IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

FREDERICK W. HOPKINS, M.D., M.P.H.,	)	
	)	
Plaintiff,	)	Case No. 4:17cv404-BRW
	)	
v.	)	
	)	
LARRY JEGLEY et al.,	)	
	)	
Defendants.	)	

PLAINTIFF'S BRIEF IN SUPPORT OF HIS MOTION FOR A PRELIMINARY INJUNCTION OR IN THE ALTERNATIVE A TEMPORARY RESTRAINING ORDER

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INTRODUCTION

In recent years, Arkansas has enacted a multitude of laws to obstruct a woman's access to abortion care,[1] including eight enacted in 2017 alone.[2] The four restrictions Plaintiff is challenging in this lawsuit are part and parcel of that campaign. Plaintiff files this brief in support of his Motion for preliminary injunctive relief against enforcement of the four challenged laws, based on the claims in the following Counts of the Complaint:

- Count I, which challenges the D&E Ban, *see infra* Facts Point I, Argument Point I.A.;
- Counts III and IV, which challenge the Medical Records Mandate, *see infra* Facts Point II, Argument Point I.B.;
- Counts VI and VIII, which challenge the Local Disclosure Mandate, *see infra* Facts Point III, Argument Point I.C.; and
- Counts X and XI, which challenge the Tissue Disposal Mandate, *see infra* Facts Point IV, Argument Point I.D.

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[1] Ark. Code Ann. §§ 20-16-801-817 (2016) (mandating parental consent for a minor's abortion); *id.* §§ 20-16-1504 (2016) (banning off-label use of abortion inducing drugs); *id.* § 20-16-1703 (2015) (mandating 48-hour delay before an abortion and two, in-person trips to facility); *id.* § 20-16-1602 (2015) (banning public funding to any individual or entity that provides, counsels in favor of, or refers for abortion); *id.* §§ 20-16-1301-1307 (2013) (banning abortion at 12 weeks, requiring abdominal ultrasound to detect fetal cardiac activity, and mandating disclosure of cardiac activity if present) (ban at 12 weeks struck down by *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015)); *id.* §§ 20-16-1401-1410 (2013) (banning abortion after 20 weeks of post-fertilization); *id.* § 23-79-156 (2013) (banning abortion coverage in state insurance exchange plans).

[2] In addition to the four laws Plaintiff has challenged: H.B.1428 (mandating license revocation or suspension for abortion clinics—but no other health centers—for minor health code violations); *id.* (limiting abortion providers to physicians); S.B. 156 (banning state funds for public schools from going to abortion referral or services); S.B. 146 (excluding abortion from telemedicine care).

If allowed to take effect, these restrictions will impose severe and unwarranted burdens on women seeking abortion care. To prevent this irreparable and unconstitutional harm, Plaintiff seeks entry of preliminary injunctive relief and/or a temporary restraining order before the restrictions take effect, which is July 30, 2017, except for the Medical Records Mandate, whose effective date is January 1, 2018.

FACTS

In support of his Motion, Plaintiff relies on his own declaration and the declarations of Mark D. Nichols, M.D., and Lori Williams, M.S.N., A.P.R.N., filed simultaneously with this Brief. Dr. Nichols has been a board-certified obstetrician-gynecologist for over 30 years; has delivered approximately 3,000 babies; and is Director Emeritus of the Family Planning Fellowship and a professor at the Oregon Health and Science University in Portland, Oregon. Ms. Williams is a nurse practitioner and the long-serving Clinic Director at Little Rock Family Planning Services, where Plaintiff provides care in Arkansas. *See* Declaration of Frederick W. Hopkins, M.D., M.P.H., dated June 15, 2017 (Hopkins Decl.), Declaration of Mark D. Nichols, M.D., dated June 8, 2017 (Nichols Decl.) ¶ 1, Declaration of Lori Williams, M.S.N., A.P.R.N., dated June 17, 2017 (Williams Decl.) ¶¶ 1, 3.

Background: Abortion in Arkansas

Legal abortion is extremely safe, and safer for a woman than carrying to term and giving birth. Nonetheless, the earlier in pregnancy a woman is able to access abortion care, the safer it is for her, because the risks associated with abortion increase as pregnancy advances. Hopkins Decl. ¶ 28; Nichols Decl. ¶ 10. Hence, for a woman who has decided to end her pregnancy, anything that adds delay increases medical risk.

In Arkansas, as in the nation as a whole, the vast majority of women who seek abortion care do so in the first trimester, approximately the first 14 weeks of pregnancy as measured from the first day of the woman's last menstrual period ("LMP"). Hopkins Decl. ¶¶ 2, 8. Of the 3,771 abortions reported in Arkansas in 2015, approximately 83% occurred in the first trimester; of those performed in the second trimester, two-thirds took place in the first four weeks of the second trimester. *Id.* ¶ 8 (citing Arkansas Department of Health statistics).

Women seek abortions for personal and medical reasons, including their need to care for the children they already have: among abortion patients in Arkansas in 2015, two-thirds had had one or more previous live births. A disproportionate number of abortion patients also struggle with poverty. Hopkins Decl. ¶ 27; Williams Decl. ¶¶ 5-6. Some are young themselves: in 2015, there were 141 abortion patients under 18 years old; of those, 126 obtained parental consent for their abortion decisions—and most had a parent accompanying them to the clinic—and 15 used the judicial bypass process to obtain authorization for their care. Hopkins Decl. ¶ 49 (citing Arkansas Department of Health statistics); *see also* Williams Decl. ¶ 36 (in 2016, the clinic where Plaintiff practices in Little Rock saw 69 patients under the age of 17, 66 of whom had parental consent and 3 of whom obtained a judicial bypass).

Women seek abortions in the second trimester for all these same reasons, but often with added layers entailing delay. A woman may suffer delay in locating a provider of these services, and/or in struggling to gather the funds to pay for the procedure, for transportation, and for care for her children. She may have to travel long distances. Plaintiff is aware of only two entities providing abortion care in Arkansas: Little Rock Family Planning Services, where he practices, which provides abortions and treatment for miscarriage in the first and second trimesters, and

Planned Parenthood Great Plains, which provides only early medication abortion, in the first 10 weeks of the first trimester, in Little Rock and Fayetteville. Hopkins Decl. ¶ 6.

These burdens are exacerbated by Arkansas's mandate that a woman make an additional trip to the clinic, to receive the state-mandated counseling in person, and then delay at least 48 hours before returning to the clinic to receive or commence her medical care. This extra-trip requirement creates significant challenges for Arkansas patients. For some women, it results in delays much longer than 48 hours. *Id.* ¶ 7; Williams Decl. ¶ 7.

For women seeking abortion, confidentiality is a primary concern. All medical care is private, but women who have decided to end a pregnancy may fear reprisals ranging from condemnation in their communities, schools and jobs to violence by their intimate partners. Any threat to confidentiality can terrify a patient, delay her care, or deter her from accessing abortion altogether. Hopkins Decl. ¶ 38; Williams Decl. ¶ 9.

These are the patients whose medical and spiritual wellbeing Plaintiff has dedicated his life to serving. Hopkins Decl. ¶ 3-4.

I. H.B. 1032 (THE D&E BAN)

A. D&E Practice and the New Ban

H.B. 1032 bans dilation and evacuation procedures (D&Es), the safest and most common method of second-trimester abortion and essentially the only method available to Arkansas women after approximately 14 weeks LMP. *See* Nichols Decl. ¶ 19; Hopkins Decl. ¶ 17 (in 2015, D&E accounted for all second-trimester abortions reported in Arkansas). The vast majority of abortions performed at Little Rock Family Planning Services, where Plaintiff provides care, are first-trimester procedures. However, the clinic also provides care for hundreds of women in need of second-trimester abortion services each year. *See* Williams Decl. ¶ 16;

Hopkins Decl. ¶ 15 (of 3771 abortions in Arkansas in 2015, 638—about 17%—were at or after 14 weeks LMP). Plaintiff offers the same treatment for women experiencing miscarriage, to ensure that the products of conception are fully removed expeditiously and to decrease the risk of complications such as bleeding and infection. Hopkins Decl. ¶ 2.

In the first trimester of pregnancy, abortion can be performed by medical or instrumental means. In a typical medication abortion, a woman takes first one drug and then a second drug approximately 24 hours later. Nichols Decl. ¶ 12. She times taking these medications so that she can pass the products of conception at home over a period of hours or days, and collect and dispose of them in the same manner as she would during menstruation or a spontaneous abortion (miscarriage). *Id.* Early medication abortion is generally available through only part of the first trimester. The instrumental method of abortion available in the first trimester is suction aspiration, also known as a dilation and curettage or D&C, in which clinicians use a plastic tube, called a cannula, attached to a syringe or electrical pump, to empty the uterus. Nichols Decl. ¶ 13; Hopkins Decl. ¶ 10.

Starting in the second trimester, it is generally not possible to perform an abortion using suction alone, and physicians providing outpatient care use the D&E method. Nichols Decl. ¶ 17; Hopkins Decl. ¶ 14. A D&E has two steps: (1) dilation of the cervix sufficient to allow the safe passage of instruments, followed by (2) removal of the fetus and other contents of the uterus using instruments such as forceps, often in conjunction with suction. Nichols Decl. ¶¶ 17-18; Hopkins Decl. ¶¶ 13-14. Because the cervical opening is smaller than the fetus, disarticulation (separation) of fetal tissue usually occurs as the physician brings fetal parts through the cervix. Nichols Decl. ¶ 18; Hopkins Decl. ¶ 14. Although it does not use recognized medical terminology, H.B. 1032 bans D&E because it criminalizes the use of surgical instruments to

cause disarticulation (or, in the ban's terms, "dismemberment") of a "living" fetus.[3] H.B. 1032, 91st Gen. Assemb., Reg. Sess. (Ark. 2017), to be codified at Ark. Code Ann. § 20-16-1802(3) (2017); *see also* Nichols Decl. ¶ 6; Hopkins Decl. ¶ 23.

B. The Impact of H.B. 1032

Banning D&E would impose a terrible burden on women in Arkansas, and would constitute a significant step backward: the development of D&E was a significant advance in safety over earlier methods of second-trimester abortion. Nichols Decl. ¶ 19; *see also City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 435-36 (1983), *overruled in part on other grounds by Planned Parenthood v. Casey*, 505 U.S. 833 (1992) ("Since [*Roe v. Wade* was decided], the safety of second trimester abortions has increased dramatically. The principal reason is that the D&E procedure is now widely and successfully used . . . .") (footnotes omitted). Moreover, starting in the early second trimester, D&E is the only procedure that can be performed on an outpatient, ambulatory basis. Nichols Decl. ¶ 14; Hopkins Decl. ¶ 17; *see also City of Akron*, 462 U.S. at 436. This significantly reduces the expense of a second-trimester abortion. Nichols Decl. ¶ 14.

Given its impressive safety record and its availability in outpatient settings, D&E accounts for 95% of all second-trimester abortions nationally. Nichols Decl. ¶¶ 14-16. The

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[3] H.B. 1032 bans "dismemberment abortion," defined as an abortion "that purposely dismembers the living unborn child and extracts one (1) piece at a time from the uterus through the use of instruments such as . . . forceps" that "slice, crush, or grasp a portion of the body of the unborn child to cut or tear off a portion of the body of the unborn child." The banned conduct "includes an abortion in which suction is used to extract the body of the unborn child subsequent to the dismemberment," but "not . . . an abortion that uses suction to dismember . . . parts . . . into a collection container." H.B. 1032 § 20-16-1802(3). The ban's narrow exception allows otherwise banned treatment only when "necessary to avert either . . . death . . . or the serious risk of substantial and irreversible physical impairment of a major bodily function." *Id.* §§ 20-16-1802(6)(A), -1803(a). Violation of H.B. 1032 is a Class D felony and grounds for professional disciplinary action and civil liability. *Id.* § 20-16-1804 -1805.

only alternative to D&E is an induction procedure, in which physicians use medication to induce labor and delivery of a non-viable fetus. *Id.* ¶ 14. In contrast to D&E, induction of labor must be performed at a facility, such as a hospital, with the capacity to keep patients for an extended stay, not an outpatient clinic such as Little Rock Family Planning Services. *Id.*; *see also* Hopkins Decl. ¶ 12. Such hospital-based induction abortion services are all but unavailable in Arkansas: no induction abortions were reported in Arkansas in 2015. Hopkins Decl. ¶ 12. And unlike D&E, which takes 10 to 15 minutes to complete, an induction abortion takes anywhere from 5 hours to 3 days to complete, and is virtually always far more expensive than D&E because it cannot be performed on an outpatient basis. Nichols Decl. ¶ 14; Hopkins Decl. ¶ 12. In addition, an induction requires a woman to go through labor, which is painful, psychologically challenging for some women (particularly certain women obtaining abortions after learning of a devastating fetal diagnosis), and medically contraindicated for some women (including those who have had previous cesarean deliveries). Nichols Decl. ¶ 14; Hopkins Decl. ¶ 12.

If the D&E Ban took effect, it would force Plaintiff to stop performing abortions at approximately 14 weeks LMP, the point after which he cannot know he will be able to ensure fetal demise before he must take actions banned under H.B. 1032. Hopkins Decl. ¶¶ 23, 26; *see also* H.B.1032 §§ 20-16-1802(3)(a)(i), -1803(a) (prohibiting the performance of a "dismemberment abortion" where there is a "living" fetus). Under the ban, the only D&E that would be legal is one in which a physician had *successfully* induced fetal demise—through an additional procedure—prior to starting the evacuation phase of the D&E. *Id.* § 20-16-1802(3)(a)(i). Because that is not feasible or safe for every patient, H.B. 1032 outright bans D&E: Plaintiff cannot start *any* D&E because he knows that he may well not be able to complete the procedure without violating the ban.

