No. 19-2690

United States Court of Appeals
for the
Eighth Circuit

LITTLE ROCK FAMILY PLANNING SERVICES; PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, doing business as Planned Parenthood Great Plains; STEPHANIE HO, MD, M.D. on behalf of herself and her patients; TOM TVEDTEN, M.D., on behalf of himself and his patients,

Plaintiffs-Appellees,

– v. –

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas; LARRY JEGLEY, in his official capacity as Prosecuting Attorney of Pulaski County; MATT DURRETT, in his official capacity as Prosecuting Attorney of Washington County; SYLVIA D. SIMON, M.D., in her official capacity as Chairman of Arkansas State Medical Board; ROBERT BREVING, M.D., in his official capacity as member of the Arkansas State Medical Board; VERYL D. HODGES, D.O., in his official capacity as member of the Arkansas State Medical Board; JOHN H. SCRIBNER, M.D.,

(For Continuation of Caption See Reverse Side of Cover)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF ARKANSAS
NO. 4:19-CV-00449 KGB (HONORABLE KRISTINE G. BAKER)

OPENING BRIEF OF PLAINTIFFS-APPELLEES

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Defendants-Appellants.

JUSTIN BUCKLEY DYER, PH.D., *et al.*,

Amici on Behalf of Appellant(s).

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SUMMARY OF CASE AND STATEMENT REGARDING ARGUMENT

Plaintiff-appellees have challenged three Arkansas abortion restrictions. The first, Act 493, the "18-Week Ban," bans abortion at an arbitrary pre-viability point in pregnancy—18 weeks from a woman's last menstrual period (LMP). The second, Act 619, or the "Reason Ban," prohibits women from obtaining an abortion based on a prenatal Down syndrome indication. The third, Act 700, the "OBGYN Requirement," prohibits physicians other than board-certified or certification-eligible obstetrician-gynecologists (OBGYNs) from providing abortions. This Requirement would bar most women who seek abortion care in Arkansas from accessing it, while offering no offsetting benefit.

Because these three laws violate binding precedent, the district court properly found plaintiff-appellees likely to prevail on the merits of their due process challenges and preliminarily enjoined each law. The State now resists that ruling, based almost exclusively on its disagreement with the district court's factual findings. Because the State does not even argue (must less meet its burden of demonstrating) that those findings are clearly erroneous, oral argument is not necessary to affirm. If this Court schedules argument, however, plaintiff-appellees request 15 minutes per side.

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JURISDICTIONAL STATEMENT[1]

The district court had jurisdiction under 28 U.S.C. § 1331 and 1343(a)(3). The district court issued a preliminary injunction on August 6, 2019, and Arkansas filed a notice of appeal that same day. This Court has jurisdiction to review the preliminary-injunction order under 28 U.S.C. § 1292(a).

This Court does not, however, have jurisdiction to review the district court's orders consolidating this case with *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*, No. 4:15-cv-00784-KGB (E.D. Ark.), for the reasons explained in plaintiff-appellees' previously-filed motion to dismiss that portion of this appeal.

STATEMENT OF THE ISSUES

1. Did the district court correctly enjoin the ban on pre-viability abortions starting at 18 weeks LMP?

Whole Woman's Health v. Hellerstedt, 136 S. Ct. 2292 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768 (8th Cir. 2015); *Edwards v. Beck*, 786 F.3d 1113 (8th Cir. 2015).

2. Did the district court correctly enjoin the ban on pre-viability abortions based on women's reasons for pursuing such care?

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[1] This brief refers to the State's brief as "Br." Unless otherwise noted, internal quotation marks and citations are omitted and emphasis is added.

Whole Woman's Health, 136 S. Ct. 2292; *Casey*, 505 U.S. 833; *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962 (7th Cir. 2012).

3. Did the district court correctly enjoin the ban on abortions performed by physicians other than board-certified or board-certification-eligible OBGYNs, based on well-substantiated findings that this requirement has little (if any) benefit, and imposes significant burdens on access to pre-viability abortion care?

Whole Woman's Health, 136 S. Ct. 2292; *Casey*, 505 U.S. 833; *Missouri ex rel. Gaines v. Canada*, 305 U.S. 337 (1938).

4. Should this Court order random reassignment on remand where there is no evidence of judicial bias?

Sentis Grp., Inc. v. Shell Oil Co., 559 F.3d 888 (8th Cir. 2009); *United States v. Tucker*, 78 F.3d 1313 (8th Cir. 1996); Charles A. Wright et al., Federal Practice & Procedure § 2383.

STATEMENT OF THE CASE

1. In recent years, Arkansas has enacted more than 25 laws that obstruct access to abortion. *See* JA2313 n.19. The three challenged here are the latest in that campaign. First, the 18-Week Ban prohibits abortion after 18 weeks in almost all cases. Specifically, it prohibits a physician from providing an abortion if the pregnancy has advanced beyond "eighteen (18) weeks' gestation," as measured

"from the first day of the [woman's] last menstrual period." Ark. Act 493, § 20-16-2004(b); *id.* § 20-16-2003(9). The Ban includes only two limited exceptions: (1) in the case of a "medical emergency," narrowly defined as "a condition that . . . necessitates an abortion to preserve the life of the pregnant woman whose life is endangered by a physical [condition] . . . or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function," *id.* §§ 20-16-2004(b), 20-16-2003(6), (7); and (2) where the pregnancy is the result of rape or incest, as defined by Arkansas code, *id.* § 20-16-2004(b). The Ban contains no exception for the many cases where failure to perform an abortion imposes the risk of serious medical harm short of "substantial and irreversible impairment of a major bodily function." *Id.* § 20-16-2003(7). Violation is a Class D felony, punishable by six years in prison and a fine of $10,000, and the law also subjects physicians to mandatory license suspension or revocation. *See id.* §§ 5-4-201(a)(2), -401(a)(5), 20-16-2006(a)(1), -2006(b).

Second, the Reason Ban prohibits a physician from providing an abortion "with the knowledge" that a pregnant woman is seeking an abortion because of: (1) a test "indicating" Down syndrome; (2) a prenatal diagnosis of Down syndrome; or (3) "[a]ny other reason to believe" Down syndrome affects the pregnancy. Ark. Act 619, § 20-16-2003(a). The Ban's two narrow exceptions allow care only (1) when an abortion is necessary to save the woman's life or preserve her health, *id.* § 20-16-

2002(1)(B)(i); and (2) when the pregnancy resulted from rape or incest, *id.* § 20-16-2003(d). Violation of the Ban is a Class D felony, punishable by six years in prison and a fine of $10,000. Ark. Code Ann. §§ 5-4-201(a)(2), -401(a)(5); Act 619, § 20-16-2004. Violation also leads to mandatory license revocation, Act 619, § 20-16-2005(c), and renders the physician liable for actual and punitive damages to any "woman who receives an abortion in violation of [the Ban] . . . , the parent or legal guardian of the woman if the woman is an [unemancipated] minor, or the legal guardian of the woman if the woman has been adjudicated incompetent," *id.* § 20-16-2005(b)(1)-(2).

Third, the OBGYN Requirement prohibits physicians from providing abortions unless they are "board-certified or board-eligible in obstetrics and gynecology." Ark. Act 700, § 20-16-605(a). Under preexisting law, a "physician licensed to practice medicine in the State" could provide abortions. *See* Ark. Code Ann. § 5-61-101(a). A violation of the new Requirement is "a Class D felony," punishable by six years in prison and a fine of $10,000. *Id.* § 20-16-605(b); Ark. Code Ann. §§ 5-4-201(a)(2), -401(a)(5). It may also result in the revocation, suspension, or non-renewal of the physician's and/or facility's professional license(s). Act 700, § 20-16-605(b).

Arkansas imposes no analogous medical-specialty requirement on any other comparable medical procedures—not administration of oral medications other than

abortion pills, not outpatient procedures of comparable or greater medical risk (such as colonoscopies or tonsillectomies), not pregnancy or birthing care at a birthing center (even though carrying to term, labor, and delivery pose significantly greater risk than abortion), and not miscarriage management. .

Moreover, abortion is already highly regulated in Arkansas, including through mandates that:

- doctors largely cannot provide abortion after 20 weeks post-fertilization—roughly 22 weeks LMP, Ark. Code Ann. § 20-16-1405;

- anyone seeking an abortion be evaluated via a medical history, physical examination, counseling, and laboratory tests, *see* Ark. Admin. Code. 007.05.2-8;

- abortion facilities have various medical devices available to assist in the unlikely event of complications, *see id.*;

- abortion facilities have an adequate number of qualified personnel available to provide direct patient care, *id.* 007.05.2-7;

- abortion facilities providing medication abortions "have a signed contract with a physician who agrees to handle complications" and who has "active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug," Ark. Code Ann. § 20-16-1504(d)(1), (2); and

- abortion facilities satisfy a variety of ongoing obligations to educate staff about best practices and to assess their own services, Ark. Admin. Code 007.05.1-10, 2-5, 2-6(G), 2-7(D).

Additionally, the State regularly inspects abortion facilities. JA1603-04.

