25. Indeed, physicians from various specialties, including family medicine, pediatrics, and internal medicine, have been safely providing abortions throughout the United States. *Id.*; *see also* Grossman Decl. ¶¶ 39-40. Currently, about one-quarter to one-third of abortion providers in the nation come from specialties other than ob-gyn. Prine Decl. ¶ 16.

For example, abortion is well within the broad scope of practice of family medicine physicians. *See id.* ¶¶ 10-11, 16. Family medicine physicians also perform outpatient surgical procedures that are significantly more complex than abortion up to 16 weeks lmp. *Id.* ¶ 10. And, family medicine physicians routinely provide miscarriage care, which requires the same technical skills as abortion. *Id.*

[3] Defendants withdrew all of their experts during the discovery process and thus cannot introduce any expert testimony in support of their defense of the ob-gyn requirement. Order, ECF No. 169, ¶ 5.

Further, competence in abortion care is not a prerequisite for graduating from an ob-gyn residency program nor for becoming certified by the American Board of Obstetricians and Gynecologists. Parker Decl. ¶ 20. Ob-gyn residents can opt out of any abortion training. *Id.* Thus, many board certified or eligible ob-gyns have never even observed an abortion. *Id.*

Additionally, the ob-gyn requirement would restrict the provision of medication abortion to board-certified or board-eligible ob-gyns. Medication abortion involves the administration of pills to cause pregnancy termination up to 10 weeks lmp. *Id.* ¶ 22. Most commonly, a medication abortion involves administration of the first medication, mifepristone, in the clinic; the patient then takes the second medication, misoprostol, at home. *Id.* The ob-gyn requirement mandates that only a board-certified or board-eligible ob-gyn can provide medication to a patient when that medication is for an abortion. *Id.* ¶ 23. But a variety of health professionals, including non-physicians, routinely prescribe medications to their patients for a variety of conditions, and, in other states, regularly prescribe medication abortion. *Id.*

For all of these reasons, prominent medical organizations oppose laws like the ob-gyn requirement. Prine Decl. ¶¶ 17-21. For example, ACOG recognizes that clinicians in many medical specialties can provide safe abortion care and that requiring board certification in obstetrics and gynecology is "medically unnecessary" and "designed to reduce access to abortion." *Id.* ¶ 18 (citing ACOG Comm. Op. No. 613 (Nov. 2014), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion).

In sum, the ob-gyn requirement would allow a physician with no abortion training to perform abortions at the Clinic, while preventing other qualified physicians with actual training and competency in abortion from providing such care.

V. Abortion Access in Mississippi and Surrounding States Is Limited And Has Decreased in Recent Years

In Mississippi, access to abortion is particularly limited. Grossman Decl. ¶¶ 34-37. When comparing the ratio of abortion clinics in the state to the population of women of reproductive age, Mississippi ranks the lowest in the entire country. *Id.* ¶ 35.

Approximately half of Mississippi women who obtain legal abortions each year leave the state to do so. *See* Rikelman Decl. Exs. C, D. This statistic is another indication of the limited access within the state; Mississippi is relying on other states to meet the demand for legal abortion services among its residents. Grossman Decl. ¶ 36; Rikelman Decl. Ex. C. Abortion access is also limited in the surrounding states, where legal barriers have increased and access has decreased since 2012. Parker Decl. ¶ 17; Grossman Decl. ¶ 34.

In recent years, Mississippi has continued to increase legal barriers to abortion. Since 2012, Mississippi has banned abortion outright after 20 weeks and also banned the safest method of abortion used later in the second trimester (dilation & evacuation). Parker Decl. ¶ 16.

VI. The Ob-Gyn Requirement Is a Barrier to Expanding Abortion Access in Mississippi

The Clinic's ability to provide abortion services is directly tied to the availability of its physicians. Brewer Decl. ¶¶ 6-10; Carr-Ellis Decl. ¶¶ 16-17, 26. Right now, two physicians provide the vast majority of abortions at the Clinic: Dr. Carr-Ellis and Dr. Doe.[4] Brewer Decl. ¶ 7. Each of these physicians has other work commitments. *Id.*; Carr-Ellis Decl. ¶ 5. Each also lives outside of Mississippi and thus travels to the state to provide care. Brewer Decl. ¶ 7. Currently, Dr. Carr-Ellis and Dr. Doe travel to Mississippi twice per month, on alternating weeks. *Id.* ¶ 9. On each trip, the physician usually provides abortion services at the Clinic on

[4] Plaintiffs use a pseudonym to refer to the other physician out of concern for his safety and privacy.

three consecutive days: on the first two days, the physician provides both aspiration and medication abortion. *Id.* On the third day, the physician provides only medication abortion. *Id.*

Accordingly, because of the physicians' availability, the Clinic generally provides medication abortion services on only three days per week and aspiration abortion only two days per week. *Id.* This limitation in scheduling creates delays for women. Brewer Decl. ¶¶ 12-20.

