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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Planned Parenthood Arizona, Inc.; William Richardson, M.D.; and William H. Richardson M.D., P.C., doing business as Tucson Women's Center,

Plaintiffs,

v.

Will Humble, Director of the Arizona Department of Health Services, in his official capacity,

Defendant.

Case No. 4:14-CV-01910-TUC-FRZ

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION AND MEMORANDUM IN SUPPORT THEREOF[1]

(Oral Argument Requested)

[1] For reasons discussed herein, Plaintiffs request that the Court set a hearing on their application for preliminary injunction prior to April 1, 2014. If a full hearing on the preliminary injunction cannot be set prior to that date, 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.

TABLE OF CONTENTS

Page

PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION 1
STATEMENT OF FACTS 2
A. Medication Abortion Background 2
B. The Challenged Law and Its Impact on Plaintiffs and Their Patients 5
ARGUMENT 7
I. PLAINTIFFS ARE ENTITLED TO A PRELIMINARY INJUNCTION AND, IF NECESSARY, A TEMPORARY RESTRAINING ORDER 7
II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS 8
A. The Arizona Law Violates a Woman's Right to Choose Abortion 8
1. Neither a medication abortion ban nor an FPL mandate serves women's health. 8
2. Regardless of its reach, the Arizona law would also impose a substantial obstacle. 11
B. The Act Violates Patients' Right to Bodily Integrity 13
C. The Arizona Law is Unconstitutionally Vague 15
D. The Act Violates the Equal Protection Clause 16
III. PLAINTIFFS FACE IRREPARABLE HARM FOR WHICH THERE IS NO ADEQUATE REMEDY AT LAW 18
IV. THE BALANCE OF HARMS STRONGLY FAVORS PLAINTIFFS AND THE PUBLIC INTEREST IS SERVED BY AN INJUNCTION 18
CONCLUSION 19

TABLE OF AUTHORITIES

Page(s)

Cases

Akron v. Akron Ctr. for Reprod. Health,
462 U.S. 416 (1983) 8, 9, 11

Alliance for the Wild Rockies v. Cottrell,
632 F.3d 1127 (9th Cir. 2011) 18

Buckman Co. v. Plaintiffs' Legal Comm.,
531 U.S. 341 (2001) 16

City of Cleburne v. Cleburne Living Ctr.,
473 U.S. 432 (1985) 16, 18

Cline v. Okla. Coal. for Reprod. Justice,
313 P.3d 253 (Okla. 2013) 10, 12

Colautti v. Franklin,
439 U.S. 379 (1979) 15

Connecticut v. Menillo,
423 U.S. 9 (1975) 9

Cruzan v. Dir., Mo. Dep't of Health,
497 U.S. 261 (1990) 13, 14

Del Rio v. Morgado,
CV 10-8955-FMO JPR, 2013 WL 1935295 (C.D. Cal. Apr. 2, 2013) 13

Forbes v. Napolitano,
236 F.3d 1009 (9th Cir. 2000) 15, 16

Galassini v. Town of Fountain Hills, Ariz.,
CV-11-02097-PHX-JAT, 2011 WL 5244960 (D. Ariz. Nov. 3, 2011) 19

Gonzales v. Carhart,
550 U.S. 124 (2007) 11, 12

Grayned v. City of Rockford,
408 U.S. 104 (1972) 15

Isaacson v. Horne,
716 F.3d 1213 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014) 1, 13, 17

Johnson v. Couturier,
572 F. 3d 1067 (9th Cir. 2009) 19

Johnson v. Meltzer,
134 F.3d 1393 (9th Cir. 1998) 13

Mazurek v. Armstrong,
520 U.S. 968 (1997) 9

McCormack v. Hiedeman,
694 F.3d 1004 (9th Cir. 2012) 8, 11

Melendres v. Arpaio,
695 F.3d 990 (9th Cir. 2012) 7, 18, 19

MKB Management Corp. v. Burdick,
2012 ND 10

Olmos v. Ryan, No. CV 11-914-PHX-GMS (MEA),
2012 WL 177859 (D. Ariz. Jan. 23, 2012) 8

Pimentel v. Dreyfus,
670 F.3d 1096 (9th Cir. 2012) 7

Planned Parenthood Ariz., Inc. v. Betlach,
899 F. Supp. 2d 868 (D. Ariz. 2012) 19

Planned Parenthood of Cent. Mo. v. Danforth,
428 U.S. 52 (1976) 8, 11

Planned Parenthood Greater Memphis Region v. Dreyzehner,
853 F. Supp. 2d 724 (M.D. Tenn. 2012) 18

Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott,
951 F. Supp. 2d 891 (W.D. Tex. 2013) 10, 12, 13

Planned Parenthood of Idaho v. Wasden,
376 F. Supp. 2d 1012 (D. Idaho 2005) 18

Planned Parenthood of S. Ariz. v. Lawall,
180 F.3d 1022 (9th Cir. 1999) 15

Planned Parenthood of Se. Pa. v. Casey,
505 U.S. 833 (1992) ..... *passim*

Planned Parenthood Sw. Ohio Region v. DeWine,
696 F.3d 490 (6th Cir. 2012) 10, 12, 13, 15

Planned Parenthood of Wis. v. Van Hollen,
738 F.3d 786 (7th Cir. 2013) 11, 17

Riggins v. Nevada,
504 U.S. 127 (1992) 13, 14

Rochin v. Calif.,
342 U.S. 165 (1952) 13, 14

Roe v. Wade,
410 U.S. 113 (1973) 9

Romer v. Evans,
517 U.S. 620 (1996) 17

Schmerber v. Calif.,
384 U.S. 757 (1966) 14

Simopoulos v. Virginia,
462 U.S. 506 (1983) 8, 9

Stenberg v. Carhart,
530 U.S. 914 (2000) 11

Stormans, Inc. v. Selecky,
586 F.3d 1109 (9th Cir. 2009) 18

Stuart v. Loomis,
1:11-CV-804, 2014 WL 186310 (M.D.N.C. Jan. 17, 2014) 15

Tucson Women's Clinic v. Eden,
379 F.3d 531 (9th Cir. 2004) ..... *passim*

United Food & Commercial Workers Local 99 v. Brewer,
817 F. Supp. 2d 1118 (D. Ariz. 2011) 19

Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.,
455 U.S. 489 (1982) 15

Washington v. Glucksberg,
521 U.S. 702 (1997) 13

Washington v. Harper,
494 U.S. 210 (1990) 13, 14

Winter v. Natural Res. Def. Council, Inc.,
555 U.S. 7 (2008) 2, 7

Women's Med. Ctr. of Nw. Houston v. Bell,
248 F.3d 411 (5th Cir. 2001) 18

Statutes

A.R.S. § 13-3603.02 6

A.R.S. § 20-1057(V) 17

A.R.S. § 20-2326(A) 17

A.R.S. § 33-449.01(2) 5

A.R.S. § 33-449.03 ..... 1, 5, 6

A.R.S. § 36-2153 6

Regulations

A.A.C. R9-10-1508(G) 1, 5

A.A.C. R9-10-1515 5

Other Authorities

U.S. Const., First Amendment 15

U.S. Const., Fourteenth Amendment 8, 13

Arizona House Bill 2036 1

Fed. R. Civ. P. 65(c) 1, 19

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

Plaintiffs 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 Defendant from enforcing a portion of Arizona House Bill 2036 of 2012 ("HB 2036"), Section 2, codified at A.R.S. § 36-449.03(E)(6) ("Act"), and its implementing regulation, A.A.C. R9-10-1508(G) ("Regulation") (collectively, "Arizona law").[2] This Motion is supported by the following Memorandum of Points and Authorities, the accompanying exhibits, and the entire court record which is incorporated herein by reference.

MEMORANDUM OF POINTS AND AUTHORITIES

INTRODUCTION

Plaintiffs are Arizona health care providers who for more than a decade have offered their patients the option of an early, safe abortion using medications alone. In providing this treatment option, Plaintiffs follow the most current standard of care – one recommended by the American Medical Association ("AMA") and the American College of Obstetricians and Gynecologists ("ACOG"). In Arizona, nearly half of eligible patients choose this method, usually based on a strong preference or medical need. Many women wish to avoid surgery or to experience the abortion at home, surrounded by family, rather than in a clinic. Victims of rape, sexual abuse, or molestation may choose medication abortion to retain more control over their medical treatment and to avoid trauma from having instruments inserted into their bodies. And for women with certain medical conditions that make surgical abortion more difficult, medication abortion is not only preferred but medically indicated.

Without any medical justification, Arizona has enacted a law that as of April 1 would either ban this treatment altogether or set it back 20 years, with disastrous consequences for women. However it is construed, the Arizona law would prevent at least some women from having a medication abortion, with no exception for medical necessity.

[2] HB 2036 is part of a package of abortion restrictions, another part of which was already struck down in *Isaacson v. Horne*, 716 F.3d 1213 (9th Cir. 2013), *cert. denied,* 134 S. Ct. 905 (2014).

At best, it would allow some women to choose this method but force them to follow a drug regimen barely used since the 1990s that is less effective, less accessible, more expensive, and causes more side effects.

As is more fully explained below, a preliminary injunction is warranted because: 1) Plaintiffs are likely to succeed on their claim that the Arizona law violates the constitutional rights of Plaintiffs and their patients; 2) Plaintiffs and their patients will suffer irreparable harm if the Arizona law 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. *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

STATEMENT OF FACTS

A. Medication Abortion Background

Women seek abortions for a variety of medical, psychological, emotional, familial, economic, and personal reasons. Ex. 1, Decl. of William Richardson, M.D. ("Richardson Decl.") ¶¶ 12-15. 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. Ex. 2, Decl. of Daniel Grossman, MD ("Grossman Decl.") ¶ 5. Currently, Arizona women in the first nine weeks of pregnancy (through 63 days from the first day of their last menstrual period ("lmp")) who seek abortion can choose between a surgical abortion or a procedure using medications alone (medication abortion). *Id.* ¶¶ 10-15.

A medication abortion involves a combination of two prescription drugs: mifepristone and misoprostol.[3] Richardson Decl. ¶ 11. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Under current practice, a patient takes mifepristone at her health care facility and about 24 to 48 hours later, usually at home, she takes misoprostol, which causes her uterus to contract and expel the pregnancy within hours, thereby completing the abortion. Grossman Decl. ¶¶ 10-13. Medication abortion is one of the safest procedures in contemporary medical practice, and

[3] Mifepristone is commonly known as "RU-486" or by its commercial name Mifeprex. Misoprostol is also known by its commercial name Cytotec. Grossman Decl. ¶¶ 11-12.

carries a far lower risk of major complications than pregnancy and childbirth. Richardson Decl. ¶ 11; Grossman Decl. ¶¶ 22-23.

For many women, medication abortion offers important advantages over surgical abortion. It allows them to avoid surgery, and to experience the abortion in a non-clinical setting (usually at home) with family or other loved ones. Richardson Decl. ¶ 12; Grossman Decl. ¶ 19. Victims of rape, or women who have suffered sexual abuse, may choose it to retain more control over the experience and to avoid trauma from having instruments inserted into their bodies. Richardson Decl. ¶ 14; Grossman Decl. ¶ 20. For some women, it is significantly safer than a surgical abortion. Richardson Decl. ¶¶ 13-15; Grossman Decl. ¶ 21. Medication abortion is increasingly prevalent, chosen by more women each year. Grossman Decl. ¶ 17. It also has continued to improve since the U.S. Food and Drug Administration ("FDA") approved mifepristone for marketing as an abortion-inducing drug in 2000.[4] Grossman Decl. ¶¶ 25-35.

