No. 17-51060

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

WHOLE WOMAN'S HEALTH, On Behalf of Itself, Its Staff, Physicians and Patients; PLANNED PARENTHOOD CENTER FOR CHOICE, On Behalf of Itself, Its Staff, Physicians, and Patients; PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, On Behalf of Itself, Its Staff, Physicians, and Patients; PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, On Behalf of Itself, Its Staff, Physicians, and Patients; ALAMO CITY SURGERY CENTER, P.L.L.C., On Behalf of Itself, Its Staff, Physicians, and Patients, doing business as Alamo Women's Reproductive Services; SOUTHWESTERN WOMEN'S SURGERY CENTER, On Behalf of Itself, Its Staff, Physicians, and Patients; NOVA HEALTH SYSTEMS, INCORPORATED, On Behalf of Itself, Its Staff, Physicians, and Patients, doing business as Reproductive Services; CURTIS BOYD, M.D., On His Own Behalf and On Behalf of His Patients; JANE DOE, M.D., M.A.S., On Her Own Behalf and On Behalf of Her Patients; BHAVIK KUMAR, M.D., M.P.H., On His Own Behalf and On Behalf of His Patients; ALAN BRAID, , M.D., On His Own Behalf and On Behalf of His Patients; ROBIN WALLACE, M.D., M.A.S., On Her Own Behalf and On Behalf of Her Patients

Plaintiffs-Appellees,

v.

KEN PAXTON, Attorney General of Texas, In His Official Capacity; FAITH JOHNSON, District Attorney for Dallas County, In Her Official Capacity; SHAREN WILSON, Criminal District Attorney for Tarrant County, In Her Official Capacity; ABELINO REYNA, Criminal District Attorney for McLennan County, In His Official Capacity

Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division
No. 1:17-cv-00690

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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STATEMENT REGARDING ORAL ARGUMENT

Appellees believe that oral argument is warranted because, while the Texas statute at issue clearly imposes an undue burden under applicable Supreme Court precedent, Appellants would have this Court ignore that precedent and reach a result that is unsustainable as a matter of fact and law. Oral argument is also warranted because this case involves the facial constitutional validity of a state law restricting women's fundamental right to access abortion and because the factual record in this case, following a five-day bench trial, is complex and voluminous.

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STATEMENT OF ISSUES

1. Did the District Court properly conclude under the Supreme Court's decisions in *Stenberg v. Carhart*, 530 U.S. 914 (2000), and *Gonzales v. Carhart*, 550 U.S. 124 (2007), that the ban on dilation and evacuation ("D&E") procedures is unconstitutional?

2. Did the District Court properly apply the undue burden standard, as clarified in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), and correctly conclude that the burdens imposed by the D&E ban, including that there is no fail-safe means by which physicians can ensure demise and that the ban forces women to undergo unnecessary medical procedures, outweigh the benefits asserted by the State, and therefore the ban is unconstitutional?

INTRODUCTION

Appellees are eight licensed abortion providers and three individual physicians who provide abortions in Texas. They challenge Texas Senate Bill 8 ("SB8" or "the ban") because it prohibits D&E procedures, the most common method of abortion after approximately 15 weeks of pregnancy. ROA.1592, 1601. SB8 would undermine the safety and availability of D&Es by requiring physicians to perform a medically unnecessary procedure to ensure fetal demise in every instance prior to performing the D&E procedure. ROA.63-89. Because there is no fail-safe way to ensure fetal demise, and because even attempting to do so subjects women to unnecessary and invasive medical procedures, as well as for many an extra trip to the clinic and an overnight delay, the burdens that would result from enforcement of the ban are severe and unprecedented.

The District Court found that the ban imposes an undue burden on a woman's right to choose abortion. ROA.1613.[1] In doing so, it properly articulated and applied the undue burden standard, which provides robust protection for the right to access abortion, regardless of what interests a state asserts in support of an

[1] The District Court held a five-day bench trial in which it heard testimony from 19 witnesses. The Court's findings of fact are based on the "greater weight of credible evidence," following its review of the entire record and its observation of the demeanor of the witnesses. ROA.1590-91, n.5. *See also Garcia v. Kerry*, 557 Fed. Appx. 304, 309 (5th Cir. 2014) ("the weight to be accorded expert opinion evidence is solely within the discretion of the judge sitting without a jury").

abortion restriction. In weighing the law's benefits against its burdens, the District Court gave proper weight to the State's asserted interests, guided in that task by the Supreme Court's decisions in *Stenberg* and *Gonzales.*

The ban creates an impossible situation in which physicians are required, on pain of criminal prosecution, to ensure demise prior to performing every D&E, even though there is no means by which they can safely do so in every case and no way to predict in advance whether demise will occur. Physicians cannot be expected to continue to provide D&E procedures in these circumstances. Even if physicians could continue to provide, SB8 requires women to accept an unnecessary demise procedure, which subjects them to additional risk, in order to exercise their constitutional rights. The State's interest in potential life cannot outweigh these immense burdens. The District Court did not err in holding the ban facially unconstitutional.

STATEMENT OF THE CASE

SB8 Bans D&E Procedures

No party disputes that SB8 bans standard D&E abortions unless performed after a separate fetal demise procedure. ROA.1592.[2] It is also undisputed that after approximately 15 weeks of pregnancy as dated from the first day of the

[2] As the District Court explained, it used the term "standard D&E" as that term was used by the Supreme Court in *Gonzales*, to distinguish between the common D&E procedures banned by SB8 and the less common "intact D&E" procedure. ROA.1589, n.3 (citing *Gonzales*, 550 U.S. 124 (2007).

woman's last menstrual period ("LMP"),[3] prior to viability, standard D&E without demise is the most common method of second-trimester abortion in the United States, including Texas. ROA.1592, 1601. Standard D&E is extremely safe and is routinely performed in an outpatient setting. ROA.1601, 1921-22.

In the first trimester, suction aspiration is used to perform instrumental abortions. ROA.1917, 1919. The provider first dilates the woman's cervix and then evacuates the contents of the uterus using a plastic tube attached to the suction device. ROA.1917. Like D&E, a suction procedure removes the pregnancy tissue in pieces; demise occurs as a result of the aspiration. ROA.1919, 2398.

In a standard D&E, physicians may use medications or dilators (graduated rods), and later in the second trimester, laminaria (seaweed sticks that absorb moisture and expand) to dilate the cervix just enough to be able to safely perform the procedure. ROA.1601, 1923, 2015, 2089. D&E prior to approximately 18 weeks is usually a one-day procedure. ROA.1601. For procedures after 18 weeks, laminaria are commonly used to achieve the necessary dilation. Because laminaria expand gradually, patients usually have them inserted and return the next day to complete the procedure. ROA.1923-24, 2015, 2089-91, 2111-13. The physician then evacuates the uterus using forceps, sometimes in combination with suction, to remove the fetus in pieces. ROA.1601. The development and

[3] All references to weeks of pregnancy are based on LMP.

widespread use of standard D&E is a major innovation in second-trimester abortion care, offering improved health benefits as compared with older methods. ROA.1601, 1922, 1925, 2798-806.[4]

The State asserts that physicians can avoid SB8's criminal penalties by performing a separate procedure to cause fetal demise prior to evacuating the uterus. ROA.1602. The State proposes three demise procedures: (1) digoxin injection; (2) potassium chloride ("KCl") injection, and (3) umbilical cord transection ("UCT"). ROA.1602.

As the District Court correctly found, there is no fail-safe way to ensure demise before every D&E procedure. ROA.1602-03, 1609. As a result, the State's proposed procedures do not solve the foundational constitutional problem created by the ban. In addition, none of these demise procedures generate any medical benefit for patients, all carry additional risks beyond the risks involved in the D&E procedure itself, and, in many cases, these procedures would be experimental. ROA.1602-03, 1610-11, 1915-16, 1942, 2091, 2208-09. The State attempts to support its arguments by asserting numerous facts that are contrary to the District Court's findings and unsupported by the record. In no instance has the State

[4] The only alternative abortion procedure available after approximately 15 weeks is induction of labor using medications, which must be performed in a hospital and can take anywhere from five hours to three days. ROA.1601-02. The State is not suggesting that induction is a reasonable alternative to D&E.

established that any findings of the District Court are clearly erroneous, and thus the State's alternative view of the facts should be rejected.

Aspiration Procedures Cannot Be Used for All Abortions Up to 17 Weeks

In order to minimize the sweeping impact of the ban, the State asserts that suction aspiration is possible in all cases up to 17 weeks. Applt's Br. at 4-8. At 15 weeks and sometimes sooner, however, most physicians use forceps during surgical abortion, bringing the procedure within the ambit of SB8. ROA.1601, 1920-21, 2017, 2176-77, 2388, 2800. While it may be possible in some circumstances to use only suction beyond 15 weeks, it will be impossible to do so for many patients. ROA.1601, 1920, 1978, 2224-25 2689, 2807. Even the one physician who testified that she could use suction up to 16.0 weeks, and would attempt to go through 16.6 weeks if the law took effect, stated that she could not always count on being able to rely on suction alone. ROA.2204-05, 2221-23. There is simply no way ahead of time to know if forceps will be necessary to safely complete the procedure. ROA.1601, 1920, 2807.