Mississippi's existing mandatory delay, two-trip law increases those delays. Under this law, each woman must make two separate trips to the Clinic before she can obtain an abortion, at least twenty-four hours apart. Miss. Code Ann. § 41-41-33(1). At the first appointment, the Clinic must provide the woman with state-mandated information. *See id.* The woman must then wait at least twenty-four hours before returning to begin the abortion procedure. *See id.*

The scheduling limitations and the two-trip law compound each other to create delays of up to a week for some of the Clinic's patients. For example, a woman who comes to the Clinic for her state-mandated appointment on the third day that the Clinic is providing abortions that week typically has to wait at least four days before returning for an abortion procedure. Brewer Decl. ¶ 17. Similarly, women who come for the state-mandated appointment on the first or second day that the Clinic is providing abortions, but who cannot return in the next two days because of their own work or family commitments, usually must wait approximately a week before obtaining an abortion. *Id.* ¶ 16. And, some of the women who come for their state-mandated visit who are very close to 16 weeks lmp and would be beyond 16 weeks by the time they could return are not able to obtain an abortion at the Clinic and must leave the state or be denied an abortion altogether. *Id.* ¶ 20; Carr-Ellis Decl. ¶¶ 19, 23.

Delay creates numerous burdens for women. First, it can preclude a woman from obtaining the abortion procedure that is best for her. Parker Decl. ¶ 35. For example, the Clinic

often sees women who lose the option of a medication abortion because they present at the Clinic for their first appointment close to or after 10 weeks lmp. Carr-Ellis Decl. ¶ 21. Women may seek a medication abortion rather than a surgical abortion for a variety of reasons, including that it is medically indicated. Parker Decl. ¶ 35. In particular, medication abortion may be a better option for obese women, women with certain fibroids or women living with domestic violence who can present a medication abortion as a miscarriage, if necessary. *Id.*; Carr-Ellis Decl. ¶ 22. Similarly, delay can push a woman from a first-trimester to a second-trimester procedure and increase the cost of the abortion itself. Brewer Decl. ¶¶ 19, 28. Second, delay forces women to experience the physical symptoms and emotional consequences of remaining pregnant, even after they have made the decision to end the pregnancy. Carr-Ellis Decl. ¶ 28; Parker Decl. ¶ 32. Third, delays in obtaining abortion can increase health risks. Grossman Decl. ¶ 16; Parker Decl. ¶ 38. And, fourth, women who do not live close to the Clinic and who must make two trips several days apart because of the Clinic's schedule endure more costs for travel and child care and have to take more time off from work. Carr-Ellis Decl. ¶ 29; Brewer Decl. ¶ 27.

Finally, the delays created by the ob-gyn requirement force some women to leave the state and travel long distances for care. Brewer Decl. ¶ 20; Carr-Ellis Decl. ¶¶ 23-25. When women are forced to travel long distances for care, many will delay obtaining an abortion further until they can find the money or arrange transportation for a trip. Grossman Decl. ¶ 16. Additionally, faced with these circumstances, some women attempt to end the pregnancy on their own by using less safe methods. *See id.* ¶ 17.

The Clinic wants to hire additional physicians so that it can increase the number of days that it offers abortion services, decreasing delays for patients and the additional costs, associated emotional burdens, and health risks that such delays impose. Carr-Ellis Decl. ¶¶ 11, 27-32. In

the past, when the Clinic has been able to offer abortion services on more than three days per week, its schedule has been full, indicating that there is additional demand for services. Brewer Decl. ¶¶ 11, 24. In particular, the Clinic would like to be open more Saturdays, because it is often the most convenient day for patients, many of whom can more easily secure child care or time off from work that day. *Id.* ¶ 30; Carr-Ellis Decl. ¶ 30. Indeed, on the occasions that the Clinic has been open on a Saturday, it has been its busiest day of the week. Brewer Decl. ¶ 30.

The ob-gyn requirement prevents the Clinic from hiring additional physicians to expand its services. The Clinic has identified a number of family medicine physicians whom it would like to hire, but it cannot proceed with the hiring process with the requirement in place. Carr-Ellis Decl. ¶ 11; Brewer Decl. ¶¶ 21-22. Additionally, before 2012, an ob-gyn who is not board-certified or board-eligible provided abortion services at the Clinic, and the Clinic would like to rely on that physician again but cannot under the law at issue. Brewer Decl. ¶ 23.