The FDA approved mifepristone based on clinical trials from the 1990s that showed the following regimen to be safe and effective for women with gestational ages through 49 days lmp: the patient takes 600 mg of mifepristone orally at the health center, returns two days later to take 400 micrograms ("µg") of misoprostol orally, and then returns approximately 14 days later for a follow-up visit. Ex. 3, Decl. of Lisa D. Rarick, M.D., ("Rarick Decl.") ¶ 7. The Final Printed Label ("FPL") produced by the manufacturer and approved by the FDA therefore outlines this regimen.[5] Rarick Decl. ¶ 10; Grossman Decl. ¶¶ 25-26.

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[4] Mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug. Misoprostol is approved only for the treatment of ulcers. Grossman Decl. ¶¶ 26, 30.

[5] The FDA regulates how drugs are marketed, but it does not regulate how physicians practice medicine. Among physicians, the practice of administering medication to reflect clear, significant, generally accepted developments in medical research is common, and is referred to as "off-label" or "evidence-based" medicine. The AMA and ACOG have endorsed the responsible practice of evidence-based medicine, and the FDA itself has recognized that this is a common, appropriate and accepted practice. Rarick Decl. ¶¶ 15-18. Numerous drugs are commonly used differently from the protocols on their FPLs, including drugs that pose far greater risks than medication abortion. Rarick Decl. ¶ 20.

Even by the time the FDA approved mifepristone, which was a number of years after the clinical trials, newer research showed that a lower dose of mifepristone combined with a different dose and manner of administering misoprostol was at least equally safe, had fewer side effects, and was effective through at least 63 days lmp. Grossman Decl. ¶ 27. From the start, therefore, most abortion providers prescribed a protocol different from the FPL regimen. *Id*. Today, the overwhelming majority of providers, Plaintiffs included, provide a regimen in which the patient takes 200 mg of mifepristone orally at the health center, self-administers 800 µg of misoprostol buccally (dissolving the pills between her cheek and gum) 24 to 48 hours later at a location of her choosing, most often at home, and then returns to the clinic 1-3 weeks later for a follow-up visit. Richardson Decl. ¶ 22; Grossman Decl. ¶ 28; Ex. 4, Decl. of Bryan Howard ("Howard Decl.") ¶¶ 5-7.

The regimen Plaintiffs provide is supported by vast amounts of clinical data—from hundreds of thousands of patients, as compared to the under 3000 patients studied in the FDA trials. Grossman Decl. ¶¶ 32-33, 36. ACOG and the AMA have endorsed the evidence-based regimen used by Plaintiffs, recently stating that this regimen "make[s] medical abortion safer, faster, and less expensive, and result[s] in fewer complications as compared to the protocol approved by the FDA over 13 years ago." *Id.* ¶ 35. ACOG has just released a Practice Bulletin to this effect as well. *Id.*

More specifically, the evidence-based regimen used by Plaintiffs is superior to the FPL regimen in the following ways: First, it is more effective, both having a lower incidence of continued pregnancy and lower risk of needing surgical intervention to complete the procedure. Second, it is effective for longer in pregnancy, through at least 63 days lmp, which is significant because many women do not detect their pregnancies until close to 49 days lmp. Third, by allowing a woman to take the misoprostol dose at home, it reduces her need to travel. It also allows her greater control over the timing of the procedure, and ensures that she experiences the resulting bleeding and cramping in a safe location, rather than in the car on the way home from the clinic. Fourth, the lower mifepristone dosage reduces its side effects and significantly reduces its cost. *Id*. ¶¶ 32-35.

B. The Challenged Law and Its Impact on Plaintiffs and Their Patients

The Arizona law requires the medical director of a facility licensed as an abortion clinic to "ensure that any medication, drug or other substance used to induce an abortion is administered in compliance with the protocol that is authorized by the United States Food and Drug Administration and that is outlined in the final printing labeling instructions for that medication, drug or substance." A.R.S. § 36-449.03(E)(6); A.A.C. R9-10-1508(G). Only licensed abortion clinics are subject to this law, and those that fail to comply are subject to a civil penalty, license suspension or revocation, or other enforcement actions by DHS. A.R.S. § 33-449.03; A.A.C. R9-10-15-15.

Because any abortion-inducing medication may be used only as "outlined in the final printing label instructions *for that medication*" A.R.S. § 36-449.03(E)(6); A.A.C. R9-10-1508(G) (emphasis added), under one construction, the law bans medication abortion altogether because the second drug used in a medication abortion, misoprostol, is not labeled for abortion.[6] Grossman Decl. ¶¶ 30, 50; Howard Decl. ¶ 16. A complete ban on medication abortion would substantially burden Arizona women, particularly women who strongly prefer to avoid surgery or have medical conditions that make medication abortion a significantly safer option (and may also have a medical need to terminate their pregnancy). Grossman Decl. ¶¶ 18-21, 51.[7]

Alternatively, the Arizona law might be construed to allow misoprostol to be used in a medication abortion, but require that both medications be used as outlined on the Mifeprex FPL (an "FPL mandate"). Even under this construction, because the FPL regimen is limited to 49 days lmp, the Arizona law would impose all of the hardships described above for women 50 through 63 days lmp. For women 49 days lmp or under, it

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[6] The Arizona law also potentially bans all medication abortion because it requires abortion-inducing drugs to be administered "in compliance with the protocol that is authorized by the [FDA]," and the FDA does not in fact authorize drug protocols. Rarick Decl. ¶ 8.

