NO. 17-2879

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FREDERICK W. HOPKINS — Plaintiff-Appellee

v.

LARRY JEGLEY, et al. — Defendants-Appellants

APPEAL FROM THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS

THE HONORABLE KRISTINE BAKER
UNITED STATES DISTRICT COURT JUDGE

APPELLEE'S ANSWERING BRIEF

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RESPONSIVE STATEMENT REGARDING ORAL ARGUMENT

Plaintiff-Appellee believes that 30 minutes of oral argument per side is warranted. The State here appeals a preliminary injunction that temporarily bars enforcement of four new restrictions on access to abortion in Arkansas. In a 140-page opinion, which followed oral argument and the court's consideration of the record before it, the District Court carefully construed the terms of each statute, made detailed, well-founded factual findings, and ultimately held that each restriction was likely unconstitutional. The court appropriately exercised its discretion to enter a preliminary injunction pending full litigation of the case. Because these four statutes would impose severe harms on women if the injunction is lifted; the several constitutional rights at stake are so important; and the State's briefing attempts to create much confusion through misleading conclusory assertions, Plaintiff-Appellee believes that the Court will benefit from a full hour of argument.

Appellants' statement regarding oral argument errs in asserting that the District Court's opinion is "riddled with error," applies the wrong standards, and "misconstrues" matters. In fact, the State is forced to resort to such *ad hominem* attacks because the opinion is, throughout, well-grounded in both law and evidence. The State has established no basis on which to overturn the court's appropriate exercise of its discretion in entering the preliminary injunction.

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STATEMENT OF ISSUES AND AUTHORITIES

1. Did the District Court act within its discretion in granting a preliminary injunction, based on likelihood of success, threat of irreparable harms, balance of harms, and the public interest?

- *Planned Parenthood v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (en banc)

2. Did the court correctly apply the undue burden standard by employing the balancing that Supreme Court precedent requires, under which a law is unconstitutional when the benefits it actually advances do not outweigh the burdens it imposes?

- *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) ("*WWH*")
- *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)

3. Did the court act within its discretion in finding that the D&E Ban would eliminate second-trimester abortion in Arkansas and therefore likely is unconstitutional?

- *WWH*, 136 S. Ct. 2292
- *Gonzales v. Carhart*, 550 U.S. 124 (2007)
- *Stenberg v. Carhart*, 530 U.S. 914 (2000)
- *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976)

4. Did the court act within its discretion in holding that the Medical Records Mandate imposes unclear, subjective requirements that will delay abortion

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care without any countervailing benefit, and thus likely imposes an undue burden and is unconstitutionally vague?

- *WWH*, 136 S. Ct. 2292
- *Johnson v. United States*, 135 S. Ct. 2551 (2015)

5. Did the court act within its discretion in holding that the Local Disclosure Mandate – which conditions teenagers' abortions on disclosure to local police naming them "victims" and their sexual partners "suspects," and requires "evidence" collection of "fetal tissue," despite no circumstances indicating any wrongdoing – likely imposes an undue burden and violates informational privacy?

- *WWH*, 136 S. Ct. 2292
- *Eagle v. Morgan*, 88 F.3d 620 (8th Cir. 1996)

6. Did the court act within its discretion in holding that the Tissue Disposal Mandate – by importing a law from another context into abortion care – mandates third-party notice of a woman's abortion, paralyzes providers with uncertain but far-reaching compliance requirements, and thus likely imposes an undue burden and is unconstitutionally vague?

- *WWH*, 136 S. Ct. 2292
- *FCC v. Fox Television Station, Inc.*, 567 U.S. 239 (2012)

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STATEMENT OF THE CASE

On behalf of himself and his patients, Plaintiff-Appellee Dr. Frederick W. Hopkins filed suit seeking pre-enforcement, preliminary injunctive relief against four Arkansas abortion restrictions. After a hearing and consideration of evidence, including the opening and rebuttal declarations of Drs. Hopkins and Mark D. Nichols, and the declaration of Little Rock Family Planning Services ("LRFP") Director Lori Williams, the District Court granted that relief.

I. Abortion in Arkansas

Dr. Hopkins, a board-certified obstetrician-gynecologist licensed to practice in Arkansas, has 25 years of experience caring for women. The care he provides at LRFP includes medication abortion in the early first trimester, surgical abortion through 21 weeks, and miscarriage management for patients throughout their reproductive years. Add. 3; Declaration of Frederick W. Hopkins, M.D., M.P.H., June 15, 2017 ("Hopkins Decl.") ¶¶ 1-2, Appx. 108-09. LRFP is one of only two Arkansas abortion providers and the only clinic providing abortion after 10 weeks.[1] Arkansas hospitals provide no abortion care, or do so in only rare circumstances. Add. 3-4; Hopkins Decl. ¶ 6, Appx. 110; Rebuttal Declaration of Mark D. Nichols,

[1] The other, Planned Parenthood, provides only medication abortion, available only through 10 weeks. Add. 3-4; Hopkins Decl. ¶ 6, Appx. 110; Rebuttal Declaration of Frederick W. Hopkins, M.D., M.P.H., July 19, 2017 ("Hopkins Rebuttal Decl.") ¶ 2, Appx. 452.

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M.D., July 19, 2017 ("Nichols Rebuttal Decl.") ¶ 4, Appx. 445.

LRFP patients seek abortions for a variety of personal, medical, financial and familial reasons. Many women seeking second-trimester abortions face diagnosis of fetal anomaly later in pregnancy, difficulty making financial or logistical arrangements, and/or domestic violence. Women must arrange for time off work, childcare if they have children, transportation, and, in some cases, overnight accommodations. These burdens – exacerbated by Arkansas's two-trip requirement, mandating in-person counseling at least 48 hours before an abortion – are particularly acute for the substantial proportion of patients who are low-income. Add. 4-5; Hopkins Decl. ¶ 27, Appx. 117; Declaration of Lori Williams, M.S.N., A.P.R.N., June 17, 2017 ("Williams Decl.") ¶¶ 5-12, Appx. 152-53. Any additional mandated trip to the clinic would delay some women's abortions, and prevent others' completely. Add.16-17; Declaration of Mark D. Nichols, M.D., June 8, 2017 ("Nichols Decl.") ¶ 26, Appx. 77; Hopkins Decl. ¶ 28, Appx. 117; Williams Decl. ¶¶ 13-14, 19-20, Appx. 154-55.

Approximately 30% of U.S. women have an abortion at some point in their lives. First- and second-trimester abortion is safer than carrying to term as to both morbidity and mortality. Add. 5; Nichols Decl. ¶¶ 7-8, Appx. 71. In Arkansas, approximately 83% of abortions occur during the first trimester (before 14 weeks), using either medication or aspiration abortion. The remaining 17% are second-

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trimester dilation and evacuation (D&E) procedures. Add. 6; Hopkins Decl. ¶ 8, Appx. 110. Another second-trimester method, induction abortion, entails medication-induced labor, which can require anesthesia for pain and be psychologically difficult. It is unavailable in outpatient clinics, can span multiple days, is far more expensive than D&E, and is unavailable in Arkansas. Add. 7-8; Nichols Decl. ¶¶ 14-16, Appx. 73-74; Hopkins Decl. ¶ 12, Appx. 111. D&E accounts for 100% of the 638 second-trimester abortions reported in Arkansas in 2015. Add. 8; Hopkins Decl. ¶ 17, Appx. 113.

II. Challenged Statutes

Arkansas has enacted numerous laws to obstruct a woman's abortion access,[2] including eight in 2017 alone.[3] The four restrictions challenged here are part of this campaign; if allowed to take effect, they would severely restrict, if not eliminate, abortion access in Arkansas.

[2] *E.g.*, Ark. Code Ann. §§ 20-16-810-817 (2016) (parental consent for minor's abortion); *id.* § 20-16-1504 (2016) (banning off-label use of abortifacients); *id.* § 20-16-1703 (2015) (48-hour delay / two-trip requirement); *id.* § 20-16-1602 (2015) (banning public funding to individual or entity that provides, counsels for, or refers for abortion); *id.* §§ 20-16-1301-1307 (2013) (12-week ban, struck down by *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015)); *id.* §§ 20-16-1401-1410 (2013) (20-week post-fertilization ban).

[3] *See* 2017 Acts 383, 834, 203.

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A. D&E Ban

Section 20-16-1802(3)(A)(i) criminalizes purposely performing a "dismemberment abortion," defined as "dismember[ing] the living unborn child and extract[ing] one (1) piece at a time from the uterus through the use of clamps, grasping forceps … or similar instruments[.]" The sole exception is for care "necessary … to avert either death" or "serious risk of substantial and irreversible physical impairment of a major bodily function." *Id.* §§ 20-16-1802(6)(A), -1803(a). Violation is a Class D felony and grounds for professional disciplinary action and civil liability. As fully supported in its detailed factual findings, the court correctly held that the Ban eliminates access to second-trimester abortion. Add. 10-16, 61.

Although lacking recognized medical terms, the Ban clearly prohibits standard D&E. Before approximately 14 weeks, a surgical abortion entails suction to empty the uterus. Thereafter, suction alone is typically insufficient to complete the procedure, and a physician uses D&E – first dilating the cervix and then, in a 5-10-minute procedure, evacuating the uterus with instruments, such as forceps. At 14-17 weeks, both steps can occur on the same day. At 18-22 weeks, appropriate dilation is typically achieved overnight with osmotic dilators – thin rods placed in the cervix that absorb moisture and thus slowly dilate the cervix. Inasmuch as physicians dilate only enough to allow safe passage of instruments and fetal tissue

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through the cervix, and the fetus is larger than the opening of the cervix, fetal tissue generally comes apart as the physician removes it through the cervix. Add. 6-8; Nichols Decl. ¶¶ 18-19, Appx. 74-75; Hopkins Decl. ¶¶ 13-16, Appx. 112; Nichols Rebuttal Decl. ¶ 5, Appx. 445.