2. Plaintiff-appellees Little Rock Family Planning ("LRFP") and Dr. Thomas

Tvedten—a clinic and a physician providing abortion care—sought to preliminarily enjoin enforcement of all three laws.[2] Since 1973, LRFP has offered an array of medical care, including abortion, basic gynecological care, STD testing, and contraceptive counseling and services. JA431. It currently provides medication abortion up to 10 weeks LMP, and surgical abortion up to 21 weeks and 6 days LMP, which is before any pregnancy is viable. JA2246.[3] While the vast majority of abortions at LRFP are first-trimester procedures, the clinic also provides care for hundreds of women in need of second-trimester services each year. JA2252. In 2018, LRFP provided 170 abortions after 18 weeks LMP. JA2252.

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[2] Upon learning in July 2019 that the Fayetteville clinic of Planned Parenthood of Arkansas and Eastern Oklahoma (PPAEO) would be closing due to a landlord dispute, JA530, PPAEO and its main abortion provider, Dr. Stephanie Ho, withdrew from the preliminary-injunction motion, JA528-33. Plaintiff-appellees' economist, Dr. Jason Lindo, then updated his estimates regarding the OBGYN Requirement's impact in a supplemental July 9, 2019 declaration, which the State received 13 days before the injunctive-relief hearing. JA534-35. Although the State moved to strike that declaration, DE38 at 3, the district court properly denied that motion, reasoning that it "includes the same 'methodology, assumptions, and analysis described in [the] original report,'" and any "limited" prejudice claimed by the State could be "mitigated *via* future proceedings." DE41, at 2-3. On July 19, 2019, 3 days before the hearing, and in conjunction with plaintiff-appellees' reply brief, Dr. Lindo submitted a rebuttal declaration to respond to certain claims in the State expert's declaration. JA1277.

[3] Medication abortions involve taking two pills at least one day apart to induce an early miscarriage. JA14-15. Surgical abortions are performed by dilating the cervix and then using gentle suction and/or instruments to empty the uterus. JA15. Although characterized as "surgical," surgical abortions do not involve any incision into the woman's skin and are often performed with only local anesthesia. JA15-16.

As the district court found after a hearing, most of LRFP's abortion services were provided by two clinicians: Dr. Tvedten and Dr. Thomas Horton. JA1854. Dr. Tvedten is not an OBGYN and cannot become one without the enormous outlay of time and expense required to restart medical training after decades of safely providing care to Arkansas patients. JA1866-68. Dr. Horton completed his residency in OBGYN, but is neither board-certified nor certification-eligible because that qualification is not necessary to provide safe abortion care; he cannot become board-certified or certification-eligible without taking significant time away from his patients and professional responsibilities, which he cannot do. JA1954 n.15, JA2223-25. Together, Drs. Tvedten and Horton have provided 94% of the abortion care at LRFP over the past three years. JA279. They received assistance approximately once every-other month from Dr. Fred Hopkins, a board-certified OBGYN who lives in California. JA2221. Dr. Hopkins is unable to increase his patient volume at LRFP because of full-time professional obligations in California, including his role as an Associate Clinical Professor at Stanford University Medical School. *See* JA1548-49, JA1555-56, JA2222.[4]

[4] Since the district court issued the preliminary injunction, plaintiff-appellees have, as a result of their extensive efforts to comply, extended offers to two additional board-certified OBGYNs. *See infra* pp.47-48. Because neither provider can commit to providing care full-time or long-term, they do not alleviate the OBGYN Requirement's burdens. *Id.*

In June 2019, after extensive, unsuccessful efforts to comply with the OBGYN Requirement,[5] LRFP and Dr. Tvedten sued, arguing they are entitled to injunctive relief because Arkansas's three new laws directly contravene decades of binding precedent holding that a State may not ban or unduly burden access to pre-viability abortion. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016). To speed resolution of their legal challenge, plaintiff-appellees moved to consolidate this case with *Jegley*—which applied the same legal standard to similar factual issues presented by two of the same plaintiffs against two of the same defendants with at least one of the same witnesses. JA525-27.

The district court judge to whom this case was randomly assigned consolidated this case with *Jegley*; it was accordingly reassigned it to the *Jegley* judge. The *Jegley* judge denied the State's subsequent motion to reconsider the consolidation order, JA 521-27, holding that the two matters are "closely related" and consolidation would "result in significant savings of judicial resources," JA523.[6]

[5] Although the State suggests that plaintiff-appellees have a history of falsely claiming inability to comply, *see* Br. 16, the only example they cite is *Jegley*. There was no false statement in that case. Rather, the *Jegley* plaintiffs found one physician willing to be a back-up provider only after years of extensive recruiting efforts.

[6] The district court also properly denied the State's motion for responses to outstanding *Jegley* discovery requests. As that court explained, (i) "no party represent[ed] that any such discovery requested in *Jegley* [was] uniquely relevant to the claims or defenses in this case," and (ii) "there remain[ed] an unopposed motion to dismiss pending in [*Jegley*]." JA547.

The State sought expedited discovery, and plaintiff-appellees promptly responded to certain discovery requests, while opposing others. JA1827. After entry of a protective order, plaintiff-appellees provided the State with additional information, including protected patient data on which plaintiff-appellees' expert, Dr. Jason Lindo, relied (*see* JA3003 (exhibits PX0062 and PX0073, filed on disc)).

On July 22, 2019, the district court heard testimony on plaintiff-appellees' motion for injunctive relief. JA1520. Dr. Hopkins, a board-certified OBGYN who trains post-residency family-planning fellows at Stanford Medical School, testified that medication abortion is "very safe," roughly as safe as tonsillectomy or colonoscopy, with risks similar to "taking commonly prescribed over-the-counter medications such as antibiotics" and "Motrin, Advil, Aleve." JA1539-40. He further testified that board eligibility and board certification do not "require demonstration of competence in abortion care," JA1543; as such, a board-certified OBGYN would not necessarily be more competent to perform abortions or handle any of the rare complications that may arise during abortions. JA1541-48. He also noted that prominent medical organizations, including the American College of Obstetricians and Gynecologists, support non-OBGYNs providing abortions. JA1547.

Dr. Linda Prine, a family-medicine doctor who has trained thousands of clinicians to provide abortion care over three decades, also testified that OBGYN

board-certification does not help doctors "know how to provide abortion care," and that non-OBGYNs can provide abortions safely and effectively because "competencies [in abortion care] do not depend on board certification in OBGYN but, rather, on the training and experience of the individual physician." JA1574; JA1580-81.

Lori Williams, a nurse-practitioner and LRFP's clinical director, testified about LRFP's unsuccessful efforts to locate additional board-certified or certification-eligible OBGYNs, including by mailing a letter to every OBGYN licensed in Arkansas, contacting the National Abortion Federation regarding OBGYNs outside Arkansas, and discussing LRFP's needs at national meetings of abortion providers. JA1606-07.[7] She testified that LRFP struggles to attract and hire new providers due to the intense stigma surrounding abortion in Arkansas. JA1609-10. Multiple clinicians testified on this point, detailing the harassment and stigma they routinely face as abortion providers. *See, e.g.*, JA1549, JA1834-35. Ms. Williams further explained that, because LRFP was unable to locate any board-certified or certification-eligible OBGYNs who could work at LRFP full-time, LRFP

[7] Although PPAEO did not seek a preliminary injunction, its own extensive, unsuccessful efforts to retain board-certified or certification-eligible OBGYNs further confirm the difficulty of complying with the OBGYN Requirement. *See* JA152-55.

would be forced to close if the OBGYN Requirement took effect. JA1610-11.[8]

Plaintiff-appellees' economics expert, Texas A&M Professor Dr. Lindo, testified that the OBGYN Requirement would prevent most women who wanted to have abortions in Arkansas from doing so. JA1633. Specifically, he testified that—even assuming the limited number of Arkansas board-certified OBGYN providers operated at their maximum capacity—the OBGYN Requirement would prevent most women seeking Arkansas abortion care from obtaining it. JA1633-35. The Requirement would have a particularly severe effect on women seeking surgical abortions—the only type of abortion available after 10 weeks LMP—with *89 to 100%* of them rendered unable to obtain care. JA1633. Although these numbers are drastic, they actually understate the impact of the Requirement, because Dr. Lindo's analysis assumes providers can operate at the maximum capacity they demonstrated over the previous three years. JA1636.[9]

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[8] Notwithstanding the State's assertions, Ms. Williams is not "unfamiliar with Arkansas's abortion regulations," Br. 10. She did not say that Arkansas law requires Dr. Hopkins to personally obtain informed consent or precludes LRFP from charging for the informed-consent visit; she said LRFP cannot pay a doctor solely to obtain consent because state law forbids *collecting payment* at that appointment. JA1610-11; *see* Ark. Code Ann. § 20-16-1703(d).

[9] On cross-examination, the State asked Dr. Lindo whether his data showed that Dr. Hopkins had provided up to 28 abortions in a day, rather than the 21—the figure Dr. Lindo cited in his analysis. JA1650. After the hearing, Dr. Lindo re-examined the data and determined that a spreadsheet-merging error by plaintiff-appellees' counsel resulted in duplication of the April 2018 entries in the data provided to the State. JA1822. Dr. Lindo filed a supplemental declaration on July

Several witnesses testified for the State. Dr. Tumulesh Solanky disagreed with Dr. Lindo's conclusions, but he provided (i) "no justification for his criticism" that Dr. Lindo "incorrectly calculate[d] the maximum capacity of abortion providers," and (ii) no alternative capacity-calculation methodology or capacity estimates. JA2269-70; *see* JA2370 n.28. Judy McGruder testified about her experience obtaining an abortion in 2000 at LRFP after receiving a Down syndrome diagnosis through amniocentesis. JA2272; *see* JA2298. She conceded, however, that none of the physicians involved in this case provided her care. JA1797. And Dr. Donna Harrison, the Executive Director of the American Association of Pro-Life OBGYNs, admitted that, although she remains a board-certified OBGYN, she could not provide abortion care without additional training. JA2268.