In particular, the ob-gyn requirement prohibits the Clinic from hiring from a pool of physicians who have been at the vanguard of providing abortion services in the South: family medicine physicians. Prine Decl. ¶ 16; Carr-Ellis Decl. ¶ 10. Only a small number of physicians are currently willing to perform abortions in the South, given the harassment and violence against abortion providers and the profound stigma against abortion in this geographic region. Parker Decl. ¶¶ 26-30; Carr-Ellis Decl. ¶ 9. Family medicine physicians have increasingly stepped in to help improve abortion access in the South, and many of the physicians currently providing abortion services in the South are family medicine physicians. Prine Decl. ¶ 16; Carr-Ellis Decl. ¶ 10; Parker Decl. ¶ 29.

The ob-gyn requirement is thus a very real barrier to the Clinic adding more physicians to its staff, which would allow it to expand access in the state by increasing the number of days per

week on which abortions are available. Brewer Decl. ¶¶ 21, 31; Carr-Ellis Decl. ¶¶ 12, 26, 32.

ARGUMENT

A court grants summary judgment when there is no genuine dispute of material fact and judgment is appropriate as a matter of law. *See* Fed. R. Civ. P. 56(a)*; see also, e.g.*, *Diaz v. Kaplan Higher Educ. L.L.C.*, 820 F.3d 172, 175 (5th Cir. 2016). Once Plaintiffs introduce competent evidence into the record regarding the material facts, it is Defendants' burden to demonstrate a genuine dispute about those facts. *See Diaz*, 820 F.3d at 176 (affirming grant of summary judgment when party opposing motion failed to articulate specific evidence in record that would create a genuine dispute). Here, there can be no genuine dispute about the material facts, particularly when Defendants have withdrawn all of their experts and have no evidence contradicting Plaintiffs' clear showing that the ob-gyn requirement limits abortion access in Mississippi while offering no medical benefit whatsoever. Accordingly, the Court should grant Plaintiffs summary judgment on their undue burden claim.

I. The Undue Burden Standard Requires Meaningful Judicial Scrutiny of Abortion Restrictions

"[F]or more than forty years, it has been settled constitutional law that the Fourteenth Amendment protects a woman's basic right to choose an abortion." *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 453 (5th Cir. 2014) (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)). Accordingly, abortion restrictions are unconstitutional when they impose an "undue burden" on abortion access. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)). As the Supreme Court recently clarified, the undue burden standard "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* In doing so, a court must "consider[] the evidence in the record" and "weigh[] the asserted benefits against the

burdens." *Id*. at 2310. When a law fails to confer "benefits sufficient to justify the burdens," those burdens are "undue," and thus unconstitutional. *Id.* at 2300; *see also Jackson Women's Health Org.*, 760 F.3d at 458 (explaining undue burden analysis of abortion restriction as based on "the entire record and factual context in which the law operates," including strength of State's interest); *Barnes v. Mississippi*, 992 F.2d 1335, 1339 (5th Cir. 1993) (stating that under *Casey*, "constitutionality of an abortion regulation [] turns on an examination of the importance of the state's interest in the regulation and the severity of the burden that regulation imposes on the woman's right to seek an abortion").

The undue burden standard requires meaningful review of abortion restrictions. A court should not simply defer to the State's assertions about benefits or burdens as such deference is inconsistent with the status of the abortion right as a "constitutionally protected personal liberty." *Whole Woman's Health*, 136 S. Ct. at 2309 (It "is wrong to equate the judicial review applicable to the regulation [of abortion] with the less strict review applicable where, for example, economic legislation is at issue."). Instead, a court should "place[] considerable weight upon evidence and argument presented in judicial proceedings," and, for a law to be upheld, the record should show that the law actually furthers the State's asserted interest. *Id*. at 2310.

II. The Ob-Gyn Requirement Fails the Undue Burden Standard Because It Burdens Women's Access to Abortion and Confers No Health Benefit

The ob-gyn requirement cannot survive the undue burden standard because it serves no health interest while limiting women's access to abortion in Mississippi. Accordingly, the Court should declare it unconstitutional and permanently enjoin it statewide.

A. The Ob-Gyn Requirement Has No Health Benefits

For an abortion restriction to survive scrutiny under the undue burden standard, evidence in the record must demonstrate that it actually advances its stated goal. *Id.* at 2311 ("We have

found nothing in Texas' record evidence that shows that, compared to prior law . . . , the new law advanced Texas' legitimate interest in protecting women's health."); *id*. at 2315 ("There is considerable evidence in the record supporting the District Court's findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary."). As the Fifth Circuit has admonished, a court is "not to accept the government's proffered purpose if it is a mere 'sham.'" *Okpalobi v. Foster*, 190 F.3d 337, 354 (5th Cir. 1999) (quoting *Edwards v. Aguillard*, 482 U.S. 578, 586-87 (1987)), *vacated on reh'g en banc on other grounds*, 244 F.3d 405 (5th Cir. 2001).