At 18-22 weeks, some physicians, including Dr. Hopkins, generally undertake an additional procedure to attempt to cause fetal demise before evacuation, to establish compliance with the intent requirements of federal and state partial-birth abortion bans. Add. 10, 12; Nichols Decl. ¶¶ 21-23, Appx. 76; Hopkins Decl. ¶¶ 18-21, Appx. 113-114. Nonetheless, the American Congress of Obstetrics and Gynecologists ("ACOG") has concluded: "No evidence currently supports the use of induced fetal demise to increase the safety of second-trimester … abortion." Add. 12 (citing ACOG, Practice Bulletin No. 135: Second Trimester Abortion, 121(6) Obstetrics & Gynecology 1394, 1396, 1406 (2013)).

These attempts at demise generally entail injecting a drug, digoxin, with a spinal needle under ultrasound guidance through the abdomen, vaginal wall, or cervix and then into the fetus if possible, or into the amniotic fluid. Digoxin injections carry risks, are contraindicated by some cardiac conditions, and can be difficult or impossible for a patient who is very obese, has anatomical variations such as fibroids or an elongated cervix, or has certain fetal positioning. Even where the physician can perform the injection, digoxin fails to cause demise 5-10%

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of the time. There is no way of knowing ahead of time when digoxin will fail. Add. 11-12; Nichols Decl. ¶¶ 25-28, Appx. 77-78; Hopkins Decl. ¶¶ 20, 25a-c, Appx. 113, 115.

When digoxin works, it works slowly. Doctors typically wait 24 hours after injection to determine whether it has caused demise. Because dilation is typically achieved overnight at 18-22 weeks, administering digoxin at this stage does not delay care or require an extra trip to the clinic. Nichols Decl. ¶¶ 23, 26, Appx. 76-77; Hopkins Decl. ¶¶ 18, 20, Appx. 113. When digoxin fails to cause demise after 24 hours, physicians, including Dr. Hopkins, can legally continue with the procedure, establishing compliance with existing laws by taking steps with forceps to ensure fetal demise; under the D&E Ban, they could not. Add. 14; Hopkins Decl. ¶ 21, Appx. 114.

A single digoxin injection performed after 18 weeks is the only well-studied method of attempting fetal demise prior to evacuation. There is *no record evidence of any physician attempting digoxin early in the second trimester*, when most second-trimester abortions are performed. There is thus no way to know – or counsel patients on – the safety, risks, or effectiveness of such an attempt. Digoxin before 18 weeks would be experimental and outside the standard of care. Add. 12-13; Nichols Decl. ¶ 26, Appx. 77; Hopkins Decl. ¶ 24, Appx. 114-15; Nichols Rebuttal Decl. ¶ 9, Appx. 447. Repeat injections of digoxin, after the first injection

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fails, are also unstudied, and would subject women to an additional procedure, clinic visit, and delay. Add. 12-13; Nichols Decl. ¶ 29, Appx. 78; Hopkins Decl. ¶ 25b, Appx. 115.

Other methods of attempting demise are unstudied and present serious medical risks. Potassium chloride successfully injected directly into the fetal heart is immediately effective, but rarely used: it carries severe risks for the woman, including death, if injected incorrectly; requires the extensive training of sub-specialists in high-risk obstetrics; and requires advanced ultrasound technology generally available only in a hospital and too expensive for most clinics. As with digoxin, the injection itself can be difficult or impossible, especially early in pregnancy. Add. 14-15; Nichols Decl. ¶¶ 27, 31, Appx. 77, 79; Hopkins Decl. ¶¶ 22, 25a, Appx. 114-15. Umbilical cord transection – rupturing the membranes and, with suction or instruments, grasping the cord and dividing it, causing demise over 5-10 minutes – is neither widely practiced nor well researched. It can be very difficult to attempt to identify and transect the cord without grasping fetal tissue, especially early in the second trimester. Moreover, doing so would add time and passes with forceps, both of which increase the risks of uterine perforation and other complications. The single study of the practice supports no conclusions about safety. Add. 16; Nichols Decl. ¶¶ 32-35, Appx. 79-80; Hopkins Decl. ¶¶ 25d-e, Appx. 116.

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Under the Ban, physicians would be unable to begin any D&E because no method can guarantee demise prior to evacuation. There are no methods Dr. Hopkins can attempt before 18 weeks; although he can attempt to inject digoxin for most patients at 18-22 weeks, he will not endanger or experiment on patients with unstudied methods. Because digoxin fails in 1-2 of every 20 patients, and is difficult or impossible to inject for some patients, Dr. Hopkins would know when starting a procedure that he may not be able to complete it without violating the Ban. To avoid the choice between abandoning a patient mid-procedure and risking prosecution, physicians could not start any D&E under the Ban. Add. 11-13, 61; Nichols Decl. ¶ 36, Appx. 80; Hopkins Decl. ¶¶ 25-26, Appx. 115-17. Because eliminating second-trimester abortion imposes significant burdens without benefits sufficient to justify them, the court correctly found Dr. Hopkins likely to succeed on his undue burden challenge. Add. 56.

B. Medical Records Mandate

Under the Medical Records Mandate, "the physician" performing an abortion "shall" first:

> (b)(2)(A) Request the medical records of the pregnant woman relating directly to [her] entire pregnancy history ….
>
> > (B) An abortion shall not be performed until reasonable time and effort is spent to obtain the medical records … described in subdivision (b)(2)(A)[.]

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Ark. Code Ann. § 20-16-1904(b)(2). Violation is a Class A misdemeanor, punishable by imprisonment and licensing sanctions. Add. 65-66.

Requesting prior records is medically relevant for only a "tiny fraction" of abortion patients: for 25 of LRFP's 3,000 annual abortion patients, for example. Add. 17, 70; Nichols Decl. ¶ 9, Appx. 72; Hopkins Decl. ¶¶ 33-34, Appx. 119; Williams Decl. ¶ 24, Appx. 155-56. Yet of those 3,000, most have prior pregnancies or received care from another provider for the current pregnancy, and are thus subject to the Records Mandate. Add. 18, 70, 74-75; Hopkins Decl. ¶ 32, Appx. 118.

Subsection (b)(2)'s Records Mandate imposes "a second, independent requirement" from subsection (b)(1)'s requirement that the physician ask the patient if she knows the sex of the embryo/fetus. As the District Court found, "there is no ambiguity in the language" and the statute "should be read as enacted[.]" Add. 68-70 (citing *Short v. State*, 79 S.W.3d 313, 495 (Ark. 2002); *Henderson v. Russell*, 589 S.W.2d 565, 568 (Ark. 1979)).[4] Nonetheless, the court also considered the State's construction under which the Mandate applies only to patients who report knowing the sex of the embryo/fetus in response to subsection

[4] Far from "embrac[ing] the only reading that rendered the provision potentially ambiguous," *see* App. Br. 46, the court applied the clear, definite meaning of the statute, rejecting the existence of any ambiguity. Add. 68-70.

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(b)(1). Add. 70.

Regardless of construction, requiring abortion providers to try to collect patients' historical medical records imposes harmful delay, breaches confidentiality, and imposes disabling processing requirements on providers – with no health exception – to advance no valid interest. Add. 70-79. The court's findings detailed how the Mandate's indeterminate delay imposes substantial obstacles to time-sensitive care, as do the Mandate's logistical burdens, "simply shut[ting] down care" for affected patients. Add. 70-75; Hopkins Decl. ¶¶ 36-41, Appx. 119-21; Williams Decl. ¶¶ 26-33, Appx. 156-57. The evidence shows that "compliance would violate … women's confidentiality" and interfere with protected decision-making. Add. 75; Hopkins Decl. ¶ 38, Appx. 120; Williams Decl. ¶¶ 27-28, Appx. 156. By contrast, no record evidence supports that the Mandate would improve patient care or aid compliance with the new ban on abortions obtained solely based on the sex of the embryo/fetus. Add. 76-78. Thus, the court correctly concluded that "Dr. Hopkins is likely to succeed in showing that" the Mandate "imposes an undue burden on a large fraction of women" affected. Add. 79.

The Mandate also contains "no objective criteria or clear guidelines" for compliance and is therefore likely unconstitutionally vague. Add. 90. The court correctly found that "the phrase 'reasonable time and effort' is subjective" and

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lacks "specified boundaries," and that it was unclear what "actions a doctor must take" with records received. Add. 87-90; Hopkins Decl. ¶¶ 35-37, Appx. 119-20; Williams Decl. ¶¶ 29-31, Appx. 157.

C. Local Disclosure Mandate

The Local Disclosure Mandate significantly expands a 2013 law enacted only for abortion patients under 14. For all 14- to 16-year-olds, regardless of circumstances, the Mandate and its regulations now require providers to inform local police of the abortion and provide the resulting tissue – with paperwork naming the patient a "victim" and her sexual partner "the suspect," and disclosing her address. Ark. Code Ann. § 12-18-108; Ark. Admin. Code 171.00.2(1)-(3); Add. 19, 95-104; Hopkin Decl. ¶ 44, Appx. 121-22; Compl., Ex. C4, Appx. 60 (transmission form).

Dr. Hopkins challenges the Mandate only as applied to 14- to 16-year-olds whose abortions dictate no reporting to Arkansas's specialized unit investigating potential abuse under the Child Maltreatment Act ("CMA") ("Non-CMA Teenage Patients"). Medical providers are CMA-mandatory-reporters where there is any reasonable cause to suspect child sexual abuse. Ark. Code Ann. § 12-18-402; Add.

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19-20, 93.[5]

For each Non-CMA Teenage Patient, the "facts indicate no potential abuse or criminality," and her health care is protected as private. Add. 96, 98. Sexual intimacy with a similar-age partner or spouse, *and* involving no caretaker or forcible compulsion, falls outside reportable sexual abuse. Add. 95. Yet this Mandate requires physicians to enmesh such patients in the criminal justice system as "victims." Physicians must inform them (and the parent whom almost *every* such patient involves in her abortion, Add. 19) of the required "evidence" collection, outreach to community police, and indefinite fetal tissue storage. Add. 95-105; Hopkins ¶ 50, Appx. 123. It imposes these intrusions on only abortion patients, and not on patients seeking miscarriage, prenatal, or sexually-transmitted-infection care. Add. 105.