[7] Although, as noted above, the Arizona law allows physicians and hospitals to continue offering medication abortion, including under a current evidence-based regimen, this does not mitigate the effect for women because those providers are not publicly known. Moreover, physicians may only offer four first trimester abortions per month until they too are "abortion clinics" subject to the Arizona law. A.R.S. § 33-449.01(2).

would still impose other substantial burdens, particularly in light of the pre-existing restrictions on abortion access already in place in Arizona.

Already, before having an abortion in Arizona, a woman must travel to a clinic at least 24 hours beforehand, meet with a physician, undergo an ultrasound, hear a detailed description of the fetus, discuss her reasons for having an abortion, and undergo state-directed counseling. A.R.S. § 36-449.03(D)(4), § 36-2153, and § 13-3603.02. Many women, moreover, must travel hundreds of miles (each trip) to reach a provider. Howard Decl. ¶ 18. Although advanced practice clinicians can safely provide early abortions and had done so for years in Arizona, recent laws have prohibited this practice, thereby shrinking the network of licensed abortion clinics in the sixth-largest state from 16 to 10 (all concentrated in a few metropolitan areas). *Id.* ¶ 14. These laws burden and stigmatize abortion patients and their providers, and this new law will compound that effect. *Id.* ¶ 19.

Thus, the Arizona law would exacerbate the burdens already imposed by Arizona's mandatory counseling and waiting period law, requiring *four* separate trips to an abortion facility over the course of two weeks: 1) for the state-mandated counseling and ultrasound; 2) for the mifepristone; 3) for the misoprostol; and 4) for the follow-up. The FPL mandate would also increase side effects, raise the cost of the procedure by hundreds of dollars, and increase the risk that patients will need surgical completion or other follow-up care. Grossman Decl. ¶¶ 33-34, 51, 57; Howard Decl. ¶ 10. Moreover, requiring women to take the misoprostol at the clinic would force them to bleed and cramp either at the clinic or during their journey home, rather than (as is currently the case) in one safe place. Grossman Decl. ¶ 56.

Women in northern Arizona would suffer in particular. This region, which is larger than most states, has only one licensed abortion clinic: Planned Parenthood of Arizona's ("PPAZ") Flagstaff clinic. Howard Decl. ¶ 18. Due to the staffing and facilities requirements related to surgical abortion, PPAZ's Flagstaff clinic only has the capacity to provide medication abortion. *Id.* ¶ 15. If the Arizona law bans medication abortion, safe and legal abortion would become entirely unavailable in northern Arizona. *Id.* ¶¶ 14, 18. And even if the law is an FPL mandate, the likely consequence would be that far fewer

patients would choose this inferior treatment, which would make it impossible for the Flagstaff clinic to continue offering it. *Id.* ¶ 18. The next closest clinic in Arizona to Flagstaff is 134 miles away, in Glendale. As a result, northern Arizona women would have to travel up to 744 miles roundtrip, for those traveling from the farthest parts of the state, to reach a licensed Arizona abortion provider. *Id.* Arizona's 24-hour waiting period, along with the law challenged here, would force them to make this trip multiple times or be away from home for an extended period. These extra trips, over longer distances, will require additional time away from home, children, and work, which will be particularly difficult for low-income women, women who live in rural areas, women who have limited access to transportation, and women who are victims of abuse. *Id.*; Grossman Decl. ¶ 56. In some cases, the added travel time will cause delay, which itself increases medical risk. Grossman Decl. ¶¶ 6-7.

The Arizona law will impose all the above burdens on women, without improving their health or safety in any way. To the contrary, it will harm women's health by forcing Arizona physicians to provide medical care contrary to the current medical research, years of doctors' practical experience, and the recommendations of major medical organizations like ACOG and the AMA.

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." *Winter*, 555 U.S. at 20; *Melendres v. Arpaio*, 695 F.3d 990, 1000 (9th Cir. 2012). 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). "[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

A. The Arizona Law Violates a Woman's Right to Choose Abortion

Women have a fundamental liberty interest, protected by the Fourteenth Amendment, in deciding whether to continue a pre-viability pregnancy. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992); *Tucson Women's Clinic v. Eden*, 379 F.3d 531, 539 (9th Cir. 2004). An abortion restriction that the state justifies as promoting women's health is unconstitutional if it either does not actually further women's health, or has the effect of imposing a substantial obstacle on women seeking an abortion. *See id.* at 540 ("[I]n the context of a law purporting to promote maternal health, a law that is poorly drafted or which is a pretext for anti-abortion regulation can both place obstacles in the way of women seeking abortions and fail to serve the purported interest very closely, if at all."). The Arizona law fails on both accounts.

1. Neither a medication abortion ban nor an FPL mandate serves women's health.

In evaluating an abortion restriction purportedly designed to protect women's health, the Court should independently assess the evidence to determine whether it actually serves that interest, and whether it is consistent with the standard of care. *See, e.g., Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (finding regulations "appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions"); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 435-37 (1983) (concluding the state's justification for regulation was "convincingly undercut[]" by "present medical knowledge"); *id.* at 430 ("the decisive factor" in upholding informed consent and recordkeeping regulations in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976), was that "the State met its burden of demonstrating that these regulations furthered important health-related State concerns"). In conducting this analysis, the Supreme Court has repeatedly looked at the generally-accepted standards set by the nation's major health organizations. *E.g.*, *Simopoulos*, 462 U.S. at 517 (considering ACOG and other standards); *Akron*, 462 U.S. at 435-37 (same).