Just as in *Whole Woman's Health*—in which the Supreme Court struck down provisions of a Texas law that imposed burdens on abortion access while advancing no health interest—there is not a shred of evidence in the record that the ob-gyn requirement will actually benefit the health of Mississippi women. *See* 136 S. Ct. at 2311-12 ("[W]hen directly asked at oral argument whether Texas knew of a single instance in which the new requirement would have helped even one woman obtain better treatment, Texas admitted that there was no evidence in the record of such a case."). First, the ob-gyn requirement is at odds with current medical practice throughout the country. *See supra* at 7-8. In the rest of the United States, physicians other than board-certified or board-eligible ob-gyns routinely and safely provide abortions. Prine Decl. ¶¶ 12-16; Grossman Decl. ¶¶ 25, 39, 40. Indeed, one-quarter to one-third of clinicians who provide abortions in the United States are not board-certified or board-eligible ob-gyns. Prine Decl. ¶ 16. For this reason, major medical organizations oppose "medically unnecessary" laws like the ob-gyn requirement. *Id.* ¶ 18 (citing ACOG Comm. Op. 613 (Nov. 2014)). As the Supreme Court has made clear, regulations that lack a medical basis do not serve the State's interest in women's health. *See Whole Woman's Health*, 136 S. Ct. at 2311-12 (summarizing evidence, including

from ACOG, undermining State's rationale for abortion law); *City of Akron v. Akron Ctr. for Reproductive Health*, *Inc.*, 462 U.S. 416, 435-37 (1983) (concluding "present medical knowledge" "convincingly undercut[]" State's justification for abortion law after examining standards of major medical organizations), *overruled in part on other grounds by Casey*, 505 U.S. 833 (1992).

Second, the ob-gyn requirement singles out abortion for unique regulation, even though abortion is extremely safe and remains so when performed by a range of trained health care providers, including physicians of various specialties (and in some states, non-physicians). Grossman Decl. ¶¶ 39-40; Prine Decl. ¶¶ 12-15; Parker Decl ¶¶ 23, 25. "[T]he differential treatment of abortion vis-à-vis medical procedures that are at least as dangerous as abortions and probably more so" undermines the strength of the State's claimed interest. *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 791 (7th Cir. 2013) (preliminarily enjoining admitting privileges requirement); *see also Whole Woman's Health*, 136 S. Ct. at 2315 (imposing requirements on abortion facilities not based on differences between abortion and other surgical procedures indicates law is unrelated to women's health). Mississippi imposes no similar requirement for comparable outpatient procedures, *see supra* at 5-6, nor for more risky procedures, including other pregnancy care. *See supra* at 6 (citing birthing center regulations); *see also* Grossman Decl. ¶¶ 11-14; *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 914 (7th Cir. 2015) (reasoning that state's "indifferen[ce] to complications of any other outpatient procedures, even when they are far more likely to produce complications than abortions" undermines its interest), *cert. denied*, 136 S. Ct. 2545 (2016); *Whole Woman's Health v. Hellerstedt*, No. 1:16-cv-01300-SS, 2017 WL 462400, at *8 (W.D. Tex. Jan. 1, 2017) (noting fact that certain Texas regulations apply to abortions but not miscarriage or ectopic pregnancy

was "evidence [the State's] stated interest is a pretext for its true purpose, restricting abortions"). The ob-gyn requirement's application to medication abortion is particularly infirm because it bars all physicians except board certified or eligible ob-gyns from administering oral medication only when that medication is for an abortion. *Cf. Whole Woman's Health*, 136 S. Ct. at 2315 (finding ambulatory surgical center requirement "provides no benefit" to medication abortion patients). Mississippi law imposes no similar restriction on physicians administering other oral medication. *See* Miss. Code Ann. § 73-25-33 (prescribing and directing use of medication is part of practice of medicine); Code Miss. R. 30-17-2615:1.5 (permitting physician assistants to administer medications under agreement with physician). [5]

Third, "there [is] no significant health-related problem" the ob-gyn requirement "help[s] to cure," nor is it "more effective than pre-existing [state] law" in furthering women's health. *See Whole Woman's Health*, 136 S. Ct. at 2311, 2314; *cf. Veasey v. Abbott*, 830 F.3d 216, 239 (5th Cir. 2016) (en banc) ("We cannot say that the district court had to simply accept that legislators were really so concerned with this almost nonexistent problem."), *cert. denied*, 137 S. Ct. 612 (2017). Pre-existing Mississippi law required that every abortion provider associated with an abortion facility be a licensed physician, Miss. Code. Ann. § 41-75-1(f), and have additional training, for instance through a residency in family medicine or obstetrics and gynecology. Code Miss. R. 15-16-1:44.1; *cf. Whole Woman's Health*, 136 S. Ct. at 2314 (observing prior Texas law "already contained numerous detailed regulations" of abortion). There is no credible evidence that layering the ob-gyn requirement on top of these pre-existing