On July 23, 2019, the district court granted plaintiff-appellees' request for a temporary restraining order. JA1825.

On July 30, 2019, the State requested a preliminary-injunction hearing, but the district court denied the State's request, explaining that (i) the matters the State wished to raise were known to the State at the July 22 hearing, (ii) no party had represented to the district court that they were unable to present testimony or make

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23, 2019, explaining this error and making clear that his assumptions about Dr. Hopkins' capacity—that he has provided no more than 21 abortions in a day—remain accurate. JA1823.

arguments at that hearing, and (iii) all parties were allowed to file supplemental written evidence and additional post-hearing briefing. JA2182-83.

3. On August 6, 2019, the district court issued a preliminary injunction. JA2201. The district court held as a threshold matter that plaintiff-appellees have Article III standing to challenge the laws on behalf of themselves and their patients seeking pre-viability abortion care. JA2276. The court rejected the State's argument that plaintiff-appellees lack standing because they have not made sufficient efforts to comply with the OBGYN Requirement, citing record evidence showing their extensive but unsuccessful efforts to find new providers. JA2280-81. Accordingly, the district court found that the OBGYN Requirement, not any failure of plaintiff-appellees', was the proximate cause of plaintiff-appellees' alleged harm. JA2281.

The district court then held that plaintiff-appellees were likely to prevail on the merits of their due process challenge to all three laws. JA2284. First, it held that the 18-Week Ban is facially unconstitutional because it prohibits pre-viability abortions, contrary to clear and longstanding precedent. JA2293; *see* JA2302-03 n.12 (explaining binding definition of viability).

Second, the district court found that the Reason Ban is facially unconstitutional because it, too, prohibits "certain abortions prior to viability." JA2296, 2301. As the court explained, before viability, "the State's interests are not strong enough to support a prohibition of abortion." JA2298.

Third, the district court held that the OBGYN Requirement is unconstitutional because it "confers little, if any, benefit upon women in the context of abortion care in Arkansas," JA2303, while significantly burdening access. The district court rejected the State's conclusory argument that board-certification or certification-eligibility in OBGYN "must confer some benefit," finding that "there [is] no significant health-related problem" the Requirement "help[s] to cure"; nor is it "more effective than pre-existing [state] law" in furthering the State's asserted interests. JA2304 (citing *Whole Woman's Health*, 136 S. Ct. at 2311, 2314). In particular, the district court found that abortion is already extremely safe, JA2308-09, JA2313, and that there is no evidence that board-certification or certification-eligibility in OBGYN would enhance its safety, JA2340-41; *see* JA1574, JA1543-48—especially relative to Arkansas's already-extensive abortion regulations, JA2348-49. Accordingly, the district court held that "at this stage of the proceeding and based upon the record evidence before it . . . plaintiffs have demonstrated that they are likely to prevail in showing that [the OBGYN Requirement] confers little, if any, benefit" on abortion patients. JA2303.[10]

[10] The district court also found unconvincing the State's efforts to refute this evidence with irrelevant, decades-old allegations against Dr. Tvedten unrelated to abortion care and evidence that LRFP has called an ambulance roughly 3 times per year. Specifically, it found that the record evidence showed Dr. Tvedten was a "highly skilled practitioner," JA2311-13; he was never disciplined by the Medical Board in connection with his decades of abortion care; and he never "attack[ed] someone," as the State claims, *compare* Br. 10; *with* JA1691-94. Rather, he broke

At the same time, the district court found that the OBGYN Requirement would substantially burden a large fraction of women seeking abortions in Arkansas. JA2378. Specifically, it found—based on Dr. Lindo's analysis—that the OBGYN Requirement would preclude 62 to 70% of women who annually seek abortions in Arkansas from doing so. JA2375.[11] Even those women who are able to obtain abortion care in Arkansas will face undue burdens obtaining that care, including delays in obtaining care, greater health risks stemming from those delays, longer travel, and higher costs. JA2226-32, JA2376-77.

Weighing the benefits and the burdens of the OBGYN Requirement, the district court found that the Requirement unduly burdens a large fraction of women seeking abortions in Arkansas, and that those burdens "substantially outweigh[]" any state interest or benefit to those women. JA2379.

Holding that all three Acts would imminently and irreparably harm plaintiff-

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the camera of a man photographing abortion patients who refused to stop. *See* JA1694. The court also found that LRFP's hospital-transfer rate simply confirms that "complication rates for abortion care are exceedingly low," JA2310—and there is no evidence the OBGYN Requirement would mitigate these already-low risks, JA2311-12 & n.18.

[11] Even accepting the State's contention that Dr. Hopkins could perform 525, rather than 252, abortions per year—a proposition that did "not convince[]" the district court—53% of women would not be able to obtain an abortion in Arkansas under the OBGYN Requirement. JA2376. And even focusing only on women who seek abortions in Little Rock and accepting the State's view of Dr. Hopkins's capacity, 43% of women seeking care would be unable to obtain it in Arkansas. JA2376 n.43.

appellees and their patients, the district court preliminarily enjoined the State from enforcing them. JA2382, JA2385.

STANDARDS OF REVIEW

Although this Court reviews legal conclusions de novo, *see Heartland Acad. Cmty. Church v. Waddle*, 335 F.3d 684, 690 (8th Cir. 2003), its review of preliminary injunctions is otherwise "doubly circumscribed": the district court's factual findings are "binding" unless "clearly erroneous," and this Court "may not disturb that court's balancing of the equities absent an abuse of discretion." *Edudata Corp. v. Sci. Computers, Inc.*, 746 F.2d 429, 430 (8th Cir. 1984). Under the clear-error standard, this Court will reverse only if it has a "definite and firm conviction that a mistake has been committed," and its deference is "even greater" when, as in this case, the district court relied on "determinations regarding the credibility of witnesses," because only it can see and hear "the variations in demeanor and tone of voice that bear so heavily on" credibility. *Anderson v. City of Bessemer City*, 470 U.S. 564, 573, 575 (1985). In fact, "a district court's ruling as to the credibility of competing witnesses can virtually never be clear error," *Culpepper v. Vilsack*, 664 F.3d 252, 257 (8th Cir. 2011), "even if [this Court] would have viewed the evidence differently," *Dixon v. Crete Med. Clinic, P.C.*, 498 F.3d 837, 847 (8th Cir. 2007).

In tacit recognition that it cannot prevail under this controlling legal test, the State endorses a different and incorrect articulation of the preliminary-injunction

standard. The State cites *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley*, 864 F.3d 953, 957-58 (8th Cir. 2017), for the proposition that plaintiff-appellees must make a "rigorous showing" of likelihood of success, Br. 20. The State misreads the case. *Jegley* cited *Planned Parenthood of Minnesota, North Dakota, and South Dakota v. Rounds*, 530 F.3d 724 (8th Cir. 2008) (en banc), for the "rigorous" language, *Jegley*, 864 F.3d at 957-58. And *Rounds* said merely that the "likely to prevail" standard was "more rigorous" than the "fair chance of success" standard the district court there had used. *Rounds*, 530 F.3d at 730. These cases, far from helping the State, confirm that a preliminary injunction properly issues where the moving party is likely to prevail on the merits of their claim.

SUMMARY OF THE ARGUMENT

After considering thousands of pages of materials and hearing from nine witnesses during an eight-hour hearing, the district court properly preliminarily enjoined the three challenged laws in a detailed, 186-page opinion. As the district court held, the 18-Week Ban and the Reason Ban unconstitutionally prohibit pre-viability abortions, flouting longstanding Supreme Court and Eighth Circuit precedent. JA2290-2302. And as the district court further found, the OBGYN Requirement is unconstitutional because it affords little (if any) benefit, yet precludes 62 to 70% of women who currently seek Arkansas abortion care from doing so and imposes undue burdens on even women who are able to obtain care.

JA2302-80. Because the district court found that plaintiff-appellees are likely to succeed on the merits—and that the other factors favor plaintiff-appellees, too—the district court properly granted a preliminary injunction to preserve the status quo, allowing plaintiff-appellees to continue providing safe and effective pre-viability abortion care, as they have done for decades. JA2381-86.

The State largely fails to even allege legal errors in the district court's decision, devoting most of its brief to disputing the district court's factual findings. But the record robustly supports those findings. Moreover, those findings are reversible only for clear error—and the State merely cites the clearly erroneous standard once, Br. 20, without ever arguing that the district court's factual findings were clearly erroneous. It has thus waived any such argument. *See, e.g.*, *White v. Jackson*, 865 F.3d 1064, 1076 n.1 (8th Cir. 2017) (party waives claim by providing no "meaningful argument" in opening brief). Because the State has not met its burden on appeal, this Court should affirm.