As an initial matter, there is simply no reasonable or accepted procedure available for a physician providing a D&E even to attempt demise in a way that might avoid the ban before 18 weeks LMP. Nichols Decl. ¶ 36; Hopkins Decl. ¶ 24. Moreover, any such attempts would mean experimentation and the imposition of risks with no medical benefit. They are virtually untested; have unknown risks and uncertain efficacy; and would be outside the standard of care. Nichols Decl. ¶ 26; Hopkins Decl. ¶ 24. Thus, H.B. 1032 effectively bans D&E from 14 to 18 weeks LMP, Hopkins Decl. ¶¶ 25-26, when the vast majority of D&Es occur, *id.* ¶ 15 (of 683 D&Es reported in Arkansas in 2015, two-thirds occurred during those first four weeks of the second trimester).[4]

Starting in the later part of the second trimester, a minority of physicians attempt to induce fetal demise by injecting a drug called digoxin either transabdominally or transvaginally. Nichols Decl. ¶ 21. Doing so confers no medical benefit on the patient, as the American College of Obstetricians and Gynecologists ("ACOG") has made clear: "'No evidence currently supports the use of induced fetal demise to increase the safety of second trimester medical or surgical abortion.'" *Id.* ¶ 22 (quoting American College of Obstetricians and Gynecologists, *Practice Bulletin Number 135: Second Trimester Abortion*, 121 OBSTETRICS & GYNECOLOGY 1394 (2013)). For the most part, these physicians use such injections to establish compliance with the federal so-called "partial-birth abortion" law and state analogs. *Id.* ¶ 23; Hopkins Decl. ¶ 19. That includes Plaintiff in his role at Little Rock Family Planning Services: beginning at 18 weeks

[4] As discussed immediately below, later in the second trimester, some physicians attempt to cause fetal demise with digoxin injections, which take 24 hours to work. Even if such injections in the early weeks of the second trimester were not experimental and outside the standard of care, they would convert a one-day procedure to a two-day procedure, thus requiring the patient to make three visits to the clinic. This would impose a tremendous burden on Plaintiff's patients, including by increasing the costs they must bear. Hopkins Decl. ¶ 24.

LMP, to comply with existing federal and state laws, 18 USC § 1531; Ark. Code Ann. § 20-16-1203 (2009), physicians at the clinic generally attempt to induce fetal demise prior to the evacuation phase of a D&E, via a transvaginal digoxin injection. Hopkins Decl. ¶ 20.

This practice does not save H.B. 1032 from invalidation, even for the period starting at 18 weeks LMP. First, injections are not possible for every patient who seeks care at and after 18 weeks LMP. For example, a patient's anatomical characteristics, such as fibroids or an elongated cervix, may contraindicate such injections. Other patients have a medical contraindication to digoxin, such as a heart arrhythmia. Nichols Decl. ¶ 27; Hopkins Decl. ¶ 25a. Second, for some patients, digoxin fails to cause fetal demise, and physicians simply cannot know before starting a procedure for which patients it will fail. Nichols Decl. ¶ 28; Hopkins Decl. ¶ 25c.[5] The proper course of treatment when digoxin fails is to complete the abortion without additional delay. Hopkins Decl. ¶¶ 25d, 25f; Nichols Decl. ¶ 29. However, if digoxin does not result in fetal demise after 24 hours, H.B. 1032 would compel the physician to attempt a second injection of digoxin, which is completely untested and contrary to the standard of care. Hopkins Decl. ¶ 25b; Nichols Decl. ¶ 29. Administering a second injection and waiting an undetermined amount of time for demise, rather than completing the abortion, would put a patient who is already dilated and whose uterus may have already started to contract at risk of infection or delivery outside the clinic. Nichols Decl. ¶ 29; Hopkins Decl. ¶ 25b. Plaintiff would not, however, feel comfortable asserting that those risks, while real and unacceptable, rise to the very high level of H.B. 1032's narrow exception, limited to circumstances in which banned

[5] Notwithstanding such failures, digoxin use helps establish compliance with the federal law because of that law's intent requirements; because H.B. 1032 lacks similar requirements, physicians cannot rely on digoxin to protect them from prosecution under H.B. 1032. Nichols Decl. ¶ 23; Hopkins Decl. ¶ 25e.

treatment is "necessary to avert either . . . death . . . or the serious risk of substantial and irreversible physical impairment of a major bodily function." H.B. 1032 §§ 20-16-1802(6)(A), -1803(a).

The medical treatment Plaintiff recently provided to an Arkansas patient at 21 weeks LMP illustrates that the possibility of attempting fetal demise with digoxin for some patients in no way mitigates the dangers H.B. 1032 would impose on women. Right after injecting digoxin, and while preparing to initiate the overnight dilation process, Plaintiff found that the patient's cervix was already dilated, and then her water broke. Hopkins Decl. ¶ 25f. For her safety, he completed the D&E immediately, even though the digoxin could not yet have caused fetal demise. Sending her home overnight for no reason other than to allow time for the digoxin to work would have exposed the patient to increased risks, including infection, but would not rise to the level of the ban's extremely narrow exception. *Id.* ¶ 25f.

The other methods of attempting to induce fetal demise are unreliable, unsafe and/or unavailable in the clinic setting. Injection of potassium chloride (KCl) directly into the fetal heart effectively causes demise, but can only be performed by highly specialized physicians after years of training and with ultrasound magnification requiring an advanced machine typically available only in a hospital, not clinic, setting. Nichols Decl. ¶ 31; Hopkins Decl. ¶ 21. This level of training and equipment are necessary because inadvertent injection of KCl into a patient's blood stream can put her into cardiac arrest. Like the vast majority of obstetrician-gynecologists, Plaintiff does not have this specialized training. Nichols Decl. ¶ 31; Hopkins Decl. ¶ 22. Umbilical cord transection, where a clinician attempts to grasp and transect the cord to cause fetal demise, is not possible in every case and exposes the woman to an increased risk of uterine perforation, cervical injury and bleeding, while unnecessarily prolonging the D&E

procedure. Nichols Decl. ¶¶ 32-34. Additionally, in seeking to grasp the umbilical cord, physicians will often have no way to avoid grasping fetal tissue instead of or in addition to the cord. Doing so would violate H.B. 1032, and thus provides no way to circumvent its ban. Hopkins Decl. ¶¶ 25d-25e; Nichols Decl. ¶ 35.

It is contrary to Plaintiff's medical judgment and ethics to subject his patients to unnecessary medical procedures that increase risk, but provide no benefit to the patient: H.B. 1032 would force him to contravene his medical judgment. Hopkins Decl. ¶ 4. Indeed, although Dr. Hopkins is a highly trained and experienced obstetrician-gynecologist, and can attempt digoxin injections to try to cause fetal demise in most patients beginning at 18 weeks LMP, he, like other clinic-based physicians, will not experiment on patients by attempting injections earlier than that; will not do injections when medically contraindicated; will not do a second injection if the first one fails; and will not start a procedure when he does not know whether he will be able to finish it without violating the ban. Hopkins Decl. ¶ 24. Thus, H.B. 1032 would end D&E practice, which represents 100% of abortion care reported in Arkansas in 2015 starting at 14.0 weeks LMP. Nichols Decl. ¶ 38; Hopkins Decl. ¶ 23. As set forth under Irreparable Harm, *infra* p. 55, this ban would have a far reaching, deleterious effect on women in need of abortion care.

II. H.B. 1434 (THE MEDICAL RECORDS MANDATE)

A. H.B. 1434

H.B. 1434 mandates that "an abortion shall not be performed until" the physician "requests the medical records of the pregnant woman relating directly to [her] entire pregnancy history," and then spends "reasonable time and effort . . . to obtain" such records. H.B. 1434, 91st Gen. Assemb., Reg. Sess. (Ark. 2017), to be codified at Ark. Code Ann. § 20-16-1804(b)(2)

(2017). The statute fails to define what constitutes "reasonable time and effort"; fails to define or in any way limit the scope of "medical records relating directly to the entire pregnancy history" of the patient; and fails to specify what actions, if any, the physician is to take upon receiving any records. It also lacks any provision allowing the physician to proceed based on medical risks to the woman, no matter how serious.

H.B. 1434 carries severe penalties. A physician who "knowingly performs or attempts to perform an abortion" prohibited by the Medical Records Mandate is guilty of a Class A misdemeanor, punishable by up to one year in jail, a fine or both. *Id.* §§ 20-16-1805, 5-4-201, 5-4-401. A physician who performs an abortion prohibited by the Medical Records Mandate "engage[s] in unprofessional conduct for which his or her license . . . shall be suspended or revoked . . . ." *Id.* § 20-16-1806(c). H.B. 1434 also provides for damages, *id.* § 20-16-1806(a)(1), and creates a cause of action for injunctive relief against a physician who knowingly violates the law, which may be brought by the Attorney General or by the patient's spouse, parent, guardian, or current or former licensed health care provider. *Id.* § 20-16-1806(d)(1).

H.B. 1434 separately provides that a physician "shall not intentionally perform . . . an abortion" knowing that the "woman is seeking the abortion solely on the basis of" the sex of the embryo or fetus, and requires the physician to ask her if she knows the sex. *Id.* §§ 20-16-1804(a), (b)(1). Plaintiff, who is unaware of such a case in Arkansas, does not challenge those provisions of H.B. 1434. Hopkins Decl. ¶ 30; *see also* Williams Decl. ¶ 22.

B. The Impact of H.B. 1434

Obtaining prior medical records is medically indicated for only a tiny fraction of abortion patients, and even then, only a request for certain records related to a specific medical issue is appropriate. Nichols Decl. ¶ 9; Hopkins Decl. ¶¶ 33-34; *see also* Williams Decl. ¶ 24. Even in

those cases, unless the records are transmitted very quickly, any medical benefit of waiting for the records is outweighed by the fact that delaying abortion care increases the risks associated with the procedure for the patient. Hopkins Decl. ¶ 39; Nichols Decl. ¶ 9.

H.B. 1434's broad and vague terms would, effectively, bar abortion for the great majority of women seeking care in Arkansas. The only patients H.B. 1434 would not affect are those with no prior pregnancies and no pregnancy-related care for their current pregnancy—except for patients who received past care solely from the provider from whom they seek abortion care. That is a small minority of patients. Two-thirds of Arkansas abortion patients have given birth at least once, and many of the others are likely to have had medical care related either to the current pregnancy, or to a prior pregnancy that was molar or ectopic or that ended in abortion or miscarriage. Hopkins Decl. ¶ 23. For all those patients, H.B. 1434 precludes abortion unless and until Plaintiff complies with terms so vague that he cannot know how to comply. *Id.* ¶ 37.

Attempting to comply would mean waiting until Plaintiff had spent an undefined amount of time trying to obtain a potentially huge volume of records, without any defined end in sight. Even for the very targeted requests that occur for the tiny number of patients for whom any records request is appropriate, it may take anywhere from a few hours to several weeks (in which case, again, waiting for records is medically inappropriate); for the comprehensive requests H.B. 1434 mandates, the delay could be even greater.[6] Williams Decl. ¶ 26. The delay would be compounded for patients who had obtained pregnancy-related care outside Arkansas or outside the U.S., and particularly for patients whose records are in another language and must be translated into English. Hopkins Decl. ¶ 41; Williams Decl. ¶ 30. The statute requires

[6] Federal law allows U.S. providers 30 days for their initial response to records requests; the actual medical records may follow later; and the patient's recourse for non-production of records involves review by government officials and/or litigation. 45 CFR § 164.524.

"reasonable effort" to obtain that entire pregnancy history. These delays would harm many patients by delaying their abortions until later in pregnancy, when the risks are greater, and would harm many others by simply preventing them from obtaining abortions at all. Hopkins Decl. ¶ 42; Williams Decl. ¶ 34.

The drain on providers' resources would likewise block care: the staff, copying and other processing costs of requesting and attempting to compile all these records for the great majority of patients would be overwhelming. The Arkansas clinic where Plaintiff practices requests records for only approximately 25 patients per year, but provides abortion care for approximately 3,000 patients each year. Williams Decl. ¶¶ 24, 32. The Arkansas Medical Board advises that Arkansas medical providers can charge per-page copying fees and separate fees for retrieval of records from storage. *See* Ark. Code Ann. § 16-46-106 (2008); Arkansas State Medical Board, Access to Medical Records, http: /www.armedicalboard.org (hover over "for the Public" tab and select "Access to Medical Records" from the drop down menu). The patient would herself need to gather past information—including the identity of all her prior and other pregnancy-related care providers, and the dates she received services, going back potentially decades—and complete a signed request for each former provider. Williams Decl. ¶ 33. These administrative obstacles are simply insurmountable.

Finally, even were Plaintiff to attempt to comply, doing so would violate his patients' confidentiality: requesting medical records would disclose the fact of the patient's pregnancy and abortion decision to all her previous and other current pregnancy-related health care providers. Many patients are adamant that that not occur. Hopkins Decl. ¶ 38; Williams Decl. ¶ 28.