[5] In an email forwarded to Representative Sam Mims, the Act's sponsor, the Vice President for Legal Affairs at Americans United for Life, an organization with a mission to end legal abortion, noted that the ob-gyn requirement was probably unconstitutional because "it seems unlikely that many doctors in other specialties are subject to" this type of requirement. *See* Rikelman Decl. Ex. B; *see also id*. ("[T]here is no rational or medically-based reason to exclude physicians who are trained . . . surgeons from performing surgical abortions. But, under this language, a trained surgeon could not perform abortions.").

regulations adds any benefit. *See* Prine Decl. ¶ 22; Grossman Decl. ¶¶ 39-40.

Fourth, the ob-gyn requirement is a poor fit for advancing women's health, and instead undermines that goal. The requirement arbitrarily bars trained and competent physicians from providing abortion care at the Clinic. Prine Decl. ¶¶ 16, 22; Grossman Decl. ¶ 39; Parker Decl. ¶¶ 19, 24, 26. Indeed, its illogic is plain: it would permit a board-certified ob-gyn with no training in abortion to provide services at the Clinic, while preventing another physician, including a family medicine physician trained and experienced in abortion care, from doing so. Prine Decl. ¶¶ 16-17; Parker Decl. ¶¶ 19-24. As the Fifth Circuit has recognized, "there cannot be a total disconnect between the State's announced interests and the statute enacted." *Veasey*, 830 F.3d at 262; *see also Whole Woman's Health*, 136 S. Ct. at 2311-13 (finding that lack of fit between abortion restriction and Texas's purported health interest undermined State's argument).

The requirement is also under-inclusive: it does not apply to every physician who may legally provide abortion in Mississippi, including physicians who may provide abortions in a private medical office. Rather, it applies only to physicians associated with licensed abortion facilities; and, of course, the Clinic is the only licensed facility in the state. *See* Miss. Code. Ann. § 41-75-1 (applying ob-gyn requirement to "facility operating substantially for the purpose of performing abortions and is a separate identifiable legal entity from any other health care facility[,]" which excludes physicians performing fewer than 10 abortions per calendar month or 100 abortions per calendar year).[6] If the State's goal were to improve women's health, it should

[6] A court in this district has addressed the constitutionality of a similarly under-inclusive requirement. *See Jackson Women's Health Org. v. Amy*, 330 F. Supp. 2d 820, 825 n.4 (S.D. Miss. 2004) (preliminarily enjoining law that would have had effect of barring Clinic from performing second-trimester abortions because "its specialty, by practice and experience, is abortions, while other facilities," which "lack [] specific [abortion] training and expertise," could perform such procedures). The ob-gyn requirement likewise prevents qualified physicians from practicing at the Clinic because its specialty is abortions, while allowing a range of physicians to provide abortions in medical offices that do not specialize in it.

have designed the ob-gyn requirement to apply to all physicians who may legally provide abortions. *Cf. City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 450 (1985) (suggesting that under-inclusivity is a sign of poor fit which may indicate improper purpose).

Additionally, because many abortion providers in the South are not board-certified or board-eligible ob-gyns, a woman unable to obtain an abortion in Mississippi may well obtain this very procedure from one of these physicians at an abortion clinic in a neighboring state. *See* Carr-Ellis Decl. ¶ 10; Parker Decl. ¶ 29; Prine Decl. ¶ 16. This result—Mississippi women obtaining abortions from physicians who are not board certified or eligible ob-gyns—is the very result the State supposedly sought to avoid with the ob-gyn requirement. *See Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 685-86 (W.D. Tex. 2014) (remarking that if "State's true purpose in enacting [the challenged law was] to protect the health and safety of Texas women who seek abortions, it is disingenuous and incompatible with that goal to argue that Texas women can seek abortion care in a state with lesser regulations" while observing that state's position was "perfectly congruent" with goal of "reduc[ing] or eliminat[ing] abortion in parts of Texas"), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), *rev'd and remanded sub nom. Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

Finally, a court in this district preliminarily enjoined an earlier Mississippi requirement that a physician performing abortions "must have ob-gyn training through an American Medical Association-approved residency program;" there, the court concluded that plaintiffs were likely to succeed on their undue burden claim. Bench Opinion at 17, *Pro-Choice Mississippi v. Thompson*, No. 3:96-cv-00596-WHB (S.D. Miss. Oct. 3, 1996) (Rikelman Decl. Ex. E).[7] The