ARGUMENT

I. PLAINTIFF-APPELLEES ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR DUE PROCESS CLAIMS.

A. Plaintiff-appellees are likely to succeed on the merits regarding the 18-Week Ban.

For more than 45 years, the Supreme Court has recognized that the right to privacy, rooted in the Fourteenth Amendment, "encompass[es] a woman's decision

whether or not to terminate her pregnancy." *Roe v. Wade*, 410 U.S. 113, 153 (1973).[12] The central tenet of *Roe* and its progeny is that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992) (plurality op.). This is because "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's" access. *Id.* at 846. The Supreme Court has never wavered from this essential holding. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2309; *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007). Expressly forbidding pre-viability abortion bans like the 18-Week Ban, the Supreme Court has explained that a state may not "proclaim one of the elements entering into the ascertainment of viability—be it *weeks of gestation* or . . . or any other single factor—as the determinant of when the State has a compelling interest in the . . . fetus. Viability is the critical point." *Colautti v. Franklin,* 439 U.S. 379, 388-89 (1979); *see also* JA2287-88 (citing numerous decisions invalidating bans at particular points in pregnancy).

Notwithstanding this unbroken line of unambiguous precedent, Arkansas banned abortions starting at 18 weeks LMP, which all agree is a pre-viability point in pregnancy. The district court correctly recognized that is the end of the matter,

[12] This brief refers to "women," but the challenged statutes also inflict irreparable harm on transgender and gender-fluid people who need abortion care.

JA2293, and this Court should affirm.

Each of the State's contrary arguments is meritless. *First*, the purported state interests underlying the Ban, Br. 23, are legally irrelevant. The Supreme Court has already determined that, prior to viability, *no* state interest can justify a ban on abortion. *See Casey*, 505 U.S. at 846 *see also, e.g.*, *id.* at 860 ("[V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify" an abortion ban.); *Jackson Women's Health Org. v. Dobbs*, 2019 WL 6799650, at *8 (5th Cir. Dec. 13, 2019) (invalidating ban on abortion after 15 weeks LMP, except in cases of medical emergency or severe fetal anomaly). This Court has faithfully applied that precedent. *See, e.g.*, *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772-73, 776 (8th Cir. 2015) (striking 6-week ban and observing that the definition of viability "adopted by the Supreme Court" aligns with the assertion that "viability occurs at about 24 weeks"; *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (striking 12-week ban because it applies "at a point before viability"). It should do so again here.

Second, the State's argument that the 18-Week Ban's exceptions insulate it from invalidation, Br. 23, is meritless. As the Supreme Court explained in *Casey*: "Regardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." 505 U.S. at 879. This Court has reached the same

conclusion. *See Edwards*, 786 F.3d at 1117 (rejecting assertion that 12-week ban is "regulation, not a ban"). It should do so again here.

Third, plaintiff-appellees had no burden to "estimate the fraction of women who would be required to forgo or materially delay" abortion under the 18-Week Ban, Br. 24. As the district court explained, the large-fraction analysis is inapposite where a ban on pre-viability abortions is at issue. JA2293. In any event, the 18-Week Ban, *by definition*, imposes an obstacle that is not merely substantial but absolute for 100% of women for whom it is relevant: women seeking pre-viability abortions starting at 18 weeks LMP. *See Casey*, 505 U.S. at 895 (holding that facial relief is warranted if "in a large fraction of the cases in which [the restriction] is *relevant*, it will operate as a substantial obstacle to . . . abortion."). That "one hundred percent correlation" well exceeds the large-fraction test's threshold for facial relief. *Isaacson v. Horne*, 716 F. 3d 1213, 1230-31 (9th Cir. 2013); *accord Stenberg v. Carhart*, 530 U.S. 914, 945-46 (2000) (facially invalidating ban of particular abortion method); *Women's Med. Prof. Corp. v. Voinovich*, 130 F. 3d 187, 202-03 (6th Cir. 1997) (same).

Fourth, citations to dissenting opinions cannot change the outcome under the unbroken line of precedent. *See* Br. 24. Indeed, given lower courts' obligation to follow Supreme Court rulings, this Court has no alternative but to affirm the district court's decision enjoining the 18-Week Ban. *See* U.S. Const., art. VI, cl. 2;

Rodriguez de Quijas v. Shearson/Am. Express, Inc., 490 U.S. 477, 484 (1989) (holding that lower courts "should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions"); *Edwards*, 786 F.3d at 1117; *MKB Mgmt.*, 795 F.3d at 773 (acknowledging that this Court is "bound by" *Roe* and *Casey*).

B. Plaintiff-appellees are likely to succeed on the merits regarding the Reason Ban.

Like the 18-Week Ban, the Reason Ban is unconstitutional because it prohibits pre-viability abortions. *See supra* Part I.A. As the district court found, JA2301, regardless of the asserted state interests, the Reason Ban violates the categorical rule that no state interest can justify a ban on abortion before viability, *Casey*, 505 U.S. at 879. The State may not veto a woman's decision to end her pregnancy before viability based on her reasons. *See, e.g.*, *id*. at 851 (abortion is one of "the most intimate and personal choices a person may make," and a constitutional right precisely because "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life"); *Isaacson*, 716 F.3d at 1225 (explaining that undue burden analysis has "no place where, as here, the state is *forbidding* certain women from choosing pre-viability abortions" (emphasis in original)).

The State's contrary arguments have no force. The separate opinion of a single Justice concurring in the denial of certiorari in *Box v. Planned Parenthood of*

Indiana & Kentucky, Inc., 139 S. Ct. 1780 (2019), Br. 27, changes nothing: The Court let stand the decision striking down Indiana's reason ban. And nothing in "*Casey* strongly indicates" that the Reason Ban is constitutional. Br. 29. As the State acknowledges, *Casey* did not even consider Pennsylvania's prohibition on sex-selection abortions. Br. 29-30. Nor do *Casey* and *Gonzales*, which upheld certain *regulations* of pre-viability abortion, Br. 30, support an outright prohibition on some pre-viability pregnancies. Rather, the Reason Ban falls under the same categorical rule that condemns any ban at a pre-viability point in pregnancy.

C. Plaintiff-appellees are likely to succeed on the merits of their challenge to the OBGYN Requirement.

1. *Plaintiff-appellees have standing.*

Plaintiff-appellees have third-party standing to assert the rights of their patients.[13] For more than 50 years, courts have deemed it "appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision," even where the state justified the challenged laws as

[13] The State wrongly suggests, for the first time, that plaintiff-appellees lack first-party standing. Br. 32. Plaintiff-appellees have consistently maintained that the Requirement will harm their professional reputations and business operations, including by suspending LRFP's operations altogether and preventing Dr. Tvedten from providing any abortions in Arkansas. *See* JA24, JA32. Those injuries establish first-party standing. *See, e.g.*, *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health,* 699 F.3d 962, 980-81 (7th Cir. 2012) (upholding finding that laying off workers, closing clinics, and ceasing medical services is irreparable harm). By failing to dispute those injuries below, the State has waived any opportunity to contest them now.

beneficial to patients, *Singleton v. Wulff*, 428 U.S. 106, 118 (1976); *see Whole Woman's Health*, 136 S. Ct. 2292 (adjudicating physicians' and clinics' 42 U.S.C. § 1983 action against abortion restrictions on behalf of themselves and their patients).[14] This rule exists for good reason: the close physician-patient relationship between abortion providers and their patients means that, "[a]side from the woman herself . . . the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, that decision." *Singleton*, 428 U.S. at 117. And obstacles may prevent women from bringing their own claims, including concerns about anonymity, stigma, and the potential mootness of the claims. *Id.* at 117-18; *see id.* at 116 n.6 (recognizing that such obstacles do not necessarily make patients' assertion of their own rights "impossible," but holding that impossibility is not the standard). Further, third-party standing is appropriate where, as here, "enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004).

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[14] *See also, e.g.*, *Bellotti v. Baird*, 443 U.S. 622, 627 n.5 (1979) (holding physician plaintiff had standing to raise minor patients' claims against abortion restriction that allegedly protected minors); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 683-84, 690 (1977) (granting third-party standing to challenge contraception restriction justified as protecting health); *Eisenstadt v. Baird*, 405 U.S. 438, 445-46, 450 (1972) (allowing third-party standing to challenge contraception restriction justified as "regulating . . . potentially harmful articles"); *Edwards*, 786 F.3d 1113; *Little Rock Family Planning Servs., P.A. v. Jegley*, 192 F.3d 794 (8th Cir. 1999).

In fact, where a challenged abortion restriction directly regulates the providers' conduct and thus imposes a redressable injury-in-fact under Article III, the Supreme Court has repeatedly held that abortion providers may challenge abortion restrictions that burden their patients' constitutional rights. *See, e.g.*, *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 62 (1976); *Doe v. Bolton*, 410 U.S. 179, 188 (1973). This is precisely such a case. The OBGYN Requirement directly regulates plaintiff-appellees' conduct under threat of sanction. JA2277-78, JA2302-03. And as the district court found, enforcing it against plaintiff-appellees will violate their patients' due process rights. JA2280-81. Plaintiff-appellees are thus well-situated to contest the OBGYN Requirement.