III. H.B. 2024 (THE LOCAL DISCLOSURE MANDATE)

A. H.B. 2024's Amendment to Section 12-18-108 and the Scope of this As-Applied Challenge

H.B. 2024 amends a 2013 law, Section 12-18-108, to expand its reach. As originally enacted, the law applied only to the tiny number of abortion patients who are 13 and under. H.B. 2024 now expands its reach to all patients under 17. For every abortion patient under 17 years old, her medical provider must (1) disclose the fact of her abortion to her local police department and (2) preserve all embryonic or fetal tissue from her abortion as "evidence." H.B. 2024, 91st Gen. Assemb., Reg. Sess. (Ark. 2017), amending Ark. Code Ann. § 12-18-108(a)(1). Dr. Hopkins and his colleagues at the clinic take very seriously their obligation to alert the state Child Abuse Hotline of any suspected sexual abuse. Hopkins Decl. ¶ 43; Williams Decl. ¶ 38. Dr. Hopkins challenges these new requirements only as applied to those 14-, 15- and 16-year-olds whose sexual activity indicates no potential sexual abuse, and thus is not included in the reporting requirements under the Child Maltreatment Act (the "Non-CMA Teenage Patients").[7] This is the great majority of 14- to 16-year-old patients. For those patients, H.B. 2024 serves no

[7] The sexual activity of 14- to 16-year-olds does not constitute reportable "sexual abuse" when it takes place with a similar-age partner or that teenager's spouse (and not with a caretaker or involving forcible compulsion). For 14-year-olds, for example, consensual activity with partners 14 to 17 does not trigger reporting, *see* Ark. Code Ann. § 12-18-103(20)(B) (2015); for 15-year-olds, consensual activity with partners 14 to19 years old does not trigger reporting, *see id.* § 12-18-103(20)(C). Likewise, such similar-age consensual sexual activity does not constitute criminal activity. *See id.* §§ 5-14-101(2009), -103 (2013), -110 (2016), -124 (2013), -125 (2013), -126 (2009), -127 (2009). For 16-year-olds, because Arkansas does not regulate the age of their consensual sexual partners, abuse reporting or criminality arises when the person involved uses force or is a caretaker or other person in a similar relationship of power. *See id.* §§ 5-14-101(2009), -103 (2013), -110 (2016), -124 (2013), -125 (2013), -126 (2009), -127 (2009). In addition, almost all of the patients in this affected 14- to 16-year-old age group are receiving abortion care with a parent involved. *See supra* p. 3. Some may have a husband involved as well.

proper state purpose, and instead would function only to violate their privacy and stigmatize their decision.

B. Section 12-18-108's Requirements for Physicians

Section 12-18-108 mandates that a physician "shall preserve . . . fetal tissue extracted during the abortion in accordance with rules adopted by the office of the State Crime Laboratory," Ark. Code Ann. § 12-18-108(a)(1) (2017), and that the physician or facility "shall contact the law enforcement agency in the jurisdiction where the child resides," *id.* § 12-18-108(a)(3). Section 12-18-108 applies only to abortion, and not treatment for spontaneous miscarriage or removal of an ectopic pregnancy. *Id.* § 12-18-103(2)(B). Section 12-18-108, as amended by H.B. 2024, thus exposes the fact of a Non-CMA Teenage Patient's abortion to her local police, and mandates retention of tissue from her abortion indefinitely in a crime laboratory, even where facts indicate no potential abuse or criminality. A physician's failure to comply with "this section or any rule adopted under this section shall constitute unprofessional conduct under the Arkansas Medical Practices Act," *id.* § 12-18-108(c), and therefore subjects the physician to license suspension or revocation and other disciplinary penalties, *see id.* § 17-95-409 (2009).

As directed by Section 12-18-108(b)(1), the State Crime Laboratory has prescribed Rules to implement the statute (the Rules), including a requirement that "[a]ll products of conception should be preserved" and immediately frozen, in an air-tight container, with a label that includes "the patient's name and date of birth." Ark. Admin. Code §§ 171.00.2(1)-(2) (2013). The "physician must properly establish and maintain the chain of custody for this evidence," by completing a "Fetal Tissue Submission Form," and contacting the local law enforcement where the child resides. The form includes the name and "address of the victim, [and her] parent and/or

legal guardian," her date of birth, and the name and date of birth of the "suspect." *Id.* § 171.00.2(3). However, the sexual partner of the Non-CMA Teenage Patients at issue here would be a consensual partner, typically of the same or similar age, and would *not* be a criminal or abuse suspect, just as the patient would not be a victim.[8]

The rule for "proper disposal of fetal tissue preserved" under Section 12-18-108 states that "[u]pon completion of DNA analysis, any remaining samples will be disposed of by the Arkansas State Crime Laboratory after receipt of a 'letter of destruction' from the respective investigating agency." *Id.* § 171.00.2(4). This rule, like each of the others adopted under the original Section 12-18-108, assumes that the context is always a criminal or abuse investigation. The rule does not specify any process for the eventual disposal of the tissue when there was no need for any investigation, as will be true under the Local Disclosure Mandate for all of the Non-CMA Teenage Patients at issue.

C. Experience Reporting to Local Police for Patients 13 and Under

In the experience of Little Rock Family Planning Services, it is the long-standing Child Maltreatment Act and corresponding criminal law, not Section 12-18-108, that does the work of protecting children. Local police forces are rarely familiar with Section 12-18-108. Williams Decl. ¶ 41. When clinic personnel contact them pursuant to the current scope of the statute (for patients 13 and younger), they often must inform the officer of the law's existence and requirements through more than one phone call and with an email form the clinic has developed.

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[8] Subsection (a)(2) of Section 12-18-108 states that "[b]efore submitting the tissue under subdivision (a)(1) of this section, the physician shall redact protected health information as required under the [federal] Health Insurance Portability and Accountability Act of 1996," but that reference to redaction does not translate into privacy for the patient. Section 12-18-108 and its implementing Rules specifically require that personal information accompany the "evidence" collected, and HIPPA allows such disclosures made to law enforcement pursuant to state law.

Id. On many occasions, they must work to convince an officer to retrieve the preserved tissue, as the statute contemplates. *Id.*[9]

Moreover, unlike contacting the state hotline, which is staffed by specially trained personnel, contacting local law enforcement under Section 12-18-108 is highly problematic. For example, Little Rock Family Planning Services has encountered a police force with only two officers, greatly increasing the likelihood that the officer knows the patient or her family. *Id.* ¶ 45. Some officers the clinic has contacted pursuant to Section 12-18-108 have responded by expressing hostility to abortion. *Id.* In addition, while some officers retrieve the tissue relatively quickly, others do not come for significant periods, even with prodding. *Id.* ¶ 41. In the two instances in which the clinic has, pursuant to Section 12-18-108, contacted local law enforcement agencies outside Arkansas, they refused to retrieve the tissue. *Id.* ¶ 42.

D. H.B. 2024's Impact on the Non-CMA Teenage Patients

H.B. 2024, by expanding the application of Section 12-18-108 and its implementing Rules, can be read to bar medication abortion for patients under 17 through its mandate that "[a]ll products of conception" be preserved. H.B. 2024 also explicitly mandates disclosure of intensely private information for all of the Non-CMA Teenage Patients.

Consistent with applicable standards of care, and when appropriate, Dr. Hopkins offers 14- to 16-year-old patients medication abortion. Hopkins Decl. ¶ 52. After counseling (and, in virtually all cases, with the assistance of an involved parent or guardian), many such patients decide that medication abortion is better for them than suction aspiration. *Id.*; *see also* Williams

[9] Where facts do suggest that criminal sexual abuse has occurred, the state Child Maltreatment Hotline and law enforcement are almost always involved before the girl visits the clinic; the medical providers know from the outset that there is an investigation and assist in evidence preservation under the direction of the investigators; and the clinic is not initiating the process or cold-calling local law enforcement. *Id.* ¶ 39.

Decl. ¶ 36. In certain instances, such as when the young woman has uterine anomalies or high body mass index, the physician may determine that medication abortion is medically indicated. Hopkins Decl. ¶ 52. In other instances, the patient prefers or will better tolerate medication abortion, for example if she has never had a pelvic exam, does not want instruments introduced, or otherwise finds medication abortion more comfortable. Hopkins Decl. ¶ 52; Williams Decl. ¶ 47. Were H.B. 2024 to go into effect, however, Dr. Hopkins will no longer be able to offer medication abortion to any patients under 17, because with medication abortion, a physician cannot collect and preserve "[a]ll products of conception," and he cannot risk violating this statute and its implementing Rules. *See* Ark. Admin. Code § 171.00.2(1) (2014).

In addition, for the Non-CMA Teenage Patients at issue in this case—those with no indication of abuse for state hotline reporting—abortion providers would also have to disclose and explain, during their pre-abortion counseling, H.B. 2024's mandated local police reporting and tissue transmittal. Hopkins Decl. ¶ 50; Williams Decl. ¶ 46. But because these teenagers' sexual activity does not implicate child abuse concerns or criminal law, this discussion of police contact and "evidence" collection would be confusing, punitive and likely humiliating for these patients and their families. To prevent notice to their hometown police force, some patients may forego abortion care—or at least significantly delay their procedures by seeking care out of state. Williams Decl. ¶ 46; Hopkins Decl. ¶ 50.

For patients who proceed with care in Arkansas, H.B. 2024 will result in notice to local police of the private facts of pregnancy and abortion, which is especially disturbing given that local police may be familiar with the young woman. This required notice of abortion and transmittal of "crime lab" evidence will stigmatize these young women, and potentially subject them to the range of negative reactions that can occur in response to the revealed decision to end

a pregnancy. Absent any indication of child maltreatment, the revelation to the police officers and personnel—members of the patient's local community—is itself a harm, and minor patients will likely be terrified of such revelation. Moreover, while officers will presumably treat such information as confidential, once the information is known by those local community members and written on various required documents, there are risks to the young woman's privacy, which can engender strong fear on her part. Hopkins Decl. ¶ 47; Williams Decl. ¶ 45.

The required transmittal to the local police of the patient's and her parent's address creates heightened concerns for (i) those few teenagers who rely on the judicial bypass so that they need not involve a parent in their abortion decision, (ii) young women who, along with one parent or guardian, decide not to inform another parent or household member, because of concerns about his or her reaction, and (iii) other young women living under similar circumstances that might expose them to physical or other serious harm should the fact of their abortion or their sexual activity become known in their home or local community. H.B. 2024's amendments mandate local disclosures for these young women along with all other 14- to 16-year-old patients.

IV. H.B. 1566 (TISSUE DISPOSAL MANDATE)

A. Current Law and Changes Under H.B. 1566

Consistent with current law, embryonic and fetal tissue generated from abortion and miscarriage care is handled in a number of ways. Women who have medication abortions or complete miscarriage through medication dispose of the tissue at home.[10] For almost all surgical

[10] Current Arkansas law generally permits tissue that is passed at home, rather than at a medical facility, to be disposed of without being regulated as medical or pathological waste. *See generally* Ark. Code. Ann. § 20-32-101 (1993) (governing disposal of commercial medical waste); *id.* § 20-32-101(5) (defining "medical waste," in relevant part, as limited to "waste from

abortions, a contractor collects medical waste and embryonic or fetal tissue generated at the clinic and disposes of it out of state through incineration. Williams Decl. ¶ 49. A few patients each year choose to have the tissue cremated and those patients make arrangements with the cremation facility. *Id.* ¶ 49. Also, for a few patients each year, tissue is sent to pathology labs to test for specific medical conditions or to determine the cause of anomalies and the likelihood of recurrence in future pregnancies. In addition, following some abortions, tissue is preserved and made available to law enforcement. *See* Williams Decl. ¶ 39.

H.B. 1566 changes current law to require that all embryonic or fetal tissue—whether from an abortion or miscarriage—be disposed of in accordance with the Arkansas Final Disposition Rights Act of 2009 ("FDRA"), Ark. Code Ann. § 20-17-102 (2013). H.B. 1566 § 2 (removing "fetal tissue" from the definition of "human tissue"); § 1 (requiring that a "dead fetus" be disposed in accordance with the FDRA); § 3 (requiring that a "physician or facility that performs an abortion shall ensure that fetal remains and all parts are disposed" of in accordance with the FDRA and Ark. Code Ann. § 20-17-801, which itself refers back to the FDRA). Under H.B. 1566, abortion providers face criminal penalties for failure to dispose of tissue in accordance with the FDRA. H.B. 1566 § 3.

The FDRA primarily governs which family members have "[t]he right to control the disposition of the remains of a deceased person, the location, manner, and conditions of disposition." Ark. Code Ann. § 20-17-102(d)(1). Under the FDRA, if a decedent has not appointed anyone to control the final disposition of his or her remains, that right vests in individuals in the order the FDRA prescribes, including the decedent's spouse; child or children;

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healthcare-related facilities"); *id.* § 20-32-101(5)(A) (defining "pathological waste"); *id.* § 20-17-802 (2015) (requiring disposal of tissue from abortion "in a fashion similar to that in which other tissue is disposed").

parent or parents; and so on, including other family members, or, ultimately, a state government actor with the statutory obligation to arrange for the disposition of a decedent's remains. *See id.* §§ 20-17-102(d)(1)(A)–(L). When the disposition right vests in the decedent's parents and one parent is "absent," the right vests solely in the remaining parent only after "reasonable efforts have been unsuccessful in locating the absent surviving parent." *Id.* § 20-17-102(d)(1)(E)(ii). The FDRA defines neither "absent" nor "reasonable efforts." *Id.* § 20-17-102. In addition, the right to control the disposition of the remains of a deceased person vests only in persons who are 18 years old or older. *Id.* § 20-17-102(d)(1).