[7] After amendments to the challenged regulations were adopted in 1999, the court dismissed the case

court held that the State was unable to meet its burden to show that the law was "directed to preserve the woman's health." *Id.* at 18. The ob-gyn requirement is even more restrictive than the law challenged in *Pro-Choice Mississippi* and even less supported by medical evidence.[8]

Because the ob-gyn requirement does not improve women's health and instead disqualifies competent physicians from providing services at the Clinic—singling out abortion and the one licensed abortion facility in the state—it furthers no valid state interest. Simply put, it "does not benefit patients and is not necessary." *Whole Woman's Health*, 136 S. Ct. at 2315.

B. The Ob-Gyn Requirement Imposes Numerous Burdens on Abortion Access in Mississippi

"[I]n the face of no threat to women's health," *id*. at 2318, and while advancing no valid interest, the ob-gyn requirement restricts who can provide abortion and thereby limits abortion access in Mississippi, imposing numerous burdens on women. Given the lack of medical benefit, these burdens are unjustified and unconstitutional.

As part of the undue burden analysis, courts should consider "the entire record and factual context in which the law operates." *Jackson Women's Health Org*., 760 F.3d at 458. This analysis should include "the ways in which an abortion regulation interacts with women's lived experience, socioeconomic factors, and other abortion regulations." *Planned Parenthood*

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without prejudice and without a further decision on the merits.

[8] Courts have struck down other restrictions that impose limits on who can provide an abortion beyond state licensure as a physician. *See, e.g.*, *Doe v. Bolton*, 410 U.S. 179, 199 (1973) (holding unconstitutional Georgia statute requiring agreement by two physicians (other than the woman's physician) before an abortion could be performed upon concluding that "[i]f a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment"); *Mahoning Women's Ctr. v. Hunter*, 610 F.2d 456, 460 (6th Cir. 1979) (relying on similar analysis to invalidate city ordinance limiting abortion providers to obstetricians), *vacated and remanded on other grounds*, 447 U.S. 918 (1980); *cf. Birth Control Ctrs., Inc. v. Reizen*, 743 F.2d 352, 363-64 (6th Cir. 1984) (upholding rule requiring abortion providers have "adequate qualifications acquired by special training and experience" based on interpretation of rule as not requiring that "only a specialist provide abortions" but only that physician "be qualified to do whatever he or she undertakes").

of Ariz. v. Humble, 753 F.3d 905, 915 (9th Cir. 2014). For example, courts have considered burdens such as delay, travel, arranging for child care and time away from work, along with the financial burdens associated with these logistical obstacles and the cost of the procedure itself. *See Whole Woman's Health*, 136 S. Ct. at 2314, 2318; *Schimel*, 806 F.3d at 919; *McCormack v. Hiedeman*, 694 F.3d 1004, 1016-17 (9th Cir 2012).

The ob-gyn requirement imposes numerous burdens on women. First, it shrinks the pool of providers who can perform abortions in the state. By shrinking this pool, the requirement directly limits the availability of abortion services by reducing the number of days that the Clinic can provide abortions. *See supra* at 11-12. Reducing the availability of services is a well-recognized burden. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2317-18 (discussing clinic closures and inability of remaining clinics to accommodate increased demand); *Schimel*, 806 F.3d at 910 (discussing burdens associated with the fact that law "reduced the number of doctors who [were] allowed to perform abortions"); *Humble*, 753 F.3d at 915 (discussing "practical considerations, such as the frequency with which clinics can see patients").

Additionally, the ob-gyn requirement exacerbates the burden women face accessing abortion in Mississippi by shrinking the pool of providers against a backdrop of "[a] severe scarcity of abortion doctors [] nationwide and particularly in the South." *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1348 (M.D. Ala. 2014) ("*Strange I*"). *See also* Carr-Ellis Decl. ¶¶ 7-8; Parker Decl. ¶ 18. In evaluating the burdens of an abortion restriction under the undue burden standard, an Alabama District Court recently recognized that there is a small pool of trained abortion providers in the United States and particularly in this region. *Strange I*, 33 F. Supp. 3d at 1348 (discussing limited availability of ob-gyn residency training in abortion in the region and noting that only 14% of ob-gyns perform abortions in the United States and only