To the extent the State hypothesizes that suction could be used to cause demise in all procedures up to 17 weeks, even if forceps are used to remove some or all fetal parts, that suggestion should be rejected. The State cites to no study to support this claim, and no witness testified that it would be safe or possible to do so in every case. To the contrary, the record establishes that physicians may begin

a procedure using forceps because it is the safest way to complete the procedure, (ROA.1920, 2959-60, 1978), and for some patients, such as those with anatomical anomalies, using suction would impose safety risks. ROA.2223-24.

Digoxin Injection Is Not a Feasible Method of Demise

To attempt to cause fetal demise by digoxin, physicians administer the drug using a 3- to 4-inch spinal needle either transabdominally (through the woman's abdomen) or transvaginally (through the woman's vaginal wall or the cervix). ROA.1603, 1929-30, 2092-95, 2210-12. Digoxin injection is invasive and can be painful, (ROA.1603, 1929-30, 2092-95), often requiring a numbing injection, (ROA.1603, 2092-94), or even forms of intravenous sedation. ROA.1603, 2095, 2651.[5]

Digoxin injection is a separate procedure demanding a separate consent process addressing its risks and benefits. ROA.1928, 1943, 2109-10, 2791-94, 4314-16, 4309-10, 4444-65, 4486-771. Digoxin has numerous health risks over and above the risks of D&E alone, including infection and increased risk of

[5] The State incorrectly faults the District Court for stating that digoxin is administered without anesthesia (Applt's Br. at 10) when in fact the District Court noted that the pain of the injection "may be somewhat alleviated by injecting digoxin transvaginally, preceded by pain-relieving injections and moderate sedation." ROA.1603. The State fails to acknowledge that the means by which it might be possible to reduce the pain of the injection adds additional medically unnecessary procedures. Under the State's view, it is reasonable to require women to undergo either a painful procedure with one injection or a less painful process with two injections and moderate sedation.

hospitalization and bleeding. ROA.1604, 1938-40, 2030, 2452, 4308, 4327, 4438-43. The District Court properly found, and all experts agree, that digoxin is associated with a significantly increased risk of delivery prior to the patient's return to the healthcare facility ("extramural delivery"). ROA.1604, 1938-40, 2030, 2666-68. Digoxin is specifically contraindicated for women with certain heart conditions. ROA.1940, 2665.[6]

Factors such as fetal or uterine positioning, and common conditions such as obesity and fibroids, can make it "difficult or impossible" to carry out a digoxin injection for some women. ROA.1603-04, 1946-47, 2099-100, 2217, 2655-56.

Physicians generally allow 24 hours after the injection of digoxin to ensure demise prior to evacuating the uterus. ROA.1603, 1937, 1941, 1946, 2029, 2101, 2658-59. Contrary to the State's assertions, it is the standard of care and consistent with the evidence for patients to wait approximately 24 hours between receiving a digoxin injection and returning to the health center for a procedure. ROA.1602-05, 1937, 1941, 1946, 2029, 2101, 2209.[7] SB8 would therefore require women

[6] The State's assertion that there are "zero" reports of complications from fetal demise in the past five years, (Applt's Br. at 2, 9, 33), is misleading. Southwestern Women's Surgery Center produced medical charts and the corresponding complication forms to the state where complications occurred from digoxin. ROA.2810-11.

[7] The State's contention that digoxin causes demise within several hours, (Applt's Br. at 46), is contradicted by the weight of the evidence. The State cites only to testimony regarding an anecdotal case series, which was contradicted by the testifying experts with experience administering digoxin, and a Planned

seeking D&E procedures who would normally undergo dilation and completion of the procedure in one day (virtually all patients prior to 18 weeks) to make an additional trip to the clinic and delay the procedure by a day. ROA.1604, 1941, 2030, 2101, 2113. This additional delay is in addition to the requirement that women receive state-mandated information in-person at least 24 hours prior to the abortion, Texas Health & Safety code §171.012(a)(4), meaning that SB8 requires at least three separate trips to the clinic. ROA.1604-05. Unlike the trip for the mandatory counseling, however, it is important for women who have received a digoxin injection to return the next day in order to minimize the risks of extramural delivery and infection. ROA.1605, 1917, 1941, 2017, 2030, 2042, 2101, 2113, 2195. Thus, under SB8, women would have to be able to come to the clinic on two consecutive days in addition to their first trip to the clinic for counseling. This extra trip imposes a significant burden on all women, but especially on low-income women. ROA.1605, 1610-11, 2030, 2039-42, 2095, 2113, 2195.

Parenthood Federation of America ("PPFA") guidance document, which actually supports the district court's findings. The PPFA guidance, along with the published studies, clearly show that digoxin can take up to 24 hours to work. *See* ROA.1937, 1941, 1946, 2029-30, 2101, 2150, 2658-59. The time it takes digoxin to cause demise depends on several factors, including whether the physician can administer it intrafetally versus intraamniotically, and a physician cannot know ahead of time which will occur. ROA.1603, 1936-37, 1944, 2098-100. Accordingly, the District Court's finding that digoxin must be administered 24 hours before completion of the D&E procedure is not clearly erroneous. ROA.1603.

Some physicians may attempt to induce demise, some starting at 18 weeks and most at 20 weeks, by injecting digoxin into the fetus (intrafetal) or into the amniotic fluid (intraamniotic). ROA.1603, 1928-31, 2090-91, 2172, 2208, 2239. They do so because they believe it provides protection from liability under the ban on "partial birth abortions" or because, based on their personal experience, they believe that, at these later stages of pregnancy, digoxin's benefits outweigh the additional risks by making it easier to extract the fetal tissue. ROA.2091, 2109, 2207-09, 2239, 2791-94. While some physicians hold this view, according to the American Congress of Obstetricians and Gynecologists ("ACOG"), "[n]o evidence currently supports" the use of any demise procedure "to increase the safety of second-trimester medical or surgical abortion." ROA.1965.

Inducing demise with digoxin is virtually unstudied prior to 18 weeks, (ROA.1604, 1944-45, 1947-48, 2028, 2208-09), and no physician in Texas attempts to do so. ROA.4309-10, 4314-16, 4444-65, 4486-771. The District Court found that "[r]equiring digoxin injection prior to 18 weeks of pregnancy would . . . require women be subjected to an arguably experimental procedure." ROA.1604. The State takes issue with this finding, citing evidence in the record, but notably does not claim that the District Court's finding is "clearly erroneous." Applt's Br. at 36. The District Court did not, as the State suggests, fail to acknowledge the studies on which the State relies. Rather, based on the entire record, the District

Court found: "Only a few studies have included cases at 17 weeks, and no study has been presented to the Court on the efficacy, dosage or safety of injecting digoxin into women before 17 weeks of pregnancy." ROA.1604. This finding is supported by the record, (ROA.1944-45, 1990, 2660-61), and entitled to deference.[8] *See infra* at 20.[9]

The District Court correctly found, and all experts agree, that digoxin does not always cause demise. ROA.1603, 1936, 2099, 2214-15, 2647-48, 2779. The typical failure rate evidenced by expert experience and medical literature and found by the District Court is 5% to 10%. ROA.1603, 1936, 2099, 2214-15, 2647-48, 2779. Intrafetal injection has a lower failure rate than intraamniotic injection but is more technically difficult to achieve, particularly at earlier gestational ages. ROA.1930-31, 1936, 1944, 1991, 2093, 2098-99, 2101, 2103, 2452, 2649, 2757-58, 2773, 2789.

The State's suggestion that providers inject a second dose of digoxin should the first injection fail is untenable. ROA.1605, 1937-38, 1946, 2108-09, 2216-17.

[8] The State finds further fault with the District Court's findings because they are similar to those found by another court. Applt's Br. at 36-38. It is hardly remarkable, and certainly not grounds to find error, that courts faced with similar evidence, and here a fully developed factual record, come to similar conclusions.

[9] In a last-ditch effort to avoid the troubling finding that digoxin prior to 18 weeks is experimental, the State argues that even if digoxin cannot be used prior to 18 weeks, other methods of demise are available. Applt's Br. at 36-37. This argument fails because none of the State's other proposals provide a feasible means to comply with the ban.

Repeat injections are unstudied at any gestational age, and demanding a second injection whenever the first fails is nothing short of experimentation. ROA.1946. Additional injections subject women to all of the same risks as an initial injection, carry no benefits, can also potentially fail, and add yet another day of delay. ROA.1937-38, 1946, 2108-09, 2216-17.

Given digoxin injection's failure rate, experimental nature before 18 weeks, increased risk of significant complications, and increased travel burden, pain, and invasiveness, the District Court correctly found that digoxin injection is not a feasible method of inducing fetal demise before performing the evacuation phase of a standard D&E. ROA.1605.