Under other provisions of the FDRA, a person may exercise disposition rights only if willing to assume liability for the costs associated with disposal, and only if the person "exercise[s] his or her right of disposition within two (2) days of notification of the death of the decedent." *See id.* §§ 20-17-102(e)(1)(B), (C). Further, where there is a dispute among people who share equal disposition rights, the circuit court for the county decides to whom to award the disposition right. *See id.* § 20-17-102(e)(2).

The FDRA defines "final disposition" as "the burial, interment, cremation, removal from Arkansas, or other authorized disposition of a dead body or fetus." *Id.* § 20-17-102(2)(C). It is not clear what "other authorized disposition" includes. In addition, a person with disposition rights may "dispose of the remains in any manner that is consistent with existing laws, rules, and practices for disposing of human remains, including . . . cremat[ion]." *Id.* § 20-17-102(i).

B. The Impact of H.B. 1566

H.B. 1566 imposes burdensome and confusing requirements that threaten Plaintiff's ability to continue providing abortion and miscarriage care. The fact that both "parents" have disposition rights mandates notice and consent of the patient's sexual partner (as the other

"parent" of the tissue), and requires that, when the other "parent" is "absent," unspecified "reasonable efforts" be made to locate him prior to disposition. *See* Ark. Code Ann. § 20-17-102(d)(1)(E). In the case of a minor, her sexual partner would control if he is at least 18; if he is also a minor, then her parent(s) *and* his parent(s) (as the "grandparents" of the tissue) would control. *See id.* § 20-17-102(d)(1)(G). Because Plaintiff cannot provide care without knowing that the tissue can be disposed of lawfully, H.B. 1566 requires him to notify and seek the consent of at least one third party before every woman's abortion. Accordingly, it requires intervention into a woman's pregnancy care by her partner or spouse, by a person no longer in her life, or even by a perpetrator of sexual assault. For minors, it bypasses the State's constitutionally-mandated judicial bypass process, through which a minor can seek *not* to involve her parent in her abortion decision and instead obtain judicial authorization, and potentially expands those involved to 4 "grandparents." These forced disclosures to additional decision-makers, beyond the patient, are alone enough to severely interfere with abortion care.

Moreover, H.B. 1566 requires physicians to ensure compliance with the FDRA's other requirements, though it does not explain how this could be accomplished. *See* H.B. 1566 § 3(a). Plaintiff would have to ensure, for example, that within each class of decision-makers, such as "grandparents," present class members "used reasonable efforts to notify" the others, and that any dispute was resolved by a vote of extant class members or a proceeding before the circuit court. *See* Ark. Code Ann. §§ 20-17-102(d)(1)(E), (d)(1)(G), (e)(2). In addition, those with control could request disposition "in any manner that is consistent with existing laws, rules, and practices for disposing of human remains," thereby leaving the clinic uncertain as to what methods of disposition might be selected, and whether those means are acceptable. *See id.* §§ 20-17-102(d)(2), (e)(2). Further, under the FDRA, only those willing to pay the costs of

disposition have a say in the plan. *See id.* § 20-17-102(e)(1)(C). Ascertaining and documenting the fact that a person with disposition rights forfeits input because he or she is unwilling to assume financial responsibility may be difficult or impossible for Plaintiff. All of these hurdles would, as a practical matter, make abortion impossible to access: Plaintiff and his clinic simply cannot set up systems sufficient and timely enough to ensure meeting all the requirements of the FDRA before he provides abortion care. *See* Hopkins Decl. ¶ 58; Williams Decl. ¶¶ 50-51, 55-56, 59, 62. If Plaintiff proceeded despite an inability to ensure FDRA compliance and in the face of the vast uncertainties here, he would risk criminal penalties.

In addition, it is unclear whether at-home disposal of tissue following a medication abortion or treatment of a miscarriage is permitted under the FDRA, thus further threatening Plaintiff's ability to continue to provide this care. Plaintiff, facing criminal penalties should he fail to properly dispose of tissue following an abortion, cannot be sure if the current disposition of embryonic tissue following a medication abortion or a miscarriage at home is permitted as an "other authorized disposition" and/or is "consistent with existing laws, rules, and practices for disposing of human remains, including . . . cremat[ion]," Ark. Code Ann. §§ 20-17-102(a)(2)(C), (i); such disposal also could apparently not occur without the FDRA's elaborate disposition-control provisions applying. Absent certainty on these points, Plaintiff will have no choice but to stop providing medication abortion, rather than risk criminal liability or other penalties from the continued at-home tissue disposal by his patients. *See* Hopkins Decl. ¶ 55; Williams Decl. ¶ 52. Further, Plaintiff's obligation to "ensure" disposition in accordance with the FDRA applies even if the tissue is sent to a pathology lab. *See* H.B. 1566 § 3(a). Plaintiff cannot control how pathology labs dispose of tissue after testing, but H.B. 1566 nonetheless threatens Plaintiff with criminal liability based on the actions of third parties who receive tissue for reasons other than

disposition.[11] Hopkins Decl. ¶ 60; Williams Decl. ¶ 53. This puts Plaintiff in the impossible position of risking liability under H.B. 1566 or not sending tissue to pathology, notwithstanding medical indications to do so.

ARGUMENT

Plaintiffs Are Entitled to a Preliminary Injunction to Preserve the *Status Quo* During the Pendency of this Litigation.

"The primary function of a preliminary injunction is to preserve the status quo until, upon final hearing, a court may grant full, effective relief." *Kan. City S. Transp. Co., Inc. v. Teamsters Local Union No. 41*, 126 F.3d 1059, 1066 (8th Cir. 1997) (citation omitted). In deciding a preliminary injunction motion, the district court considers four factors: (1) the probability that the movant will succeed on the merits; (2) the threat of irreparable harm to the movant; (3) the balance of equities; and (4) the public interest. *Grasso Enterprises, LLC v. Express Scripts, Inc.*, 809 F.3d 1033, 1035 n.2 (8th Cir. 2016) (citing *Dataphase Sys., Inc. v. C L Sys., Inc.*, 640 F.2d 109, 114 (8th Cir. 1981)). For the reasons set forth below, Plaintiff satisfies this standard and is therefore entitled to a preliminary injunction as to each of the challenged restrictions.

I. PLAINTIFF IS LIKELY TO PREVAIL ON THE MERITS OF HIS CLAIMS

Plaintiff is likely to prevail on his challenges to the D&E Ban and the Medical Records, Local Disclosure, and Tissue Disposal Mandates, because each one violates Due Process by imposing an undue burden on his patients' rights to make decisions about their pregnancy-related medical care. In addition, Plaintiff is likely to prevail because the Medical Records and Tissue

[11] Nor can Plaintiff control how law enforcement disposes of tissue, but Plaintiff arranges transport of tissue to law enforcement "consistent with existing laws," Ark. Code Ann. § 20-17-102(i), and accordingly understands this disposition to be consistent with the FDRA.

Disposal Mandates also violate Due Process protections against unconstitutionally vague standards, and the Local Disclosure Mandate invades the informational privacy right of Plaintiffs' patients.

The Due Process Clause protects "all fundamental rights comprised within the term liberty." *Casey*, 505 U.S. at 847 (quoting *Whitney v. California*, 274 U.S. 357, 373 (1927) (Brandeis, J., concurring)). Among these rights are "personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs," *Obergefell v. Hodges*, 135 S. Ct. 2584, 2597 (2015), such as "choices concerning contraception, family relationships, procreation, . . . childrearing," *id.* at 2599 (citing *Lawrence v. Texas*, 539 U.S. 558, 574 (2003)), and "medical treatment," *Casey*, 505 U.S. at 857. It is "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally effecting a person as the decision whether to bear or beget a child," *id.* at 851 (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)), including the right to terminate a pregnancy, *id.* at 879.

Restrictions on abortion are unconstitutional when they impose an "undue burden." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (quoting *Casey*, 505 U.S. at 878). "[T]here 'exists' an 'undue burden' on a woman's right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the 'purpose or effect' of the provision 'is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'" *Id.* at 2300 (quoting *Casey*, 505 U.S. at 878) (emphasis omitted). As the Supreme Court recently reiterated, the undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309 (citing *Casey*, 505 U.S. at 887-98). Not only must there be "a constitutionally acceptable"

justification for regulating abortion, but the regulation must also actually advance that goal in a permissible way. *Id.* at 2309-10.

Moreover, a regulation will not be upheld unless the benefits it advances outweigh the burdens it imposes. *Id.* at 2310. This standard requires close judicial scrutiny, because, as the Supreme Court has explained, it would be "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.* at 2309 (citing *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 491 (1955)).

Plaintiff applies this standard first to the D&E Ban's unconstitutional obstacle to abortion, and then turns to each of the other challenged laws—which not only impose an undue burden on abortion, but also are impermissibly vague (Medical Records and Tissue Disposal Mandates), invade patients' rights to informational privacy (Local Disclosure Mandate), and interfere with access to miscarriage care (Tissue Disposal Mandate)—setting forth the additional constitutional principles each of those violates below. Under these well-established protections, there can be no question that Plaintiff is likely to prevail on the merits of his challenges to each law.

A. Plaintiff Is Likely to Prevail on His Challenge to H.B. 1032's D&E Ban Because It Imposes an Undue Burden on His Patients.

H.B. 1032 bans D&E: the safest and most common second-trimester abortion method; the only method that can be performed on an outpatient basis in the second trimester; and, in 2015, the method used for 100% of reported abortions in Arkansas at or after 14 weeks LMP.

Four decades of unwavering U.S. Supreme Court precedent squarely hold that it is unconstitutional to ban the most common second-trimester abortion method. *See Gonzales v. Carhart*, 550 U.S. 124, 165 (2007); *Stenberg v. Carhart*, 530 U.S. 914, 945-46 (2000); *Planned*

Parenthood of Cent. Mo. v. Danforth, 428 U.S. 52, 77-79 (1976). Because H.B. 1032 directly conflicts with this precedent, Plaintiff is likely to prevail on this claim.

In *Danforth*, the Supreme Court held that a Missouri law banning the then-most common method of second-trimester abortion, saline amniocentesis, was unconstitutional. 428 U.S. at 77-79. In overturning the lower court's ruling upholding the ban, the Court focused on several factors, including "the prevalence" of that method "as an accepted medical procedure in this country," which the Court found to range from 68 to 80% of all second-trimester abortions. *Id.* at 77. The Court also considered 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 the state could offer no evidence that alternatives were available in Missouri. *Id.* Finally, the Court recognized 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 79.

Next, in *Stenberg*, the Supreme Court affirmed the judgment of the Eighth Circuit and struck down a Nebraska law banning so-called "partial-birth abortion." And the Court did so precisely because the law was so broadly written that it banned 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 unconstitutional undue burden on a woman's right to abortion. *Id.*

Since *Stenberg*, federal courts have consistently struck any ban that reaches D&E, including laws that, like H.B. 1032, target D&E specifically. *W. Ala. Women's Ctr. v. Miller*, 217 F. Supp. 3d 1313 (M.D. Ala. 2016) (preliminarily enjoining law similar to H.B. 1032, targeting D&E), *appeal filed,* No. 16-17296 (11th Cir. Nov. 29, 2016); *see also Northland*

Family Planning Clinic, Inc. v. Cox, 487 F.3d 323 (6th Cir. 2007) (affirming district court decision that law prohibiting D&E created an unconstitutional burden), *cert. denied*, 552 U.S. 1096 (2008); *Hope Clinic v. Ryan*, 249 F.3d 603 (7th Cir. 2001) (per curiam) (holding unconstitutional under *Stenberg* state laws prohibiting D&E); *Eubanks v. Stengel*, 224 F.3d 576 (6th Cir. 2000) (per curiam) (affirming under *Stenberg* district court decision that law prohibiting D&E created an unconstitutional burden); *Causeway Med. Suite v. Foster*, 221 F.3d 811 (5th Cir. 2000) (same); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127 (3d Cir. 2000) (same); *A Choice for Women v. Butterworth*, 2000 WL 34403086 (S.D. Fla. 2000) (permanently enjoining law prohibiting D&E); *Daniel v. Underwood*, 102 F. Supp. 2d 680 (S.D. W. Va. 2000) (same); *accord Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436 (6th Cir. 2003) (upholding state ban on D&X variant because it explicitly exempted D&E); *R.I. Med. Soc'y v. Whitehouse*, 239 F.3d 104 (1st Cir. 2001) (per curiam).

Most recently, in *Gonzales*, the Supreme Court affirmed that the state may not ban the D&E procedure. The Court in *Gonzales* interpreted a federal ban on so-called "partial-birth abortion" to reach *only* D&X procedures, a distinct variant of D&E used by a minority of physicians, not the standard D&E procedure, and held that the constitutionality of the federal ban rested on the continued availability of the "prototypical" D&E. 550 U.S. at 153, 164, 166-67. In so holding, the Court both distinguished and affirmed the continued vitality of *Danforth*. The statute at issue in *Danforth* was unconstitutional, the Court in *Gonzales* explained, *because* it banned the then-dominant second-trimester abortion method. *Id.* at 165. By contrast, the ban at issue in *Gonzales* did not impose a substantial obstacle on a woman seeking abortion because it allowed for the continued availability of the "commonly used and generally accepted [D&E] method" that H.B. 1032 targets. *Id.* The Court likewise both distinguished and affirmed

Stenberg, explaining that the statute at issue in that case was unconstitutional because it banned both D&X and standard D&E, *Gonzales*, 550 U.S. at 154, whereas the law at issue in *Gonzales* did not ban standard D&E—the most common method of second-trimester abortion, *id.* at 165-66. Hence, "*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.*, 487 F.3d at 336-37 (post- *Gonzales*, striking down ban that reached D&E).

