IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

FALLS CHURCH MEDICAL CENTER, LLC, *et al.*,

Plaintiffs,

v.

M. NORMAN OLIVER, *et al.*,

Defendants.

CASE NO: 3:18-CV-428-HEH

REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

The undisputed facts show that Virginia's Physician-Only Law and Hospital Requirement do not benefit patient safety, but rather impose on patients *increased* medical risk and a range of other harms by delaying and even preventing access to constitutionally protected healthcare. Mem. of Law in Supp. of Pls.' Mot. for Partial Summ. J. ("Pls.' SJ Mem."), ECF No. 95. These facts support summary judgment for Plaintiffs on Counts III and IV of the Amended Complaint under the controlling "undue burden" standard. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309–10 (2016); *Planned Parenthood Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992).

Defendants' response does not meet their burden of producing *evidence*—beyond speculation—to dispute the facts that are material to the undue burden analysis. Instead, Defendants try to weaken that standard, arguing first that a burden must be "substantially" greater than any corresponding benefit to be "undue"; then that physician-only laws are per se exempt from undue-burden balancing because in 1997 the Supreme Court found a Montana physician-only law *facially* constitutional; and finally that they need not justify these restrictions medically because abortion, unlike other medical care, terminates potential life. None of these arguments overrides the Supreme Court's clear guidance that because the Constitution protects the right to end a pregnancy before viability, restrictions on that right must be justified by *evidence* of benefits that outweigh any burdens. *Whole Woman's Health*, 136 S. Ct. at 2310.

On the facts, Defendants fail to genuinely dispute that the Physician-Only Law and the Hospital Requirement impose more burdens than they confer benefits. Defendants effectively concede that these laws provide no actual medical benefit, while citing vague, threadbare speculation by their sole medical expert witness that there might, in theory, be situations in which these restrictions *could* confer some benefit. This speculation is insufficient to withstand summary

judgment, particularly in the face of uncontroverted evidence that these laws significantly restrict patients' access to care.

Defendants also question the *degree* to which the Physician-Only Law constrains access (not *whether* it does so), but the undisputed material facts show that this restriction limits when and where women can access care and delays their exercise of a constitutional right. Finally, Defendants stress that a few women are able to access second-trimester abortion at hospitals in addition to the two where abortion is generally available (VLPP's Virginia Beach surgical center and VCU Hospital), but they do not dispute that these other hospitals provide second-trimester abortions only to an extremely small number of *established* patients *in response to medical emergencies* and therefore that most Virginia women have only two options in the entire Commonwealth for obtaining an abortion after thirteen weeks and six days of pregnancy.

In short, Defendants have failed to identify evidence raising a meaningful dispute as to the material facts supporting Claims III and IV. Summary judgment is warranted.

I. Defendants' Proposed Legal Tests Fail

As set forth in Plaintiffs' summary judgment brief, Pls.' SJ Mem. at 16–17, the question before this Court is whether, given the undisputed evidence, the Physician-Only Law and Hospital Requirement impose burdens that are disproportionate to their benefits.

Defendants offer a number of legal arguments why this is not the proper inquiry, all of them unavailing. First, as in their earlier briefing, Defendants urge this Court to adopt a more lenient standard under which abortion restrictions are constitutional as long their burdens do not "substantially outweigh" their benefits. Defs.' Resp. in Opp'n to Pls.' Mot. for Partial Summ. J. ("Defs.' Opp'n") at 10–11, ECF No. 105. As detailed in Plaintiffs' opposition brief, Defendants' proposed standard relies on nonbinding case law of dubious precedential value. Pls.' Mem. of Law in Opp'n to Defs.' Mot. for Partial Summ. J. ("Pls.' Opp'n") at 8–10, ECF No. 106. Defendants'

proposed standard also fails to provide the level of scrutiny that a "constitutionally protected personal liberty" demands. *See Whole Woman's Health*, 136 S. Ct. at 2309; *Casey*, 505 U.S. at 846–47 (1992) (plurality opinion); *see also Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 919–920 (7th Cir. 2015) (requiring defendants to show "that the restrictions are not disproportionate, in their effect on the right to an abortion, to the medical benefits that the restrictions are believed to confer"); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 912–14 (9th Cir. 2004) ("The more substantial the burden, the stronger the state's justification for the law must be to satisfy the undue burden test; conversely, the stronger the state's justification, the greater the burden may be before it becomes 'undue.'").