The court correctly found likelihood of success for both Dr. Hopkins's challenges. Add. 104-05, 110. It emphasized that because Non-CMA Teenage Patients are engaged in "non-criminal, non-reportable activity that is affirmatively

[5] As the court held, these Non-CMA Teenage Patients are defined by the scope of the CMA, and not by Dr. Hopkins. Add. 100. This case does not concern his subjective assessment of any patient, but rather seeks to enforce constitutional limits on the Mandate. *Id.*; *cf.* App. Br. 55. The undisputed record evidence reflects that Dr. Hopkins and his colleagues are vigilant in fulfilling their obligations as mandatory reporters of any potential abuse. Add. 100-02; Hopkins Decl. ¶ 43, Appx. 121; Williams Decl. ¶¶ 35-39, Appx. 158.

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constitutionally protected," the Mandate "serves no valid state purpose." Add. 95-105. Providers fully cooperate with a criminal investigation law enforcement initiates, but under the Mandate, clinicians must initiate local police involvement in *all* Non-CMA Teenage Patients' abortions. Add. 102-04; Williams Decl. ¶ 39, Appx. 158. Local police departments can be as small as two officers, lack the specialized training of the state child abuse unit, and have sometimes been hostile to clinic staff and their patients' abortion decisions. Add. 20; Williams Decl. ¶¶ 43-45, Appx. 160.

The court correctly found "substantial obstacles" for Non-CMA Teenage Patients that tipped the undue burden balancing decisively against constitutionality. Add. 104 (obstacles including delay, confusion, humiliation, and fear); Add. 97 (evidence of punitive, stigmatizing impact, which delays or blocks care, including by forcing women to attempt to seek care out of state; breach of anonymity to police). Further, to the extent the Mandate prohibits medication abortions, because tissue cannot be collected and given to the police, that is an additional undue burden. Add. 96, 99, 104; Hopkins Decl. ¶¶ 51-52, Appx. 124-25; Williams Decl. ¶ 47, Appx. 160.

The court also found these "most intimate and personal aspects of a woman's life" protected by the right to informational privacy against compelled disclosure to the government. Add. 106-10. With no "justifying state interest" for

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disclosure of Non-CMA Teenage Patients' abortion and sexual activity, the court correctly held Dr. Hopkins likely to succeed on both decisional and informational privacy grounds. Add. 110.

D. Tissue Disposal Mandate

Under longstanding law, unrelated to Arkansas's Final Disposition Rights Act (FDRA), providers of abortion, miscarriage management, or other care dispose of human tissue in a "respectful and proper manner." Ark. Code Ann. §§ 20-17-801(a)(1)(A), (b)(2)(C)-(D); *see also id*. § 20-17-802(a) (tissue from abortion must be disposed "in a fashion similar to that in which other tissue is disposed"). The Tissue Disposal Mandate specifies no new disposal methods. *Id.* § 20-17-102(i) (under FDRA, disposal may be in any manner "consistent with existing laws, rules, and practices"). Rather, it forces clinicians to comply with complex regulations, including third-party notices, to determine *who controls* tissue disposal. *Id.* § 20-17-802(a); *see also id.* § 20-17-801(b)(1)(B). On threat of criminal prosecution, it requires "[a] physician or facility that performs an abortion" to "ensure" that tissue is disposed of in accordance with the FDRA, *id.* § 20-17-802, yet provides no clear path for doing so. *Id.*[6]

[6] The State's implications notwithstanding, the FDRA's reference to "fetus" has been relevant only for the rare patient who opts to send tissue to a funeral home. It

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The FDRA governs *who* holds the "right to control the disposition of the remains of a deceased person[.]" *Id.* § 20-17-102(d)(1). If a decedent has not appointed anyone to control disposition, the FDRA ranks classes of individuals who may do so, beginning with the decedent's spouse, then children, then parents, etc. *Id.* §§ 20-17-102(d)(1)(A)-(L). Disposition rights cannot vest in anyone under 18. *Id.* § 20-17-102(d)(1).

Importing this elaborate scheme into the abortion and miscarriage context, the Mandate vests disposition rights first, and jointly, in any "surviving parent[s,]" *id.* § 20-17-102(d)(1)(E), i.e., the patient and her sexual partner. Where one "surviving parent" is "absent," the disposition right vests in a remaining parent only after undefined "reasonable efforts have been unsuccessful in locating the absent surviving parent." *Id.* § 20-17-102(d)(1)(E)(ii); Add. 118. If only one "parent" is at least 18, whether the patient or her sexual partner, s/he has sole control over disposition. These rights vest in a patient's sexual partner even if he sexually assaulted her. If both are minors, control vests instead in "the majority of the grandparents," Ark. Code Ann. § 20-17-102(d)(1)(G), i.e., the patient's parents *and* her partner's parents. Less than a majority are "vested with rights … [only] if they have used reasonable efforts to notify" all other "grandparents." *Id.* § 20-17-

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was not the source of any medical providers' obligation to dispose of tissue respectfully. *Cf.* App. Br. 50-51.

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102(d)(3); Add. 122.

If a majority of those with shared rights cannot decide "the location, manner, and conditions of disposition," a state court resolves the dispute. Ark. Code Ann. §§ 20-17-102(d)(1), (e)(2). Individuals forfeit disposition rights if, for instance, they are unwilling to pay for disposition or they fail to exercise their right within the earlier of two days after notification of death or five days of death. *Id.* § 20-17-102(e)(1). The FDRA immunizes funeral establishments and crematoria when they rely on individuals' representations claiming disposition rights. *See, e.g.*, *id.* §§ 20-17-102(f), (g). It provides no protection for medical providers. Add. 119.

The court correctly held Dr. Hopkins likely to succeed on his undue burden and vagueness claims. Add. 127-28, 136. Importing the FDRA's elaborate scheme into abortion care would impose significant burdens: It would require involvement of individuals a woman has a constitutionally-protected right *not* to involve in her abortion; greatly complicate and delay care, if care can proceed at all; and establish an "unclear … scope of obligations" for providers to "ensure" compliance. Add. 116-26, 136; Hopkins Decl. ¶¶ 56-58, Appx. 125-26; Williams Decl. ¶¶ 56-63, Appx. 162-63. Physicians and facilities must know they can dispose of tissue lawfully before beginning a procedure. Add. 121; Hopkins Decl. ¶ 61, Appx. 127; Williams Decl. ¶¶ 54-55, Appx. 162. As the court found, the Mandate to ensure FDRA compliance would essentially end abortion services in Arkansas. Add. 121-

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22.[7] Against such burdens, the court found the Mandate advanced no valid interest, and held the undue burden claim likely to succeed. Add. 115-16 (assuming legitimacy of state interests); Add. 116-28 (concluding state interests not furthered and finding undue burden). Rejecting the State's attempts to rewrite the FDRA, the court further held the vagueness claim likely to succeed. Add. 116.

STANDARD OF REVIEW

The factors governing the motion for preliminary injunction are likelihood of success on the merits; threat of irreparable harm; balance between that harm and any harm the injunction imposes; and the public interest. *See Rounds*, 530 F.3d at 732-33 (citing *Dataphase Sys. v. C L Sys.*, 640 F.2d 109 (8th Cir. 1981) (en banc)). This Court's "sole task" now "is to determine whether the court abused its discretion." *Olin Water Servs. v. Midland Research Labs., Inc.*, 774 F.2d 303, 307 (8th Cir. 1985); *see also Planned Parenthood v. Jegley*, 864 F.3d 953 (8th Cir. 2017), *appeal docketed*, No. 17-935 (U.S. Jan. 2, 2018); *Rounds*, 530 F.3d at 732-33. Its "task is not to pass final judgment on the underlying issues, but only to

[7] As the court noted, it is implausible for the State to suggest that medication abortion would remain available because it does not constitute "perform[ing] an abortion" under the Mandate. Ark. Code Ann. § 20-17-802(a). Further, it is unclear under what authority the Department of Health issued an emergency regulation purportedly exempting medication abortion, App. Br. 51 n.9; its regulation applies to abortion facilities, and does not protect physicians. Regardless, the court held the Mandate likely unconstitutional with or without this regulation. Add. 124-26, 136.

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ensure that the injunction did not improperly issue on the basis of any clearly erroneous findings of fact or any clear error on an issue of law that may have affected the ultimate balancing of" the factors. *Olin Water Servs.*, 774 F.2d at 307. Here, the District Court acted fully within its "broad discretion." *See Novus Franchising, Inc. v. Dawson*, 725 F.3d 885, 893 (8th Cir. 2013).

SUMMARY OF ARGUMENT

The Constitution forbids undue burdens on a woman's right to terminate a pre-viability pregnancy. Reaffirming that longstanding undue burden standard in 2016, the Supreme Court made clear that an abortion restriction may be upheld only if its benefits justify its burdens. The District Court correctly found that Dr. Hopkins established a likelihood of success on his claims that each law failed this test.

Arkansas's D&E Ban unconstitutionally eliminates pre-viability, second-trimester abortion. The State proposes various unsupported, experimental procedures to attempt fetal demise before the evacuation phase of a D&E, but as the court found, there is no safe, effective way to guarantee demise, and thus no way to circumvent the Ban. No benefit justifies eliminating second-trimester abortion, and the Ban creates an undue burden for all or a large fraction of women affected.

The Medical Records Mandate creates an undue burden and is vague. Under

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either its plain meaning or the State's proposed construction, it unreasonably delays care, violates confidentiality, lacks a health exception, and thus imposes an undue burden for all women affected. As the State failed to show the Mandate advanced any legitimate interest, these burdens outweigh any benefit. Additionally, the failure to define "reasonable time and effort," the scope of relevant records, and the actions physicians must take with any records received renders the Mandate unconstitutionally vague.

The Local Disclosure Mandate imposes an undue burden and violates patients' informational privacy. It requires collection of tissue as "evidence" and reporting of "victim" and "suspect" to all 14- to 16-year-old patients' local police – when no circumstances indicate abuse or criminal activity. As applied to patients whose conduct implicates no abuse, this targeted dragnet for abortion care – and no other medical care indicating sexual activity, including miscarriage care – simply deters minors from seeking abortion services, stigmatizes these patients, and precludes medication abortion. Its burdens outweigh any benefit, and there is no constitutionally sufficient justification for mandating disclosure of this intimate medical information.