Eighth Circuit precedent likewise establishes that a ban on D&E cannot stand: when presented with bans that reached D&Es in Arkansas, Nebraska and Iowa, the Court struck down all three. *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 388 (8th Cir. 1999); *Carhart v. Stenberg*, 192 F.3d 1142, 1145-46 (8th Cir. 1999); *Little Rock Family Planning Servs., P.A. v. Jegley*, 192 F.3d 794, 797-98 (8th Cir. 1999). The court reasoned that because "the D&E procedure is the most common procedure for second-trimester abortions," "[i]f [this] procedure [is] barred by" a law, "an undue burden is created for a woman seeking a second-trimester abortion for" before viability. *Little Rock Family Planning Servs.*, 192 F.3d at 797-98; *accord Carhart*, 192 F.3d at 1145; *Planned Parenthood of Greater Iowa*, 195 F.3d at 388; *see also Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015) (striking down Arkansas ban on abortion after 12 weeks).

D&E is still the most common second-trimester abortion method; H.B. 1032 clearly bans it; and "in doing so, [it] imposes an undue burden on a woman's right to choose to have an abortion." *Carhart*, 192 F.3d at 1151. H.B. 1032's ban on D&E is unconstitutional under this unbroken line of Supreme Court and Eighth Circuit precedent and must be enjoined.

For two reasons, it is irrelevant that H.B. 1032 would not trigger prosecution if, prior to a D&E, a physician used a separate procedure to try to cause fetal demise, and that attempt was

successful. First, as a factual matter, there is absolutely no evidence that such attempts are feasible or safe in the early weeks of the second trimester, when two-thirds of D&Es occur, and they are not reliably successful or safe in all patients in the later weeks. *See supra* pp. 8-10. The fact that physicians can attempt demise for some patients in the later weeks does not change the fact that a physician, knowing such an attempt could fail, would risk prosecution in beginning any D&E for any patient. Second, as a legal matter, just as the Supreme Court held in *Danforth* that the state cannot ban the most common method of second-trimester abortion simply by pointing to purported "alternatives" that were not actually available, so Arkansas cannot ban D&E simply by pointing to similarly unavailable purported work-arounds. *See Danforth*, 428 U.S. at 77-79. As explained above, there are no "work-arounds"—no way for physicians to ensure demise in a way that is safe for patients and protects physicians from prosecution.

H.B. 1032 is divorced from any valid state interest, and imposes significant medical and logistical burdens on patients. Plaintiff has established a likelihood of success on his claim that it is unconstitutional.

B. Plaintiff Is Likely to Prevail on His Challenge to H.B. 1434's Medical Records Mandate, Because It Is Unconstitutionally Vague and Imposes an Undue Burden on His Patients.

1. The Conduct Prohibited Is Unconstitutionally Vague and Subjects Physicians to Arbitrary Enforcement Actions.

Under the Due Process Clause, "an enactment is void for vagueness if its prohibitions are not clearly defined." *D.C. v. City of St. Louis*, 795 F.2d 652, 653 (8th Cir. 1986) (quoting *Grayned v. City of Rockford*, 408 U.S. 104, 108-09 (1972)). Due process requires that laws provide fair notice by giving a "person of ordinary intelligence a reasonable opportunity to know what is prohibited, so he may act accordingly." *Id.* Due process also demands explicit standards to prevent arbitrary or discriminatory actions by those charged with enforcement. *Id.*

If a law "threatens to inhibit the exercise of constitutionally protected rights," the Constitution demands an especially high level of clarity. *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 499 (1982). Likewise, when violation of a law carries criminal penalties, "a strict test of specificity" applies. *D.C.*, 795 F.2d at 654. Even if a law "nominally imposes only civil penalties," if those are "prohibitory and stigmatizing," courts still undertake a close review for vagueness. *Hoffman Estates*, 455 U.S. at 499. The Medical Records Mandate triggers the strictest vagueness review, because it both inhibits the exercise of constitutionally protected rights to liberty and privacy, *see infra* Argument Point I.B.2., and imposes criminal and other stigmatizing penalties, such as the finding of "unprofessional conduct" and revocation of a physician's license to practice, H.B. 1434 § 1.

Even a lesser standard would be fatal to the Medical Records Mandate, which is unconstitutionally vague in at least three respects. ***First***, it gives no guidance on what constitutes "reasonable time and effort," leaving the word "reasonable" with no content and no context. How much effort is needed to be "reasonable"? How long is it "reasonable" to wait for records? H.B. 1434 is silent, yet medical records requests may take days or weeks to fulfill, or simply go unanswered. *See supra* p. 13.

H.B. 1434 also does not explain whether *any* facts—beyond the effort expended to request records and the number of days or weeks of delay spent awaiting their arrival—are relevant in assessing what is "reasonable." Is the amount of money the physician or patient must pay for searching, copying, and, where necessary, securing translation of records into English relevant to what is "reasonable"? Williams Decl. ¶ 30. There is no exception allowing a physician to provide care absent "reasonable time and effort" where necessary to protect a patient from increased risk, yet increased risk will necessarily result from the indefinite delay

inherent in the Mandate. Is it "reasonable" to proceed without receiving records in order to avoid the increased risk of a one-month delay? A one-week delay? To avoid pushing a woman's care into the second trimester, past 14.0 weeks LMP, when she would need a D&E, which entails higher risks than a suction abortion (and which H.B. 1032 would ban)? If so, does that mean it is "reasonable" to delay for a number of weeks—and make follow up contacts to numerous providers seeking records—for a patient who initially seeks care at 10 weeks, but not for a patient who initially seeks care at 13 weeks and some number of days? For that patient, how many days is it "reasonable" to delay? Is just making the initial records request alone ever "reasonable"? Is it "reasonable" to force a woman to delay 3 weeks if she has the financial resources and flexibility to return in 3 weeks, but not reasonable in the case of a woman struggling financially, who absolutely cannot return—and pay for a later, more expensive procedure—in 3 weeks? Where, as here, subjective terms such as "reasonable time and effort" have no specified boundaries, a statute fails to provide fair notice and invites arbitrary enforcement. *See, e.g.*, *Grayned*, 408 U.S. at 113 (highlighting the due process problems with a "completely subjective standard").

Second, H.B. 1434 fails to define or in any way limit the scope of "medical records relating directly to the [patient's] entire pregnancy history." H.B. 1434 § 1. Hence, the indeterminate, "reasonable" search requirements apply to a vast, undefined target covering all care related to a patient's current and prior pregnancies, if any, whether molar or ectopic, and whether they resulted in abortion, miscarriage, or birth. Hopkins Decl. ¶ 31. Does a "direct" relation to a patient's entire pregnancy history include care by her general practitioner for pregnancy-related symptoms? Must Plaintiff request records from a laboratory or ultrasound

center? These are just a few of the paralyzing uncertainties that a physician would face under H.B. 1434.

Third, H.B. 1434 gives no direction whatsoever on what actions, if any, the physician is to take upon receiving any records. In the few instances in which records are relevant to an abortion patient's care, the physician, with the patient's consent, requests targeted records for a specific medical purpose. Williams Decl. ¶¶ 24-25. *See supra* pp. 12-13. Here, with a mandatory search for the patient's "entire pregnancy history," must the physician review every record, and, if so, for what purpose? If the Medical Records Mandate is connected in any way to the same law's ban on abortion decisions based solely on the sex of the embryo or fetus, the nature of such a connection is utterly mysterious, for the law is silent. Surely the Medical Records Mandate, which necessarily imposes delay, can bear no relation to the law's other stated purpose, to "[p]rotect women from the risks inherent in late-term abortions." Ark. Code Ann. § 20-16-1802(b)(2). Contrary to the Due Process Clause, the Medical Records Mandate fails to provide clear standards for physicians, inviting arbitrary enforcement by prosecutors, the Arkansas Medical Board, and others. Dr. Hopkins is therefore likely to prevail in this challenge to the Mandate.

2. The Medical Records Mandate Imposes an Undue Burden Because It Delays or Bars Most Abortions, Contains No Health Exception, and Imposes Prohibitive Requirements on Providers.

H.B. 1434's massive records mandate—requiring, for the great majority of patients, requests for every record directly related to care throughout the current and all prior pregnancies—will simply shut down care. It will do so because the clinic that provides 3,000 of the 3,800 abortions reported in Arkansas each year cannot process that volume of requests. Williams Decl. ¶¶ 24, 32 (the clinic currently makes targeted records requests for approximately

25 patients per year and cannot handle the comprehensive, open-ended requests the Mandate would require for the great majority of patients). "[A]t some point increased cost could become a substantial obstacle." *Casey*, 505 U.S. at 901.[12]

In addition, H.B. 1434 will deny access to care because its indefinite delay will run out the clock on a woman's time to obtain abortion care in Arkansas, which bans abortions after 21.6 weeks LMP. Ark. Code Ann. § 20-16-1405 (2013) (banning abortion after 20.0 weeks post-fertilization, which is 22.0 weeks LMP). And it will prevent women from obtaining care because many simply cannot manage the logistical and financial obstacles of indefinite delay. Williams Decl. ¶ 34; *cf.* Hopkins Decl. ¶ 42. That effective ban will apply even where abortion is necessary to prevent a serious health risk to the patient, for the Mandate has no exception allowing physicians to act without the required records search in such cases. Given the vague terms, criminal and other serious penalties, and risk of arbitrary enforcement, *see supra* Argument Point I.B.1, physicians cannot risk violation. Such a burden on a woman's access to abortion violates the Constitution. *Casey*, 505 U.S. at 877.

Even were Plaintiff to attempt to comply, the delay would impose unconstitutional harm. His patients would not even know when their delay in accessing abortion *might* end in Arkansas, because they cannot know when other providers might deliver the records, or when a "reasonable" time has passed. This kind of indefinite delay unquestionably erects a substantial obstacle to abortion access. *See Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 920

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[12] These burdens are especially inappropriate because they appear to serve no proper state purpose. *See Whole Woman's Health*, 136 S. Ct. at 2318 (an abortion regulation is unconstitutional where it provides "few, if any" medical benefits); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 920 (7th Cir. 2015) emphasizing that the "feebler the medical grounds (in this case, they are nonexistent), the likelier" it is that any burden on abortion is disproportionate and therefore undue).

(7th Cir. 2015) (explaining that delay causes women to "forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks. Other women would be unable to obtain any abortion, because the delay would push them past" the point in pregnancy at which abortion care is available), *cert. denied*, 136 S. Ct. 2545 (2016); *Planned Parenthood Ark. & E. Okla. v. Jegley*, No. 4:15-CV-00784-KGB, 2016 WL 6211310, at *29 (E.D. Ark. Mar. 14, 2016) (delay forces "women into later abortions that are both riskier and more expensive, if they can obtain them at all"), *appeal filed*, No. 16-2234 (8th Cir. May 18, 2016). In the context of judicial bypass procedures, which allow a minor to obtain abortion care without otherwise mandated parental involvement, the Supreme Court has made clear such procedures are unconstitutional unless they assure an expeditious time frame for completion of the process; for the same reason, the Medical Records Mandate is unconstitutional because of the wholly indefinite delay it imposes. *See, e.g., Bellotti v. Baird*, 443 U.S. 622, 644 (1979) (holding that judicial bypass process for minor "must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained"); *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1110 (5th Cir. 1997) (striking down judicial bypass statute that lacked time limits and noting that "[s]uch an open-ended bypass procedure has never been approved"), *overruled on other grounds by Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001).

Finally, any attempt to comply with the Medical Records Mandate would disclose the patient's desire for an abortion to all her other providers of pregnancy-related health care. Hopkins Decl. ¶ 38; Williams Decl. ¶ 27. This involuntary disclosure of highly personal information would violate Plaintiff's patients' right to the confidentiality of their reproductive decision-making, and would further interfere with their right to decide to end a pregnancy.

Bellotti, 443 U.S. at 655; *see infra* 39. This violation of confidentiality will cause some women to forego abortion in Arkansas rather than risk disclosure to medical providers who they know strongly oppose abortion and/or who are family friends or neighbors. *See* Williams Decl. ¶ 28.

C. Plaintiff Is Likely to Prevail on His Challenge to H.B. 2024's Local Disclosure Mandate Because It Violates Both Decisional and Informational Privacy Protections.

Plaintiff is likely to prevail on the merits of his challenge to H.B. 2024 as applied to Non-CMA Teenage Patients because that law imposes unconstitutional burdens on abortion access and patient confidentiality. The 14- to 16-year-old patients at issue in this case have engaged in sexual intercourse involving neither reportable abuse nor criminality, and thus the State has no valid investigatory or other interest in the law's requirements. H.B. 2024 mandates disclosure of a young woman's inherently private information to local police and seemingly bars her access to medication abortion without justification.

1. H.B. 2024 Imposes an Undue Burden on Access to Abortion.

The undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. An abortion restriction passes this balancing test only if it actually advances a "constitutionally acceptable" interest *and* that its benefits outweigh its burdens. *Id.* at 2309-10. Here, H.B. 2024 serves no valid state objective that might justify the harms it imposes on the Non-CMA Teenage Patients, who seek abortion care absent any indication of abuse or crime.