8% of ob-gyns in the South do so). Courts have also noted that, "it is difficult to hire [] doctors [trained in abortion care] because of the vilification, threats, and sometimes violence directed against abortion clinics and their personnel in states . . . in which there is intense opposition to abortion." *Schimel*, 806 F.3d at 917; *see also Planned Parenthood Se., Inc. v. Strange*, 172 F. Supp. 3d 1275, 1289 (M.D. Ala. 2016) ("*Strange II*") (noting that "hostile and pervasive anti-abortion sentiment in the State . . . would prevent the clinics themselves from recruiting new physicians who could comply with the requirement"), *judgment entered,* No. 2:13CV405-MHT, 2016 WL 1178658 (M.D. Ala. Mar. 25, 2016). The Clinic and its physicians have been targets for ongoing harassment and threats of violence. Carr-Ellis Decl. ¶ 9; Parker Decl. ¶¶ 26-29; *see also, e.g.*, *United States v. McMillan*, 53 F. Supp. 2d 895 (S.D. Miss. 1999) (prosecution of anti-abortion extremist who made threatening comments when he saw the Clinic's physician). The ob-gyn requirement further shrinks the already small group of providers willing to perform abortions in the climate of opposition in which the Clinic operates.

Second, limiting availability of services creates delays for patients seeking this time-sensitive health care. Courts have repeatedly recognized that laws decreasing the number of abortion providers lead to delay. *See*, *e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2313 (recognizing clinic closures "meant fewer doctors [and] longer waiting times"); *Schimel*, 806 F.3d at 920 ("[R]educing the number of abortion doctors in [the state] thereby increase[s] the waiting time for obtaining an abortion."); *Van Hollen*, 738 F.3d at 796 (noting "[p]atients will be subjected to weeks of delay because of the sudden shortage of eligible doctors"). Mississippi's mandatory delay, two-trip law compounds the burdens imposed by the ob-gyn requirement, often delaying patients beyond the state-mandated twenty-four hours. *See supra* at 10-11.

The legal harms of delaying abortion—"to a stage at which abortion would be less safe,

and eventually illegal"—are well established. *Van Hollen*, 738 F.3d at 796; *see also Schimel*, 806 F.3d at 920 (explaining delay "in turn compel[s] some women to defer abortion to the second trimester of their pregnancy—which the studies . . . find to be riskier than a first-trimester abortion"); *Humble*, 753 F.3d at 915-16 (discussing "[e]vidence that [the] law delays and deters patients obtaining abortions, and that delay in abortion increases health risks'" (internal quotation marks and citation omitted)); *Strange II*, 172 F. Supp. 3d at 1289 (observing that women who "obtain abortions only after considerable delay" face "increase[ed] risks associated with the procedures" (internal citation omitted)).

Delay causes some women to forgo the abortion that is best for them, which is itself a burden. For example, delay makes some women ineligible for medication abortion, which is available up to 10 weeks lmp. Brewer Decl. ¶ 19; Carr-Ellis Decl. ¶¶ 21-22; Parker Decl. ¶ 35; *see also Humble*, 753 F.3d at 915, 917 (noting "medication abortion is a common procedure strongly favored over surgical abortion by many women" and fact that surgical abortion remains available "does not preclude a finding of undue burden"); *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-CV-00784-KGB, 2016 WL 6211310, at *30 (E.D. Ark. Mar. 14, 2016) ("Removing medication abortion as an option for women will result in negative consequences for those women for whom [it] is medically indicated."), *appeal docketed*, No. 16-2234 (8th Cir., May 18, 2016). Delay can also mean women "forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks." *Schimel*, 806 F.3d at 918; *see also* Brewer Decl. ¶ 19; Carr-Ellis Decl. ¶¶ 21, 29; Grossman Decl. ¶ 28.

Third, because the Clinic provides abortion only up to 16 weeks lmp, "a delayed procedure [] likely become[s] a denied procedure for many women and [] there is a significant risk that some women, faced with the inaccessibility or unavailability of an abortion provider []

pursue dangerous, unregulated abortions." *Strange II*, 172 F. Supp. 3d at 1289 (internal citations omitted); *see also Schimel*, 806 F.3d at 918 (recognizing delays related to challenged law "push [some women] past the . . . deadline for the Planned Parenthood clinics' willingness to perform abortions").[9] Further, while women unable to access care at the Clinic might leave the state to obtain an abortion, *see supra* at 11, "a state cannot lean on its sovereign neighbors to provide protection of its citizens' federal constitutional rights." *Jackson Women's Health Org.*, 760 F.3d at 457. Accordingly, Mississippi cannot deny these women access to legal abortion "without imposing an undue burden upon . . . the exercise of their constitutional rights." *Id.* at 449.