By importing the FDRA's elaborate vesting rules into the abortion context, the Tissue Disposal Mandate creates an undue burden and is unconstitutionally vague. It requires third-party notice to patients' sexual partners and, for minors,

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parents and their sexual partners' parents; significantly delays care; and is impossible to comply with. None of the State's proposed "shortcuts" absolves clinicians of the obligation to ensure FDRA compliance. These burdens clearly outweigh any purported benefit, for all affected women. Further, the Mandate leaves unconstitutionally vague how clinicians must ensure compliance.

The court correctly held that, for each law, all the *Dataphase* factors favor preliminary injunctive relief. The State has pointed to no abuse of discretion that would warrant disturbing the court's well-reasoned, amply supported decision.

ARGUMENT

I. The District Court Correctly Applied the Undue Burden Standard.

The Supreme Court has consistently held that a woman's right to end a pregnancy is a fundamental liberty protected by the Fourteenth Amendment. *See, e.g.*, *WWH*, 136 S. Ct. at 2309-10; *Casey*, 505 U.S. at 851-53; *Roe v. Wade*, 410 U.S. 113, 152-54 (1973). Contrary to the State's argument, the District Court correctly "applie[d] the 'undue burden' standard developed in *Casey*, 505 U.S. at 876-79 (plurality opinion), and [*WWH*], 136 S. Ct. at 2309-11," in assessing Dr. Hopkins's likelihood of success in establishing violations of his patients' liberty rights. Add. 38. The court also went out of its way to explain its rejection of the tests the State urged, which were contrary to Supreme Court dictates. Add. 40-41. Altering course on appeal, the State now asserts that a law is constitutional unless

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its burdens "substantially outweigh[]" its benefits. App. Br. 24-25. This proffered test is likewise inconsistent with Supreme Court precedent. The court below applied the governing standard, making no mistake of law.

A. The District Court Faithfully Followed Supreme Court Precedent.

Far from "creat[ing] its own standard," App. Br. 27, the District Court scrupulously followed governing Supreme Court law. "In *Casey*, the Supreme Court described the 'undue burden' test as follows: '[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion'" before viability. Add. 39 (quoting *Casey*, 505 U.S. at 877); *see also Stenberg*, 530 U.S. at 921; *Jegley*, 864 F.3d at 958. As the Supreme Court made explicit in *WWH*, the "undue burden analysis requires [a] [c]ourt to 'consider the burdens a law imposes on abortion access together with the benefits … confer[red],'" Add. 39 (quoting *WWH*, 136 S. Ct. at 2309), and to uphold it only if it confers benefits "sufficient to justify [its] burdens." 136 S. Ct. at 2300.

As in *WWH*, the court "considered the evidence in the record – including expert evidence" – and "then weighed the asserted benefits against the burdens." 136 S. Ct. at 2310. The court correctly held Dr. Hopkins likely to succeed on his undue burden claims because each law's asserted benefits were insufficient to justify its burdens. Add. 55-56, 76-79, 104-05, 127-28; *see WWH*, 136 S. Ct. at

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2300. This is not the lower court's "own standard" that it "conjured" itself, App. Br. 27, but exactly tracks *WWH* and earlier decisions. The court neither "fail[ed] to weigh" the relative benefits and burdens of each law, nor "presume[d] unconstitutionality," App. Br. 27; it engaged in precisely the balancing that Supreme Court precedent mandates.

Hewing to Supreme Court precedent, the court also properly granted facial relief: As to each of the three laws subject to facial challenge, the court made detailed, numerical findings of an undue burden on a large fraction of women affected. Add. 59-63, 80-82, 128-34; *see WWH*, 136 S. Ct. at 2320; *Casey*, 505 U.S. at 894-95 (spousal notification mandate facially invalid because it impacted large fraction of married women who wished not to notify their husbands, although they represented only 1% of abortion patients); *see also Jegley*, 864 F.3d at 958-60 (remanding for findings to estimate but "not … calculate the exact number of women unduly burdened").

The State simply obfuscates in arguing, for example, that the court referred solely to "some women" affected by the D&E Ban, without specific "large fraction" findings. App. Br. 42-43. That false assertion *completely ignores* pages of analysis and repeated determinations that "100% or all 638 of these women will experience a substantial obstacle to abortion." Add. 59-63. This Court should not countenance such a gross misstatement.

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B. The State Suggests an Erroneous Standard.

Courts applying the undue burden test's required balancing determine whether a law confers "benefits sufficient to justify [its] burdens. *See WWH*, 136 S. Ct. at 2300. The State instead invents a test where a law fails constitutional review only when it "completely fails to advance a legitimate interest (or does so in such a trifling way that it lacks any rational connection with the governmental interest) and imposes exceptional and truly significant burdens." App. Br. 24-25. This erroneously imports "rational basis" language into the undue burden analysis and contends that burdens must "substantially outweigh" benefits. This test appears nowhere in Supreme Court precedent and would eviscerate constitutional protections: It "is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty" with rational basis review. *WWH*, 136 S. Ct. at 2309. Instead, courts "appl[y] the correct legal standard" when they "weigh[] the asserted benefits against the burdens," *id*. at 2310, as the District Court did here.

This Court has, as a factual matter, described one outcome in *WWH* as resulting from a Texas law's "numerous burdens substantially outweigh[ing] its benefits." *Jegley*, 864 F.3d at 958; *see also id.* at 960 n.9 (using "substantially outweigh" phrase in dicta). But neither the Supreme Court nor any other court has ever adopted a standard that requires burdens on abortion to "substantially

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outweigh" benefits before a law is struck down. Such a standard would uphold restrictions whose burdens outweigh any benefits, run afoul of *WWH*'s straightforward balancing test, and undermine constitutionally protected liberty. *See* 136 S. Ct. at 2300, 2310.

In any event, as the court concluded and as discussed further below, none of the laws at issue here poses a close balancing question. The D&E Ban, for example, imposes an extreme burden, banning the only second-trimester method available in Arkansas for 100% of affected women. Add. 55-57, 59-64. Even using the State's erroneous standard would not affect the outcome here, where the court found each law's burdens dwarf its benefits. Nonetheless, this Court should reject the State's incorrect standard.

C. The District Court Properly Weighed the State's Asserted Interests.

Finally, the State contends that the court "disregarded" and failed to weigh the State's moral or ethical justifications for the challenged laws. App. Br. 28-29. But the court either explicitly determined that each law failed to advance the asserted state interest, or fully weighed the State's interests in its balancing, whether that interest was promoting potential life, women's health, or another proffered interest. *See, e.g.*, Add. 43, 56 (weighing "the asserted state interests against the effects of the [D&E] provision"); Add. 127 (No "interest … in potential life [can] support the Tissue Disposal Mandate … when there is no 'potential

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life.'").

With no acknowledged irony, the State now raises this asserted "error," despite having argued below that *WWH*'s balancing standard applied only to health regulations; where a regulation purports to advance potential life or ethics, the State insisted, the court must not balance, but rather must accept the asserted benefits and assess only burdens, and only certain burdens at that. Add. 40-41. The court rejected this argument; correctly concluded there is but one undue burden test, which requires balancing, *id.*; and in each instance also separately assessed burdens and found them significant, Add. 46-63, 68-79, 95-105, 116-26; *see also* Add. 56 (D&E Ban so burdensome that "whether this Court weighs the asserted state interests against the effects or examines only the effects[,]" undue burden claim is likely to succeed). Contrary to the State's mischaracterizations, the court never refused to engage in balancing or to weigh benefits beyond women's health.

II. D&E Ban

A. Undue Burden

1. Banning D&E is Unconstitutional.

Arkansas has banned D&E – the "usual abortion method in [the second] trimester," *Gonzales*, 550 U.S. at 135, the only second-trimester method available on an outpatient basis, and the method used for 100% of second-trimester abortions

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in Arkansas in 2015. Add. 8. Four decades of unwavering Supreme Court precedent preclude banning the most common second-trimester method.

Danforth, for example, held unconstitutional a Missouri ban on the then-most-common second-trimester method. The Court considered "the prevalence" of this method, "employed in a substantial majority … of" second-trimester abortions. 428 U.S. at 77. Of the alternatives, one was largely "experimental," with "severe limitations on … [its] availability," and the remaining two would impose "methods more dangerous to" the woman's "health than the method outlawed." *Id*. at 77-79. Because it "inhibit[ed] the vast majority of [second-trimester] abortions," it was unconstitutional. *Id.* at 79.

The Court reaffirmed this principle by affirming this Court in *Stenberg v. Carhart*, where a purportedly narrow partial-birth abortion ban also reached standard D&E, "the most common[] … method for … previability second trimester abortions." 530 U.S. 914, 945 (2000). Such a ban "'impose[d] an undue burden on a woman's ability' to choose [D&E] abortion, thereby unduly burdening the right to choose abortion itself." *Id.* at 930 (quoting *Casey*). *Stenberg* controls here.

Since *Stenberg*, courts have consistently struck any ban that reaches D&E, including laws like Arkansas's. *Whole Woman's Health v. Paxton*, No. A-17-CV-690-LY, 2017 WL 5641585 (W.D. Tex. Nov. 22, 2017) (enjoining similar law targeting D&E), *appeal filed*, No. 17-51060 (5th Cir. Dec. 1, 2017); *W. Ala.*

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Women's Ctr. v. Miller, No. 2:15-CV-497-MHT, 2017 WL 4843230 (M.D. Ala. Oct. 26, 2017) ("*WAWC*") (same), *appeal filed*, No. 17-15208 (11th Cir. Nov. 22, 2017); *Hodes & Nauser MDs, P.A. v. Schmidt*, 368 P.3d 667 (Kan. Ct. App. 2016) (same), *argued*, No. 114, 153 (Kan. Mar. 16, 2017); *Nova Health Sys. v. Pruitt*, No. CJ-2015-1838, 2015 WL 10319422 (Okla. Cty. Dist. Ct. Oct. 28, 2015) (same); *see also Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323 (6th Cir. 2007) (prohibiting D&E created unconstitutional burden); *Eubanks v. Stengel*, 224 F.3d 576 (6th Cir. 2000) (per curiam) (same); *Causeway Med. Suite v. Foster*, 221 F.3d 811 (5th Cir. 2000) (same); *Planned Parenthood v. Farmer*, 220 F.3d 127 (3d Cir. 2000) (same).