Second, Defendants appear to revive their previously unsuccessful argument that this Court need not weigh the benefits and burdens of the Physician-Only Law because the Supreme Court upheld a Montana physician-only law more than two decades ago, under very different medical and social facts. Defs.' Opp'n at 11–14 (citing *Mazurek v. Armstrong*, 520 U.S. 968 (1997)). As this Court has already recognized, Mem. Op. at 17–19, ECF No. 52, and as set forth in Plaintiffs' opposition brief, Pls.' Opp'n at 10–11, *Mazurek* does not control. *Mazurek* concerned a claim of improper purpose, not undue effects; indeed, in *Mazurek* the Court was careful to note "undisputed evidence" that the challenged restriction did not limit access to abortion care. 520 U.S. at 972–73. Here, by contrast, Plaintiffs present extensive evidence that Virginia's Physician-Only Law obstructs access to abortion. *See infra* Part II.B.

Moreover, *Whole Woman's Health* requires that ostensible health and safety regulations provide evidence-based benefits, and the record here is clear: Virginia's Physician-Only Law provides no such benefits. *See infra* Part II.A. It is undisputed that in the decades since the Court considered the Montana physician-only law in *Mazurek*, the U.S. Food and Drug Administration

approved medication abortion—specifically allowing it to be provided by advanced practice clinicians (APCs)—and Defendants have not offered even speculation that there might be any safety advantage in barring APCs from prescribing this low-risk medication. Pls.' SJ Mem., Statement of Undisputed Material Facts ("Pls.' SUMF") ¶¶ 3, 12; *see infra* n.4. Defendants also concede that, since *Mazurek*, substantial research has demonstrated that: 1) APCs can provide medication and aspiration abortion just as safely as do physicians; and 2) restrictions on the availability of abortion delay patients in obtaining abortion care, subjecting them to increased medical risk. Pls.' SUMF ¶¶ 8, 10, 25, 35–42, 45.

Also since *Mazurek*, APC education and licensing has become far more standardized, and Virginia, like other states, has authorized APCs to provide an increasing range of care, including treatments equally as or more complex than abortion. Decl. of Joanne Spetz, Ph.D. ("Spetz Decl.") ¶¶ 21–41, 62–72, ECF No. 97. Thus, as this Court has already recognized, *Mazurek* does not relieve Defendants of the burden of producing evidence that *Virginia*'s Physician-Only Law *actually* improves patient safety enough to justify the significant burdens it imposes.[1]

[1] Defendants also cite to language from *Roe v. Wade*, 410 U.S. 113, 165 (1973), *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 447 (1983), *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) (per curiam), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 885 (1994) (plurality opinion), indicating approval of physician-only requirements. None of these cases supports Defendants' position here. The *Roe* and *Akron dicta* they cite merely reflects that in the seventies and early eighties, a physician-only requirement appeared medically reasonable, *see supra* Part I (explaining medical and professional advancements since 1997). *Menillo* held that states can protect patients by prohibiting *unlicensed* practitioners who "ha[ve] never had *any medical training*" from performing abortion procedures. 423 U.S. at 9 (emphasis added); *id*. at 10 (explaining that *Roe* established a "right to a clinical abortion by *medically competent personnel*" (emphasis added)). And the *Casey* passage Defendants cite expresses that states have "broad latitude to decide that particular functions may be performed only by *licensed professionals*," 505 U.S. at 885 (emphasis added)—which does not help Defendants justify a ban on licensed APCs providing abortion.

Finally, Defendants assert that they need not even justify these laws medically because abortion, unlike other medical care, terminates potential life.[2] That argument is fundamentally inconsistent with *Whole Woman's Health*, which clearly holds that if the state restricts abortion in the name of patient safety, its chosen means must actually further that end.