Casey did not overrule previous decisions evaluating abortion restrictions predicated on the state interest in women's health and those cases remain good law for how the courts should evaluate such laws. *Casey* 505 U.S. at 883 (overruling *Akron* and *Danforth* only "to the extent that we permit a State to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed"); *id.* at 858 ("Even on the assumption that the central holding of *Roe* was in error, that error would go only to the strength of the state interest in fetal protection"); *id.* at 870 (reaffirming the "central premise" of *Akron* and *Thornburgh* with respect to the commitment to *Roe's* "essential holding"). Rather, *Casey* allowed broader regulation of abortion to further the state's interest in potential life than permitted under *Roe v. Wade*, 410 U.S. 113 (1973) and it concerned almost exclusively restrictions designed to further that interest.

Moreover, confronted with recordkeeping and reporting regulations that the state justified on the basis of women's health, the *Casey* Court performed the same analysis as in *Akron*) and *Thornburgh*: it considered whether the regulations would actually serve women's health and concluded that because they were "a vital element of medical research," they were "reasonably directed to the preservation of maternal health." 505 U.S. at 900-01 (quoting *Danforth*, 428 U.S. at 80). The Ninth Circuit has recognized this too, explaining that the *Casey* Court, in considering whether a law furthered women's health, "took care to verify that the law could be reasonably understood to promote [that interest], in some legitimate fashion." *Eden*, 379 F.3d at 540.[8]

[8] Because the *Eden* plaintiffs had argued that the undue burden standard should not apply to their claims at all, *see* 379 F.3d at 540, the Ninth Circuit cited to *Mazurek v. Armstrong*, 520 U.S. 968 (1997), as supporting its decision that the undue burden standard applies to all abortion restrictions that are not "facially pretextual or irrational." *Eden*, 379 F.3d at 541. Plaintiffs in this case, however, are not arguing that the undue burden standard should not apply, and they submit that *Akron* is a better guide than *Mazurek* to evaluating the constitutionality of the restriction at issue here. Moreover, *Mazurek* concerned solely the constitutionality of a physician-only law, which the U.S. Supreme Court had upheld previously under the *Roe* standard. *See, e.g., Connecticut v. Menillo*, 423 U.S. 9 (1975). In any event, the law challenged here *is* "facially pretextual or irrational."

The Arizona law fails this analysis. Each of the "findings" the Arizona legislature made to support this law is erroneous, misleading and/or irrelevant. Grossman Decl. ¶¶ 36-48. Medication abortion is safe and effective, with extremely low complication rates that are comparable to those associated with surgical abortion. *Id.* ¶¶ 22-24. Women have important personal reasons for choosing it over surgical abortion. *Id.* ¶¶ 18-20. And for some women, it is the medically-indicated abortion option. *Id.* ¶¶ 21, 51; Richardson Decl. ¶ 13. Depriving women of this option – either entirely or after 49 days lmp – does nothing to further their health; rather it harms it.

Even if the Arizona law allows medication abortion, it would be an FPL mandate, also without any medical justification. As the AMA and ACOG have recognized, the FPL regimen is *inferior* to Plaintiffs' practices. Grossman Decl. ¶ 35. It is less effective, cannot be used as long into pregnancy, has increased side effects, costs more, and is more burdensome than the evidence-based regimen Plaintiffs use. *Id.* ¶¶ 33-34; Richardson Decl. ¶ 24. It also would require women to bleed and cramp on their way home from the health center. Grossman Decl. ¶ 56. There is simply no legitimate reason for requiring Arizona women to follow an inferior regimen. As the Oklahoma Supreme Court recently held in striking down a similar restriction, the Arizona law "is **so completely at odds with the standard that governs the practice of medicine** that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those who do." *Cline v. Okla. Coal. for Reprod. Justice*, 313 P.3d 253, 262 (Okla. 2013).[9]

[9] A North Dakota trial court also reached the same conclusion. *MKB Management Corp. v. Burdick*, 2012 ND E. Cent. Jud. Dist. Ct., Case No. 09-2011-CV-02205 (July 15, 2013) (on appeal), *available at http://jurist.org/paperchase/2013-07-15_MKBvBurdick_Perm_Injunction.pdf.* And although the Sixth Circuit and a Texas district court partially upheld FPL mandates (enjoining them where required for health reasons), these courts did not consider whether those restrictions actually furthered women's health. *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490 (6th Cir. 2012); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013). The factual record in *DeWine*, moreover, was from 2004, before additional evidence, presented here, was available confirming the superiority of the evidence-based regimen used today. Grossman Decl. ¶¶ 22, 46.

2. Regardless of its reach, the Arizona law would also impose a substantial obstacle.

Even if Defendant could show that the Arizona law "could be reasonably understood to promote" women's health, "in some legitimate fashion," *Eden*, 379 F.3d at 540, it would nonetheless be unconstitutional because it places a substantial obstacle on women seeking abortions, and thus is not "a permissible means of serving [a] legitimate end[]." *Casey*, 505 U.S. at 877; *see also Akron*, 462 U.S. at 438.

In assessing whether the Arizona law creates a substantial obstacle, the Court should consider its impact within the existing regulatory landscape. *Planned Parenthood of Wis. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013) ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered."); *cf. Eden*, 379 F.3d at 541-43 (remanding to district court to consider whether provisions of challenged law in aggregate, including increased costs, reduced access, and stigma, amounted to substantial obstacle); *McCormack*, 694 F.3d at 1016-17 (discussing "overburdened path that . . . pregnant women . . . face when deciding whether to obtain an abortion," including cost, distance, arrangements for childcare, and harassment by protesters); *id.* at 1017 (women who "must travel long distances to the closest abortion provider . . . [have to] take time to miss work, find childcare, make arrangements for travel to and from the hospital and/or clinic, and to possibly make arrangements to stay overnight to satisfy the 24-hour requirement"). Additionally, the "feebler" the medical grounds offered in support of an abortion restriction justified on the basis of women's health, the "likelier the burden, even if slight, [is] to be 'undue' in the sense of disproportionate or gratuitous." *Van Hollen*, 738 F.3d at 798.