The Supreme Court reaffirmed protection for D&E in *Gonzales*. There the Court upheld a partial-birth abortion ban because it was narrowly drawn, reached only the uncommon intact D&E method, and – unlike the ban struck in *Stenberg* – did not reach standard D&E, "the usual [second-trimester] … method." 550 U.S. at 135, 146-47, 165. *Gonzales* made abundantly clear, as had *Danforth* and *Stenberg,* that a ban on the "dominant" second-trimester method "imposes an undue burden." *Id.* at 150. Contrary to the State's argument, App. Br. 41-42, *Gonzales* sharply distinguished between standard and intact D&E, stating: "There would be a flaw in this Court's logic, and an irony in its jurisprudence," if it "were to conclude a ban on both [D&E] and intact [D&E] was overbroad and then to say it is irrational to

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ban only intact [D&E]." 550 U.S. at 160. Thus, *Gonzales* reaffirmed: "a prohibition on D&E" is "an undue burden." *Northland Family Planning Clinic*, 487 F.3d at 336-37.

This Court has always followed that unbroken precedent, striking any ban that reached D&E. *Planned Parenthood 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). Because "D&E … is the most common procedure for second-trimester abortions[,]" "barr[ing]" it is "an undue burden." *Little Rock Family Planning Servs.*, 192 F.3d at 797-98; *accord Carhart*, 192 F.3d at 1145; *Miller*, 195 F.3d at 388; *see also Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015).

Significantly, every federal court presented with the argument that providers could circumvent a D&E ban by attempting demise has rejected it. The ban struck in *Stenberg* did not apply if the physician was able to cause demise beforehand, and the Court was aware of purported means to attempt demise. 530 U.S. at 925 (discussing digoxin and potassium chloride injections). But the existence of such procedures was insufficient to uphold a D&E ban then, and it is insufficient now.

Indeed, mandating an "attempt to ensure fetal demise … operate[s] as an additional undue burden." *Evans v. Kelley*, 997 F. Supp. 1283, 1318 (E.D. Mich. 1997); *see also Farmer*, 220 F.3d at 145 ("The increased risk of injury or death to

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the woman by attempting to ensure fetal demise … clearly constitutes an undue burden."); *Paxton*, 2017 WL 5641585 at *9 (Mandating this "additional step to an otherwise safe and common[]" procedure is "an undue burden[.]"); *WAWC*, 2017 WL 4843230 at *15 ("forc[ing]" woman "to undergo an unwanted, risky, invasive, and experimental procedure" is an undue burden); *Hodes & Nauser*, 368 P.3d at 678 (same); *cf. Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 612 (E.D. La. 1999) (ban on abortion unless "fetal demise is first induced" imposes "risker or costlier … procedures" and undue burden), *aff'd* 221 F.3d 811 (5th Cir. 2000).

Thus, under unbroken precedent, Arkansas's ban on D&E, the most common second-trimester method, "imposes an undue burden," *Carhart*, 192 F.3d at 1151, regardless of any purported demise works-arounds. "[B]ased on existing precedent alone, [it] must fail." *Paxton*, 2017 WL 5641585 at *6.

2. Demise Attempts Do Not Save the Ban.

The court correctly concluded that the Ban blocks abortion access, there are no feasible alternative second-trimester procedures,[8] and the State's unsupported suggestions otherwise, App. Br. 37, 45, 63, cannot save the Ban. None of the

[8] The State does not contest the finding that induction abortions are essentially unavailable in Arkansas: none were reported in 2015. Add. 8. Further, inductions entail labor that requires expensive hospitalization, and can take three days to complete. Add. 7-8. The court correctly found inductions do not save the Ban. Add. 7-8, 63.

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State's suggested patchwork of additional procedures, App. Br. 37-38, is "feasible for inducing fetal demise before … D&E," Add. 56.[9]

Digoxin. It is undisputed that digoxin injections are virtually unstudied before 18 weeks, are not safe for some patients after 18 weeks, and fail 5-10% of the time. Add. 51; App. Br. 37-38. The court thus correctly found that physicians cannot rely on digoxin to cause demise. Add. 48.[10]

The State's three counter-arguments all fail. *See* App. Br. 37-39. First, demise cannot be accomplished with "another alternative methodology" when digoxin fails or is contraindicated, App. Br. 37-38, 40, 42-43. *No* method can guarantee demise prior to evacuation. *See supra* pp.7-10*; WAWC*, 2017 WL 4843230 at *28 ("[N]one of the three alternatives would be safe or feasible.").

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[9] Contrary to the State's assertions, App. Br. 36, the court clearly considered the challenges *any* doctor would encounter under the Ban. *See* Add. 9, 56, 60 ("[T]here are no other providers … that could fill this gap in care."). The Ban's failings are not specific to Dr. Hopkins, who does not seek "unfettered choice" in abortion procedures. *Gonzales*, 550 U.S. at 163. Rather, he argues that banning D&E unconstitutionally leaves no "reasonable alternative procedures." *Id.*; *see also Stenberg*, 530 U.S. at 945-46 (ban reaching D&E unconstitutional because "[a]ll those who" provide D&E "must fear prosecution, conviction, and imprisonment").

[10] Further, mandatory digoxin at this stage adds a day to the procedure, imposing logistical obstacles beyond Arkansas's two-trip requirement. Add. 50; *see also Paxton*, 2017 WL 5641585, at *12 (even "[s]tanding alone" delay caused by mandatory digoxin "constitutes an undue burden"); *Planned Parenthood v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013) ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.").

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Second, the court did not "decline[] to acknowledge evidence establishing that second injections [of digoxin] have been safely administered[.]" App. Br. 38 n.7. The referenced study did not record the efficacy of a second digoxin injection, and addressed neither safety generally, nor whether the risks of digoxin would increase with repeat injections, Appx. 253-54. Thus, the court correctly found there are "no reported studies of record on using a second injection of digoxin … after the first dose fails." Add. 50.[11] Third, the court did not fail to address purported "undisputed expert testimony" speculating about dosages and side effects of digoxin before 18 weeks. *See* App. Br. 38-39 (emphasis removed). It remains undisputed that digoxin before 18 weeks is virtually unstudied, and the referenced testimony from Dr. Biggio does not even address whether the risks of digoxin, including uterine infection, extramural delivery, and digoxin toxicity, would be increased before 18 weeks. Add. 13.[12]

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[11] This Court should reject the State's citations to medical journals without the interpretation of medical experts. *See e.g.*, App. Br. 9, 34-35, 40. Absent expert testimony on "methodological soundness[,] reliability" and "applicability[,]" studies can be "misunderst[ood] and misappl[ied][.]" *Lebron v. Sec'y of Fla. Dep't of Children & Families*, 772 F.3d 1352, 1369-71 (11th Cir. 2014) (refusing to admit or take judicial notice of studies without expert testimony); *Dartez v. Fibreboard Corp.*, 765 F.2d 456, 465 (5th Cir. 1985).

[12] Moreover, Dr. Biggio's testimony from *WAWC,* 2017 WL 4843230, Appx. 256-308, is irrelevant to this case and should be disregarded. *See Tuosto v. Phillip Morris USA Inc*., No. 05-CV-9384-PKL, 2007 WL 2398507 at *13 (S.D.N.Y. Aug. 21, 2007) (rejecting expert affidavit from another matter); *cf. First Sec. Bank*

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Nothing in *Gonzales*, where experts testified in court, justifies reliance on the testimony of one expert in another case to claim there is medical uncertainty about digoxin. *See Gonzales*, 550 U.S. at 161-62; App. Br. 39. Here, there is unanimous agreement that digoxin is untested early in the second trimester, when most D&Es take place, and often fails. Add. 11-13; App. Br. 37. The State's attempt to conjure uncertainty does not amount to the genuine disagreement in *Gonzales*. Add. 53 n.6; *see also WAWC*, 2017 WL 4843230 at *26 (giving "less weight" to Biggio's testimony, which was "largely theoretical and not based on experience").

Potassium Chloride. Potassium chloride injections require the extensive training of sub-specialists in high-risk obstetrics and advanced ultrasound technology, typically found only in hospitals and prohibitively expensive for most clinics. Add. 14-15. A misplaced potassium chloride injection can cause cardiac arrest and death. Add. 14 (citing declarations). Nothing in *Gonzales* indicates that Arkansas can require Dr. Hopkins to undertake years of specialized training to perform abortions or LRFP to obtain prohibitively expensive equipment. Add. 52; *see also WWH*, 136 S. Ct. at 2318 (considering cost of compliance when assessing

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v. Union Pac. R.R. Co., 152 F.3d 877, 879 (8th Cir. 1998) (affirming exclusion of expert report "prepared in conjunction with an unrelated lawsuit"). *See* Appx. 256-60.

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undue burden).

Umbilical Cord Transection. Umbilical cord transection is not well-studied, would be difficult if not impossible to perform earlier in the second trimester, poses risks to the patient, and, in any case, cannot circumvent the Ban. Add. 54-55. The limitations of the sole study of this "experimental procedure," *Paxton*, 2017 WL 5641585 at *12, are well documented. Add. 54; *see also* *WAWC*, 2017 WL 4843230 at *19-20 ("women cannot be required to undergo a risky procedure based on one questionable study" that is "unreliable" and "provides paltry evidence as to the safety of performing" cord transection). Successfully identifying and transecting the cord would add time and passes with forceps (especially earlier in pregnancy), which, all experts agree, increases risks including uterine perforation. Add. 54-55 (citing declarations). To the extent there are differences among the experts, the court properly deemed Biggio's testimony less credible. Add. 53 n.6; *WAWC*, 2017 WL 4843230 at *26; *WWH*, 136 S. Ct. at 2310 (courts must resolve questions of medical uncertainty); *Gonzales*, 550 U.S. at 165 ("Court[s] retain[] an independent constitutional duty to review factual findings where constitutional rights are at stake.").