II. Defendants Fail to Show a Genuine Dispute Of Fact Material to the Undue Burden Analysis

A. There is No Dispute That Neither The Physician-Only Law Nor The Hospital Requirement Benefits Patients

Defendants open their response by proclaiming that, because this Court is considering the constitutionality of the Physician-Only Law and the Hospital Requirement only as applied to Plaintiffs, "the question before this Court is not 'is abortion safe?' or 'can a nurse practitioner be trained to perform abortions?'" Defs.' Opp'n at 1. In fact, those are *key* questions before this Court, and the answer to both is indisputably "yes." Whether applied to facial or as-applied claims, the undue burden standard requires this Court to determine whether the challenged laws' burdens exceed their benefits. Mem. Op. at 11, ECF No. 52.

While Defendants assert that these laws—as applied to Plaintiffs—are necessary to protect patients, they offer only thin speculation to support that assertion while conceding material facts

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[2] *Harris v. McRae*, 448 U.S. 297, 325 (1980), which Defendants rely on for this position, stands only for the proposition that the state need not fund abortion exactly as it does other medical care, not that the state has carte blanche to single out abortion for medically unnecessary restrictions. 448 U.S. at 324–26 (holding that because women have no constitutional right to *government-funded* abortion, rational-basis review rather than heightened constitutional scrutiny applies to government's decision not to fund abortion, and that this funding decision rationally furthers a legitimate government interest in "protecting potential life"). When the state restricts abortion, *Casey* and *Whole Woman's Health* apply. *See id*. at 326 (holding that the more deferential standard under which the interest in protecting potential life justifies a funding restriction applies only where "the Congress has neither *invaded a substantive constitutional right or freedom*, nor enacted legislation that purposefully operates to the detriment of a suspect class" (emphasis added)).

that fatally undermine it. Plaintiffs are entitled to summary judgment on this record.[3] *See Thompson v. Potomac Elec. Power Co.*, 312 F.3d 645, 649 (4th Cir. 2002) ("[T]he non-moving party . . . ha[s] the ultimate burden of demonstrating a genuine issue of material fact for trial. Conclusory or speculative allegations do not suffice . . . ." (citation omitted)); *Tao of Sys. Integration, Inc. v. Analytical Servs. & Materials, Inc.*, 330 F. Supp. 2d 668, 671 (E.D. Va. 2004) (acknowledging that a non-moving party cannot create a genuine dispute of material fact through "the building of one inference upon another" (quoting *Beale v. Hardy*, 769 F.2d 213, 214 (4th Cir. 1985))); *see also United States v. 1866.75 Bd. Feet and 11 Doors and Casings, More or Less, of Dipteryx Panamensis Imported from Nicar.*, 587 F. Supp. 2d 740, 746 (E.D. Va. 2008).

1. The Physician-Only Law

Defendants concede that there is "no medical reason why [APCs] couldn't be trained" to safely provide medication and aspiration abortions. Pls.' SUMF ¶ 9. They also concede that abortion is one of the safest medical procedures available; that both medication and aspiration abortion are simple and brief procedures; that APCs in other states provide medication and aspiration abortion as safely as do physicians; that APCs in Virginia (including APCs at Plaintiffs' and Defendants' expert's facilities) already provide treatments identical to medication and aspiration abortions in technique and risk; that complications from early abortion are extremely rare and are usually minor when they do occur; that APCs in Virginia already manage abortion complications that do arise; that abortion care is safer when performed earlier in pregnancy; that

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[3] While Defendants urge the Court to disregard evidence in the record "unrelated to Plaintiffs' statement of facts," Defs.' Opp'n at 9 & n.4, this Court may consider all material in the record, Fed. R. Civ. P. 56(c)(3), and "the Court may assume that facts identified by the moving party in its listing of material facts are admitted, unless such a fact is controverted in the statement of genuine issues filed in opposition to the motion," L.R. 56(B).

the Physician-Only Law restricts access to abortion; and that restrictions on access delay treatment. *Id*. ¶¶ 1, 3, 4, 8, 10, 12, 13, 20.