Here, the Arizona law bans a common method of first trimester abortion – which has become the chosen method of nearly half of eligible patients – either entirely or after 49 days lmp. Grossman Decl. ¶17. A ban on a safe, effective, commonly-used abortion method imposes an impermissible burden. *See Stenberg v. Carhart*, 530 U.S. 914, 915-46, 924 (2000) (striking down a ban on "the most commonly used" second trimester procedure); *Danforth*, 428 U.S. at 78 (same); *cf. Gonzales v. Carhart*, 550 U.S. 124, 135,

156 (2007) (federal ban on "partial-birth abortion" upheld because it would not "prohibit the vast majority of" "the usual abortion method" in the second trimester).[10]

Moreover, even for those women, if any, for whom medication abortion would still be legal, the extra, unnecessary trips to a clinic and the increased costs the Arizona law would require, on top of those already imposed by existing law, *see supra* at 6, would put medication abortion out of reach for many – especially young women, women who live in rural areas, low-income women, and victims of domestic violence. Grossman Decl. ¶56; Howard Decl. ¶ 18. The impact of an FPL mandate would be to raise the number of required clinic visits to four (only one or two of which can be understood to be medically indicated); increase the price of medication abortion by about 40 percent if not more; increase side effects; increase the risk of surgical follow-up; and require women to endure bleeding and cramping on their trip home. Grossman Decl. ¶¶ 34, 56-67; Howard Decl. ¶ 10. Finally, whether or not the Arizona law is a ban, its impact would be increased manifold if it caused PPAZ Flagstaff to halt services; women would have to travel anywhere from 300 to over 700 miles multiple times to obtain a safe and legal abortion by any method. Howard Decl. ¶ 18.

For all of the above reasons, the Arizona law, coming on top of Arizona's other laws burdening abortion, will place a substantial (and therefore unconstitutional) obstacle in the path of Arizona women seeking an abortion. *See Eden*, 379 F.3d at 542 (holding that a reasonable factfinder could conclude that "by increasing the cost of abortion and limiting the supply of abortion providers and hours during which they can provide abortions, [the challenged law] imposes a substantial obstacle").[11]

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[10] The ban upheld in *Gonzales* also is distinguishable from the Arizona law because it was intended to advance a state's interest in fetal life, which is not the case here.

[11] *DeWine*, 696 F.3d 490, and *Abbott*, 951 F. Supp. 2d 891, are distinguishable for several reasons. Unlike the Arizona law, neither the Texas nor the Ohio law could be read to ban medication abortion entirely (in contrast to the Oklahoma law recently ruled unconstitutional, a decision the United States Supreme Court recently declined to review, *Cline*, 313 P.3d 253, *cert. dismissed as improvidently granted*, 134 S. Ct. 550 (2013)). And in neither case was there evidence, as there is here, that a ban or a restriction would likely force women in half the state to travel over 200 more miles on average to reach a clinic, or that the law would further stigmatize abortion providers. These distinctions

The Arizona law also imposes a substantial obstacle because it fails to provide an exception for situations where a medication abortion is necessary to protect a woman's health. Grossman Decl. ¶ 21. As the Ninth Circuit has twice held in recent years, "[a]n adequate health exception is a *per se* constitutional requirement. To preclude a woman from receiving a medically necessary abortion is to impose an unconstitutional burden." *Isaacson*, 716 F.3d at 1227 (quoting *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 922-3 (9th Cir. 2004)) (internal punctuation omitted).

In sum, because the Arizona law serves no interest in women's health and it imposes a substantial obstacle in the path of women seeking abortion, Plaintiffs are highly likely to succeed on their claim that the law violates the right to choose abortion.

B. The Act Violates Patients' Right to Bodily Integrity

Because the Arizona law will force many women to undergo surgery when they otherwise would have chosen to terminate their pregnancy through safe non-surgical means, it also infringes their right to bodily integrity without adequate justification. It is "long recognized" that the Fourteenth Amendment protects against unwarranted intrusions into one's body. *See, e.g.*, *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (bodily integrity is among "certain fundamental rights and liberty interests" given "heightened protection against government interference"); *Riggins v. Nevada*, 504 U.S. 127 (1992) (right to refuse unnecessary antipsychotic drugs); *Washington v. Harper*, 494 U.S. 210, 221-222, 227 (1990) (same); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990) (assuming a right to refuse life-sustaining treatment); *Rochin v. Calif.*, 342 U.S. 165, 173-74 (1952) (prohibition on pumping a suspect's stomach for evidence); *see also Johnson v. Meltzer*, 134 F.3d 1393, 1397 (9th Cir. 1998); *Del Rio v. Morgado*, CV 10-8955-FMO JPR, 2013 WL 1935295 *5 (C.D. Cal. Apr. 2, 2013); *cf. Casey*, 505 U.S. at 849 ("the Constitution places limits on a State's right to interfere with a person's most

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matter because, as *Eden* recognized, the "substantial obstacle" inquiry is "record-dependent," 379 F.3d at 541, and must take a range of effects into account, including cost and availability of providers, *id*. at 542-43. Moreover, in both cases the FPL mandate remains enjoined to the extent it lacks a valid exception to protect women's lives and health. *DeWine*, 696 F.3d at 499-500; *Abbott*, 951 F. Supp. 2d at 908-909, *aff'd in part and stayed in part pending app.*, 734 F.3d 406, 419 (5th Cir. 2013).

basic decisions about family and parenthood *as well as bodily integrity*") (emphasis added) (citations omitted).