Umbilical cord transection cannot circumvent the Ban, which applies when one acts "purposely," defined as having "conscious object[ive]." Ark. Code Ann. § 20-16-1802(3)(A)(i), (5). When a person is aware of the natural and probable

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consequences of an act, engaging in that act is evidence of a "conscious objective" to engage in the conduct resulting in those consequences. *Walker v. State*, 918 S.W.2d 172, 173 (Ark. 1996). It is undisputed that physicians would be aware that in grasping for the cord with forceps, they are likely to grasp fetal tissue, thus violating the Ban. Add. 58 (citing declarations). Given the law's defined terms, physicians cannot attempt cord transection and credibly maintain that they did not violate the Ban in grasping fetal tissue. Add. 58.[13]

B. The District Court Properly Assessed the Burdens and Balanced Them Against Benefits.

The court's assessment of the Ban's burdens is thus based on a thorough analysis concluding that neither induction nor the State's proposed alternatives, none of which guarantees demise, could preserve access to second-trimester abortion. Add. 7-8, 46-54, 62-63; *Danforth*, 428 U.S. at 79 (striking abortion

[13] The State proffered two additional arguments below. First, while causing demise with suction is not banned, the State asserted falsely that physicians can rely on suction throughout the second trimester to avoid liability. The court rightly rejected this argument. Add. 45 n.9. Second – although it would not save the Ban even if true, *Northland Family Planning Clinic*, 487 F.3d at 340, – the State falsely claimed that "women who need" D&E "for medical reasons" could obtain care under the medical exception. Add. 59. The court correctly found the exception far too narrow to justify that assertion. *Id.*; *see also WAWC*, 2017 WL 4843230 at *29 (similar exception "provides vanishingly little protection for patients or doctors"). A woman who is already dilated and for whom digoxin has failed needs an abortion "for medical reasons[,]" but that care is not yet "necessary to avert" her "death" or "serious risk of substantial and irreversible" physical harm. Ark. Code Ann. § 20-16-1802(6); Add. 59.

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method ban where alternatives were unavailable).

Notwithstanding the gravity of the burden, the court fully considered the State's interests, recognizing "the legitimacy of" the interest in regulating medical ethics and promoting respect for potential life. Add. 43. [14] The court correctly concluded that the burdens outweighed them: "whether … weigh[ing] the asserted state interests against the effects of the provisions or examin[ing] only the effects of the provisions, Dr. Hopkins has carried his burden of demonstrating" an undue burden. Add. 56; *see also Casey*, 505 U.S. at 846 (no state interest justifies substantial obstacles before viability); *Paxton*, 2017 WL 5641585 at * 13 ("whether the court weighs the asserted state interests against the effects of the provision or examines only the effects of the provisions," D&E ban "creates an undue burden"); *WAWC*, 2017 WL 4843230 at *31 (same). Even if the standard required burdens to substantially outweigh benefits, that standard is met here.

[14] The State's contrary suggestions notwithstanding, the Ban *harms* women's health. There is no evidence that mandating demise attempts regardless of patient preference would benefit women's health, let alone justify the burdens imposed. *See* Nichols Decl. ¶¶ 16-18, Appx. 449. The belief that attempting demise decreases procedure time and risks is without support. Appx. 195 (Demise "prior to the D&E procedure did not appear to decrease the procedure duration."); Nichols Decl. ¶ 10, Appx. 447 (recent, rigorous, well-designed studies disprove State's assertion).

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C. The Ban Imposes an Undue Burden on a Large Fraction of Women.

By denying women access to second-trimester abortion, the Ban creates an undue burden for a large fraction of affected women, as the court correctly held. Add. 56; *Casey*, 505 U.S. at 894-95. Because there is no way to attempt fetal demise before 18 weeks, there would be no D&E access, and thus an undue burden, for 100% of the 407 women seeking abortion at 14-17 weeks in Arkansas.[15] Because there is no way to guarantee demise even after 18 weeks, ethical and legal obligations prevent physicians from starting any D&E. Thus "100% or all 638" second-trimester patients would face an undue burden, justifying facial relief. Add. 59-63.

III. Medical Records Mandate

A. Undue Burden

The State's argument for reversal reduces to the assertion that the court should have adopted a reading of the Medical Records Mandate under which it applies only to patients who report knowing the sex of the embryo/fetus, App. Br. 44-45. With such narrowing, the State contends, "virtually all the burdens … disappear." App. Br. 47. As the court correctly held, that argument fails. First, Arkansas canons of construction require giving the Mandate its plain meaning,

[15] This would apply even if the court were to credit the State's scienter argument. Add. 61 n.9.

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which unambiguously applies to all women, *see supra* p.11; second, the court analyzed – and found likely unconstitutional – *both* the Mandate's plain meaning and the State's narrowing construction. Add. 68-70.

Indeed, the Mandate's burdens affect the entire universe of women to whom it applies. The court found that harmful delays would be severe for all affected patients, but *especially so* for women who report knowing the sex, given the State's admission that they are later in pregnancy than most patients on average. A woman delayed may become ineligible for a method that would otherwise be best for her, be left with a relatively riskier procedure, or be forced to forgo an abortion if delayed past Arkansas's legal abortion limit. Add. 72-73. The State conceded that, as the legislative findings reflect, delay can increase risk. Add. 72, 77. The Mandate's records requests and "reasonable time and effort" to search impose precisely the type of indeterminate delay forbidden in abortion regulations. *E.g.*, *Bellotti v. Baird*, 443 U.S. 622, 644 (1979) (judicial bypass "must assure … resolution … with … sufficient expedition"); *Causeway Med. Suite v. Ieyoub*, 109 F.3d 1096, 1110 (5th Cir. 1997) (rejecting process without time limits; "[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); *see also* Add. 73.

Violations of confidentiality likewise occur for all women the law affects. Add. 75-76 ("request for medical records made by" LRFP "discloses that the

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patient likely is seeking an abortion[;]" "this violation of confidentiality … interfere[s] with a woman's right to" abortion).[16] The court also correctly held that the lack of health exception – to "allow physicians to act without the required medical records search in cases" of "serious health risk" – condemns the Mandate regardless of the group affected. Add. 74.

Against these burdens, the State points to no evidence that the Mandate advances any interest, and does not attempt to show that any purported benefit outweighs these significant burdens.[17] Hence, the Court correctly concluded that Dr. Hopkins established a likelihood of success on the undue burden claim. Add. 70-79; *see also WWH*, 136 S. Ct. at 2309-18 (nonexistent, few, or tangential benefits cannot outweigh burdens); *Planned Parenthood v. Schimel*, 806 F.3d 908, 920 (7th Cir. 2015) (the "feebler" the state interests, the likelier that any burden is disproportionate and therefore undue).

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[16] Inasmuch as the State has never disavowed enforcing the Mandate, there is no merit to *Amicus* Eagle Forum's suggestion that the harms inherent in the statutory provisions may never materialize. *See* Eagle Forum Br. 13-15.

[17] The State implies that the Mandate strengthens the separate "sex-selection" ban. App. Br. 47. But the State neither explains how mandating voluminous, time-consuming records requests improves on the colloquy that subsection (b)(1) requires, *see* Ark. Code Ann. § 20-16-1904(b)(1), nor shows that the "sex-selection" ban addresses any problem in Arkansas. *See WWH*, 136 S. Ct. at 2314 (in striking restriction, emphasizing absence of evidence that it advanced purposes any more than pre-existing provisions); *id*. at 2311 ("the new law helped to cure" no problem).

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With that conclusion, Add. 79, the court then detailed, with specific numerical calculations, that the burdens would fall on all or most women affected – i.e., more than a large fraction. Add. 80-81; *see also* Add. 70. Even considering application of the Mandate "only to women who" report "know[ing] the sex … the undue burdens … will apply to all of those women" and "will substantially outweigh its benefits"; the same is true under the plain-meaning application to all patients. Add. 80-81. The State's proposed statutory construction cannot save it, *cf.* App. Br. 44-48, and the State offers no other basis for reversal.

B. Vagueness

In addition, several of the Mandate's provisions – which provide no guidance on what "reasonable time and effort" is required in searching for records, what scope of records "relat[e] directly" to a woman's "entire pregnancy history[,]" or what physicians or enforcement authorities must do with any records obtained – render the Mandate impermissibly vague. *See* Ark. Code Ann. § 20-16-1904(b)(2).

In arguing otherwise, the State asserts that because physicians routinely exercise reasonable medical judgment, and request records for medical purposes, they must "*fully* understand" what the Mandate requires. App. Br. 49-50. But by the State's own reading, the mandatory searches and undefined tasks to undertake with records received are not based on medical judgments, but instead purportedly

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relate to a new policy goal, App. Br. 47, about which doctors have no expertise. Moreover, unlike in *Karlin v. Foust*, 188 F.3d 446, 464, 467 (7th Cir. 1999), on which the State relies, App. Br. 49, this law lacks '"fair warning' as to what conduct is expected of [physicians] in order to avoid … liability[,]" employs no "objective reasonableness" standard, and describes no clear parameters. Add. 85-90. Substantiating that the Mandate is likely unconstitutionally vague, the court specified numerous aspects of its indeterminacy, pointedly refuting the State's efforts to clarify the law with language and standards absent from the enacted text. Add. 82-90.

The State's attempt to narrow the Mandate to require only "records relevant to" determining whether a "woman is seeking a sex-selective abortion[,]" App. Br. 49, is textually unsupported, and also could not cure the vagueness. It fails to clarify how long and expansive a search is "reasonable," what records "relate directly" to a woman's "entire pregnancy history," or how a physician must use any such records. *See* Ark. Code Ann. § 20-16-1904(b)(2). The vagueness also exacerbates the delays and confusion that will ensue for patients, and does nothing to eliminate the unbounded disclosure of their abortion decision. Add. 71-79; *see supra* pp. 12-13, 39-40.

As the court correctly explained, this vagueness is fundamentally unfair and unworkable. Add. 82-90; *see also Johnson v. United States,* 135 S. Ct. 2551,

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2556-57 (2015) (prohibition of vague criminal statutes is well-recognized). The State's scant attempts to save this provision establish no abuse of discretion.