First, H.B. 2024 and its implementing Rules are seemingly inconsistent with any medication abortions, because a physician cannot prescribe that procedure and also preserve the products of conception as "evidence." *See supra* pp. 18-19.[13] H.B. 2024 will thus force a young

[13] H.B. 2024's application to medication abortions is vague: Section 12-18-108 refers to "tissue extracted during the abortion," which could exclude medication abortions from its impact, because the physician extracts no tissue in that treatment option, but the definition of abortion in both the Child Maltreatment Act (of which Section 12-18-108 is a part) and its implementing Rules explicitly includes abortions accomplished with "drug[s]," Ark. Code Ann. § 12-18-103(2)(A); Ark. Admin. Code § 171.00.2 (2014), and the Rules for Section 12-18-108 direct

woman to have a suction aspiration, even if she and Plaintiff Dr. Hopkins believe medication abortion is preferable for her. *Cf. Planned Parenthood of Ariz., Inc. v. Humble*, 753 F.3d 905, 915-917 (9th Cir. 2014) (finding law barring some medication abortions imposed an undue burden because "medication abortion and surgical abortion are very dissimilar procedures" and the state had no sufficiently weighty interest in forbidding "a common procedure strongly favored over surgical abortion by many women"). In cases where medication abortion is medically indicated, suction aspiration itself may not be an option, and thus under H.B. 2024's universal tissue collection and preservation requirement, Dr. Hopkins would have to consider more complex surgical interventions to comply with the law. Hopkins Decl. ¶ 52. *See Jegley*, 2016 WL 6211310, at *30 ("[R]emoving medication abortion as an option for women will result in negative consequences for those women for whom [it] is medically indicated.").

Second, as discussed above, H.B. 2024 mandates informing the local police, who may know the patient or her family, of the abortion. Knowledge of this required post-abortion disclosure in her community may delay or dissuade a young woman in effectuating her decision. Hopkins Decl. ¶ 50; Williams Decl. ¶ 46. *See generally Lambert v. Wicklund*, 520 U.S. 292, 295 (1997) (if an abortion statute requires parental consent, a judicial bypass that "ensures the minor's anonymity" is required to satisfy constitutional requirements); *Casey,* 505 U.S. at 894 (recognizing undue burden of spousal notification requirement on married women who seek an abortion without such disclosure; a "significant number of women … are likely to be deterred

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physicians to preserve "all products of conception." Ark. Admin. Code § 171.00.2 To avoid violating H.B. 2024, Plaintiff will have no choice but to stop providing medication abortions for any patients under 17 years old. In this suit, he challenges that harm as it affects Non-CMA Teenage Patients, but does not concede the constitutionality of its impact on other teenagers. Dr. Hopkins also pleads a vagueness claim against H.B. 2024, because of the uncertain standard it imposes on him. Hopkins Decl. ¶ 53.

from procuring an abortion as surely as if the Commonwealth had outlawed abortion"); *Thornburgh v. Am. Coll. of Ob. & Gyn.*, 476 U.S. 747, 766-67 (1986) (emphasizing that a "woman and her physician will necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known" to third parties), *overruled in part on other grounds, Casey*, 505 U.S. at 881.

Yet H.B. 2024 serves no valid state purpose as applied to a 14- to 16-year-old who has become pregnant through consensual sexual intercourse with, for example, a teenager of the same age: her health care is a purely private matter, with no mandatory reporting and no role for the local police or the state crime laboratory. The mandated "evidence" collection and notification to the local police, as applied to these teenagers, is completely disconnected from any state interest in addressing child abuse and criminal conduct.

Indeed, when the General Assembly first enacted Section 12-18-108, exclusively for abortions involving girls *13 and under*, it targeted "sexual crimes on child victims" and "sexually predatory adults." H.B. 1447 §§ (1)(a), (b) (Findings and Purposes), 89th Gen. Assemb., Reg. Sess. (Ark. 2013). It was directed at "reporting medical facilit[ies]" and explicitly contemplated that its application was co-extensive with mandatory reporting. *Id.* §§ (1)(b)(3), (5). That original statute's focus on girls 13 and under also tracked the criminal threshold for statutory rape; that rape charge also has an affirmative defense if the actor is not more than three years older than the girl. Ark. Code Ann. § 5-14-103(a)(3)(A) (2013). H.B. 2024 now greatly expands Section 12-18-108's reach, without justification, to non-criminal, non-reportable activity that is affirmatively constitutionally protected: here, the abortions sought by the Non-CMA Teenage Patients after sex occurred under circumstances indicating no form of sexual abuse.

Thus, under *Casey* and *Whole Woman's Health* there is no "constitutionally acceptable" state interest to balance against the substantial obstacles erected by H.B. 2024. The law imposes an undue burden on reproductive liberty because no proper purpose outweighs its apparent ban on medication abortion and its forced disclosures to local law enforcement. *Whole Woman's Health*, 136 S. Ct. at 2309-10. Even if its obstacles were not substantial (which they are), H.B. 2024 would still fail constitutional review, given the lack of any justifying state purpose. *Id.*; *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 788 (7th Cir. 2013) (stressing that the weaker the state's grounds for its regulations, "the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous"); *Comprehensive Health of Planned Parenthood Great Plains v. Williams*, No. 2:16-cv-04313, 2017 WL 1407656, *3 (W.D. Mo. April 19, 2017) (the necessary balancing "means that the burden to be considered undue is greatly reduced . . . as the benefit from the regulation becomes miniscule, if any").

2. H.B. 2024 Infringes On Protected Informational Privacy Interests.

a. The Right to Informational Privacy Shields Highly Personal Medical and Sexual Information, Including About a Minor's Abortion and Sexual Activity.

The Fourteenth Amendment "safeguard[s] individuals from unwarranted governmental intrusions into their personal lives." *Eagle v. Morgan*, 88 F.3d 620, 625 (8th Cir. 1996) (citing *Whalen v. Roe*, 429 U.S. 589, 598 n.23 (1977)). This right not only protects against undue burdens on private decisions, but also shields the confidentiality of "highly personal matters" in "the most intimate aspects of human affairs." *Id.* (quoting *Wade v. Goodwin*, 843 F.2d 1150, 1153 (8th Cir. 1988)). The Eighth Circuit has described this constitutional right as applying to information where disclosure would be "a shocking degradation or an egregious humiliation," or "a flagrant bre[a]ch of a pledge of confidentiality which was instrumental in obtaining the personal information." *Id.* (quoting *Alexander v. Peffer*, 993 F.2d 1348, 1350 (8th Cir. 1993)).

The Court has also stressed that "[w]hen the information is inherently private, it is entitled to protection." *Id.* (quoting *Fraternal Order of Police, Lodge 5 v. City of Philadelphia*, 812 F.2d 105, 116 (3d Cir. 1987)).

Constitutional protection turns on the nature of the material and whether the person has "a legitimate expectation that the information would remain confidential." *Id.* Medical information is almost always "considered extremely personal and entitled to protection under the fourteenth amendment." *Shuda v. Williams*, No. 4:08CV3168, 2008 WL 4661455, at *3 (D. Neb. Oct. 20, 2008) (finding plaintiff stated a constitutional claim for disclosure of treating physicians and diagnoses). As the Western District of Arkansas noted in *Bolt v. Doe*, the right to informational privacy under the Fourteenth Amendment "extends to medical test results, medical records, and medical communications. *See Ferguson v. City of Charleston*, 532 U.S. 67, 78 (2001) (individuals have a reasonable expectation of privacy in medical test results and that those results will not be shared with nonmedical personnel without the patient's consent)." No. 5:14-CV-5223, 2014 WL 5797706, at *5 (W.D. Ark. Nov. 7, 2014).[14]

Because independent decision-making about abortion is itself protected as a fundamental right, a woman's ultimate decision is the type of highly personal information that lies at the core of informational privacy. Involuntary disclosure of an abortion is a flagrant breach of the premises of medical care, and could expose the patient to "egregious humiliation" or worse. *Alexander*, 993 F.2d at 1350; *cf. id.* at 1351 (distinguishing information about failure

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[14] *See also, e.g., A.L.A. v. West Valley City*, 26 F.3d 989, 990 (10th Cir. 1994) ("There is no dispute that confidential medical information is entitled to constitutional privacy protection."); *Doe v. City of N.Y.*, 15 F.3d 264, 267 (2d Cir. 1994) (acknowledging the "recognized constitutional right to privacy in personal information," including medical information); *U.S. v. Westinghouse Elec. Corp.*, 638 F.2d 570, 577 (3d Cir. 1980) ("There can be no question that . . . medical records, which may contain intimate facts of a personal nature, are well within the ambit of materials entitled to privacy protection.").

to qualify for police job, found not protected, from materially different "matters deemed to be fundamental rights" or "highly personal medical or financial information"). Likewise, "choices about sex . . . are interests of an intimate nature which define significant portions of our personhood . . . [and] that we regard as highly personal and private." *Bloch v. Ribar*, 156 F.3d 673, 685-86 (6th Cir. 1998); *see also Thorne v. City of El Segundo*, 726 F.2d 459, 468-69 (9th Cir. 1983) (rejecting polygraph questions about sexual relationships, miscarriage, and identity of sexual partner as infringing on constitutionally protected interests).

The Constitution's protection of intimate medical or sexual facts against involuntary disclosure applies to minors as well as adults. *See, e.g.*, *C.N. v. Ridgewood Bd. of Educ.*, 430 F.3d 159, 179 (3d Cir. 2005); *Sterling v. Borough of Minersville*, 232 F.3d 190, 196-97 (3d Cir. 2000) (finding clearly established constitutional privacy right implicated where police officer threatened to disclose minor's homosexuality to his grandfather, and minor committed suicide upon his release from police custody). Indeed, minors may have a particularly acute need to protect the privacy of their abortion information. *See, e.g.*, Hopkins Decl. ¶ 49 (discussing Arkansas teenager who committed suicide when she learned that her plan for an abortion was going to be disclosed by another adult to her parent). For all these reasons, Plaintiff's patients have a strong, constitutionally protected interest in avoiding disclosure of their sexual activity and their abortion to local police.

b. For the Non-CMA Teenage Patients, Arkansas Has No State Interest to Justify Invasion of Their Informational Privacy.

Once information is found protected, the individuals' interest in keeping that information private must be balanced against any articulated state interest in requiring disclosure. *See Taylor v. U.S. Internal Revenue Serv.*, 915 F. Supp. 1015, 1023 (N.D. Iowa 1996) (in financial disclosure case, requiring "substantial" state interest and narrow focus on state's purpose), *aff'd*

sub nom. Taylor v. United States, 106 F.3d 833 (8th Cir. 1997). The state will ultimately bear the burden of showing a valid interest, that the state narrowly tailors the infringement on confidentiality, and that its interests are strong enough to outweigh the privacy harms at issue. *See Thorne*, 726 F.2d at 469 (government "must show that its inquiry into appellant's sex life was justified by the legitimate interests of the police department [and] that the inquiry was narrowly tailored to meet those"); *Bloch*, 156 F.3d at 686 ("[W]e must . . . balance the Blochs' privacy interest against the state's interest . . . ."). Here, because the highly personal information disclosed concerns exercise of a fundamental right (abortion), the state would need an especially weighty interest to justify this infringement.

But the state can advance no proper government interest in H.B. 2024's disclosures as applied to the patients at issue. As established above, H.B. 2024's requirements serve no legitimate state interest for these patients. *See supra* pp. 39-40. Instead, these teenagers are inappropriately swept up in a process designed for criminal abuse situations, and are labeled as "victims" with "evidence" to capture when they are not. The fact of their abortion, and tissue from it, are exposed to their local police and to indefinite storage in the state crime lab—along with accompanying information about their parents and sexual partner. *Cf. Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 552 (9th Cir. 2004) (recognizing harm of disclosure to government employees of individuals' abortions and the sensitive nature of this information; "the fact that they are government employees is no solace to the numerous neighbors, relatives and friends of DHS employees"). These required disclosures under H.B. 2024 cause significant harm by exposing inherently private information, in breach of the confidential physician-patient relationship, to local police officers and others without any countervailing state interest. H.B.

2024, as applied, therefore fails any constitutional balancing and impermissibly infringes on informational privacy.

D. Plaintiff Is Likely to Prevail on His Challenge to H.B. 1566's Tissue Disposal Mandate Because It Imposes an Undue Burden and Is Unconstitutionally Vague.

1. H.B. 1566 Burdens the Personal Liberty of Plaintiff's Patients Seeking Pregnancy-Related Medical Care.

As set out above, *supra* pp. 26-27, laws that impede the right to make decisions about abortion are unconstitutional when they impose an "undue burden." *Whole Woman's Health*, 136 S. Ct. at 2300 (quoting *Casey*, 505 U.S. at 878). The Constitution's limits on the State's power to interfere with women seeking treatment for miscarriage are at least as rigorous as those regarding abortion. *See generally Casey*, 505 U.S. at 851; *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687 (1977) ("[T]he Constitution protects individual decisions in matters of childbearing from unjustified intrusion by the State.").