All these facts demonstrate that barring APCs from providing abortion care serves no medical purpose and in fact undermines patient safety by delaying care. Defendants strain to dispute that ultimate conclusion by citing testimony from their medical expert, Dr. Lunsford, that she doubts whether APCs "in general" receive sufficient academic training to manage the rare complications from medication and aspiration abortion without physician "oversight." Tr. of Dep. of Elizabeth Lunsford, M.D. ("Lunsford Dep.") 310:2–313:11, ECF No. 105-1. But Dr. Lunsford, who does not perform abortions, offered no specific data or experience to justify her doubt, and, as set forth above, Plaintiffs have presented extensive uncontested evidence demonstrating that, with appropriate training, APCs are wholly qualified, and have been shown, to provide this care safely. For example, Plaintiffs presented evidence that APCs working at VLPP's health centers (five of whom have advanced degrees in women's health, Tr. of Dep. of Paulette McElwain ("McElwain Dep.") 37:13–38:1, 38:18–22, ECF No. 89), already have more experience managing abortion complications than the average physician; indeed, those APCs *already* staff complication visits at VLPP's health centers.[4] Tr. of Dep. of Shanthi S. Ramesh, M.D., MSCR, FACOG ("Ramesh Dep.") 33:1–21, ECF No. 106-7. Thus, Dr. Lunsford's general doubt is entirely speculative and unsupported, and should be given no weight.

Nor does Dr. Lunsford explain why her doubt about whether APCs are "generally" trained to manage complications would justify a complete ban on APCs performing the procedure itself,

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[4] Thus, not only is there no medical reason why APCs cannot manage complications from abortion, but the Physician-Only Law *allows* them to do so. This is particularly so for medication abortion, because any complications from that method arise only once patients take the second medication *outside* the clinic. Decl. of Mark D. Nichols, M.D. ("Nichols Decl.") ¶ 37, ECF No. 96.

or why physicians at Plaintiffs' health centers could not provide the required "oversight" as they already do with other comparably low-risk and straightforward procedures: by training APCs, auditing their performance, credentialing them for that procedure, and remaining available for consultation or referral. Ramesh Dep. 22:21–24:22, ECF No. 106-7; 87:22–88:20, ECF No. 101-1. Indeed, Dr. Lunsford herself concedes that the APCs who work for *her* perform comparable procedures and that they are perfectly capable of referring patients to her if needed to manage complications. Lunsford Dep. 308:13–309:2, 309:3–9, 311:8–14, ECF No. 101-2.

Dr. Lunsford's bare conjecture—not only unsupported, but contradicted by Plaintiffs' evidence and by Dr. Lunsford's own experience and practice—does not come close to creating a genuine dispute of material fact as to whether the Physician-Only Law is medically justified. *See Potomac Elec. Power Co.*, 312 F.3d at 649; *Tao of Sys. Integration, Inc.*, 330 F. Supp. 2d at 671; *1866.75 Board Feet*, 587 F. Supp. 2d at 746 (granting summary judgment to plaintiff where the opposing party had "attempt[ed] to create a genuine issue of fact by relying on the . . . speculation of a witness"); *see also Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 797 (7th Cir. 2013) (concluding that speculative and anecdotal medical witness testimony is insufficient evidence of abortion restriction's medical benefit: "One (doubtful) case in 29 years is not impressive evidence of the medical benefits of the Wisconsin statute").

2. The Hospital Requirement

Plaintiffs' opening brief showed that the Hospital Requirement provides no medical benefits. *See* Pls.' SJ Mem. at 6–9. Defendants concede that aspiration abortion is the same procedure whether performed in the first trimester, as Plaintiffs safely and legally do in their licensed abortion facilities, or in the early second trimester, when the Hospital Requirement bars these same facilities from providing that care. Pls.' SUMF ¶ 19. They concede that neither aspiration abortion nor D&E, the most common method of second-trimester abortion after

approximately fifteen to sixteen weeks LMP, needs to be performed in a sterile operating room. *Id*. ¶¶ 5, 6.[5] Defendants do not dispute that both methods of second-trimester abortion are safe; that complications are rare; and that when complications do occur, they can generally be managed in an outpatient clinic setting. *Id.* ¶ 20. They agree that in Virginia, procedures with risks comparable to or higher than the risks from abortion are routinely performed in outpatient clinics and physicians' offices, including the office of Defendants' medical expert. *Id.* ¶ 22.