KCl Injection Is Not a Feasible Method of Demise

The District Court correctly found that intracardiac injection of KCl is not a feasible method for Texas abortion providers to induce demise. ROA.1605-07. KCl injections are "very rare," ROA.1606, 1938, 1948, 1950-51, 2027, 2030-31, 2115-16, 2220, 2439-40, 2943-45, and cannot be integrated into the abortion clinic context.

Only specially trained physicians, the large majority of whom are Maternal-Fetal Medicine Specialists ("MFMs"), inject KCl directly into the fetal heart to cause demise, generally in the context of multi-fetal pregnancy reduction. ROA.1606, 1948-49, 2405-06, 2943-45. Those physicians do so using an

ultrasound machine to guide the insertion of a long surgical needle through a woman's abdomen, and uterine muscle, and then into the fetal heart, which is very small. ROA.1605, 2940. The District Court found that KCl injections are usually performed in a hospital setting, (ROA.1605, 1948-50, 2115-16, 2437-38, 2441-42, 2448, 2671, 2672, 2683), because they necessitate the use of hospital-grade ultrasound equipment and the assistance of a highly trained ultrasound technician. ROA.1948-50, 2115-16, 2437-38, 2448.

As with digoxin, these injections involve a separate medical procedure that is invasive and painful. ROA.1605, 1949-50, 2031. KCl must, however, be administered with more precision than digoxin and is associated with serious medical risks, including potentially fatal cardiac arrest, if the physician misses the fetal heart. ROA.1606, 1951-52, 2031, 2115-16, 2443-42, 2449-50, 2947. Other risks include infection and uterine perforation. ROA.1606, 1952, 2097-98, 2452, 2665. Though intracardiac KCl injections are generally effective at causing fetal demise, they are not always successful and in some cases cannot be administered because of fetal positioning and maternal conditions, including obesity and uterine fibroids. ROA.1607, 1950, 1953, 2450, 2680-82, 2942. These risks and the potential rate of failure increase when KCl is injected by unstudied hands outside the hospital setting. ROA.1605-06, 2442, 2947. For all these reasons, abortion providers state that they would not feel comfortable administering such injections

to their patients and that such a procedure is well outside the standard of care. ROA.1999, 2116-17.

The State's assertion that the District Court's KCl findings are clearly erroneous, (Applt's Br. at 37), fails in light of the record evidence before the Court. First, the State incorrectly asserts that the testimony of Dr. Berry, himself an MFM, that any physician who can do a digoxin injection can, without additional training, administer KCl, is "virtually unrefuted." Applt's Br. at 37. Dr. Berry, testified, however, that he has never trained another doctor to perform such an injection. ROA.2438. And in fact, another highly qualified MFM testified about his own experience performing KCl injections and the extensive training that MFM residents and fellows receive in how to perform them. ROA.2937-2945. *See also* ROA.1605, 1948-50, 2115-16, 2437-38, 2448. No Texas abortion provider has the specialized training to inject (or has ever injected) KCl, (ROA.1606, 2030, 2080, 2115, 2220, 2806), and the District Court correctly found that "it would be virtually impossible" for them to do so. ROA.1606.

In a further attempt to minimize the risks to women and the highly specialized skills needed to cause demise by KCl, the State suggests that physicians could inject KCl into other areas of the fetus. Again, this is a virtually unstudied approach that exposes women to additional risks. ROA.1951, 2000, 2442-43, 2616-17, 2940, 2945-47. The goal is always to inject KCl into the fetal

heart; injection by non-specialists elsewhere in the fetus would reduce the likelihood of demise and increase medical risks for the woman. ROA.2940, 2947. Given that physicians face criminal prosecution unless demise is achieved, not just attempted, the State's reliance on a less effective method of causing demise does not support their assertions regarding KCl.

For all of these reasons, the District Court correctly concluded that KCl injection is not a feasible procedure for Texas abortion providers to cause demise. ROA.1607.

UCT Is Not a Feasible Method of Demise

The District Court properly found that, due to its experimental and risky nature, UCT is also not a feasible method of causing fetal demise. ROA.1608-09. To perform UCT, the physician dilates the woman's cervix enough to allow the passage of instruments. ROA.1607, 1954, 2114. Using ultrasound for guidance, the physician then punctures the amniotic membrane, inserts an instrument into the uterus, grasps the cord, and cuts it. ROA.1607, 1954, 2114. This often involves using instruments to search and probe the uterus in an attempt the grasp the cord. ROA.1954-61, 2031-33, 2105-06, 2114-15. The physician must then wait for the fetal heart activity to cease, which can take up to 10 minutes, after which the physician performs the evacuation phase. ROA.1607, 1962.

As with injections of either digoxin or KCl, requiring UCT in every case would add an additional step to the standard D&E procedure. As experienced D&E providers testified and the District Court correctly found, additional passes of instruments into the uterus to find and grasp and cord increase the risk of infection, hemorrhage, cervical injury, and uterine perforation. ROA.1608, 1960-61, 2032, 2114, 2978. Waiting for fetal demise prolongs the patient's exposure to anesthesia and increases risk of bleeding. ROA.1962.

UCT is not a feasible way for physicians to comply with SB8. ROA.1607. The success of the procedure depends on the location of the cord, and only in a small number of cases is the cord easily reachable. ROA.1607-08, 1954, 2031, 2106. In other cases, the cord is located beyond the fetus and unreachable with instruments. ROA.1607-08, 2106, 2114-15. Other factors that make UCT technically difficult, and sometimes impossible, include lack of clear visualization once the amniotic fluid has been removed, and the shrinking of the uterus during the procedure, particularly at earlier gestations. ROA.1607-08, 1960, 2032-33, 2106, 2113-15, 2216. A physician simply cannot know ahead of time if he or she will be able to safely grasp the cord, (ROA.1607-08, 2113-14, 2264), and the evacuation phase of the D&E procedure must be completed once begun to avoid serious risk to the patient. ROA.2222-23.

With the exception of Dr. Wallace, who has attempted UCT on rare occasions with limited success, (ROA.2105-06), none of the abortion providers in Texas who testified in this case have ever attempted UCT for the purpose of causing fetal demise. ROA.2031, 2216, 2806-07. All of these physicians who testified expressed concern with both the reliability and safety of the procedure. ROA.2114, 2032-33, 2105-06, 2216.

The State tries to rely on the single study on UCT as a method of fetal demise. The extremely limited literature on the procedure alone is troubling, and the lone study has severe limitations, (ROA.1608, 2608, 1956-57, 2686-88), leading the District Court to conclude that "[u]mbilical cord transection is not a feasible method of demise as it is essentially an experimental procedure." ROA.1608.

As the District Court correctly found: there is no fail-safe way to ensure demise before every D&E procedure, none of these procedures generate any medical benefit for patients, all of these procedures carry risks beyond any risk involved in the D&E procedure itself, and, in many cases, these procedures would be experimental. ROA.1602-03, 1609-11, 1915-16, 1942, 2091, 2208-09.[10]

[10] The State's claim that women prefer fetal demise is unsupported by the record. The State's expert, Dr. Chireau, cited one study for the proposition that 92% of women preferred demise prior to a procedure, (ROA.2612-13), but in that study, only 35% of the participants listed a desire for demise before the procedure as a reason they would choose demise, while others indicated they would do so because

SUMMARY OF THE ARGUMENT

SB8 demands that women undergo an invasive and unnecessary procedure before they can exercise their constitutional right to terminate a pre-viability pregnancy. ROA.1611. The undue burden standard set forth in *Planned Parenthood of Sourtheastern Pennsylvania v. Casey*, 505 U.S. 833, 851-53 (1992), and affirmed in *Whole Woman's Health*, 136 S. Ct. at 2309-10, provides robust protection of that right regardless of the state's asserted interest.

The District Court correctly applied this standard, considering the burdens imposed by SB8 together with its proposed benefits, and appropriately found that SB8 effectively renders unavailable the most common second-trimester abortion procedure after approximately 15 weeks. ROA.1609-10. As the District Court found, none of the State's proposed methods of causing demise are feasible methods of complying with SB8 because none are 100% effective and all impose additional medical risks, delays, and other burdens on women. ROA.1603-04, 1609-10.

Alongside these findings, the District Court appropriately held that *Gonzalez* and *Stenberg* are directly on point—to the extent a law reaches the pre-viability

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they thought it would make the procedure easier or less painful (neither of which is borne out by the evidence). ROA.503. In fact, another study, also relied on by Dr. Chireau, found that, when given the choice, a large majority of patients expressed discomfort with inducing fetal demise and declined it because of a desire to avoid unnecessary medication. ROA.2670-72 (81% of women refused to receive digoxin when given the option).

standard D&E performed without demise, it imposes an undue burden. ROA.1594-95; *Gonzales*, 550 U.S. at 164-65; *Stenberg*, 530 U.S. at 939.

The State attempts to obscure the Supreme Court's consistent articulation of the undue burden standard by arguing that an assertion of fetal interests calls for, in essence, rational basis review. Alternatively, the State argues that the State's side of the scale in the undue burden balancing should be accorded significant weight based on its assertion of fetal interests even without any underlying proof that such interests are actually served. Both of these arguments are incorrect under *Casey* and *Whole Woman's Health*. *Casey* describes a unitary standard: "a statute which, while furthering the interest in potential life or *some other valid state interest*, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." 505 U.S. at 877.