H.B. 1566 imposes burdens on Plaintiff's patients that fall into three categories. ***First***, it requires the notice and consent to the disposition of embryonic and fetal tissue—and thus every woman's abortion—of either a woman's sexual partner (as the other "parent" of the embryonic or fetal tissue) or, if the woman and her sexual partner are minors, the parent(s) of both (as "grandparents") in direct conflict with Supreme Court precedent. In doing so, H.B. 1566 deems every woman having an abortion or miscarriage the "parent" of embryonic or fetal tissue, regardless of whether she holds that view. Williams Decl. ¶ 63. ***Second***, H.B. 1566 imports the FDRA's elaborate disclosure and decision-making provisions from its original context—establishing a framework for the orderly disposition of human remains by family members—to the disposition of embryonic and fetal tissue. As a result, H.B. 1566 will not only dissuade and delay women who seek abortions, but also make it impossible, as a practical matter, for Plaintiff

to continue providing them, because he cannot ensure that tissue disposition will ultimately take place in full compliance with the FDRA. ***Third***, H.B. 1566 further threatens women's health and safety by seemingly interfering with medication abortion and miscarriage management, because when tissue disposal occurs at home, outside the physician's control, he will be risking sanctions under this vague law. Likewise, by providing no exception for sending tissue to pathology labs, the statute imperils health as it ties the hands of physicians.

a. H.B. 1566 Imposes Unconstitutional Third-Party Notice and Consent Requirements on Women Seeking Pregnancy-Related Medical Care.

H.B. 1566's application of the FDRA to abortion and miscarriage care unconstitutionally conditions that care on the notice and consent of the woman's sexual partner, if he is at least 18 years old, or the parent or parents of both a minor patient and her sexual partner, if both are minors, thereby impeding the patient's right to make decisions about pregnancy, depriving her of privacy, exposing her to potential harm, and potentially denying or delaying her access to care. Notice and consent to disposition must be obtained prior to Plaintiff performing an abortion or providing miscarriage care because, as a practical matter, Plaintiff cannot proceed with care without first knowing that the tissue can be lawfully disposed of. *See* Williams Decl. ¶¶ 55-56. These third-party notice and consent requirements alone render H.B. 1566 unconstitutional.

The FDRA requires notification of the woman's sexual partner regarding the abortion or miscarriage as well as his consent to disposition because it gives both "parents" equal right to disposition of embryonic and fetal tissue. Ark. Code Ann. § 20-17-102(d)(1)(E). There is no exception; indeed, the FDRA mandates that "reasonable efforts" be taken to locate the woman's sexual partner if "absent." *Id.* This notice and consent requirement directly violates binding Supreme Court precedent. *See Danforth*, 428 U.S. at 69 ("[T]he State may not constitutionally

require the consent of the spouse . . . as a condition for abortion . . . ."); *Casey*, 505 U.S. at 898 (invalidating a provision requiring spousal notification prior to abortion); *see also id.* ("A husband has no enforceable right to require a wife to advise him before she exercises her personal choices," including about pregnancy.). Under these decisions, H.B. 1566's notice to a spouse/partner and involvement of him in decision-making fundamentally violates the liberty interests of a woman seeking abortion care. *Id.* In addition, because the woman's partner could be difficult to locate, could withhold consent, could seek a different means of disposition, or could otherwise delay the abortion, H.B. 1566 gives him "an effective veto" over her decision. *Id.* at 897. Moreover, notice of the abortion could subject some patients to physical and psychological abuse. *Id.* at 893; Hopkins Decl. ¶¶ 56-57; Williams Decl. ¶ 60. It thus not only burdens all women seeking abortions but is "likely to prevent a significant number of women from obtaining an abortion." *Casey*, 505 U.S. at 893.

H.B. 1566 also effectively imposes a parental consent requirement for patients under 18, circumventing Arkansas's constitutionally-mandated judicial bypass process. Current law requires that a physician obtain the written consent of one parent before providing abortion care for a minor patient. Ark. Code Ann. § 20-16-804. The law further provides that a court may authorize the minor to consent to the abortion without the consent of her parent. *Id.* §§ 20-16-808, -809. The availability of the judicial bypass process reflects long-standing constitutional requirements. *See Bellotti*, 443 U.S. at 643 ("[I]f the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained."); *id.* at 639-40 ("[A] State [can] not lawfully authorize an absolute parental veto over the decision of a minor to terminate her pregnancy." (citing *Danforth*, 428 U.S. at 74)).

The FDRA provides disposition rights only to individuals who are at least 18 years of age; accordingly, for minors with a minor sexual partner, the disposition right vests in both her parent(s) and his parent(s) as the "grandparents" of the embryonic or fetal tissue. *See* Ark. Code Ann. § 20-17-102(d)(1)(G).[15] This requirement effectively mandates parental consent, not just for disposition, but for the abortion as well because Plaintiff cannot begin providing abortion care until he is sure that he can comply with the disposition requirements once the procedure is complete. Hopkins Decl. ¶¶ 58, 61; Williams Decl. ¶¶ 55-56. But parents who do not consent to the abortion can—by withholding consent for or creating a dispute about disposition—make it impossible for Plaintiff to proceed, even if the minor already has one parent's consent for the abortion or has obtained judicial authorization for the abortion without parental consent. The State cannot, directly or through the disposition requirements of H.B. 1566, give a parent (or others) "an absolute, and possibly arbitrary, veto" over a minor's decision to have an abortion. *Danforth*, 428 U.S. at 74; *see also Bellotti*, 443 U.S. at 639-40, 644. Thus, as with the sexual partner notice and consent requirement, H.B. 1566 impermissibly requires a minor to disclose her decision to both parents, in some instances risking her health and safety by doing so, *see Hodgson v. Minn.*, 497 U.S. 417, 450-51 (1989). Indeed, it goes beyond her parents to require involvement by her sexual partner's parents, and pulls all of them into her abortion decision-making in a manner that cannot be squared with binding Supreme Court precedent.

b. H.B. 1566's Harms Extend Well Beyond Its Notice and Consent Requirements to Effectively Block Abortions.

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[15] Where a minor patient and her sexual partner are, for example, both 17 years old, the disposition right would pass to the parents of both minors, as the "grandparents" under the FDRA. *See* Ark. Code Ann. §§ 20-17-102(d)(1), (d)(1)(G). Where the minor seeking an abortion is 17 and her sexual partner is 18, however, it appears that he would have a disposition right under the FDRA, but she would not. *Id.* §§ 20-17-102(d)(1), (d)(1)(E).

The unconstitutional notice and consent features of H.B. 1566 are not isolated harms. Rather, these requirements, in conjunction with its requirement that the physician ensure that tissue is ultimately disposed of in accordance with the FDRA, will effectively ban abortion by dissuading women from pursuing care, delaying care until it is too late, or forcing Plaintiff to cease providing it. The prospect of notice to a partner or to two sets of parents would alone dissuade many patients, before the process of disclosing and involving those other people even began. *See, e.g.*, *Casey*, 505 U.S. at 894 ("[A] significant number of women . . . are likely to be deterred [by a spousal notification requirement] from procuring an abortion as surely as if the [State] had outlawed abortion in all cases."); Hopkins Decl. ¶¶ 56-57; Williams Decl. ¶ 61; *supra* pp. 22-23. If notice occurred, and those third parties became involved, many women would simply be unable to obtain abortions because those controlling tissue disposition could effectively block access. Even beyond that, mandating compliance with all of the requirements that H.B. 1566 and the FDRA impose on the disposition of embryonic or fetal tissue will prevent Plaintiff from proceeding with abortions. To avoid criminal penalties, he will have no choice but to cease providing abortions if H.B. 1566 takes effect. Hopkins Decl. ¶ 61.

Just the notice and search requirements for interested parties under the FDRA would cause significant delay. Unspecified "reasonable efforts" must be made to locate a woman's "absent" sexual partner prior to disposition. Ark. Code Ann. § 20-17-102(d)(1)(E)(ii). Likewise, "reasonable efforts to notify all other members of the class" must be undertaken for all of the "grandparents" of the tissue if disposition decision-making vests in that class. *Id.* § 20-17-102(d)(3)(A).

Moreover, it is not merely notice but control over disposition decision-making that the FDRA specifies. *Id.* § 20-17-102(d)(1) (including "the location, manner, and conditions of the

disposition, and arrangements for funeral goods and services"). If there is a dispute among those with disposition rights that cannot be resolved by their majority vote, any of those persons or "a funeral director with custody of the remains" may file a petition for the state circuit court to determine disposition. *Id.* § 20-17-102(e)(2).

Plaintiff could not proceed with abortion care unless he is certain that he can meet the disposition requirements, but whether that certainty is ever possible is unclear and the delays that would result from even attempting to achieve such certainty would harm his patients. Hopkins Decl. ¶ 58. Delay increases the risks associated with pregnancy-related care, can deny a woman her choice of abortion procedure, and, if she is pushed past the clinic's gestational limit, make it impossible for her to obtain an abortion in Arkansas. *See, e.g.*, *Schimel*, 806 F.3d at 920; *Jegley*, 2016 WL 6211310, at *29. The FDRA's civil provisions—located in the public health and welfare code, and aimed at providing legal certainty and protection against liability to decedents, next of kin, funeral homes and crematoria—do not translate clearly or well to the context of a physician offering time-sensitive, private medical care to a patient. Bound to avoid criminal liability and maintain his ability to practice, and unable to ensure compliance with the FDRA's rules, Plaintiff will be forced to curtail his services if H.B. 1566 is not enjoined.

c. H.B. 1566 Also Harms Women's Health By Its Threats to Medication Abortions, Miscarriage Care, and Pathology Services.

H.B. 1566's mandate that Plaintiff "ensure" disposition of embryonic and fetal tissue in accordance with the FDRA further threatens women's health and safety by separately depriving women of access to medication abortion and providing no exception for tissue sent to pathology. In addition to the harms already described, H.B. 1566 effectively bans medication abortion either because it is unclear whether disposition of tissue following a medication abortion at home is otherwise permitted (and whether permitted with or without the FDRA's notice and disposition

control provisions applying), *see infra* p. 53, or because disposal of tissue at home is not in fact permitted under the FDRA. In either event, Plaintiff cannot continue to provide this care. Williams Decl. ¶ 52; Hopkins Decl. ¶ 55. Because disposal from a miscarriage completed through medication at home is the same, H.B. 1566 also deprives women who experience miscarriage of this option. Hopkins Decl. ¶ 55. Losing access to this care would deprive many women of the best abortion or miscarriage management method for them, and would force a woman to have a clinical procedure in the clinic even if she prefers taking medication. Hopkins Decl. ¶ 55; Williams Decl. ¶ 52.

Furthermore, H.B. 1566 applies even if embryonic or fetal tissue is sent to a pathology lab. H.B. 1566 thus threatens Plaintiff with criminal liability based on the actions of third parties who receive tissue for reasons other than disposition. Pathological testing of tissue is important for women's health; it can screen for certain medical conditions, determine the cause of anomalies, and help predict the likelihood of recurrence in future pregnancies. Hopkins Decl. ¶ 60; Williams Decl. ¶ 53. H.B. 1566 puts Plaintiff in the impossible situation of not sending tissue when it is important for women's health or risking liability under H.B. 1566.

d. H.B. 1566 Advances No Valid Interests.

While the burdens H.B. 1566 imposes are onerous, it advances no valid interest in a permissible way. Any interest the State has in disposition of embryonic and fetal tissue in a medically appropriate way is met by current law. *See supra* Facts Point IV.A.; *Whole Woman's Health*, 136 S. Ct. at 2311, 2314 (finding no significant problem new restriction "helped to cure," nor was it "more effective than pre-existing [state] law" in advancing state's asserted interest). Notably, H.B. 1566 does not specify any new method of disposal, but instead through the FDRA references authorized dispositions that exist separate and apart from H.B. 1566 or the FDRA.

Nothing about importing the FDRA's notice and decision-making requirements into the abortion context advances any public health goal, and they certainly do not advance any interest in women's health, because delay and other negative effects instead threaten women's health and wellbeing.

Neither can any interest the State has in potential life support H.B. 1566 because it applies to tissue disposal *after* an abortion or miscarriage, when there is no "potential life." *See Whole Woman's Health v. Hellerstedt*, No. A-16-CA-1300-SS, 2017 WL 462400, at *2 (W.D. Tex. Jan. 27, 2017) ("Unlike the legitimate state interests recognized by the Supreme Court, [Texas's] professed interest regulates a time when there is no potential life."); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r*, 194 F. Supp. 3d 818, 833 (S.D. Ind. 2016) ("interest in potential life has not been extended . . . to imposing procedures taken after the pregnancy has been terminated like the fetal tissue disposition provisions do" (internal quotation marks and citation omitted)).

Nor can the State mandate that every woman accept the State's view that she is the "parent" of embryonic and fetal tissue, which must be treated as a deceased relative would be. *See Casey*, 505 U.S. at 850 ("Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage."); *Whole Woman's Health*, 2017 WL 462400, at *8 ("[B]y seeking to respect life and the dignity of the unborn regardless of gestational age, [Texas] appears to be inferentially establishing the beginning of human life as conception, potentially undermining the constitutional protection afforded to personal beliefs and central to the liberty protected by the Fourteenth Amendment."). Rather than respecting this central element of the right to abortion, H.B. 1566 denies women their right to make autonomous decisions by

imposing clearly unconstitutional notice and consent requirements, depriving women of access to essential medical care, and enshrining into law a narrow set of beliefs that replace the right "at the heart of liberty" with a viewpoint "formed under compulsion of the State." *Casey*, 505 U.S. at 851.

Weighing these burdens against the Act's failure to advance any valid interest, there is no doubt that it imposes an undue burden on a woman's liberty and is unconstitutional. *Whole Woman's Health*, 136 S. Ct. at 2310. Accordingly, Plaintiff is likely to succeed on his claim that H.B. 1566 imposes unconstitutional burdens on his patients' right to seek pregnancy-related medical care.