Fourth, Mississippi women unable to access abortion at the Clinic and who seek abortion elsewhere encounter additional obstacles, including having to travel for care. Carr-Ellis Decl. ¶¶ 24, 29; Grossman Decl. ¶¶ 16, 30; Parker Decl. ¶ 38. The burden of increased travel to obtain an abortion is well-recognized. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2302, 2313 (noting closure of Texas clinics increased number of women who lived far from an abortion clinic and "increased driving distances . . . . are but one additional burden"); *Van Hollen*, 738 F.3d at 796 (remarking that hundreds of miles of travel is "a nontrivial burden on the financially strapped and others who have difficulty traveling long distances to obtain an abortion, such as those who already have children"). Travel is "a particularly high barrier for poor, rural, or disadvantaged women"—like the Clinic's patients, Brewer Decl. ¶ 13; Carr-Ellis Decl. ¶ 29—"regardless of the absolute distance they may have to travel to obtain an abortion." *Lakey*, 46 F. Supp. 3d at 683. Indeed, "[s]ome patients will be unable to afford the longer trips they'll have to make to obtain an abortion," *Van Hollen*, 738 F.3d at 796, and may be denied their right to abortion altogether.

[9] Already, an unusually high proportion—approximately half—of Mississippi women who obtain abortions each year leave the state to do so. *See* Rikelman Decl. Exs C, D.; Grossman Decl. ¶ 36. By limiting the Clinic's ability to provide abortion services, the ob-gyn requirement only exacerbates the state's limited abortion access.

Lifting the ob-gyn requirement would significantly reduce the burdens Mississippi women face accessing abortion in the state. Absent the ob-gyn requirement, the Clinic could hire trained abortion providers who have expressed interest in working at the Clinic. Brewer Decl. ¶¶ 21-23; Carr-Ellis Decl. ¶ 11. With additional physicians, the Clinic could provide abortion services on more days, including more Saturdays, and lessen delays in providing time-sensitive health care to its patients. *See* Brewer Decl. ¶¶ 24-30; Carr-Ellis Decl. ¶¶ 27-30; *see also West Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1309 (M.D. Ala. 2015) ("Saturdays have been the [clinic's] busiest days because it is often the only day that patients can get off work or find someone to accompany them to the clinic."). Relieving these burdens would allow the Clinic to improve abortion access in the state.

Weighing the serious burdens the ob-gyn requirement imposes on abortion in Mississippi—a state that already ranks the worst in the country for abortion access—against its failure to advance any valid interest whatsoever leaves no doubt that it is unconstitutional. With no valid justification, the requirement prevents competent abortion providers who have been essential to preserving access in other Southern states from working at the Clinic and thereby increases barriers to legal abortion in Mississippi. The total lack of fit between the requirement and women's health strongly suggests that its real goal, as State officials have openly admitted, is to end legal abortion in the state. *See supra* at 5. The ob-gyn requirement is thus "a solution in search of a problem, unless that problem is access to abortion itself." *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949 953 (W.D. Wis. 2015), *aff'd sub nom. Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545 (2016) (internal citation and quotation marks omitted). In short, the burdens the ob-gyn requirement imposes are considerable and far outweigh its nonexistent benefits. The

requirement therefore imposes an undue burden.

III. The Appropriate Remedy Is to Declare the Ob-Gyn Requirement Unconstitutional and Enjoin It Statewide

As Plaintiffs have established, the ob-gyn requirement imposes considerable burdens on abortion access while furthering no valid state interest. Accordingly, the Court should declare the requirement unconstitutional and permanently enjoin its enforcement statewide.[10]

As the Supreme Court held in *Whole Woman's Health*, a court should grant facial relief when "the arguments and evidence show that a statutory provision is unconstitutional on its face." 136 S. Ct. at 2307. There, the Supreme Court granted facial relief against the Texas admitting privileges requirement because the Court agreed with the district court that "the provision was unconstitutional across the board." *Id*. The ob-gyn requirement likewise imposes burdens on Mississippi women with no benefits "across the board."

Moreover, statewide relief is necessary to end the harmful impact of the ob-gyn requirement on Mississippi women, on whose behalf Plaintiffs brought this case. As-applied relief limited to Plaintiffs would preclude additional facilities from opening to provide abortion services in Mississippi.

Statewide relief is necessary to completely relieve Mississippi women of the ongoing detrimental effects the ob-gyn requirement imposes on abortion access. In short, statewide relief is warranted under *Whole Woman's Health* because the requirement burdens abortion access throughout the state while offering absolutely no corresponding benefit for Mississippi women.

[10] Plaintiffs requested full injunctive and declaratory relief against the ob-gyn requirement. *See, e.g.*, Am. Compl., Aug. 8, 2012, ECF No. 30. A "final judgment should grant the relief to which each party is entitled," based on the evidence presented to the court. Fed. R. Civ. P. 54(c).

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 26, 2017, I electronically filed the foregoing with the Clerk of the Court by using the Court's CM/ECF system, which will send a notice of electronic filing to all counsel of record.

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