The District Court correctly determined that the group of women for whom SB8 is an actual rather than irrelevant restriction is comprised of all women after approximately 15 weeks of pregnancy seeking a D&E abortion, (ROA.1610-13), not simply the women for whom demise is ineffective. Even if physicians could continue to provide D&Es, women need not undergo an unconstitutionally imposed procedure before they even *count* as women burdened by SB8 for the purposes of the large fraction analysis.

STANDARD OF REVIEW

A District Court's legal conclusions are reviewed *de novo*, and its findings of fact for clear error. *Guzman v. Hacienda Records & Recording Studio, Inc.*, 808 F.3d 1031, 1036 (5th Cir. 2015). Factual determinations will stand so long as they are plausible. *Id.* Clear error review "plainly does not entitle a reviewing Court to reverse the finding of the trier of fact simply because it is convinced that it would have decided the case differently." *Anderson v. City of Bessemer City*, 470 U.S. 564, 573 (1985). "The clearly erroneous standard of review following a bench trial requires even 'greater deference to the trial Court's findings when they are based upon determinations of credibility.'" *Guzman*, 808 F.3d at 1036 (citations omitted).

ARGUMENT

I. SB8 Imposes an Undue Burden on Women Seeking D&E Procedures.

The Supreme Court has consistently held that a woman's right to end a pregnancy is a fundamental liberty protected by the Fourteenth Amendment. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2309-10; *Casey*, 505 U.S. at 851-53. Laws that infringe on this right are subject to the undue burden standard set forth in *Casey*, under which a law is unconstitutional if it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877 (joint opinion of O'Connor, Kennedy & Souter, JJ.). In

Whole Woman's Health, the Supreme Court explained that "[t]he rule announced in *Casey* . . . requires that Courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. at 2309. When the burdens exceed the benefits, they are undue. *See id*. at 2300, 2310.

A. The District Court Properly Articulated the Undue Burden Standard.

1. The Undue Burden Standard Does Not Vary Based on the State's Asserted Interest in Enforcing an Abortion Restriction.

The State argues that the District Court erred in applying the undue burden standard in the manner prescribed by *Whole Woman's Health*. Applt's Br. at 41. In doing so, it asks this Court to ignore the controlling decision in *Whole Woman's Health* and adhere to an interpretation of the undue burden standard that the Supreme Court expressly rejected.

The State contends that the Supreme Court has created two distinct undue burden standards—a "health-benefit-balancing test" that applies only when a state claims to be advancing an interest in patient health and a different test when it claims to be advancing an "interest in respecting unborn life." Applt's Br. at 41-42. Although it does not clearly articulate what standard should apply to laws purportedly furthering this latter interest, the State's arguments make plain that it seeks to have this Court apply a standard that was explicitly rejected in *Whole Woman's Health*, under which the Court simply defers to the State's claims that

the law furthers its asserted interests. Applt's Br. at 17-25. Alternatively, at points the State suggests a different "balancing" test that skews the weight assigned to its interests, regardless of any proof as to whether or to what extent the interests are actually furthered, to the point that the burdens on women must be virtually insurmountable in order to be undue. Applt's Br. at 26-27. This too ignores the language and the logic of the Supreme Court's abortion jurisprudence.

Neither *Casey* nor *Whole Woman's Health* suggests that a different standard applies depending on the interests the State asserts. *Casey* describes a unitary standard that applies regardless of the state's asserted interest. *See Casey*, 505 U.S. at 877 ("[A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends."). *Casey* applies this standard to all of the restrictions under review, including the spousal notification requirement, which was related to the state's interest in potential life, *id.* at 887-98; *see also Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) ("'a law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability' is unconstitutional") (quoting *Casey*, 505 U.S. at 877); *Whole Woman's Health*, 136 S. Ct. at 2309 (explicitly noting that "*Casey* . . . perform[ed] this balancing with respect to a spousal notification provision" and "with respect to a parental

notification provision," both of which relate to fetal life). The bifurcated test advocated by the State would allow a state to transform an unconstitutional law into a constitutional one simply by changing its asserted rationale—effectively obliterating the Supreme Court's mandate for meaningful review of abortion restrictions.

Although *Whole Woman's Health* concerned laws related to patient health, the Supreme Court relied on *Casey*'s analysis of laws related to potential life when explaining the balancing required by the undue burden standard, explicitly noting that "*Casey* . . . perform[ed] this balancing with respect to a spousal notification provision" and "with respect to a parental notification provision." 136 S. Ct. at 2309. Notably, when this Court previously applied the same deferential test the State advocates for here, *see Whole Woman's Health v. Cole*, 790 F.3d 563, 567 (5th Cir. 2015) (per curiam), *modified*, 790 F.3d 598 (5th Cir. 2015), the Supreme Court reversed, explaining that the "Court of Appeals' articulation of the relevant legal standard is incorrect," *Whole Woman's Health*, 136 S. Ct. at 2309.

Among other things, the Supreme Court held that this Court was wrong to treat the undue burden standard as a variant of rational basis scrutiny requiring substantial deference to legislative judgment. *Id.* ("[It] is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic

legislation is at issue."). *Id.* The Supreme Court explained that the "Court of Appeals' approach simply d[id] not match the standard that this Court laid out in *Casey*, which asks courts to consider whether any burden imposed on abortion access is 'undue.'" *Id.* at 2310.

The District Court therefore correctly rejected this argument. ROA.794 (temporary restraining order). Indeed, no Court to date has accepted the invitation to ignore what Supreme Court precedent makes clear: that the undue burden test "applies regardless of a state's asserted interests." *Id.*; *see Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1055 (E.D. Ark. 2017) (argument that the Supreme Court has created two distinct undue burden tests is "inconsistent with controlling precedents"), *appeal docketed*, No. 17-2879 (8th Cir. Aug. 28, 2017); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, In State Dep't of Health*, 273 F. Supp. 3d 1013, 1020 (S.D. Ind. 2017) (argument "that different standards are applied in *Casey* and *Whole Woman's Health*—is belied by those decisions"), *appeal docketed*, No. 17-1883 (7th Cir. April 27, 2017); *Whole Woman's Health v. Hellerstedt*, 231 F. Supp. 3d 218, 228 (W.D. Tex. 2017) ("[The State's] argument a different test applies when the State expresses respect for the life of the unborn is a work of fiction, completely unsupported by reading the sections of Supreme Court opinions [the State] cites in context."), *appeal dismissed*, No. 17-50154 (5th Cir. Dec. 6, 2017). *See also W. Ala. Women's Ctr. v. Miller*, __ F. Supp. 3d __, No.

2:15CV497-MHT (WO), 2017 WL 4843230, at *5 (M.D. Ala. Oct. 26, 2017) ("the State's interests—however legitimate—cannot 'place[ ] a substantial obstacle in the path of a woman's choice [to have a pre-viability abortion].' *Whole Woman's Health*, 136 S. Ct. at 2309. And a State's interests surely cannot swallow the right.") (additional citations omitted)).

In sum, no plausible reading of the Supreme Court's abortion jurisprudence supports the State's argument that laws related to a state's interest in potential life are exempt from the analysis required by *Whole Woman's Health*.

2. The Undue Burden Standard Requires Courts to Assess the Relative Burdens and Benefits the Law Creates.

Aside from its incorrect assertion that a different undue burden analysis applies when it asserts an interest in potential life, the State's primary argument is that the District Court did not give adequate weight to the State's interests in undertaking the balancing required by *Whole Woman's Health*. Applt's Br. at 11, 26. This argument fails because, as shown by the evidence in this case, the burdens imposed by the ban exceed constitutional limits even if the State's interests are accorded the weight the State would like, *see infra* at 40-48, and because it relies on an incorrect formulation of the balancing required under *Whole Woman's Health*.

An "undue burden" is one that imposes a "substantial obstacle" on women's access to abortion. *Casey*, 505 U.S. at 877 ("A finding of undue burden is a

shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."). These terms are relative, not absolute: whether or not an obstacle is substantial—and a burden therefore undue—must be judged in relation to the benefit the law provides. *See Whole Woman's Health*, 136 S. Ct. at 2309 ("The rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer."). Where a law's burdens exceed its benefits, those burdens are, by definition, undue, and the obstacles they embody are, by definition, substantial. *See id.* at 2300, 2309-10, 2312, 2318. As clarified by *Whole Woman's Health*, any material, not *de minimus* burden may constitute a "substantial" obstacle if it outweighs the benefits the law actually furthers. Thus, contrary to the State's assertions, (Applt's Br. at 40), the District Court did not err in construing the term "'substantial' to mean no more and no less than 'of substance.'" In any event, the evidence here established that the burdens imposed by SB8 are substantial under any measure. *See, e.g.*, ROA.1610.