IV. Local Disclosure Mandate

A. Undue Burden

The Local Disclosure Mandate requires disclosing every 14- to 16-year-old's abortion to her local police, with her home address, the name of her sexual partner, and gathering of tissue "evidence," all based simply on the abortion. Contrary to the State's suggestions, App. Br. 54-55, Dr. Hopkins's as-applied challenge for Non-CMA Teenage Patients will have no effect on the original coverage of patients under 14, who always fall within statutory rape statutes, Add. 95, 99-100, and will not alter law enforcement's ability to obtain evidence based on probable cause. The State's anecdotal examples of convictions, App. Br. 55, involved evidence collected by search warrant with individualized probable cause, not the Mandate.[18]

[18] Like the State, *Amicus* Eagle Forum falsely portrays this suit as affecting law enforcement's ordinary, case-specific investigative tools; it does not. Eagle Forum's characterization of the teenagers whose sexual activity *must be reported under the CMA* (and thus are not at issue in this suit) is also erroneously narrow. Eagle Forum Br. at 24-26. In fact, the CMA requires reporting of any possible sexual abuse or exploitation, which covers not only age differentials but also caregivers (including family members) or use of force. *See* Ark. Code Ann. §§ 12-18-103(3), (7)-(10), (20)-(22). In addition, Eagle Forum even baselessly posits that "law enforcement has every right … *to suspect* any parent" who does not want to

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This case concerns the opposite of probable cause: the *blanket*, *undifferentiated* requirement that physicians treat all Non-CMA Teenage Patients – with circumstances neither indicative of any possible abuse nor part of any individualized investigation – as crime participants, with their abortion and other extremely personal information disclosed to community police. The Legislature made no findings supporting the Mandate. Add. 94. The court of course acknowledged important interests in "protecting children from sexual abuse and in prosecuting" perpetrators, Add. 94, but the State failed to show how it serves those interests to label all Non-CMA Teenage Patients as crime victims and to reveal their private activity to local officials *because they have chosen abortion*. Add. 98-99.

As the court found, where a teenager's circumstances are not reportable under Arkansas's CMA, which exhaustively defines and requires reporting of even *suspicion* of sexual abuse or exploitation, there is no "valid state purpose" justifying forced police involvement. Add. 98, 100-04. Following *WWH*, the court correctly highlighted the Mandate's significant under- and over-inclusiveness,

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share a daughter's "pregnancy and abortion" with local law enforcement. Eagle Forum Br. 26. Mere parental desire for privacy cannot establish probable cause. *Maryland v. Pringle*, 540 U.S. 366, 371 (2003) ("probable cause is a reasonable ground for belief of guilt" particularized with respect to the person) (internal quotation marks and citations omitted).

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undercutting its purported benefits. Add. 105; *see also WWH*, 136 S. Ct. at 2315-18 (abortion restriction that is both over- and under-inclusive for purported purposes reveals its lack of necessity and limited, if any, benefit).

Contrary to the State's arguments, this Mandate for teenagers choosing abortion is not justified by 1991-1996 data on certain sexual crimes in 12 *other* states. Opposing counsel filed that compilation on the eve of the preliminary injunction hearing, Appx. 386; Dr. Hopkins then properly objected to it as impermissible hearsay, lacking expert testimony to assess its meaning. Pl.'s Reply Br. Supp. P.I. 19-23, Doc. No. 32. It is plainly not "undisputed data," App. Br. 55, but inadmissible information with no relation to sexual abuse in Arkansas or any aspect of this case. But even were a trend for forcible assaults at a particular age during a period twenty years ago credited, *id.*, that would not justify the Mandate's unique focus on abortion – while ignoring miscarriage, prenatal care, and all other care sexually active teenagers seek from clinicians and other mandatory reporters – and universal application to all 14- to 16-year-olds receiving abortions, regardless of circumstances. *See WWH*, 136 S. Ct. at 2315-18.

Beyond finding no benefits, the court catalogued the numerous burdens as applied to Non-CMA Teenage Patients. First, the Supreme Court has repeatedly found that required disclosure of abortion to third parties deters patients from pursuing care; the record here reflects the same. Add. 97 (citing record evidence

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and cases). *Casey* therefore held that forced disclosure to one's spouse imposed an undue burden. 505 U.S. at 894. Likewise, the court correctly held that required disclosure to local police "is itself" a serious harm that deters care. Add. 97-98. Contrary to the State's arguments, App. Br. 56, the court did not assume police would breach confidentiality further, but found a significant burden in disclosure to police itself. Add. 97.

Second, the mandated disclosures label a teenager's sexual activity as criminal, her partner a suspect, and abortion tissue as evidence – despite the lack of any supporting facts. As the court found, these requirements confuse, humiliate, and stigmatize – causing teenagers to fear, delay, or forgo care. Add. 95-104.

Third, the terms of the Mandate and its regulations can be read to prohibit medication abortion, because a physician cannot collect tissue, which is typically passed at home days after patients' appointments. Add. 96. Removing the medication method – medically indicated for some patients and a strong preference for others – significantly interferes with care. Add. 96, 99. While not yet deciding that the Mandate creates this bar, the court ruled that if it does, that adds weight to its other, already-substantial burdens. Add. 99, 104.[19]

[19] If the Mandate is read to allow medication abortion because, as the State contends, a teenager may circumvent the disclosures and evidence collection

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Whether or not medication abortion patients are covered, the Mandate fails *WWH* balancing because it penalizes Non-CMA Teenage Patients who seek abortion without advancing any legitimate goals. "[T]here is no 'constitutionally acceptable' interest to balance against the substantial obstacles erected" and thus it imposes an undue burden. Add. 99, 104-05 (quoting *WWH*).

The State seems to suggest, without any record support, that there might be some needle-in-a-haystack benefit, possibly placing some tiny weight on its side of the scale based on the chance that someday, somewhere a disclosure to the police *without any factual foundation for doing so* might later turn out to be useful. App. Br. 55. But that minimal, hypothetical benefit cannot outweigh the substantial harms imposed on *every* Non-CMA Teenage Patient. In the required balancing, these universal harms greatly outweigh any benefit and thus the court correctly concluded that the Mandate likely imposes an undue burden as applied to Non-CMA Teenage Patients. Add. 105, 111.

B. Informational Privacy

Dr. Hopkins is also likely to succeed in showing violations of the right to informational privacy. This Court has repeatedly recognized that the Fourteenth Amendment "safeguard[s] individuals from unwarranted governmental intrusions

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merely by choosing medication abortion as her method, App. Br. 13-14, that further undercuts the weight of any purported state interest.

into their personal lives." *Eagle*, 88 F.3d at 625 (citation omitted); *see also Cooksey v. Boyer*, 289 F.3d 513, 515-16 (8th Cir. 2002); *Alexander v. Peffer*, 993 F.2d 1348, 1349-50 (8th Cir. 1993). At a minimum, it shields the confidentiality of "highly personal matters" in "the most intimate aspects of human affairs," forbidding government prying into "inherently private" personal information without adequate justification, *Eagle*, 88 F.3d at 625-26, or when it causes "a shocking degradation or an egregious humiliation … or flagrant breech of a pledge of confidentiality which was instrumental in obtaining the personal information[,]" *Alexander*, 993 F.2d at 1350.

As the court described, Add. 97, 104, Non-CMA Teenage Patients will suffer "a shocking degradation" and "egregious humiliation" from the mandatory local police disclosure in and of itself, particularly because intimate medical care is ordinarily confidential and not disclosed within one's community. Official demand for abortion information, including a teenage patient's name, address, and sexual partner's name, discloses "inherently private" matters which the government cannot invade, absent strong proof to justify violating patients' fundamental privacy. Add. 105-10 (collecting cases). A law invading constitutionally protected privacy can be upheld "only if a substantial government interest outweighs the burdened privacy right." *O'Connor v. Pierson*, 426 F.3d 187, 202-03 (2d Cir. 2005).

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Contrary to the State's assertions, the court thoroughly explained how the forced disclosure of Non-CMA Teenage Patients' medical information – particularly about abortion and sexual history, to their community police under circumstances "lack[ing] any justifying state purpose" – meets even a "high burden" for violations of this important right. Add. 104-10. Rejecting the State's faulty premise that police can readily access intimate information simply because they in turn have a duty of confidentiality, App. Br. 57, and that only widespread public dissemination triggers constitutional protection, the court underscored that the right to informational privacy protects against unjustified *compelled disclosure to the government*. Add. 107-08; *see also Planned Parenthood v. Lawall*, 307 F.3d 783, 789-90 (9th Cir. 2002) (constitutional interest "applies … when an individual chooses not to disclose highly sensitive information to the government"); *Shuman v. City of Philadelphia*, 470 F. Supp. 449, 458 (E.D. Pa. 1979) (compelled disclosure to the police may "in and of itself" be a violation). Our constitutional system does not allow the State to demand disclosure of a teenager's abortion care, disclosure of her sexual partner's identity, and collection of tissue "evidence" of that care – without any factual basis for doing so, in a dragnet that targets uniquely teenagers who seek abortion.

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V. Tissue Disposal Mandate

A. Undue Burden

The District Court correctly concluded that the Tissue Disposal Mandate's burdens far outweigh any benefits. Contrary to the State's arguments, this conclusion rests on close adherence to the statutory texts and the onerous consequences of engrafting the FDRA into a context for which it was manifestly not designed. Add. 127-28. The State, by contrast, suggests erroneous "shortcuts" through which providers may evade the FDRA's elaborate requirements by attempting to keep an abortion and resulting tissue secret from all but one adult "parent" or "grandparent." App. Br. 52-54. But under the Mandate, providers "shall ensure" disposition "in accordance with" the FDRA, which vests equal, shared rights in *all* adult "parents" or *all* "grandparents," and requires notice to others before one individual can take control. Ark. Code Ann. §§ 20-17-802(a) & 20-17-102(d)(1)(E), (d)(1)(G), (d)(3)(A); Add. 118-22.