The Arizona law violates this right in a number of ways. First, it forces women (either entirely or after 49 days lmp) to have an invasive surgical procedure in a clinic when they would prefer a private, non-invasive and equally safe alternative at home with family and/or other loved ones. This deprives women of the basic dignity of making their own medical decisions and choosing between two radically different physical and emotional medical experiences. It also exposes women with certain physiological or psychological conditions to a pointless risk of mental trauma or bodily harm, *see* Grossman Decl. ¶¶ 20-21. Second, even if construed as an FPL mandate, it requires an antiquated regimen that forces women to take triple the necessary dose of mifepristone, comes with greater side effects, and exposes women to a greater chance of needing surgery to complete the procedure.

To assess Plaintiffs' bodily integrity claim, this Court must balance women's "liberty interests against the relevant state interests," *Cruzan*, 497 U.S. at 279, considering both: (1) the nature of the intrusion, *compare Rochin*, 342 U.S. 165 (forced stomach pumping is impermissible), *with Schmerber v. Calif.*, 384 U.S. 757 (1966) (blood test for alcohol is permissible); and (2) whether the intrusion is justified by the asserted state interests. The Arizona law unquestionably fails this balancing test. The law substantially intrudes on the bodily integrity of women because it forces them to have a surgical procedure when they otherwise would have chosen – and in some cases, need to protect their health – a safe procedure using medications alone that does not involve inserting instruments into their bodies. This intrusion does not serve *any* state interest in health let alone one substantial enough to outweigh the harms, *see supra* at 8-10; Grossman Decl. ¶¶ 32-34, 36-58. Compulsory doses of unnecessary medication, moreover, are never justified, *see Riggins*, 504 U.S. at 134; *Harper*, 494 U.S. at 221. Thus, Plaintiffs are also likely to succeed in their claim that the law violates their patients' right to bodily integrity.[12]

[12] In *DeWine*, the Sixth Circuit held that an FPL mandate did not violate women's right to

C. The Arizona Law is Unconstitutionally Vague

Vague laws offend the Fourteenth Amendment's Due Process Clause in two ways. *Grayned v. City of Rockford*, 408 U.S. 104 (1972). First, they fail to provide people targeted by the law with a "reasonable opportunity to know what is prohibited, so that [they] may act accordingly." *Id.* at 108. Second, by failing to provide explicit standards, vague laws "impermissibly delegate[] basic policy matters to policemen, judges and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory enforcement." *Id*. at 108-09.

"[T]he most important factor affecting the clarity that the Constitution demands of a law is whether it threatens to inhibit the exercise of constitutionally protected rights." *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 499 (1982). If it does, "a more stringent vagueness test should apply." *Id.* This heightened scrutiny applies to laws that threaten to chill the provision of constitutionally-protected abortion services. *Colautti v. Franklin*, 439 U.S. 379, 393-94 (1979); *Eden*, 379 F.3d at 554 ("Given the potential for harassment of abortion providers, it is particularly important that enforcement of any unconstitutionally vague provisions of [an abortion regulation] scheme be enjoined."). Indeed, Arizona has a history of enacting unconstitutionally vague abortion laws. *See, e.g., id.*; *Forbes v. Napolitano*, 236 F.3d 1009, 1013 (9th Cir. 2000); *Planned Parenthood of S. Ariz. v. Lawall*, 180 F.3d 1022 (9th Cir. 1999).

The Arizona law does not survive the exacting standard of scrutiny applicable here. It mandates that a physician provide an "abortion-inducing drug" only "in compliance

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bodily integrity. But that court asked the wrong question – whether the available alternative to a medication abortion "is so undesirable as to make the woman choose to have no abortion at all." 696 F.3d at 507. The proper inquiry is whether a woman who has chosen to exercise her fundamental right to abortion can be placed in the untenable position of either having to forgo that right or "consent" to an invasive surgical procedure – especially when the state has no legitimate interest in the restriction. Placing a woman in this position, under the false guise of protecting her health, is every bit as coercive as subjecting her to involuntary medical treatment. Women do not deserve *less* protection for their right to bodily integrity just because the procedure they have chosen is abortion. *Cf., e.g., Stuart v. Loomis*, 1:11-CV-804, 2014 WL 186310 (M.D.N.C. Jan. 17, 2014) (applying First Amendment analysis separately from an undue burden analysis).

with the protocol *authorized by the [FDA]* and that is *outlined in the [FPL] for that medication* . . .” (emphasis added). This is vague because the FDA does not authorize drug protocols, and in fact has no statutory authority to do so. *See Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341, 350-51 (2001) (holding that the FDA does not regulate the practice of medicine and off-label use is generally permitted); *see also* Rarick Decl. ¶¶ 15-18.

The Arizona law also does not provide sufficient clarity about whether a physician may provide misoprostol as part of a medication abortion. In the absence of a statutory definition of “induce,” misoprostol seems to be a “drug . . . used to induce an abortion.” Richardson Decl. ¶ 26. But misoprostol’s FPL does not “outline,” let alone “authorize,” its use in medication abortion. Thus, the Arizona law does not appear to allow clinics to provide misoprostol for purposes of a medication abortion. Richardson Decl. ¶ 27; Grossman Decl. ¶ 50. The law, therefore, leaves physicians facing an impermissible quandary of not knowing how to perform a theoretically legal medical procedure. *See Forbes*, 236 F.3d at 1012-13 (statute that permits some conduct held impermissibly vague when it does not clearly define the terms that divide the legal from the illegal).

D. The Act Violates the Equal Protection Clause

The Equal Protection Clause “is essentially a direction that all persons similarly situated should be treated alike.” *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985). Arizona’s decision to single out abortion clinics and abortion medication for unfavorable treatment violates that mandate. The Arizona law treats women, and their healthcare providers, differently depending on whether these women seek an abortion from a licensed abortion clinic or from a hospital-based or other provider. It also treats abortion providers differently from the thousands of other healthcare professionals who prescribe treatments based on current medical standards.