The Supreme Court has explained that in applying the undue burden standard courts must afford only limited deference to the legislature, especially where, as here, there are no legislative findings. It is the job of the district court to thoroughly consider the record evidence and then weigh the benefits of a law against the burdens imposed. *Whole Woman's Health*, 136 S. Ct. at 2310

("*Gonzales* went on to point out that the '*Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake*.'") (citing *Gonzales*, 550 U.S. at 165 (emphasis in original)). Thus, the State's suggestion that the Court should defer to it on questions of medical uncertainty, (Applt's Br. at 26), is directly contrary to *Whole Woman's Health*, 136 S. Ct. at 2310 ("The statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court's case law. Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings.").

In addition, courts must examine the impact of a challenged law in its real-world context. *Id.*, at 2309-10, 2313, 2318; *see also Casey*, 505 U.S. at 888-91; *W. Ala. Women's Ctr.*, 2017 WL 4843230, at *5 (citations omitted); *Jackson Women's Health Organization v. Currier*, 760 F.3d 448, 458 (5th Cir. 2014) (Court must "look to the entire record and factual context in which the law operates").

In *Whole Woman's Health*, the Court noted that "for a district court to give significant weight to evidence in the judicial record is consistent with this Court's case law." 136 S. Ct. 2310. The Court went on to explain that in "consider[ing] the evidence in the record" and "weighing the asserted benefits against the burdens," "the District Court applied the correct legal standard." *Id.* at 2310.

Here, the District Court did the same, and its findings are not clearly erroneous. The State's proposed analysis and its version of the facts should therefore be rejected.

The State's argument that the District Court gave too little weight to its interests is founded not only on its flawed articulation of the applicable legal standards, but also on its skewed version of the facts. Virtually ignoring the District Court's well-supported findings, and presenting its evidence as if this Court's review was *de novo*, the State paints a distorted picture of the record below—minimizing the burdens of the law and exaggerating its asserted benefits. The State's treatment of the factual record as if every inference should be drawn in the State's favor is merely a repackaging of its argument that, when potential life interests are asserted, the Courts should defer to the State's assertions that the law advances its interests. As noted, this argument was explicitly rejected in *Whole Woman's Health*.

B. The District Court Correctly Applied the Undue Burden Standard in Holding the D&E Ban Unconstitutional.

1. The District Court Properly Relied on *Stenberg* and *Gonzales* in Concluding the Ban Imposes an Undue Burden.

In assessing SB8, the District Court properly relied on cases in which the Supreme Court has already employed searching judicial scrutiny in striking down laws that ban the most common method of abortion in the second trimester.

ROA.1594-97. Directly controlling Supreme Court precedent makes clear that a ban like SB8 is unconstitutional under the undue burden standard.

In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 77-79 (1976), the Supreme Court held that a law banning the then-most common method of second-trimester abortion was unconstitutional. The Court considered "the prevalence" of the banned method, that there were severe limitations on the availability of alternatives to that method, that one such alternative was used only on an experimental basis, and that, "as a practical matter, [the ban] forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." *Id*. at 77-79.

In *Stenberg*, the Court struck down a law purporting to ban the intact D&E procedure, so-called "partial-birth abortion," because the law was so broadly written that it banned not only intact D&E, but also D&E, which the Court recognized as the most common abortion procedure in the second trimester. 530 U.S. at 945-46. Because the law banned D&E, the Court held that it imposed an undue burden on a woman's right to abortion and was therefore unconstitutional. *Id.*

In *Gonzales*, the Supreme Court affirmed that a state cannot ban the D&E procedure. The Court in *Gonzale*s interpreted a federal ban on so-called "partial-birth abortion" to reach only intact D&E procedures, not the standard

D&E procedure, and held that the constitutionality of the ban rested on the continued availability of the "prototypical" D&E. 550 U.S. at 153, 164, 166-67. *See also id.* at 165 (explaining that the ban at issue did not impose a substantial obstacle because it allowed for the continued availability of the "commonly used and generally accepted [D&E] method"). "*Gonzales* left undisturbed the holding from *Stenberg* that a prohibition on D&E amounts to an undue burden on a woman's right to terminate her pregnancy." *Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323, 336-37 (6th Cir. 2007).

The District Court properly looked to *Stenberg* and *Gonzales* for guidance and, finding no material distinction between the facts here and in *Stenberg*, concluded, as did the Supreme Court, that a ban on D&E procedures imposes an undue burden. ROA.1596. Notably, in *Stenberg*, the Supreme Court accepted that after 20 weeks "some physicians" use either digoxin or KCl to induce fetal demise prior to a D&E procedure. 530 U.S. at 925. And the *Stenberg* Court described the State's asserted interests as "show[ing] concern for the life of the unborn, prevent[ing] cruelty to partially born children, and preserv[ing] the integrity of the medical profession." 530 U.S. at 930-31 (inner quotes omitted). In other words, virtually the same interests the State asserts here. Thus, the State's argument that the District Court, based on the extensive record before it, erred in reaching the same conclusion rings hollow.

The State nonetheless relies on *Gonzales* to support its claim that the District Court gave too little weight to its asserted interests. But *Gonzales* supports, rather than undermines, the District Court's approach. While it is correct that the *Gonzales* Court recognized the legitimacy of the same interests that the State asserts here, it is critical that it did so in the context of the narrow ban before it. What the State fails to acknowledge is that *Gonzales* sharply distinguished between standard and intact D&E, noting that "No one would dispute that, for many, the D&E is a procedure itself laden with the power to devalue human life. Congress could nonetheless conclude that the type of abortion procedure proscribed by the Act requires specific regulation because it implicates additional ethical and moral concerns that justify a special prohibition." 550 U.S. at 158. Thus, the Court concluded: "There would be a flaw in this Court's logic, and an irony in its jurisprudence," if it were "to conclude a ban on both D&E and intact D&E was overbroad and then to say it is irrational to ban only intact D&E." 550 U.S. at 160. The interests that were insufficient in *Stenberg* to support a ban on all D&E procedures were adequate to support the narrow ban upheld in *Gonzales*. In this way, the *Gonzales* Court both distinguishes and reaffirms *Stenberg*.

Thus, contrary to the State's argument, *Gonzales* cannot be read to give the State free reign to ban D&E procedures by characterizing the procedure as brutal and asserting that it advances the same interests considered in both *Stenberg* and

Gonzales. If that were true, the next logical step would be to ban suction procedures, which, as the evidence establishes, also dismember the fetus, but which the State candidly states is permissible at the same gestational ages at which it would require fetal demise prior to a D&E procedure. Applt's Br. at 5-6.

The State's misplaced reliance on *Gonzales* does not establish error by the District Court. Rather, the District Court properly applied Supreme Court precedents, explaining that, in light of "the Supreme Court's determinations in *Stenberg* and *Gonzales* – that laws with the effect of banning the standard D&E procedure [before fetal demise] result in an undue burden upon a woman's right to have an abortion and are therefore unconstitutional – the Court concludes, based on existing precedent alone, the Act must fail." ROA.1596. *See also id.* at 1612 ("*Stenberg* and G*onzales* lead inescapably to the conclusion that the State's legitimate interest in fetal life does not allow the imposition of an additional medical procedure on the standard D&E abortion.").[11]

The District Court is not alone. Courts have consistently struck down laws that ban D&E procedures. *W. Ala. Women's Ctr. v. Miller*, 217 F. Supp. 3d 1313,

[11] The State incorrectly asserts that the District Court balanced the burdens of the law against benefits to women's health, rather than the potential life interests it asserts. Applt's Br. at 42. The Court correctly identifies the State's asserted interests. ROA.1599, 1609, 1611. The Court's references to maternal health, (*see, e.g.*, ROA.1603), only make clear that the medical procedures the State would foist on women do not benefit their health, so the Court treated that fact as relevant to the burden side of the balance.

1319-20, 1341 (M.D. Ala. Oct. 27, 2016) (permanently enjoining law similar to SB8); *Hopkins*, 267 F. Supp. 3d at 1034, 1064 (preliminarily enjoining a similar D&E ban), *appeal docketed*, No. 17-2879 (8th Cir. Aug. 28, 2017); *Hodes & Nauser v. Schmidt*, 368 P.3d 667, 677-79 (Kan. Ct. App. 2016) (affirming preliminary injunction against a similar D&E ban), *argued*, No. 114,153 (Kan. Mar. 16, 2017); *Nova Health Sys. v. Pruitt*, No. CV-2015-1838, slip op. at 5, 8 (Okla. Cty. Dist. Ct. Oct. 28, 2015), www.oscn.net/dockets/GetDocument.aspx?ct=oklahoma&bc=1031376872&cn=CV-2015-1838&fmt=pdf (granting a temporary injunction against a similar D&E ban); *see also Hope Clinic v. Ryan*, 249 F.3d 603, 606 (7th Cir. 2001) (per curiam) (holding state law prohibiting D&E unconstitutional); *Causeway Med. Suite v. Foster*, 221 F.3d 811, 812 (5th Cir. 2000) (law prohibiting D&E created an unconstitutional burden); *Eubanks v. Stengel*, 224 F.3d 576, 577 (6th Cir. 2000) (per curiam) (same); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 145-46 (3d Cir. 2000) (same); *A Choice for Women v. Butterworth*, No. 00-182—CIV-LENARD/TURNOFF, 2000 WL 34403086, at *3-6 (S.D. Fla. July 11, 2000) (permanently enjoining law prohibiting D&E); *Daniel v. Underwood*, 102 F. Supp. 2d 680, 685 (S.D. W. Va. July 7, 2000) (same).