Attempting to manufacture a dispute, Defendants cite irrelevant testimony by Dr. Lunsford about the idiosyncrasies of her practice: (1) Dr. Lunsford *induces labor* (a procedure with far higher risks than a D&E) for miscarriage management at a hospital for safety reasons; (2) she refers patients experiencing second-trimester miscarriages to a hospital for D&Es because she is not trained in D&Es and her facility lacks equipment necessary to perform this procedure; (3) complications rates rise with gestational age (though still remaining extremely low); and (4) Dr. Lunsford's office is not equipped to provide sedation. Defs.' Opp'n at 3–4 (citing Lunsford Dep. 77:8–12, 83:11–84:11, 89:4–90:1, 299:12–300:7, ECF No. 105-1; Rule 26(a)(2)(C) Expert Report of Elizabeth R. Lunsford, M.D. ("Lunsford Report") ¶ 37, ECF No. 105-3). None of this testimony demonstrates a benefit of the Hospital Requirement. Instead, it speaks only to reasons that Dr.

[5] Without evidence, Defendants suggest that medically necessary post-viability procedures may be more safely performed in a hospital. Defs.' Opp'n at 4. This assertion, even if true, is immaterial since Plaintiffs do not perform any post-viability procedures. McElwain Dep. 236:1–20, ECF No. 106-2. At any rate, this point provides no support whatsoever for a blanket hospital requirement applicable to *all* second-trimester abortions. *See Schimel*, 806 F.3d at 919–20 ("An abortion-restricting statute sought to be justified on medical grounds requires not only reason to believe . . . that the medical grounds are valid, but also reason to believe that the restrictions are not *disproportionate*, in their effect on the right to an abortion, to the medical benefits that the restrictions are believed to confer . . . ." (emphasis added)); *Planned Parenthood Se., Inc. v. Strange*, 9 F. Supp. 3d 1272, 1287 (M.D. Ala. 2014) ("[T]he court must determine whether, examining the regulation in its real-world context, the obstacle is more significant than is warranted by the State's justifications for the regulation.").

Lunsford—who is not an abortion provider—refers some patients to a hospital. This testimony does not create a disputed issue of material fact about the safety of the aspiration and D&E procedures performed in Virginia, either generally or as provided by Plaintiffs.

Searching for a disputed fact, Defendants next turn to statements in Dr. Lunsford's expert report that "*any surgical procedure* has the potential to quickly turn into an emergency that requires additional resources such as blood transfusion or laparoscopy" and that "[w]omen can lose up to 500 ml of blood in 1 minute during a *postpartum* hemorrhage." Lunsford Report ¶ 37 (emphases added). But that vague speculation does not even refer to second-trimester abortion, and the undisputed evidence shows that abortions provided in an outpatient setting only require hospital admission, surgery, or blood transfusion less than one-quarter of one percent of the time. Nichols Decl. ¶¶ 20–21. Dr. Lunsford's reference to postpartum hemorrhage only underscores the irrationality of requiring a hospital setting for second-trimester abortion when Virginia allows childbirth, which is far more dangerous, *Id*. ¶¶ 22–28, to be managed *by APCs outside a hospital setting*, *see* Va. Code Ann. § 54.1-2957.03. Dr. Lunsford's general concern that surgical procedures *can* result in complications requiring emergent care also does not create an issue of fact when undisputed evidence shows that patients with emergent complications from an abortion can be safely stabilized and transferred from an outpatient facility to a hospital. Nichols Decl. ¶ 122. Indeed, Defendant Dr. Oliver, the Virginia Health Commissioner with a deep background in public health, does not believe that the Hospital Requirement is medically justified. Tr. of Dep. of M. Norman Oliver, M.D., M.A. ("Oliver Dep.") 131:10–133:9, 135:2–4, ECF No. 107-11.

B. There Is No Genuine Dispute that the Challenged Laws Burden Abortion Access

Because there is no genuine dispute about the challenged laws' lack of medical benefit, those laws violate the Constitution if they impose even a slight burden on access to abortion. *See Whole Woman's Health*, 136 S. Ct. at 2310; *Van Hollen*, 738 F.3d at 798 ("The feebler the medical

grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous."). Plaintiffs have, however, put forth extensive undisputed evidence that the Physician-Only Law and the Hospital Requirement severely burden women seeking abortion by delaying—and in some cases, preventing—their access to that care.