There is no merit to the State's primary retort, that plaintiff-appellees' interests diverge from their patients'. Br. 32-33. The Supreme Court has repeatedly allowed physicians to assert their patients' rights in similar circumstances. For example, in *Doe v. Bolton*, physicians challenged a Georgia requirement that abortions be performed only in certain accredited hospitals—a requirement that presented the same dynamics that Arkansas alleges exist here, i.e., those whereby doctors would self-interestedly oppose a regulation that allegedly benefits patients. *See Bolton*, 410 U.S. at 192-94. Yet the Supreme Court did not hesitate to conclude that abortion providers had third-party standing to challenge that restriction. *Id.* at 188. Other courts have similarly held that plaintiffs' satisfaction of third-party

standing requirements is sufficient assurance that the third parties' constitutional rights will be well represented. *See, e.g.*, *Charles v. Carey*, 627 F.2d 772, 779 n.10 (7th Cir. 1980) (rejecting similar argument and allowing abortion provider to assert third-party standing for patients); *Okpalobi v. Foster*, 190 F.3d 337, 352 (5th Cir. 1999) (same), *superseded on reh'g en banc on other grounds*, 244 F.3d 405 (5th Cir. 2001).

Courts have reached this conclusion for good reason: Standing analysis requires courts to assume the truth of a plaintiff's *allegations*, not to determine at the outset which party has the better argument on the merits. *See, e.g.*, *Warth v. Seldin*, 422 U.S. 490, 501 (1975). And here, plaintiff-appellees argue that the OBGYN Requirement delivers no health benefit whatsoever. JA23-24; *see also Whole Woman's Health*, 136 S. Ct. 2292 (allowing plaintiff physicians to challenge abortion regulation alleged to provide no health benefit). If plaintiff-appellees are correct, their interests clearly align with the interests of the third parties they represent. The State's standing objection, therefore, collapses into the merits.

And while the State cites *Kowalski* (Br. 32-33)—which held that attorneys did not have third-party standing to assert rights of future clients, 543 U.S. at 130—that decision actually helps *plaintiff-appellees*. *Kowalski* itself relies on *Doe* as an illustration of the proper application of third-party standing. Indeed, at the very outset of *Kowalski*, the Court *affirms* third-party standing in the abortion context and

distinguishes it from the facts of that case. *See id.* (citing *Bolton* and similar cases, and stating "[b]eyond these examples—*none of which is implicated here*—we have not looked favorably upon third-party standing").

2. *The district court correctly found that the OBGYN Requirement is unconstitutional.*

As the district court correctly explained, plaintiff-appellees are entitled to a preliminary injunction of the Requirement if they can show that "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." JA2283 (quoting *Casey*, 505 U.S. at 895); *see Whole Woman's Health*, 136 S. Ct. at 2309 (requiring courts to "consider the burdens a law imposes on abortion access together with the benefits those laws confer").[15] The district court applied this test to the OBGYN Requirement in a nearly 80-page analysis. JA2302-81. The district court examined all the record evidence and found that the OBGYN Requirement confers "little, if any, benefit." JA2303-04. At the same time, it found that the Requirement would preclude 62 to 70% of women seeking abortion care in Arkansas from successfully obtaining that care. JA2374-75. As such, the district court determined that the Requirement

[15] Although the State criticizes the district court for imposing a "tailoring requirement," Br. 37-38, the district court merely held that the Requirement cannot stand because it imposes burdens that outweigh its minimal-to-nonexistent benefits. JA2378-80. That *is* the undue burden test. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2309.

unduly burdens access to pre-viability abortion care and is unconstitutional. JA2378-80.

As explained below, each of these steps in the district court's analysis—considering the Requirement's benefits, then its burdens, then weighing the benefits against the burdens—is amply supported by the record and precedent. Although the State resists each step, its brief simply contests the district court's factual findings. *See* Br. 33-36, 38-39. But the district court's findings "must govern" unless they are "[im]plausible in light of the full record," *Cooper v. Harris*, 137 S. Ct. 1455, 1465 (2017). Here, there is far more than "adequate legal and factual support" in the record for the district court's conclusion, *Whole Woman's Health*, 136 S. Ct. at 2311. And, as noted above, the State never even argues that the district court's factual findings are clearly erroneous, *see supra* p.18, even though that is the controlling legal standard.

a. *The district court correctly found that the OBGYN Requirement provides minimal, if any, benefits.*

The district court correctly found that "there [is] no significant health-related problem" that the OBGYN Requirements "help[s] to cure" because abortion is already "extremely safe." *Whole Woman's Health*, 136 S. Ct. at 2311; *see* JA2313 (finding that the OBGYN Requirement "provides no benefit if intended to address a medical safety problem," which problem does not exist). National data confirm that abortion is safer than a colonoscopy or tonsillectomy, JA2218, that the side effects

of medication abortion are comparable to those of ibuprofen, JA2309, JA2351, and that abortion is safer than carrying a pregnancy to term, JA2309. Abortion in Arkansas is especially safe: As the district court found, "the rate of complications requiring hospital transfers for abortions performed at LRFP is *lower*" than the commonly accepted rates for abortion care. JA2311 (noting only "1% to 3%" of patients develop minor complications, while only "one every few hundred" develops major ones). The district court specifically rejected the State's contrary evidence as "lacking." JA2309, JA2343-44, JA2351-52.

And far from "identif[ying] only four preexisting legal requirements" governing abortion provision and "declar[ing] without explanation that this was good enough," Br. 16, 39, the district court examined a multitude of existing Arkansas laws and regulations governing the practice of medicine generally and abortion care specifically, *see* JA2272-75, JA2334-37, and determined that the OBGYN Requirement affords no benefit over preexisting law, JA2340. In particular, it cross-referenced the many requirements associated with obtaining and maintaining an Arkansas medical license with those that must be satisfied to maintain an active OBGYN certification and found little difference. *See* JA2348-50. Indeed, the OBGYN Requirement not only adds nothing to the slew of existing Arkansas regulation; it runs counter to best medical practices. The American College of Obstetricians and Gynecologists characterizes laws like the OBGYN

Requirement as "medically unnecessary" and "designed to reduce access to abortion." JA2240, JA2341-43.[16]

The district court also agreed with plaintiff-appellees that non-OBGYNs routinely and safely provide abortions with a high degree of patient satisfaction, just as Dr. Tvedten has done in Arkansas for decades. *See supra* p.14 & n.10; *see also* JA2341-45. In reaching this conclusion, the district court specifically rejected the State's evidence purportedly showing that abortion providers who are not board-eligible or -certified OBGYNs cannot provide safe and effective care. *See* JA2309-12 & n.18.

Finally, the district court also considered whether there might "*nonetheless* [be] a benefit from Act 700" relative to Arkansas's pre-existing regulation of abortion. JA2314, JA2334-38, JA2348-49; *see Whole Woman's Health*, 136 S. Ct. at 2314 (invalidating admitting-privileges requirement in part because Texas law "already contained numerous detailed [abortion] regulations"); *contra* Br. 37-38. The district court correctly concluded that there is no such benefit, and thus that plaintiff-appellees are likely to prevail on their challenge to the OBGYN

[16] The State errs in faulting the district court for relying on the views of professional organizations with specialized expertise. Br. 37. Controlling Supreme Court and Eighth Circuit decisions routinely rely on evidence from such organizations. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2312; *Sternberg*, 530 U.S. at 928; *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 387-88 (8th Cir. 1999). The State's only contrary authorities are dissenting opinions, *see* Br. 37, which are not the law.

Requirement. JA2340.

In resisting this conclusion, the State disputes none of the district court's factual findings. It does not contend that the OBGYN Requirement responds to any "specific, ongoing Arkansas problem." Br. 38. It never questions the district court's conclusions that abortion is "one of the safest medical procedures available." JA2340. Nor does it bother arguing that the OBGYN Requirement is "necessary" to the safe provision of abortions. *See* Br. 38.[17] Because the State does not even contest these facts, it fails to show that they are clearly erroneous.

Instead, the State asks this Court to reverse the preliminary injunction based on the State's alleged interest in "imposing basic abortion-practitioner competency standards." Br. 39.[18] But there is *no* evidence that the OBGYN Requirement will somehow raise the (already high) competence of abortion care providers, thereby

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[17] *Mazurek v. Armstrong*—which preceded *Whole Woman's Health*—considered only whether the "purpose" of Montana's law "may have been to create a substantial obstacle to women seeking abortions." 520 U.S. 968, 972 (1997). The law there was so "harmless" that "no woman seeking an abortion would be required by the new law to travel to a different facility than was previously available," *id.* at 972, 974; as such, it did not pose a substantial obstacle for women seeking abortions, *id.* at 972. Here, by contrast, the OBGYN Requirement will unduly burden access to abortion because it will prevent 62 to 70% of patients from accessing abortion in Arkansas at all.

[18] The State briefly cites its interest in "protecting the integrity and ethics of the medical profession" as a justification for the OBGYN Requirement, Br. 36, but it never argues the point. Moreover, the district court found the OBGYN Requirement did not advance this state interest more effectively than preexisting Arkansas law. *See* JA2348-49.

increasing "safety" on the "margin[s]."[19] Br. 38. In fact, the record directly contradicts the State's view that the Requirement enhances abortion provider competency, for several reasons:

First, there is "no record evidence that competence in abortion care is a prerequisite for becoming a board-eligible or -certified OBGYN," JA2345; *see also* JA2210, JA2220-21, JA2223, such that imposing the OBGYN Requirement would ensure abortion provider competency. To the contrary, the record shows that "many board-certified OBGYNs have never even observed an abortion" and that "practitioners must specifically seek out . . . training" in abortion care. JA2345-46. Thus, there is "no record evidence that board-certified or board-eligible OBGYNs . . . will [even] be competent to provide abortion care," much less *more* competent than Arkansas's existing providers. JA2350. Indeed, even the State's expert OBGYN witness (Dr. Harrison) admitted "that despite her status as a board-certified

[19] The record shows that the OBGYN Requirement not only has no benefit, but in fact was enacted to restrict access to abortion care. Asked whether there is "evidence that there has been a [medical safety] problem you are fixing," the law's lead sponsor conceded: *"Not that I'm aware of."* JA1887-88. When asked why he proposed the bill, he responded, *"I'm having this bill to prevent any further abortions."* JA1887-88. This rationale is dispositive under Eighth Circuit authority: If a "requirement serves no purpose other than to make abortions more difficult, it strikes at the heart of a protected right, and is an unconstitutional burden on that right." *Planned Parenthood of Greater Iowa, Inc. v. Atchison*, 126 F.3d 1042, 1049 (8th Cir. 1997); *see also Whole Woman's Health v. Hellerstedt*, 231 F. Supp. 3d 218, 229-30 (W.D. Tex. 2017).