2. The District Court Properly Balanced SB8's Burdens and Benefits and Concluded That the Ban Imposes an Undue Burden on Women Seeking D&E Procedures.

The District Court properly concluded, based on undisputed evidence, that the standard D&E procedure is a safe method of abortion, and the most common method of second-trimester abortion after approximately 15 weeks, (ROA.1592, 1601), and, on these grounds alone, SB8 is unconstitutional. *See supra* at 30.

Rather than trying to show that SB8 actually and meaningfully advances the State's interests (i.e., one side of the balance), the State takes a "me too" approach, relying heavily on the *Gonzales* decision without acknowledging critical distinctions that wholly undermine that reliance. It also points to evidence that the District Court rightfully discounted and in any event failed to establish any actual benefits that would flow from the ban.

Despite this failure on the benefits side, the District Court went on to assess each of the fetal demise procedures offered by the State (i.e., the other side of the balance). Critically, what the State describes in this Court as "alternative methods" *see* Applt's Br. at 29, 32, are not alternatives to the D&E procedure at all, but are rather separate, additional medical procedures that the State seeks to impose on all women seeking D&E abortions. ROA.1603-04. The District Court, based on the full evidentiary record, properly concluded that the proposed methods of demise are neither feasible nor reasonable for all women and that forcing physicians to

perform these often-experimental procedures would impose substantial obstacles on women. ROA.1605, 1606, 1608-09. The State's attempt to relitigate the factual issues resolved by the District Court to both downplay the burdens and overstate the benefits of the ban is both inappropriate and unavailing. As the District Court recognized, the burdens on women imposed by the ban are so enormous as to vastly outweigh any benefit to the state. *Id.* Accordingly, SB8 cannot survive constitutional review.

C. The State Did Not Establish That Any Benefits Resulting from the D&E Ban Outweigh the Burdens It Creates.

Against the significant, indeed unprecedented burdens that women seeking D&E procedures would have to endure under SB8, the State asserts that the ban advances five interests. The District Court, based on the record evidence, properly concluded that these asserted benefits did not outweigh the clearly established burdens and correctly concluded that the law imposes an undue burden. ROA.1611.

The State's first asserted interest is in prohibiting a "brutal" procedure. Applt's Br. at 17-20. The State's graphic descriptions of the standard D&E procedure do not, however, overcome the fact that the Court in *Stenberg*, fully acknowledging what a D&E procedure entails, nonetheless found that a ban on that procedure imposes an undue burden. *See Stenberg*, 530 U.S. at 925 (during a D&E procedure "dismemberment or other destructive procedures are more likely to be

required"). As the District Court observed, while the details of a standard D&E procedure are "graphic and distasteful," it "does not remove weight" from the burdens of the law or "tip the balance in the State's favor." ROA.1601. The Supreme Court's suggestion in *Gonzales* that, as a result of the ban on intact D&E procedures "the medical profession . . . may find different and less shocking methods" of second trimester abortion, 550 U.S. at 160, cannot be taken, as the State would have it, (Applt's Br. at 20), as the Court's endorsement of unnecessary and experimental medical procedures which are themselves "horrific." ROA.2873.

The second asserted interest is that the ban will lead women to make more informed choices. Apptl's Br. at 20-22. While the Supreme Court in *Gonzales* suggested such might be true in considering the narrow ban on intact D&E at issue, to suggest the same applies to a ban on standard D&E stretches credulity. The decision in *Gonzales* was founded in large part on the continuing availability of the standard D&E procedure or, in the alternative, fetal demise when a physician believed the intact procedure provided health benefits for the patient. 550 U.S. at 164. In other words, the ban on intact D&E could arguably serve an interest in informed decision-making when other reasonable alternatives were available. Whatever tenuous link may exist in that context, however, there is no basis on which to argue that a ban on both intact D&E and standard D&E, leaving only no

abortion or an unnecessary medical procedure, yields more informed decision-making.

Third, the State argues that the ban is "supported by societal and medical ethics." Applt's Br. at 22-23. As the evidence showed, doctors have an ethical obligation not to experiment on their patients or subject them to procedures that have no medical benefit. ROA.1610-11, 1910, 1968, 2948. Indeed, the District Court was "unaware of any other medical context that requires a doctor in contravention of the doctor's medical judgment and the best interest of the patient to conduct a medical procedure that delivers no benefit to the woman." ROA.1610. All providers in Texas would face an untenable choice between providing care while violating two central tenets of medical ethics—beneficence and patient autonomy—or being unable to continue providing much-needed care. ROA.2948. At least three physicians have decided to stop providing abortions beginning at 17 weeks or earlier should the Act go into effect. ROA.2221-23, 2758. The record therefore establishes that SB8 actually violates principles of medical ethics.[12]

[12] The State's sole witness on this point, Dr. Curlin, is of the opinion that any physician who performs any abortion is acting unethically, (ROA.2465-66, 2478, 2479), and thus his opinion regarding the provision of D&E procedures offers no support to the State. Moreover, his opinions are far removed from the ethical judgments of major U.S. medical organizations, (ROA.2480-81), are based on Christian traditions as opposed to medical ethics, (ROA.2477-78), and are grounded in unsupported assumptions about society's views on the D&E

Fourth, the State argues that its interests are "reinforced" by "considering the context of the State's abortion laws among the international community." Applt's Br. at 23. The Supreme Court has never identified alignment with the laws of other nations as a benefit to be balanced against burdens on women's right to access abortion, but, in any event, the trend in international law is towards liberalization, not restriction. *See* Rachel Rebouché, *Abortion Rights as Human Rights*, 25 Soc. & Legal Stud. 765, 766 (2016). And here, the most the State's expert was willing to say was that in his opinion SB8 would move Texas law "in a very incremental fashion" in what he believes (albeit incorrectly) to be the law of the majority of countries in the world. ROA.2514. This weak claim cannot add meaningful weight to the benefits side of balance.

Moreover, as the evidence demonstrates, the State's assertion that "92% of the countries in the world already ban second-trimester abortion outright," Applt's Br. at 24, is both misleading and ultimately irrelevant. The State's expert failed to account for the many broad exceptions to numerous so-called "more restrictive" international laws, failed to present even one example of a ban on a particular abortion procedure, and is not an expert in the laws of other nations.

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procedure. ROA.2479-81. Dr. Curlin also acknowledged the weaknesses in his own position, stating that it would be inconsistent with medical ethics to force a pregnant woman to undergo an invasive procedure to benefit the fetus, (ROA.2483), and testifying that the fetal demise procedures required by SB8 are themselves unethical. ROA.2481.

ROA.2516-18. Regardless, the assertion is irrelevant because under the constitutional principles that govern here, women have a fundamental right to obtain abortion until viability. *See Casey*, 505 U.S. at 877.

The fifth interest identified by the State is "prohibiting a procedure that has the potential" to cause pain to the fetus. Applt's Br. at 24. It is notable that the State does not assert that fetuses are capable of experiencing pain, but only that it may be possible. That suggestion, however, is contrary to the evidence, which establishes that fetal pain is not possible at the gestational ages at which Plaintiffs perform D&E procedures. ROA.2823-24, 2851, 2862-64, 2902-12. Every major medical organization that has analyzed the possibility of fetal pain, including the American Medical Association, ACOG, and the Royal College of Obstetricians and Gynecologists, (ROA.2906, 2912), has concluded that fetal pain is not possible before at least 24 weeks, when connections to the cortex develop, because a functioning cortex is necessary for pain perception in the human fetus. ROA.2902-03. Moreover, the evidence established a fetus cannot experience pain at any gestational age because it is kept in a sleep-like state in the uterine environment. ROA.2901-02, 2907-11.

The State's sole "expert" on fetal pain, Dr. Malloy, testified that in her opinion a fetus can feel pain at 22 weeks,[13] (ROA.2829), when Plaintiffs do not even provide abortions. As to the relevant gestational ages, Dr. Malloy testified only that she would not exclude the possibility that a fetus feels pain. ROA.2857. Her opinions are not only unmoored from the vast body of scientific evidence on the topic, but are also undermined by her admission that she could not tell the Court "definitively that a fetus feels pain at any gestational age." ROA.2880. Dr. Malloy also admitted that the alternatives to D&E urged by the State, such as intracardiac KCl injection, would also constitute a "horrific procedure." ROA.2873.

In short, in the face of the concrete and substantial burdens established in the record, the State offers nothing of substance. The District Court therefore correctly determined that the benefits of the ban do not outweigh its substantial burdens.

D. SB8 Burdens Women by Undermining the Safety of Standard D&E Procedures.

As found by the District Court, the standard D&E procedure is an extremely safe, ten-minute, outpatient procedure. ROA.1597-98, 1601. Indeed, its development and widespread use has been a major innovation in second-trimester abortion care over the last several decades. ROA.1921-25, 2035-37, 2798-806.