Defendants concede that but for the Physician-Only Law, Plaintiffs would offer medication and aspiration abortion in more locations and at more appointment times. Pls.' SUMF ¶ 25; Decl. of Rosemary Codding ("Codding Decl.") ¶ 11, ECF No. 106-8. They agree that if a patient misses her opportunity to access abortion in the first trimester, the Hospital Requirement generally forces her to travel to either Richmond or Virginia Beach—or to another state—for a second-trimester abortion, costing her significantly more time and money. Pls.' SUMF ¶¶ 32, 43.[6] And Defendants concede that the limited number of second-trimester appointments at VLPP's Virginia Beach surgical center and at VCU's general hospital routinely delays patients' second-trimester procedures. *Id*. ¶¶ 28–30, 43. In fact, because of these limitations, VLPP's patients currently must wait nearly two weeks between their first and second appointments for a first-trimester abortion, and up to three weeks between appointments for a second-trimester abortion. Decl. of Paulette McElwain ("McElwain Decl.") ¶ 12, ECF No. 107-3. If not for the Physician-Only Law and

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[6] Defendants assert that second-trimester abortion may legally be provided at sites other than VLPP's Virginia Beach surgical center and VCU Hospital. That may be so, but record evidence demonstrates that those other sites provide second-trimester abortion care very rarely and only to established patients to treat serious medical conditions, such that second-trimester abortion care is not in fact available at those sites to the general patient population. Tr. of Dep. of Amy Hagstrom Miller ("Hagstrom Miller Reply Dep.") 65:13–67:5, attached hereto as Ex. 2; Tr. of Dep. of Dr. Jane Doe ("Doe Dep.") 20:1–3, 38:10–39:14, 100:22–101:2, 209:21–210:1, ECF No. 106-3; McElwain Dep. 236:6–13, ECF No. 106-2. And none of these other sites has been willing to lease an operating room to VLPP so that their staff can provide second-trimester care there. McElwain Dep. 217:14–218:16, ECF No. 106-2. Accordingly, Defendants' point is immaterial; for the overwhelming majority of women, and for all of Plaintiffs' patients, there are only two options in all of Virginia: VCU and VLPP's Virginia Beach surgical center.

Hospital Requirement, VLPP could see patients much sooner and, for second-trimester abortion care, at much lower cost to patients. McElwain Decl. ¶ 9; Second Decl. of Paulette McElwain ("McElwain Second Decl.") ¶ 4, attached hereto as Ex. 1; Pls.' SUMF ¶ 32.

Defendants concede that most women seeking an abortion already have children to care for, have low incomes and inflexible work schedules without paid leave, struggle to pay for basic necessities, and must travel to another county to find an abortion provider. Pls.' SUMF ¶¶ 35–37. They concede that arranging for this travel, fitting into limited appointment times, and pulling together funds for the cost of the procedure and related logistics (transportation, lodging, childcare) can be particularly difficult and can cause delay. *Id*. ¶¶ 36–38. And they concede that this delay, in turn, subjects women to increased medical risk, loss of medical options, loss of privacy, increased costs, financial strain, and other harms. *Id*. ¶¶ 32, 38–43, 45.

Rather than address this actual evidence, Defendants complain that Plaintiffs have failed to point out "specific Virginia women" for whom each law, standing alone, poses a burden. Defs.' Opp'n at 14. Notably, Defendants do not cite any legal authority that requires Plaintiffs to identify such "specific" individual patients burdened by particular restrictions taken in isolation, or for their suggestion that this Court ignore expert testimony based on statewide or nationally-representative research as "generic" and "hypothetical." *Id*. at 13. Nor do Defendants contend with the volumes of contrary authority. *See, e.g.*, *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 819–20 (7th Cir. 2018) (considering testimony from Dr. Jane Collins concerning statewide poverty-related data); *Planned Parenthood of the Heartland v. Reynolds ex rel. State*, 915 N.W.2d 206, 226 (Iowa 2018) (same); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 991 (W.D. Wis. 2015), *aff'd*, 806 F.3d 908 (7th Cir. 2015) (same); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1356–60 (M.D. Ala. 2014)

(citing testimony from Dr. Stanley Henshaw regarding nationwide data as to the effects of increased travel and from Dr. Sheila Katz regarding statewide poverty-related research); *see also Van Hollen*, 738 F.3d at 796 ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.").