OBGYN she would not attempt to offer abortion care with her current skill set." JA2355.

Second, "studies recognize that non-OBGYNs are *just as qualified* and skilled in abortion care as OBGYNs." JA2220. As the district court found, "no peer-reviewed medical literature exists demonstrating that board-eligible or board-certified OBGYNs are more competent to provide abortion care" than current abortion providers. JA2341; *see id.* ("There is no evidence that those letters after somebody's name convey any difference in clinical outcomes, there's just not."). Likewise, there is "no record evidence to support a claim that a board-certified or board-eligible OBGYN will provide care that leads to a lower complication rate than other clinicians." JA2340-41; *see* JA1547, JA1582.

Third, OBGYN training is especially irrelevant to provision of medication abortion. *See* JA2351. Medication abortion involves taking two medications by mouth. JA2214. A variety of health-care professionals, including non-physicians, routinely prescribe medications to their patients for numerous conditions—including medications that have significantly higher complication rates than medication abortion. JA189. And, in other States, a variety of health-care professionals regularly prescribe medication abortion. JA189. The State never explains this mismatch. Nor does it explain how the OBGYN Requirement would improve patient safety; in the few instances that complications from medication abortion do

arise, they generally occur well after patients have left the clinic. *See* JA150-51.

Fourth, the State has no basis for arguing that the OBGYN Requirement "ensures that abortion practitioners can handle complications," Br. 40. Complications arise rarely, JA2310, and even in those rare cases, the OBGYN Requirement does not advance the State's purported interest in maternal health and safety because a board-certified or certification-eligible OBGYN will not necessarily have *any* training in abortion care, including management of complications, JA2345-47. Moreover, the district court found that abortion providers (regardless of specialty) can handle most complications in the clinic, JA2217-18, JA2353, and that in the rare cases they cannot, an abortion provider (regardless of specialty) would transfer the patient to a hospital, JA2207, JA2221, JA2353.

Fifth, the State fares no better in claiming that the OBGYN requirement will prevent a "decline" in an abortion provider's "skills." Br. 41. Although the State cites requirements that board-certified doctors "remain current in core content of Obstetrics and Gynecology," *id.*, there is no requirement that a provider even have—let alone continue to develop—her knowledge or skills in abortion care. *See* JA2346 (finding "no record evidence" that obtaining or maintaining certification or eligibility requires continuing education or skills maintenance with respect to abortion care); JA2350 (same). Moreover, Arkansas regulations *already* require

licensed medical providers and abortion facilities to satisfy continuing-education requirements. *See* JA2348 (citing Ark. Admin. Code 060.00.1-17), JA2350 (citing Ark. Admin. Code. 007.05.2-7(D)).[20] And the State never explains how allowing OBGYNs who are merely certification-eligible furthers its claimed interest in having abortion providers with up-to-date knowledge.

In sum, there is "nothing in [Arkansas's] record evidence that shows that, compared to prior law . . . the new law advanced [the State's] legitimate interest in protecting women's health." *Whole Woman's Health*, 136 S. Ct. at 2311. If anything, the OBGYN Requirement does the opposite: It prohibits experienced physicians from providing patient care, which compromises rather than protects patients' health and safety. Accordingly, the district court did not err—much less clearly err—in finding that the OBGYN requirement "confers little, if any, benefit." JA2303. Because the OBGYN Requirement lacks any medical basis, it falls within the class of purported "health" regulations that serve no legitimate state interest. *Whole Woman's Health*, 136 S. Ct. at 2311-21.

[20] The State is wrong to dismiss these requirements because they "only apply to large abortion facilities that perform ten or more abortions *per month* and not smaller, occasional, or private practitioners." Br. 42. There are, as the parties agreed below, exceedingly few private abortion providers in Arkansas: "LRFP, PPAEO Fayetteville, and PPAEO Little Rock together provided the vast majority of abortion care in the state during 2018," with private practitioners providing fewer than six abortions during that period. JA2337. In any event, Arkansas already also regulates private providers. *See id.* (describing such laws).

b. *The district court correctly found that the OBGYN Requirement severely burdens women's access to abortion.*

Despite offering no benefits, the OBGYN Requirement would severely burden abortion access in Arkansas. As the district court found, the law would prohibit two of the State's leading practitioners—Drs. Tvedten and Horton—from performing abortions in the State. Consequently, 62 to 70% of women seeking abortions in Arkansas would be unable to obtain that care. JA2374-75. Those figures far exceed the showing necessary to establish that an abortion restriction unduly burdens a "large fraction" of women. *Jegley*, 864 F.3d at 960 n.9. Indeed, the State does not meaningfully dispute that, if these findings control, the Requirement unduly burdens a large fraction of women in Arkansas. Instead, it (1) blames plaintiff-appellees for their inability to comply with the law; and (2) takes potshots at the district court's math. Neither line of attack lands.

(i) Plaintiff-appellees are unable to comply with the OBGYN Requirement.

As the district court found, plaintiff-appellees made significant efforts to comply with the Requirement. LRFP and PPAEO each sent a letter to every OBGYN in Arkansas, articulating the OBGYN Requirement's impact and soliciting interest in joining their clinics. JA152-53, JA455, JA461, JA2254. Additionally, LRFP and PPAEO attempted to identify qualified OBGYNs through repeated outreach, including job postings via industry networks and a word-of-mouth

campaign. *See* JA153-55, JA2359-60. LRFP also asked both Dr. Hopkins and Dr. Charlie Browne (another OBGYN who had historically provided care at the clinic occasionally), to increase their patient care; Dr. Browne provided care for a few days in July 2019, and Dr. Hopkins provided care once every-other month, but competing personal and professional obligations preclude both of them from doing more going forward. JA2359-60.

Nor is this lack of success surprising: "[T]he record evidence indicates that the harassment and stigma faced by abortion providers in Arkansas is an obstacle to compliance with the OBGYN requirement." JA2360. Although the State argues that stigma or harassment towards abortion care providers is irrelevant because Arkansas did not create this hostile environment, Br. 35-36, ample case law contradicts the State's position and instructs courts to consider the practical burdens of abortion regulation in conducting the undue burden analysis. *See Casey*, 505 U.S. at 887-94 (considering effect of domestic abuse on women seeking abortions despite no evidence that State was at fault for such violence); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 917 (7th Cir. 2015) (noting "vilification, threats, and sometimes violence directed against abortion clinics and their personnel in states . . . in which there is intense opposition to abortion"); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1349 (M.D. Ala. 2014) (similar).

Although the State erroneously faults Drs. Tvedten and Horton for not

becoming board-certified or certification-eligible OBGYNs, Br. 34, the district court correctly found that path is not feasible for either provider. *See* JA207-08, JA434, JA2223-25, JA2247. The State says that "nothing legally prevents either [Tvedten or Horton] from obtaining the appropriate certifications," and that "mere convenience" precludes them from doing so. Br. 34. But both would need to abandon their practices and complete years of medically unnecessary training; that is hardly a matter of "mere convenience." Moreover, the law does not require plaintiff-appellees to complete all theoretically possible but practically infeasible acts before they can show that the OBGYN Requirement unduly burdens access to abortion care. Indeed, in *Whole Woman's Health*, the Supreme Court made precisely this point, noting that clinics had shown that a surgical-center requirement imposed an undue burden when "costs . . . to meet the surgical-center requirements were considerable." 136 S. Ct. at 2318; *see also W. Ala. Women's Ctr. v. Miller*, 299 F. Supp. 3d 1244, 1258-59 (M.D. Ala. 2017) (similar). As such, the OBGYN Requirement is the proximate cause of Drs. Tvedten and Horton's inability to perform abortions. [21]

[21] In a *cf.* citation, Arkansas hints (but does not argue) that plaintiff-appellees have not shown that the Requirement would proximately cause a decrease in abortion-care access because they have not done everything logically possible to comply. Br. 34. Texas made a similar argument in *Whole Woman's Health*, contending that abortion-care providers had to show that they had sought admitting privileges from *all* nearby hospitals, even those likely to reject them, before they could challenge Texas's admitting-privileges requirement. *See* J.A. Vol. III, 550-

Similarly, while the State claims that Dr. Hopkins could provide more abortions at LRFP, the district court credited Dr. Hopkins's testimony that his extensive professional obligations in California prevent him from doing so. JA2222, JA2358-59. And while the State argues that LRFP could have pursued other OBGYNs in Arkansas, Br. 46, the State provides no evidence such OBGYNs exist; moreover, the State's baseless argument contradicts the district court's finding that stigma prevents OBGYNs in Arkansas from providing abortion care. *See* JA2360-61.