[13] Dr. Malloy's opinion that fetuses can experience pain at 22 weeks and later is largely irrelevant because Texas bans abortions after 22 weeks except in extremely limited circumstances. *See* Tex. Health & Safety Code §§ 171.044, 171.046.

While any medical procedure, including standard D&E, is associated with some risks, in abortion care as in medicine more generally, medical ethics guides physicians to perform procedures only where the medical risks are outweighed by the medical benefits. *See* ROA.2043, 2084, 2948. Yet SB8 forces physicians to violate this fundamental principle.

The State is incorrect to suggest that standard D&E has changed over time to include the administration of digoxin or that the issue is "[a]t a minimum . . . debatable." Applt's Br. at 28.[14] Properly discharging its duty to "resolve questions of medical uncertainty," *Whole Woman's Health*, 136 S. Ct. at 2310, the District Court found to the contrary that "[e]nsuring fetal demise before evacuation is a significant change in the way a standard D&E abortion has been historically performed." ROA.1610. The record evidence supporting this finding consistently showed that no physicians use digoxin before 18 weeks, and, while

[14] In support for this dubious contention, the State cites to outdated medical protocols from PPFA and the National Abortion Federation. While the State's description of the 2007 PPFA policies regarding digoxin are inaccurate, compare Applt's Br. at 30 and n. 4 with ROA.4494, 5535 and 4502, it ignores the critical point that in 2011, PPFA changed its policies to make the provision of digoxin at 18 weeks or later optional. ROA.4581, *see also* ROA.1934-35. The State further attempts to support this point by incorrectly suggesting that Planned Parenthood of Greater Texas ("PPGT") stopped using digoxin because of the introduction of a D&E ban in Congress. Applt's Br. at 31. While in fact, PPGT stopped using digoxin out of concern that its use was prohibited by another Texas statute; Dr. Dermish testified that she does not think it makes the procedure safer; and there has been a movement away from using digoxin among abortion providers. ROA.2206-09.

some physicians use it at later gestational ages, such usage is far from uniform across providers or across patients. ROA.1603-04.

It is thus beyond dispute that SB8 would increase the medical risks for abortion procedures after approximately 15 weeks with no corresponding medical benefit, making abortion less safe for women. ROA.1603. The District Court correctly identified SB8's deviation from safe medical practice as presumptively problematic, noting that "the State's reliance on adding an additional step to an otherwise safe and commonly used procedure in and of itself leads the Court to the conclusion that the State has erected an undue burden on a woman's right to terminate her pregnancy prior to fetal viability." ROA.1602-03. Nonetheless, the Court went on to fully consider all of the testimony regarding the State's proposed methods of fetal demise, before ultimately reaching the same conclusion. ROA.1603.

With SB8, the State seeks to replace the extremely safe standard D&E procedure with various changes to physician practice, none of which provides a guaranteed path for compliance and all of which increase risks to women. For this reason, the District Court found that there is no fail-safe way for physicians to continue to provide D&Es without fear of prosecution. *See* ROA.1609-10. SB8 will accordingly turn back the clock on advances in medical care that have made second trimester abortion both safe and accessible, forcing physicians to either stop

providing D&Es entirely or risk criminal prosecution while subjecting their patients to additional and invasive medical procedures.

1. SB8 Burdens Women Seeking D&E Procedures Beginning at Approximately 15 Weeks.

In support of its argument that SB8 does not impose an undue burden, the State claims that "suction will suffice to cause demise" for abortions below 17 weeks. Applt's Br. at 33. This statement is inconsistent with both the factual record and purported benefits that the State claims flow from enforcement of SB8.

The District Court made the well-supported finding that physicians begin routinely using D&E procedures at 15 weeks and for some patients even earlier. ROA.1601, 1920-21, 2017, 2176-77, 2388, 2800. The State, in contrast, relies primarily on a single abortion provider's testimony regarding suction, ignoring the great weight of evidence considered by the District Court. Dr. Dermish testified that she typically uses suction through 16.0 weeks and that she believes she could change her practice to use suction through 16.6 weeks if SB8 went into effect. However, the State ignores her testimony that it is not possible to use only suction for every patient, due to fetal positioning, the woman's anatomy, or other circumstances, and that she has needed to use forceps for patients as early as 13 weeks. ROA.2204-05, 2223. Other witnesses, including one of the State's own witnesses, testified that they begin using forceps to safely complete abortion procedures at 14 or 15 weeks, and cannot know before starting a procedure

whether or not suction will be sufficient to safely complete the procedure or to cause demise before, in the physician's judgment, forceps should be used. ROA.1920-21, 2017, 2176-77, 2388. Expert testimony from numerous experienced abortion providers confirmed that the safest procedure for a patient will depend on the physician's experience, skill, and training, as well as the patient's particular physical characteristics, such that relying on suction alone will not always be possible and appropriate after about 15 weeks. *See* ROA.1920-21, 2090. One of the State's experts, Dr. Chireau, who has never performed an abortion herself, testified that, based on her reading of the literature, suction *can* be used through 16.6 weeks, but expressed no opinion regarding its feasibility in every case. ROA.2689. It is apparent that far from "overlook[ing]" the feasibility of suction, (Applt's Br. at 33), the District Court correctly situated Dr. Dermish's and Dr. Chireau's limited testimony regarding suction within the complete evidentiary record on the issue. *See* ROA.1601.

The State's reliance on using suction later into pregnancy as a means of complying with SB8 also directly undermines its purported interest in preventing "dismemberment" of a living fetus. There is no relevant distinction between emptying the uterus using suction aspiration or using a combination of suction aspiration and forceps to do so. The fetus, which is alive at the beginning of the evacuation process, is no longer alive upon completion of both procedures.

ROA.1919-20, 1972, 2122, 2398. The state's own witness testified that "the end result of both procedures is the same" and both are "brutal" and "inhumane." ROA.2398-99. The State has made no attempt, either at trial or on appeal, to explain why a law that encourages "us[ing] suction to dismember" a fetus yet prohibits using forceps to do so, (ROA.67-68), furthers the State's interest in potential life. Such a restriction serves only to reduce the safety of abortion in those situations where forceps would allow the physician to perform the procedure more quickly and safely.

2. None of the Other Fetal Demise Methods Proposed by the State Are 100% Effective, and All Involve Additional Medical Risks.

The State next points to a patchwork of potential fetal demise procedures (digoxin, KCl, and UCT), but each suffers from the same fatal flaw—they cannot be relied upon to comply with SB8. A physician cannot know before a procedure if any of the proposed methods will be possible for a particular patient or ultimately successful in causing demise. Because SB8 is not a fetal demise *attempt* requirement, but rather a fetal demise *success* requirement, which attaches criminal penalties to any failure, the District Court found that none of these methods can be relied on to comply with SB8. *See* ROA.1609. Thus, as in *Stenberg*, "[a]ll those who perform abortion procedures using [D&E] must fear prosecution, conviction

and imprisonment." 530 U.S. at 945. The result is an undue burden. *Id.* at 945-46.

Each of these methods is additionally associated with substantial burdens on women seeking abortion, including medical risks with no established health benefits and logistical hurdles and delays. *See supra* at 7-17. The State erroneously compares the risks from D&E to the risks from fetal demise procedures to conclude that fetal demise is safe, (Applt's Br. at 33-39), ignoring the fact that any risk from a fetal demise procedure is necessarily additive.

Digoxin has a failure rate of 5 to 10%, (*supra* at 11), and thus cannot be relied on to cause fetal demise in every instance. It is undisputed that administering an injection of digoxin is a medical procedure that itself carries risks, including infection, extramural delivery, and increased risk of hospitalization. *See supra* at 7-8. Digoxin injection is also impossible or extremely difficult to perform for some patients. *See supra* at 8. Moreover, digoxin is not administered prior to 18 weeks, and requiring it amounts to forced experimentation on women. *See supra* at 10-11. In addition, for women prior to 18 weeks, a digoxin injection adds an additional trip to the clinic 24 hours before the procedure. ROA.1610 (the delay that would accompany a digoxin injection, "standing alone," "constitutes an undue burden"). In the case of digoxin failure, a second dose of digoxin is unstudied and would subject women once again to at least the same risks as the first injection, but

with an increased risk of infection and extramural delivery, and additional delay. *See supra* at 11-12.

As with digoxin, KCl injections are not always successful, (ROA.1950, 2680-82), and for some patients they may be impossible. ROA.1607. Like digoxin, administering a KCl injection is a medical procedure that carries risks, including adverse cardiac effects, uterine perforation, and infection. ROA.1606. Because the injection must be in the fetal heart, it "requires great technical skill," (ROA.1605), and is typically done by physicians trained in the subspecialty of maternal-fetal medicine. ROA.1605. No abortion providers in Texas currently induce demise by KCl injection, and it would be virtually impossible for them to obtain the training they would need to do so. *See supra* at 14.