At any rate, Plaintiffs *have* produced substantial, uncontroverted evidence of "specific" patients burdened by these laws. Ramesh Dep. 123:15–124:4, ECF No. 101-1 (testifying that patients are regularly delayed more than a week by limited number of second-trimester abortion appointments available at VCU); Tr. of Dep. of Shanthi S. Ramesh, M.D., MSCR, FACOG ("Ramesh Reply Dep.") 166:4–167:17, attached hereto as Ex. 3 (some second-trimester patients delayed *several* weeks by travel burdens and limited appointments available); Ramesh Dep. 124:11–20, ECF No. 101-1 (patients at VCU "not infrequently" bumped from the hospital schedule because hospital staff needed for a trauma case); 145:7–22, ECF No. 106-7; 147:3–11, ECF No. 106-7; 149:3–11, ECF No. 106-7; Ramesh Reply Dep. 167:9–15, 17; McElwain Dep. 65:17–21, ECF No. 101-3 (testifying that patients "routinely" miss the gestational age limit and must be referred out for second-trimester care); Tr. of Dep. of Rosemary Codding 97:8–100:1, ECF No. 101-8 (testifying that up to six percent of patients who obtain a pre-abortion ultrasound are then delayed past the gestational age limit before they can return for their procedure); Tr. of Dep. of Rosemary Codding ("Codding Reply Dep.") 185:14–187:1, attached hereto as Ex. 4; Doe Dep. 99:22–101:8, ECF No. 106-3; Hagstrom Miller Reply Dep. 63:16–68:2, 129:12–132:6 (listing examples of individual cases where women could not be seen at Plaintiff's health center because they were past the first-trimester gestational age limit); Tr. of Dep. of C.T. ("C.T. Reply Dep.") 112:14–117:19 (testifying that patients who are delayed past the first-trimester gestational age limit "[u]sually can't afford their [second-trimester] procedures in a hospital" so they are often

referred out of state), 168:16–169:1, 171:20–172:13 (describing patient's distress at learning that she would have to seek care elsewhere because she was past the first-trimester gestational age limit, and that the patient could not afford the cost of a second-trimester procedure at another facility), attached hereto as Ex. 5.[7] *See also* McElwain Second Decl. ¶ 3 (first-trimester patients delayed up to nearly two weeks, and in some cases pushed past the cut-off for medication abortion or pushed into the second trimester, largely because of Physician-Only Law); McElwain Decl. ¶ 12 (second-trimester patients delayed up to three weeks by Hospital Requirement).

Unable to deny that women seeking abortion in Virginia are burdened, Defendants quibble over the *degree* of burden imposed by these restrictions.[8] They harp on the fact that Plaintiffs have some capacity to provide first-trimester care (in many cases, limited to certain days and times), which is immaterial because Plaintiffs have shown that the Physician-Only Law nonetheless limits their capacity in ways that delay, obstruct and burden patients with constrained schedules and

[7] With no reference or record citation, Defendants also assert that "[n]ineteen other states have hospital requirement for later-gestation abortions." Defs.' Opp'n at 15. Assuming Defendants were relying on the Guttmacher Institute's "Overview of Abortion Laws," https://www.guttmacher.org/state-policy/explore/overview-abortion-laws, that figure is overinclusive because it includes several states with restrictions that begin only at later gestational ages than Virginia's Hospital Requirement does. And in any event, the undue burden standard is context-specific, Mem. Op. at 11, ECF No. 52, so the existence—and even the constitutionality—of facially similar laws sheds no light on whether *Virginia's* Hospital Requirement is unconstitutionally burdensome. *See Karlin v. Foust*, 188 F.3d 446, 485 (7th Cir. 1999) (reasoning that a given restriction could pass constitutional muster in one state but not another "depending on the interplay of factors such as . . . the number of physicians who perform abortions, the number of abortion facilities, the distances women must travel in order to reach an abortion facility, and the average income of women seeking abortions").