At the very least, the State has failed to show that the district court clearly erred in finding that plaintiff-appellees "have attempted to comply with the OBGYN requirement," and that the "OBGYN requirement—and not plaintiffs' failure to attempt to comply . . . —is the proximate cause of the alleged harm." JA2280-81.

(ii) The OBGYN Requirement will substantially burden abortion access in Arkansas.

Because plaintiff-appellees cannot comply with the OBGYN Requirement, the law will substantially limit women's access to abortion in Arkansas. As the

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56, *Whole Woman's Health*, 136 S. Ct. 2292. The Supreme Court rejected that argument, deeming evidence that clinics would close when the requirement went into effect sufficient to show causation. 136 S. Ct. at 2313. Plaintiff-appellees have shown at least that much here. Indeed, by introducing testimony on causation at the injunctive-relief hearing, plaintiff-appellees have satisfied even the dissenters in *Whole Woman's Health*, who would have required direct (rather than circumstantial) evidence of causation, 136 S. Ct. at 2346 (Alito, J., dissenting).

district court found, roughly 3,167 women seek abortions in Arkansas each year. JA2370. If the OBGYN Requirement takes effect, 62 to 70% of those women will be unable to obtain abortions in the State (if they are able to obtain them at all), depending on whether LRFP can remain open. *See* JA2374-75. If LRFP closes, the only abortion providers in Arkansas would be Dr. Rodgers and Dr. Cathey—the sole board-certified OBGYNs at PPAEO Little Rock. JA2374. Because PPAEO Little Rock provides only medication abortion up to 10 weeks LMP, those two physicians could together annually provide at most only 956 medication abortions. JA2374. That would leave 2,211 women (70%) without abortion access in Arkansas, and *all* women without access to abortion care after the pre-viability, 10-week LMP cutoff for medication abortion. JA2374-75. Even if LRFP stays open, the district court found its capacity would be minimal. JA2375. Dr. Hopkins—LRFP's sole board-certified OBGYN at the preliminary-injunction stage—can provide only 252 surgical abortions each year, bringing the total capacity to 1,208 abortions annually (956 of which would be medication abortions)—leaving 1,959 women (62%) without abortion access in Arkansas. *Id.* By any measure, eliminating abortion access for 62 to 70% of women substantially burdens a "large fraction" of women. *See Jegley,* 864 F.3d at 960.[22]

[22] On appeal, the State raises the same criticisms of these calculations (Br. 43-54) that the district court rejected, *see* JA2366-67, JA2372-76. But even if the State's complaints were valid, the OBGYN Requirement would *still* constitute an

But even those women who could still access abortion care in Arkansas under the OBGYN Requirement will be significantly burdened. They would face increased delay, greater health risks stemming from delay, longer travel, and higher costs. JA2226-32, JA2376-77. Moreover, the time required to travel to an abortion provider may make it difficult for women to keep their abortions confidential from their workplaces. JA2230. All these burdens would fall disproportionately on poor and low-income women. JA2226-32.

1. The State's contrary arguments are irrelevant.

The State largely ignores the burdens other than complete preclusion of abortion care—and it certainly does not argue that the district court's findings about these burdens were clearly erroneous. *See* Br. 53. Instead, the State devotes much of its brief to debating the exact percentage of women unable to obtain abortions under the OBGYN Requirement, even though courts have repeatedly confirmed that the large-fraction test "is more conceptual than mathematical," *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 374 (6th Cir. 2006). The Supreme Court, too, has declined to calculate a specific percentage of women unduly burdened or to suggest that the large-fraction analysis requires as much. In fact, "*Casey* teaches that the court need not find that a law imposes an undue burden on a precise percentage of

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undue burden because, even under the State's calculations, the Requirement would bar at least 43% of women from accessing abortion care in Arkansas. JA2376 n.43.

impacted women in order [to] find that facial relief is warranted," just that a law "would unduly burden access to abortion for a significant number of the women for whom the law is relevant." *Planned Parenthood Se., Inc. v. Strange*, 172 F. Supp. 3d 1275, 1288 (M.D. Ala. 2016) (citing *Casey*, 505 U.S. at 894-95). And *Whole Woman's Health* ordered facial relief, 136 S. Ct. at 2318-20, notwithstanding the district court's express finding that it was "impossible to divine exactly how many women in Texas" would be burdened, *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 683 (W.D. Tex. 2014).

This Court's decision in *Jegley* is not to the contrary. It instructed the district court to consider "how many women would face increased travel distances," "the number of women who would forgo abortions," and "the number of women who would postpone their abortions" in conducting an undue burden analysis. *Jegley*, 864 F.3d at 959-60. But it never required these figures to be exact, and in fact observed: "we do not require the district court to calculate the exact number of women unduly burdened by the contract-physician requirement," because "the 'large fraction' standard is in some ways more conceptual than mathematical." *Id.* at 960; *see also, e.g.*, *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1462-63 & n.10 (8th Cir. 1995) (finding an undue burden where plaintiffs showed that "[r]oughly eighteen [percent] of South Dakota's minors" would not be able to obtain abortion care under South Dakota's parental-notice requirement).

Nor is there any merit to the State's argument (Br. 52) that, to satisfy the large-fraction test, plaintiff-appellees must show that the vast majority of women in Arkansas are burdened. Notwithstanding the out-of-circuit and largely pre-*Whole Women's Health* cases that the State cites, neither the Supreme Court nor the Eighth Circuit has ever required such a showing. There is no such suggestion in *Jegley*, which stated only that the district court "should conduct fact finding concerning the number of women unduly burdened by the contract-physician requirement and determine whether that number constitutes a 'large fraction.'" 864 F.3d at 960; *see also Planned Parenthood Minn., N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048, 1061 (D.S.D. 2011) (noting that "[i]f the plurality opinion in *Casey* intended 'large fraction' to mean a majority, it would have said majority").

2. Even if the State's arguments were relevant, they would fail.

Even if this Court needed to review the district court's calculations with a fine-toothed comb, the State's efforts to undermine those calculations would fail for several reasons. *First*, the State claims the district court was wrong to attribute the entire decrease in abortion-care capacity to the OBGYN Requirement, when PPAEO Fayetteville's closure also reduced capacity. *See* Br. 18, 43-44. But Dr. Lindo's analysis expressly excluded any reduction in access stemming from that clinic's closure. JA537-38, JA1639. Moreover, the district court properly evaluated the *practical* effects of the Requirement by considering it in its full context, just as the

Supreme Court has done repeatedly with other abortion restrictions. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2312-13 (crediting evidence that Texas's admitting-privileges requirement would reduce abortion access because physicians with privileges would be unwilling to provide abortions "due to . . . hostility that abortion providers face"); *Casey*, 505 U.S. at 888-95 (invalidating spousal-notification requirement that would effectively eliminate abortion access for women who would suffer abuse if they sought their husbands' permission). Accordingly, the district court rightly included "women who would seek abortions from PPAEO Fayetteville [in] the numerator of the large fraction calculation" when considering all women in Arkansas who would be affected by the Requirement. *See* JA2367.

Second, the State claims the district court overstated its denominator by assuming that the rate of abortions in Arkansas would stay constant year-to-year, as it did from 2016 to 2019. Br. 45-46. But as Dr. Lindo explained, the most recent years are the most relevant because they provide the most up-to-date information about abortion rates in Arkansas. *See* JA1279-80. The State, meanwhile, does not explain why "changes from the more-distant past" should be more probative. *Id.* Nor does the State "offer[] a counter proposal for the number of abortions that will occur annually in Arkansas in the future." JA2370 n.28. With no competing option, the district court did not clearly err by crediting plaintiff-appellees' expert. In any event, the district court alternatively held that, even if the State were correct that

abortion rates had fallen by approximately 3% per year, "such a minor reduction in abortion rates would not change this Court's ultimate conclusions." JA2370-71 n.29.

Third, the State maintains that the district court should have considered whether women would obtain abortions outside Arkansas. Br. 46-49. But it cites no case law supporting its position. That is because the availability of abortion care beyond the State's borders is irrelevant to the undue burden analysis. Rather, "the proposition that the harm to a constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction . . . [is] a profoundly mistaken assumption." *Schimel*, 806 F.3d at 918 (alterations in original); *see Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350 (1938) (similar). In other words, "a state cannot lean on its sovereign neighbors to provide protection of its citizens' federal constitutional rights," including abortion rights. *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014) (citing *Gaines*, 305 U.S. at 350). In fact, the Supreme Court made no mention of out-of-state abortion providers in *Whole Woman's Health*, even though the Fifth Circuit had upheld the constitutionality of the State's abortion restrictions in part because Texas women could and did use abortion providers in New Mexico. *See* 136 S. Ct. at 2304; *Whole Woman's Health v. Cole*, 790 F.3d 563, 596-97 (5th Cir. 2015). That is precisely because out-of-state abortion clinics are irrelevant to constitutional challenges to a State's restriction of

abortion access.

Moreover, the State's insistence that Arkansas women can travel outside Arkansas to obtain abortion care if the OBGYN Requirement becomes law is curious because the closest out-of-state providers—those in Oklahoma and Tennessee—are not subject to an OBGYN Requirement. This belies the claim that Arkansas has enacted the OBGYN Requirement to protect women's health and safety.