Under any level of scrutiny, the Arizona law fails review because it bears no rational relationship to its stated purpose. As set forth *supra* at 8-13, while the legislature purported to be protecting patients, the Arizona law in fact puts patients at risk. Moreover, were the evidence-based regimen more dangerous, it would be truly bizarre (and

irrational, to say the least) for the legislature to protect only those patients who select an abortion clinic as their provider, and not other medication abortion patients. In other words, the Arizona law's distinction between types of abortion providers is neither "narrow enough in scope [nor] grounded in a sufficient factual context for [the court] to ascertain some relation between the classification and the purpose it serve[s]." *Romer v. Evans*, 517 U.S. 620, 632-33 (1996).

The Arizona law also irrationally singles out medication abortion, either banning it or restricting it to an outdated and inferior regimen, while allowing physicians in all other areas of medicine to prescribe evidence-based regimens according to their best medical judgment. In fact, in areas other than abortion, the State actively *protects* patients' access to evidence-based advances in medicine. *See, e.g,* A.R.S. §§ 20-1057(V) (prohibiting health insurers from refusing to cover evidence-based prescription of cancer drugs); 20-2326(A) (same). This discriminatory treatment is unconstitutional, because the state has no *per se* legitimate health interest for treating abortion differently from other comparable medical procedures, *cf. Isaacson,* 716 F.3d at 1229, ("Just as for other medical procedures that carry risks of morbidity or mortality, the requirement upheld in *Casey* left women to decide, in consultation with their medical providers, whether they wish to undertake known risks."); *Eden,* 379 F.3d at 542 (noting that abortion is a comparatively low-risk procedure).[13]

Here, the Act "is so discontinuous with the reasons offered for it that [it] seems inexplicable by anything but animus toward the class it affects," *Romer,* 517 U.S. at 632 – *i.e.,* abortion clinics, and "a bare … desire to harm a politically unpopular group … [is] not [a] legitimate state interest[]." *Cleburne*, 473 U.S. at 447 (internal citations omitted);

[13] Indeed, such an apparent lack of rational basis suggests that the stated purpose is merely a pretext for an impermissible motivation. As the Seventh Circuit recently explained in upholding a preliminary injunction against a different abortion "safety" restriction, "the lack of any demonstrable medical benefit" from the restriction, and the legislature's failure to similarly restrict other, riskier procedures than abortion, were "certainly evidence that [the] Legislature's only *purpose* in its enactment was to restrict the availability of safe, legal abortion in this State." *Van Hollen,* 738 F.3d at 790 (quoting district court with approval).

see also Planned Parenthood Greater Memphis Region v. Dreyzehner, 853 F. Supp. 2d 724, 736-38 (M.D. Tenn. 2012). Because the Act singles out licensed abortion clinics and their patients, as well as abortion medication, for no legitimate reason, it fails Equal Protection review.

III. PLAINTIFFS FACE IRREPARABLE HARM FOR WHICH THERE IS NO ADEQUATE REMEDY AT LAW

Plaintiffs and their patients will be irreparably injured if the Arizona law takes effect. "It is well established that the deprivation of constitutional rights 'unquestionably constitutes irreparable injury.'" *Melendres*, 695 F.3d at 1002 (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).

The Arizona law also irreparably harms Plaintiffs because it places them in the untenable position of choosing between providing critical care in a demonstrably inferior way or ceasing to provide that care. More importantly, Plaintiffs' patients will be irreparably harmed, because in addition to depriving them of their constitutional rights, the Arizona law will threaten their health. *See, e.g., Planned Parenthood of Idaho v. Wasden*, 376 F. Supp. 2d 1012, 1021-22 (D. Idaho 2005) (finding irreparable harm where "provisions of the Act, in combination with certain circumstances, will likely threaten the health of minors seeking abortions").

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

Where a plaintiff is threatened with "irreparabl[e] los[s]," the "the balance of hardships between the parties tips sharply in favor of [the plaintiff]" and an injunction is warranted. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127, 1137 (9th Cir. 2011). In contrast to the harms that will befall Plaintiffs and their patients if the Arizona law is allowed to take effect, Defendant would suffer no harm if a preliminary injunction is granted. He would only be delayed in his ability to enforce the Arizona law while serious constitutional issues are resolved – simply a preservation of the status quo. Indeed,

Defendant obviously felt no urgency to enforce the law, as he waited almost two years to implement it. And, if the legislature had thought the problem was so pressing, it would have required Defendant to implement the Act by a certain date and more importantly, it would have made the Act apply to all patients.

Finally, the public interest will be served by the issuance of an injunction. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *Melendres*, 695 F.3d 990 at 1002 (punctuation omitted, reviewing cases). It is also in the public interest to prevent harms to women's health and to preserve their access to a demonstrably safe procedure. *See Planned Parenthood Ariz., Inc. v. Betlach*, 899 F. Supp. 2d 868, 887 (D. Ariz. 2012).[14]

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. Defendant should be enjoined from enforcing the Arizona law pending the final determination of Plaintiffs' claims

[14] Because Plaintiffs and their patients face a loss of constitutional rights, and Defendant is 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 v. Town of Fountain Hills, Ariz.*, CV-11-02097-PHX-JAT, 2011 WL 5244960 *7 (D. Ariz. Nov. 3, 2011); *United Food & Commercial Workers Local 99 v. Brewer*, 817 F. Supp. 2d 1118, 1128 (D. Ariz. 2011); *see also Johnson v. Couturier*, 572 F. 3d 1067, 1086 (9th Cir. 2009) ("Rule 65(c) invests the district court with discretion as to the amount of security required, *if any*.") (emphasis in original) (internal punctuation and citations omitted).

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**Application for admission pro hac vice forthcoming/pending*

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of March, 2014, I electronically transmitted the foregoing document to the Clerk's Office using the CM/ECF system for filing, and arranged for service of the foregoing document via process server on the following:

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