[8] Defendants deny that the Hospital Requirement is facially unconstitutional because it lacks an exception for cases in which a patient needs an immediate abortion because her health is at risk, Pls.' SUMF ¶ 8, but the statute they cite in support provides an exception only for abortions necessary to *save the patient's life*. Va. Code Ann. § 18.2-74.1. This exception does not cure the constitutional defect of an abortion restriction that lacks an exception to preserve the patient's *health*. *See Roe*, 410 U.S. at 165; *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 327–28 (2006).

limited resources.[9] They point out that VLPP is expanding its *family medicine* services to meet the needs of a newly-insured population, which is entirely irrelevant to this case, and that VLPP has hired an additional physician starting in July, while ignores testimony explaining why this new physician will not significantly increase abortion access at the Hampton site, McElwain Dep. 192:5-193:22, ECF No. 105-7. Finally, they take the fact that (because of the Physician-Only Law) VLPP is only *able* to treat a limited number of abortion patients at its Hampton clinic, McElwain Dep. 64:2–10, ECF No 105-7; Ramesh Dep. 199:15–200:4, ECF No. 106-7, and attempt to recast this as an admission that there is "minimal demand" for abortion care in that region, ignoring the fact that many Hampton-area patients are forced to travel to other clinics for care, *see* Ramesh Dep. 183:15–184:16, ECF No. 106-7.[10]

None of these manufactured issues is material; it is undisputed that the Physician-Only Law and the Hospital Requirement burden patients by significantly constraining their access to care. Because these two restrictions lack any evidence-based justification, the burdens they impose are "undue."

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[9] As discussed in Plaintiffs' opposition brief, the fact that Falls Church Health Center and Whole Woman's Health Alliance Charlottesville have no "wait lists" does not mean that patients at those health centers are not delayed: patients can book appointments rather than being placed on a wait list for future appointments, but those appointments are rarely immediate; patients are often delayed over a week between their ultrasound and their procedure. Pls.' Opp'n at 2, 14.

[10] Defendants also question whether the Hampton clinic treats underserved populations. Federal publications indicate it does. *See* Health Res. & Servs. Admin., MUA Find, https://data.hrsa.gov/tools/shortage-area/mua-find (last visited March 28, 2019) (Hampton City Service Area and Hampton / Newport News Service Area, as well as other surrounding regions, are U.S. Department of Health and Human Services (HHS)-designated Medically Underserved Areas, indicating a shortage of primary care health services for residents within those areas); Health Res. & Servs. Admin., HPSA Find, https://data.hrsa.gov/tools/shortage-area/hpsa-find (last visited March 28, 2019) (nearby Newport News and South Norfolk / Chesapeake City are HHS-designated High Needs Primary Care Health Professional Shortage Areas—areas in which primary care providers are practically inaccessible). Plaintiffs respectfully request that this Court take judicial notice of these materials. *See Sierra Club v. U.S. Dep't of the Interior*, 899 F.3d 260, 276 n.4 (4th Cir. 2018).

CONCLUSION

There is no actual dispute that the Physician-Only Law and Hospital Requirement are medically unjustified and harmful. Indeed, Defendant Dr. Oliver has agreed that restrictions such as these "mean[] that women who want[] to get these services [are] finding it more and more difficult to do so," and that such restrictions "should be done away with." Oliver Dep. 131:10–133:9, 135:2–4, ECF No. 107-11. For the foregoing reasons as well as those set forth in Plaintiffs' Memorandum of Law in support of their Motion for Partial Summary Judgment, this Court should enter summary judgment in favor of Plaintiffs on Counts III and IV; should declare unconstitutional the Hospital Requirement, the Physician-Only Law, and, as to medication and aspiration abortion provided by APCs and second-trimester abortion provided outside of hospitals, the general criminal ban on abortion; and should permanently enjoin the enforcement of those provisions.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on April 1, 2019 a copy of the foregoing has been served upon all counsel of record in this action by electronic service through the Court's CM/ECF system.

/s/ D. Sean Trainor
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