2. H.B. 1566's Requirements Are Unconstitutionally Vague.

As set forth above, the Due Process Clause requires clarity in legal standards so that those bound by the law know what is expected of them, especially where criminal penalties may be imposed and fundamental rights are implicated. *See supra* Argument Point I.B.1. Here, H.B. 1566 requires physicians to ensure that embryonic and fetal tissue is disposed of in accordance with the FDRA and that physicians must ensure that outcome, but the requirements of the FDRA as applied to abortion and miscarriage management leave many critical questions unanswered. Specifically, H.B. 1566, including its incorporation of the FDRA, is impermissibly vague in at least two respects: first, whether tissue resulting from a medication abortion or following miscarriage care may be disposed of by the patient at home, and, second, what, if any, obligations are imposed on women seeking abortion and miscarriage care and/or Plaintiff regarding "reasonable efforts" to locate an "absent" "parent" or "other members of the class" of "grandparents." Ark. Code. Ann. §§ 20-17-102(d)(1)(E), (d)(3)(B). Moreover, while the FDRA appears to concern the "[f]inal disposition" of "a dead body or fetus," *id.* § 20-17-102(a)(2)(C),

its various references to "human remains," *id.* §§ 20-17-102(b)(1)(A), (c), (h), (i), (j), are unclear, because H.B. 1566 now uses "fetal remains" to refer to tissue disposition after abortion, *see* H.B. 1566 § 3. Given the potential liability for violating H.B. 1566, Plaintiff cannot make good faith efforts to comply and hope for the best. Rather, Dr. Hopkins is faced with uncertainty that will require him to curtail services.

The FDRA addresses methods of disposition in three provisions. As noted, the statute defines "final disposition" to include "burial, interment, cremation, removal from Arkansas, or other authorized disposition of a dead body or fetus," Ark. Code Ann. § 20-17-102(a)(2)(C), gives a person with disposition rights the authority to control "the disposition of the remains of a deceased person, the location, manner, and conditions of disposition," *id.* § 20-17-102(d)(1); and also authorizes a person with disposition rights, in the absence of a declaration of final disposition by the decedent, to "dispose of the remains in any manner that is consistent with existing laws, rules, and practices for disposing of human remains, including . . . cremat[ion]," *id.* § 20-17-102(i).

These civil provisions are not drafted with the precision necessary to provide adequate notice to Plaintiff, who faces potential criminal penalties for failing to ensure tissue is disposed of lawfully. Specifically, in the case of a woman having a medication abortion (or completing a miscarriage the same way), it is unclear whether permitting her to dispose of the products of conception at home is an "other authorized disposition," or "is consistent with existing laws, rules, and practices for disposing of human remains," and whether satisfaction of one of these requirements or both is necessary. The same is true for tissue sent out for pathological testing.

Similarly, the FDRA provides no definition or explanation of the terms "absent" or "reasonable efforts," in connection with the search for a "parent" or "grandparents" who may be

entitled to be involved in disposition. *See id.* § 20-17-102(d)(1)(E)(ii), (d)(3)(A). It does not explain who has responsibility for providing notice, clarify what information must be provided, or by what means. For Plaintiff wishing to provide time-sensitive abortion and miscarriage care, it is not clear, for example, whether "absent" means that the putative father is simply not present to provide consent, that his whereabouts are known, but he is unreachable, or that his location is unknown. Nor can Plaintiff know from the FDRA what are "reasonable efforts" to find a putative father or grandparent, and who can undertake those efforts. What is reasonable is wholly in the eyes of the beholder, and could range from a text to a phone call to hiring a private investigator. Legal mandates couched in these terms leave Plaintiff to "guess at [their] meaning" and open Plaintiff to "arbitrary and discriminatory . . . enforcement." *U.S. v. Mabie*, 663 F.3d 322, 333 (8th Cir. 2011) (citation omitted).

On each of these scores, H.B. 1566's lack of clarity fails to provide Plaintiff or enforcement authorities with "fair notice of conduct that is forbidden or required." *Fed. Commc'ns Comm'n v. Fox Television Station, Inc.*, 567 U.S. 239, 253 (2012). This vagueness gives Plaintiff no option but to stop providing care, and will impermissibly deprive his patients of access to abortion and miscarriage care, including the safe and accepted method of medication abortion and disposition of the tissue at home. *See Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d at 1465, 1467.[16]

II. EACH CHALLENGED LAW WOULD IMPOSE IRREPARABLE HARM

[16] The lack of clarity as to a physician's obligations under the FDRA are compounded by the fact that Section 20-17-802 of the Arkansas Code, which imposes criminal penalties, contains no scienter requirement and appears to be a strict liability offense. *See Stivers v. State*, 118 S.W.3d 588 (Ark. 2003) (offense outside the criminal code, which contained no *mens rea* requirement, in the absence of legislative intent to include one, was a strict liability offense). *See also Stahl v. City of St. Louis, Missouri*, 687 F.3d 1038, 1041 (8th Cir. 2012) (lack of *mens rea* requirement "further demonstrate[s]" vagueness).

Enforcement of the challenged laws will inflict irreparable harm on Plaintiff and his patients for which there is no adequate remedy at law. It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm. *See Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) ("Planned Parenthood's showing that the ordinance interfered with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury.") (citations omitted); *accord Kirkeby v. Furness*, 52 F.3d 772, 775 (8th Cir. 1995) (quoting *Elrod v. Burns*, 427 U.S. 347, 373 (1976)).

Enforcement of *each* of the challenged laws would impose an undue burden on Plaintiff's patients' constitutionally protected right to decide to end a pregnancy. Enforcement of H.B. 1032, the D&E Ban, would virtually end pre-viability second-trimester abortion in Arkansas. *See Edwards v. Beck*, 946 F. Supp. 2d 843, 850 (E.D. Ark. 2013).

H.B. 1434's Medical Records Mandate would delay and deny access to abortion care for Plaintiff's patients, and subject Plaintiff to unconstitutionally vague standards under threat of criminal and other serious penalties. *See Planned Parenthood Minn., N.D., S.D. v. Daugaard*, 799 F. Supp. 2d 1048, 1069, 1076-77 (D.S.D. 2011) (finding irreparable harm after concluding plaintiffs likely to succeed on vagueness claim, including potential to chill provision of abortion services).

H.B. 2024's Local Disclosure Mandate would apparently stand in the way of early medication abortions for Non-CMA Teenage Patients, will require breaches of those patients' confidential care, and will impermissibly dissuade such patients from abortion. *See Jegley*, 2016 WL 6211310, at *33.

Finally, H.B. 1566's Tissue Disposal Mandate will impose onerous and unjustified burdens on abortion and miscarriage care by conditioning care on the notice and consent of third

parties. In so doing, H.B. 1566 imports vague standards from a context outside medical care, and subjects Plaintiff to unconstitutionally uncertain rules that will prevent him from providing the services his patients request. And even if H.B. 1566's consent and other requirements could somehow be satisfied, the significant delay associated with them would force women to remain pregnant, in further violation of their fundamental rights. *See Roe v. Crawford*, 396 F. Supp. 2d 1041, 1043-44 (W.D. Mo. 2005) (granting incarcerated woman preliminary injunction requiring prison officials to transport her to medical facility for abortion care), *stay of inj. den.* 546 U.S. 959 (2005).

In addition to the irreparable loss of rights from each of these laws, women would suffer medical harm from the obstacles they impose, *see supra* pp. 9-11, 14, 35, 49, 50-51. And those who cannot access care might resort to unsafe methods outside the medical system to end their pregnancies. Hopkins Decl. ¶ 29. Moreover, impermissible disclosure of intimate information can lead not just to physical harm but to emotional and other irreparable injuries. *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1069 (6th Cir. 1998) ("No remedy at law could adequately compensate [Dr. Hopkins' patients] for any physical, psychological, or emotional trauma they might suffer at the hands of one obtaining this personal information.").

Injunctive relief against these laws is therefore necessary not just to safeguard the constitutional rights of Dr. Hopkins and his patients, but also to protect his patients' health and wellbeing. *See Planned Parenthood of Wis., Inc.*, 738 F.3d at 795-96; *Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment).

III. THE BALANCE OF EQUITIES WEIGHS HEAVILY IN FAVOR OF PLAINTIFF AND HIS PATIENTS

A request for preliminary relief also considers "whether the balance of equities so favors the movant that justice requires the court to intervene to preserve the status quo until the merits are determined." *Dataphase Systems, Inc.*, 640 F.2d at 113. Here, the threatened irreparable harms that each law will impose if allowed to take effect, *see supra* pp. 54-56, greatly outweigh any interests of the State in enforcing these laws before their constitutionality can be finally determined, and justice therefore demands maintaining the status quo. D&E procedures are long-standing, standard practice throughout the nation and Arkansas. To allow Plaintiff and other physicians to continue to perform them will not harm any significant, immediate state interests. Likewise, there are no urgent and weighty state interests that might be advanced by mandating comprehensive medical records searches prior to abortion; evidence collection and local police disclosure beyond the scope of the Arkansas child abuse and criminal law; and unworkable tissue disposal provisions that would bring access to abortions to a halt. Arkansas currently enforces extensive laws regulating abortion that will remain in effect while the Court considers the constitutional validity of these new enactments. *See Edwards*, 946 F. Supp. 2d at 850 (granting preliminary injunction in constitutional challenge to abortion regulation because "[m]aintaining the status quo pending litigation will not deprive the State of its ability to enforce current laws aimed at protecting women's health and the potential life of the fetus" or embryo).

IV. INJUNCTIVE RELIEF IS IN THE PUBLIC INTEREST

Finally, the interests of Plaintiff and his patients are aligned with those of the general public. In a case involving constitutional claims, the public interest factor considered on a motion for a preliminary injunction "is largely dependent on the likelihood of success on the merits because the protection of constitutional rights is always in the public interest." *Edwards*, 946 F. Supp. 2d at 850 (citing *Phelps-Roper v. Nixon*, 509 F.3d 480, 485 (8th Cir. 2007)).

Without a preliminary injunction here, not only Plaintiff and Plaintiff's patients will face irreparable harm: all Arkansas women's access to constitutionally protected health care services on a confidential basis will be eroded. The public interest thus reinforces the need for injunctive relief to preserve the status quo and allow the Court to reach the merits of Plaintiff's claims. Each of the four factors that the Court must consider in weighing preliminary injunctive relief strongly favors that relief.

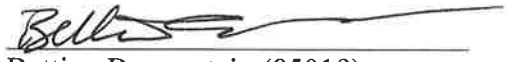
V. A BOND IS NOT NECESSARY IN THIS CASE

The Court should waive the Federal Rule of Civil Procedure 65(c) bond requirement. Although that rule typically requires the posting of security when a preliminary injunction issues, it is well-established that whether to require a bond rests in the discretion of the trial court and that factual contexts like this one support a finding that no bond is necessary. Where "plaintiffs are serving a public interest" in acting to protect constitutional rights related to abortion, and the governmental defendants "will not be harmed by the order" to preserve the status quo, it is "customary" to not require security. *Williams*, 2017 WL 1407656 at *8. Plaintiff is a healthcare provider dedicated to serving women, including many low-income women, at one of the last two abortion clinics in Arkansas, and a bond would impose unnecessary strain on him, particularly where the state faces no prospect of monetary damages in this case. *See Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs*, 826 F.3d 1030, 1043 (8th Cir. 2016) (affirming district court's waiver of bond requirement "based on its evaluation of public interest"); *Ranchers Cattlemen Action Legal Fund v. U.S. Dep't of Agric.*, 566 F. Supp. 2d 995, 1008 (D.S.D. 2008) (individual ranchers attempting to vindicate public interest not required to post bond).

CONCLUSION

For the reasons set forth above, Plaintiff respectfully requests that the Court grant his motion and enjoin Defendants and successors in office from enforcing any provision of the challenged laws during the pendency of this litigation.

Dated: June 20, 2017



Bettina Brownstein (85019)
Bettina E. Brownstein Law Firm
904 West 2nd Street, Ste. 2
Little Rock, AR 72201
Cooperating Attorney, ACLU of Arkansas
Phone: (501) 920-1764
Email: bettinabrownstein@gmail.com

Susan Talcott Camp*
Ruth E. Harlow*
Elizabeth Watson*
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004-2400
Phone: (212) 549-2633
Email: tcamp@aclu.org
rharlow@aclu.org
ewatson@aclu.org

Hillary Schneller*
Center for Reproductive Rights
199 Water Street, 22nd Fl.
New York, NY 10038
Phone: 917-637-3777
Email: hschneller@reprorights.org

ATTORNEYS FOR PLAINTIFF

*Application for *pro hac vice* pending

CERTIFICATE OF SERVICE

I, Bettina E. Brownstein, do hereby certify that on June 20, 2017, I caused to be personally served the foregoing on the following :

Larry Jegley, Prosecuting Attorney for Pulaski County; Steven L. Cathey, M.D., Chair of the Arkansas State Medical Board; Robert Breving Jr., M.D.; Bob E. Cogburn, M.D.; William F. Dudding, M.D.; Omar T. Atiq, M.D.; Veryl D. Hodges, D.O.; Marie Holder; Larry D. Lovell; William L. Rutledge, M.D.; John H. Scribner, M.D.; Sylvia D. Simon, M.D.; David L. Staggs, M.D.; John B. Weiss, M.D., officers and members of the Arkansas State Medical Board.

Bettina E. Brownstein