The State relies heavily on one of several means by which an individual *might* forfeit his rights, but ignores the FDRA's over-arching, core principle: vesting rights in all adults who share the same relationship with "the decedent[,]" *id*. §§ 20-17-102(a)-(d), which clinicians subject to the Mandate must ensure, *id*. § 20-17-802(a). Thus, the State posits erroneously that a physician may allow an adult patient to exercise the disposition right alone, without any attempt "to notify

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the partner." App. Br. 52. That would not constitute "ensuring" FDRA compliance: It would violate the FDRA's repeated requirements to make "reasonable efforts" to notify those in whom it jointly vests disposition rights. Ark. Code Ann. §§ 20-17-802(a), 20-17-102(d)(1)(E)(ii), 20-17-102(d)(3)(A).

Moreover, while the State posits scenarios in which five days pass without an adult patient's partner asserting his interests or any party raising a challenge to the disposition right of a "grandparent," if the patient is under age 18, App. Br. 52-53, there are *numerous* unpredictable variations that do not fit the State's simplistic description and contribute to making compliance impossible. For example, a patient unwilling to pay for disposition might forfeit her right, leaving only her sexual partner or others as a means of complying with the FDRA; a minor patient with an 18-year-old partner has no disposition right, but the partner does; an adult partner aware of – and opposed to – an adult patient's abortion may disagree about arrangements, triggering recourse to the courts; or if both "parents" are minors, four grandparents become involved in her abortion and may disagree about disposition, causing harmful delay and necessitating court proceedings. There is no simple "five-day" fix.

Under threat of prosecution, clinicians must ensure FDRA compliance before starting a procedure: they cannot risk removing tissue without knowing they can dispose of it lawfully. *Supra* p.18. Providers must determine disposition

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rights beforehand, including by identifying and notifying relevant third parties. Add. 121. Thus, the Mandate unconstitutionally conditions a woman's abortion on the prior involvement of either her sexual partner *or* her and his parents (the "grandparents") – depriving each patient of her right to private decision-making, carrying harmful repercussions, and delaying or denying her care. Add. 116-26. These unconstitutional third-party requirements alone support the likelihood of success. Add. 117, 126; *see also Casey*, 505 U.S. at 898 (rejecting spousal notification mandate); *Bellotti*, 443 U.S. at 639-40 (requiring confidential judicial bypass for parental-notification requirement); *Hodgson v. Minnesota*, 497 U.S. 417 (1990) (same).

In addition to unconstitutional third-party notice, the Mandate requires providers to ensure that disposition rights vest according to the FDRA's multiple layers of regulation. Ark. Code Ann. §§ 20-17-802(a), 20-17-102(a)(2)(C), 20-17-102(i). As the court discussed, attempting to comply would significantly delay care, expose women to medical risks, require elaborate notice and record-keeping systems, and leave clinicians uncertain how to ensure actions "in accordance with" the FDRA.[20] Add. 121-23, 132-34. Even ascertaining and documenting that a

[20] The State's various purported work-arounds are textually unsupported. Add. 126. For example, although admitting that if the patient and her partner are minors, neither may exercise disposition rights, App. Br. 12, the State hypothesizes

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person with disposition rights forfeited that right would delay and impede access to abortion. Add. 123. The elaborate scheme the Mandate establishes would "make it impossible" to continue providing care. *See* Add. 117, 121-26. Physicians have no capacity to police relatives, funeral directors, and others in their decision-making, dispute-resolution, and eventual "location, manner, and conditions of disposition[.]" Ark. Code Ann. § 20-17-102(d)(1).

Against these great burdens, the court found the State's interests marginally advanced, if at all. Add. 127-28. First, as the court underscored, the Mandate establishes no new method of disposal and does not advance any interest in the dignity or medical ethics of disposal. Add. 127.[21]

Second, the court correctly concluded that no interest "in potential life [can]

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that a judge hearing a judicial bypass petition could "arguably … grant[]" a minor "disposition rights," *id.* at 53 n.11. To the extent the State suggests that a judicial bypass judge could grant a minor disposition rights during a bypass proceeding, that is simply without support. The State ignores that the Mandate obligates providers and that disputes about disposition are resolved in proceedings spelled out in the FDRA – in which people *with disposition rights* argue for control – not in a bypass proceeding brought by a minor, who cannot be vested with disposition rights. Any separate FDRA proceeding or new, unauthorized participants in a bypass proceeding would impermissibly violate the minor's confidentially.

[21] The State relies on *Planned Parenthood v. Minnesota*, App. Br. 51, but the regulation there bears no resemblance to the Mandate, and the challenger conceded the state's interest in "protecting public sensibilities." 910 F.2d 479, 487-88 (8th Cir. 1990). It was upheld under a pre-*WWH* standard echoing rational basis review, *id.* at 486-87, which the Supreme Court has clarified is incorrect, *WWH*, 136 S. Ct. at 2309-10.

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support the … Mandate because it applies to tissue disposal … when there is no 'potential life.'" Add. 127 (quoting *WWH*). That decision was consistent with other courts' assessment of tissue disposal regulations. *See Whole Woman's Health v. Hellerstedt*, No. 1:16-cv-01300-DAE, slip op. at 11 (W.D. Tex. Jan. 29, 2018), Doc. No. 110 ("[T]here is no precedent showing expressing respect for the unborn by restricting [embryonic/fetal tissue] disposal after the potential for life no longer exists is a valid state interest."); *Whole Woman's Health v. Hellerstedt*, 231 F. Supp. 3d 218, 229 (W.D. Tex. 2017) (disposal regulation "when there is no potential life to protect" serves no "legitimate state interest"), *appeal dismissed*, No. 17-50154 (5th Cir. Dec. 5, 2017);[22] *Planned Parenthood v. Comm'r*, 194 F. Supp. 3d 818, 833 (S.D. Ind. 2016) (same), *appeal docketed*, No. 17-3163 (7th Cir. Oct. 19, 2017). The State cites no precedent for an interest in promoting potential life when there is none to promote. *See* App. Br. 51-52. Likewise, the State offers no evidence that the Mandate advances any interest in a permissible way, and the Mandate was accompanied by no legislative findings. *Cf. WWH*, 136 S. Ct. 2309-10 (provision must *actually* advance a proper interest).

Third, even were the State's "five-day fix" a plausible reading of the FDRA, which it is not, that would further undermine any purported government interest.

[22] The District Court mis-attributed a quotation from this case to a Supreme Court decision of the same name. Add. 127.

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The State offers no explanation or evidence of how a five-day delay between abortion and tissue disposal could advance any purported interest. *See WWH*, 136 S. Ct. at 2315 (nothing in record suggests new law advanced interest better than pre-existing law). Similarly, were the State correct that the Mandate does not apply to medication abortion, Add. 123-24; App. Br. 51 n.9, that too would undercut any interest advanced by this elaborate regulatory structure, which would still restrict all other abortion care: Whatever purported interest the State has in applying the FDRA to women who obtain abortion by other methods would necessarily apply to women receiving medication abortions.

Finally, the court properly granted facial relief, making specific findings that the Mandate, regardless of how construed, imposes an undue burden for *all* women affected: either all women seeking abortions, or those seeking non-medication abortions. Add. 128-32.

B. Vagueness

The Mandate also violates Due Process, failing to give "fair notice of conduct … forbidden or required" and inviting arbitrary enforcement. *Fox*, 567 U.S. at 253-54; *see also* Add. 82-87, 135-36 (discussing vagueness standard). In a single, conclusory sentence, the State asserts that the court erred in finding the Mandate likely unconstitutionally vague. App. Br. 54. This failure to offer any substantive argument amounts to waiver. *See* Fed. R. App. P. 28(a)(8) (brief must

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contain reasons for contentions, with citations to authorities and record); *Rotskoff v. Cooley*, 438 F.3d 852, 854-55 (8th Cir. 2006) (argument waived "because the issue was not developed" in brief); *Meyers v. Starke*, 420 F.3d 738, 743 (8th Cir. 2005) (issue is unreviewable and may be waived unless "presented in the brief with some specificity").

The State's failure to try reflects the fog of the Mandate's opaque requirements. The Mandate incorporates a law that was drafted for a different context and anticipates civil liability. Especially because the Mandate imposes strict criminal liability, with no scienter requirement, based on vague directives, Dr. Hopkins is likely to succeed. Add. 135-36. As discussed above, it is unclear how medical providers "ensure" compliance with the FDRA's elaborate scheme, including what constitutes "reasonable efforts" to notify; who must provide that notice; and how they ensure disposition eventually occurs "consistent with existing laws, rules and [undefined] practices" or as otherwise "authorized." Ark. Code Ann. §§ 20-17-802(a), 20-17-102. The Mandate's application to medication abortion also remains uncertain, regardless of the validity of the emergency regulation, which addresses only clinic licensing, not physicians' obligations under the Mandate. Add. 124. Because the Mandate leaves providers to "guess at its meaning[,]" and fails to provide adequate notice, *United States v. Mabie*, 663 F.3d 322, 333 (8th Cir. 2011) (citation omitted), the court correctly found the vagueness

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claim likely to succeed.

VI. The District Court Correctly Held the Remaining *Dataphase* Factors Favor Preliminary Injunctive Relief.

Upon finding Dr. Hopkins likely to succeed, the court correctly applied the remaining *Dataphase* factors and concluded that each favored a preliminary injunction. Add. 63-64, 90-92, 110-12, 136-38. The threatened irreparable harm – to a large fraction of women affected by each of the three provisions challenged facially; to the Non-CMA Teenage Patients by the Local Disclosure Mandate; and to Dr. Hopkins, who would be denied due process rights – "clearly outweighs" any harm to the State. Add. 64, 91, 111, 137. The preliminary injunction thus also serves the public interest. *See Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013) ("enforcement of an unconstitutional law is always contrary to the public interest").

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CONCLUSION

For the reasons stated above, the Court should affirm.

February 20, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Hopkins v. Jegley et al. (17-2879)

I certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains approximately 12,988 words, excluding the parts exempted by Fed. R. App. P. 32(f).

I also certify that the forgoing brief complies with the requirements of Fed. R. App. P. 32(a)(5)-(6) because it has been prepared in proportionally-spaced typeface using Microsoft Word in 14-Point Times New Roman.

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/s / Susan Talcott Camp
Susan Talcott Camp

CERTIFICATE OF SERVICE

I, Susan Talcott Camp, hereby certify that on February 20, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notice to all counsel of record.

/s/ Susan Talcott Camp
Susan Talcott Camp

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