Like the other methods of demise proposed by the State, UCT is not always possible. ROA.1608. It also "carries significant health risks to the patient, including blood loss, infection, and injury to the uterus." ROA.1608. As the evidence demonstrated, only one study, of little value, addresses UCT prior to D&E. ROA.1956-57, 2686-87; *see also W. Ala. Women's Ctr.*, 2017 WL 4843230, at *18. For this reason, the District Court correctly characterized it as "essentially an experimental procedure." ROA.1608.

The District Court's well-supported findings make clear why the State's argument that ensuring fetal demise before every D&E procedure mitigates the

burdens imposed by the ban must fail. SB8 requires physicians in all instances to ensure fetal demise before beginning a D&E, but none of the procedures proposed by the State will succeed in every case. SB8 thus leaves physicians in an impossible position—they cannot continue to provide standard D&E procedures using the safest means to do so without facing criminal prosecution. In this way, regardless of the State's assertions, SB8 is a ban on standard D&E procedures. Moreover, rather than reducing the burdens imposed by the ban, the State's proposed demise procedures, by "requiring a woman to undergo an unwanted, risky, invasive, and experimental procedure in exchange for exercising her right to choose abortion, substantially burdens that right." ROA.1611.

II. The D&E Ban Is Facially Unconstitutional.

As the District Court correctly found, (ROA.1611), SB8 clearly imposes an undue burden on a large fraction of women for whom it is a relevant restriction. The State's argument to the contrary yet again both applies the wrong legal test and relies upon its incorrect view of the facts.

As the Supreme Court has explained, in determining whether an abortion restriction is facially invalid, a court must consider whether in "a large fraction of cases in which [the provision at issue] is *relevant*" it imposes a substantial obstacle. *Whole Woman's Health*, 136 S. Ct. at 2320 (quoting *Casey*, 505 U.S. at 894–95) (emphasis in original); *see also id.* ("the relevant denominator is 'those

[women] for whom [the provision] is an actual rather than an irrelevant restriction'").[15] This refers to a "class narrower than 'all women,' 'pregnant women,' or even 'the class of *women seeking abortions* identified by the State.'" *Id.* (quoting *Casey*, 505 U.S. at 894–95) (emphasis in original). In *Casey*, for example, although the Supreme Court found that the spousal notification requirement would affect only one percent of women seeking an abortion, the Court struck the requirement because the "analysis does not end with the one percent of women upon whom the statute operates; it begins there." *Casey*, 505 U.S. at 894. Because the spousal notification requirement would impose a substantial obstacle in a large fraction of cases in that relevant group of women, the requirement was facially invalid. *Id.* at 895.

In this case, as the District Court properly recognized, the group of women for whom SB8 is a relevant restriction "consists of all women in Texas who are 15 weeks [or more] pregnant and seek an outpatient second-trimester D&E abortion." ROA.1609. The State's discussion of the percent of all abortions in the state of Texas that would be affected by SB8, (Applt's Br. at 44), therefore has no bearing on the undue burden analysis.

[15] The State questions whether the large fraction test is the appropriate test to apply to abortion restrictions and misleadingly states that the *Whole Woman's Health* Court did not address the issue. Applt's Br. at 43 n. 8. On the contrary, the Supreme Court in *Whole Woman's Health* clearly applied the large fraction test. *Whole Woman's Health*, 136 S. Ct. at 2320 (citing *Casey*, 505 U.S. at 894–895).

The State also applies an incorrect legal test when it implies that the only women burdened by SB8 are those for whom a fetal demise procedure is impossible or for whom such a procedure fails, presumably because an abortion procedure cannot be completed at all in those scenarios. Applt's Br. at 44. The State fails to acknowledge, however, that physicians are unlikely to start a D&E procedure because they will not be confident, to the point of risking criminal prosecution, that demise will be successful. Moreover, as the District Court found, SB8 imposes a variety of burdens on women seeking an outpatient abortion procedure at 15 weeks gestation or later, and each of these burdens is relevant to the large fraction analysis. *See Whole Woman's Health*, 136 S. Ct. at 2302, 2312-13, 2318 (identifying a wide variety of burdens that should be evaluated in considering the constitutionality of an abortion restriction, including clinic closures, additional travel and its effects on vulnerable populations, longer wait times, and increased crowding); *Casey*, 505 U.S. at 885-86, 894 (identifying burdens including delay, increased travel distances, exposure to anti-abortion harassment, loss of confidentiality, and exposure to domestic abuse). As explained above, SB8 requires virtually all Texas women at 15 weeks gestation or more to undergo an unnecessary medical procedure. *See supra* at 7-10, 13, 16-17. Many of these women will need to make an additional trip to a health center, increasing the required travel and delaying the abortion procedure, (*id.*), and every woman

faces the risk that the fetal demise procedure will be unsuccessful and additional procedures will be necessary. *Id.*

The State's claim that a large fraction of impacted women will not be unduly burdened is premised on several erroneous assertions, (Applt's Br. at 44-48), including that women between 15 and 17 weeks are not affected by the ban, that the risk of digoxin injections are only relevant if they are "significant," that digoxin almost never fails, and that KCl and UCT are feasible methods of demise that are 100% successful. *See supra* at 45-48. The State also erroneously contends that SB8 will not increase costs or cause delay, (Applt's Br. at 46-48), but the evidence shows that virtually all women seeking an abortion between 15 and 18 weeks gestation will need to make an additional trip to a health center for a digoxin injection. *See supra* at 8-9.[16]

[16] The State argues that a "mere" 48-hour delay in obtaining an abortion cannot be facially unconstitutional since *Casey* found an informed consent requirement to be valid when it would entail a 24-hour delay. Applt's Br. at 48. Critically, however, the *Casey* Court, in applying the undue burden balancing test to the informed consent requirement, found that the requirement did in fact further the state's asserted interest and so the burden imposed was not undue. *Casey*, 505 U.S. at 883. Here, in contrast, SB8 does not further the state's asserted interests, so even a minimal burden would be undue. Moreover, unless the woman lives more than 100 miles from the abortion provider, the D&E ban would require women in Texas to make a minimum of three trips to the health center—for the mandatory state information, Texas Health & Safety Code § 171.012(a)(4); for the digoxin injection; and for the procedure itself. The *Casey* Court did not consider a law that mandated three trips.

Therefore, correctly applying the large fraction test in light of the well-supported and non-erroneous facts found by the District Court, it is clear that SB8 burdens all women in Texas who seek an abortion after approximately 15 weeks gestation, or approximately 3,150 patients per year based on 2015 data. *See* ROA.4256, 4259.

The State also suggests that as-applied relief in challenges brought by individual women, rather than the facial relief sought in the instant case, is appropriate, (Applt's Br. at 48), but this is both impractical and wrong as a matter of law. Beyond the fact that SB8 is an undue burden on all Texas women seeking abortion after 15 weeks gestation, the record in this case shows that a physician cannot know whether or not demise will be successful until after the procedure has begun. Once an abortion procedure has started, any delay in completing it exposes patients to serious medical risks, *see supra* at 11-12, 16, and it is therefore absurd for the State to suggest that a woman who has had her cervix dilated, been given anesthesia, and is in stirrups should get up and go to court if the physician finds she cannot grasp and transect the umbilical cord. Without knowing at the outset that she can safely perform an abortion without violating the law, a physician cannot begin the procedure, rendering SB8 unconstitutional on its face.

III. The Unconstitutional Provisions of SB8 Are Not Severable.

In a scant one-paragraph argument, the State urges that, in the absence of outright reversal, this Court should sever any impermissible portions or applications of the ban. Applt's Br. at 48. As the Supreme Court did when faced with a similar request in *Whole Woman's Health*, 136 S. Ct. at 2318–19, this argument should be rejected. While severability provisions express the "legislature's preference for a narrow judicial remedy," Courts need not "proceed in piecemeal fashion" when confronted with a facially unconstitutional law. *Id.*

Here, any attempt to sever applications of the law should be rejected for at least four reasons. First, the District Court did not err in granting facial relief. Second, there is no word or provision that stands apart as the root of the law's invalidity, but rather the entire operational section creates the unconstitutional burdens. Third, in light of the *Stenberg* decision, it appears that the legislature intended to "set a net large enough to catch all possible offenders, and leave it to the courts to step inside to announce to whom the statute may be applied." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330 (2006). This Court should decline the invitation to "substitute the judicial for the legislative department." *Id.* (citations omitted). And fourth, the State's request, albeit vague, would improperly require "rewrit[ing] state law to conform it to constitutional requirements." *Id.* at 329 (citations omitted).

CONCLUSION

For these reasons, the judgment of the District Court declaring the provisions of Senate Bill 8 creating Texas Health and Safety Code Sections 171.151 -171.154 void and enjoining their enforcement, (ROA.1614-1617), should be affirmed.

Respectfully submitted this 11th day of April, 2018.

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CERTIFICATE OF SERVICE

I hereby certify that on April 11, 2018, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the CM/ECF system. I certify that counsel for the Defendants-Appellants are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

/s/ *Janet Crepps*
Janet Crepps

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), I hereby certify that the foregoing complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because it contains 12,874 words, excluding the items exempted by Fed. R. App. P. 32(f).

Dated: April 11, 2018.

/s/ *Janet Crepps*
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