Fourth, the State contends that the district court underestimated Dr. Hopkins's capacity to provide abortions. Br. 49-51. But its creative math does not add up. The district court calculated Dr. Hopkins's capacity based on the maximum number of patients he had ever treated in one day—21 women. JA2234. The district court then reasoned that Dr. Hopkins could conduct abortions two days per week, six times per year, for a total of 252 abortions annually. JA2237, JA2375. The State criticizes that estimate, claiming that Dr. Hopkins should be able to perform abortions *five* days per week. Br. 50. The State does not specify how much more capacity this schedule would give Dr. Hopkins, but it in district court it alleged that he could provide 25 abortions per day, JA2373; the State thus seems to believe that Dr. Hopkins could provide 750 abortions annually (25 x 5 days per week every-other month). That figure—which still far falls short of the 2,212 women in need of surgical care every year, *see* JA2369—is grossly inflated in multiple ways. Namely:

- It assumes that LRFP could remain open with Dr. Hopkins as its only provider, which is extremely unlikely. *See* JA2371.

- It assumes that Dr. Hopkins could provide care five times a week, but he cannot do so because Arkansas's 72-hour mandated delay requires LRFP to stagger its patients throughout the week, and Dr. Hopkins needs time to travel from California to Little Rock.

- The State ignores (Br 50) that Dr. Hopkins would have to spend one of his three days at the clinic obtaining patient consents, because—as the district court found—LRFP cannot afford to have a physician (for example, Dr. Tvetden or Dr. Horton) on staff solely to obtain consents, JA2256.

- It is unreasonable to assume that all women who need surgical abortions can wait until Dr. Hopkins is Arkansas. A woman seeking surgical abortion may be unavailable on the days he happens to be there and may be unable to wait until his next visit without running afoul of Arkansas's ban on abortion at 22 weeks. At minimum, delay increases risks. *See* JA2253.

In short, if Dr. Hopkins is the sole provider of surgical abortion, he would not come close to meeting the demand for surgical abortion care.

Fifth, the State rejects the district court's entire analysis as "obsolete" because LRFP has recently been able to extend offers to two part-time, out-of-state board-certified OBGYNs. Br. 51; *see* JA2404-05. Although LRFP reported these two new hires to the district court in an abundance of caution, it also informed the district court of the "substantial uncertainties" that prevent it from evaluating any potential change with regard to the burdens associated with the OBGYN Requirement. JA2405. In particular, neither physician has committed to provide care at LRFP long-term, and neither can relocate to Arkansas. *See* JA2411, JA2415. Plus, their ability to provide care at LRFP is contingent on LRFP remaining open—which, again, is unlikely if the OBGYN Requirement forces Dr. Tvedten to stop providing

abortions. Accordingly, LRFP and its patients cannot count on either OBGYN to meaningfully moot the Requirement's severe burden on abortion access.

(iii) The OBGYN Requirement is also unconstitutional because it effectively eliminates abortion after 10 weeks LMP.

On top of the independently sufficient burdens already described, the district court also correctly found that the OBGYN Requirement would effectively eliminate abortion after 10 weeks LMP. If LRFP closes, only medication abortion will be available in Arkansas. *See* JA2361, JA2374. Even if LRFP remains open with Dr. Hopkins as its only practitioner, he can provide only 252 abortions a year—far less than the 2,212 surgical abortions that LRFP currently provides. JA2375. The State contends that this result is irrelevant because women have no right to their preferred abortion procedure and medication abortion remains available. *See* Br. 55. But the State is wrong. Medication abortion is available only through 10 weeks LMP. JA2297. And over the last three years, nearly half (45%) of LRFP's patients terminated their pregnancies after 10 weeks. JA289. Seeking abortion care earlier is not feasible for many women; they may not know they are pregnant, and in any event they must gather the funds, make the logistical arrangements, and decide on the best course of action for them and their families. JA2226, JA2546. Moreover, many women prefer surgical abortion because it requires fewer visits to the clinic, and thus is associated with a lower burden in terms of time and money. JA2251,

JA2368-69. Accordingly, a de facto ban on surgical abortion, in itself, burdens a large fraction of the women to whom it is relevant.

The State's contrary authority is inapposite. *See* Br. 55 (citing *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490 (6th Cir. 2012)). In *DeWine*, abortion providers challenged the constitutionality of a state law regulating use of medication abortion. Although the Sixth Circuit held that a woman's preference for medication abortion did not constitutionally guarantee her access to medication abortion, 696 F.3d at 514-16, the state did not deprive women of access to abortion at any pre-viability point in pregnancy. By contrast, the OBGYN Requirement would deny women *any* abortion care after 10 weeks LMP. Further, and unlike in *DeWine*, the OBGYN Requirement would affect Arkansas's most common abortion method—surgical abortion. The Supreme Court has repeatedly held that banning the most commonly used abortion method imposes an undue burden. *See Stenberg*, 530 U.S. at 924, 938, 945-46 (striking down ban on certain abortion procedures that "account[ed] for about 95% of all abortions performed from 12 to 20 weeks of" pregnancy); *DeWine*, 696 F.3d at 514 ("[T]he Supreme Court in *Gonzales v. Carhart* instructed that state action is likely to constitute an undue burden where the most common abortion technique available to a particular subset of women is prohibited."). Arkansas could not enact an outright ban on surgical abortion or on

abortion after 10 weeks LMP, and it cannot accomplish the same end through more indirect means.

c. *The district court correctly found that the OBGYN Requirement creates an undue burden.*

The district court also correctly determined that the OBGYN Requirement's burdens outweigh its benefits. *See* JA2379 (quoting *Jegley*, 864 F.3d at 960 n.9). On one hand, the OBGYN Requirement would offer "little, if any, benefit." JA2303. On the other, it would preclude abortion access for most women in Arkansas. *See* JA2374-78. The district court thus did precisely as *Whole Woman's Health* instructs—it enjoined the law. *See* 136 S. Ct. at 2318 (striking down admitting privileges requirement because it "provides few, if any, health benefits for women" and "poses a substantial obstacle to women seeking abortions"); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) ("The feebler the medical grounds, the likelier the burden, *even if slight*, to be 'undue' in the sense of disproportionate or gratuitous."). This Court should affirm.

II. THE OTHER PRELIMINARY-INJUNCTION FACTORS FAVOR AFFIRMANCE.

As the district court found, the challenged restrictions would "cause ongoing and imminent irreparable harm to the plaintiffs and their patients." JA2382. Specifically, the district court found that the 18-Week Ban and Reason Ban would "unconstitutionally prohibit pre-viability abortions," and the OBGYN Requirement

would "impose[] an undue burden on the right of women in Arkansas to seek an abortion." *Id.* The resulting harms to women—including delay in accessing abortion care, total inability to access abortion care, and "forced childbirth"—are "irreparable." *Id.*; *see Bellotti*, 443 U.S. at 643 ("[T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences"). LRFP and Dr. Tvedten would also suffer harm to their professional reputations because they would be unable to provide necessary medical care; indeed, LRFP would be forced to substantially reduce its operations or close altogether. JA2381; *see United Healthcare Ins. Co. v. AdvancePCS*, 316 F.3d 737, 741 (8th Cir. 2002) ("Loss of intangible assets such as reputation and goodwill can constitute irreparable injury."); *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't of Health*, 699 F.3d 962, 980 (7th Cir. 2012) (upholding district court's finding that laying off workers, closing clinics, and stopping service to patients constitutes irreparable harm). The State's claim that the district court did not adequately make findings regarding harm is therefore without support.

The State is also wrong that plaintiff-appellees' harms are "self-inflicted," Br. 58. Each challenged law threatens severe criminal and civil penalties, *see supra* pp.2-4, and such harms are hardly self-imposed. Nor is there any support for the State's notion that plaintiff-appellees did not work sufficiently diligently to comply. *See supra* Part I.C.2(b)(i).

Moreover, the harms plaintiff-appellees would suffer outweigh any harm to Arkansas from inability to enforce its laws. As the district court put it: "the State has no interest in enforcing laws that are unconstitutional." JA2382. Other courts agree. *See, e.g.*, *Gordon v. Holder*, 721 F.3d 638, 653 (D.C. Cir. 2013) ("[E]nforcement of an unconstitutional law is always contrary to the public interest"); *Chamber of Commerce of U.S. v. Edmondson*, 594 F.3d 742, 771 (10th Cir. 2010) (state "does not have an interest in enforcing a law that is likely constitutionally infirm"). And this Court has made clear that "whether the grant of a preliminary injunction furthers the public interest . . . is largely dependent on the likelihood of success on the merits because the protection of constitutional rights is always in the public interest." *Rounds*, 530 F.3d at 752. Because a preliminary injunction serves the public interest by enjoining the enforcement of unconstitutional laws and allowing women to continue accessing safe medical care, this Court should affirm the district court's grant of a preliminary injunction.

III. REASSIGNMENT ON REMAND IS INAPPROPRIATE.

There is no basis to reassign this case on any remand, and several good reasons not to do so. *First*, this case was properly assigned to the *Jegley* judge for exactly the reason the consolidated-case rules exist: "this matter and *Jegley* are closely related," and consolidation "result[ed] in significant savings of judicial resources." JA523. *Second*, reassignment is appropriate only in cases of judicial bias—as the

State's own authority explains, *see Sentis Grp., Inc. v. Shell Oil Co.*, 559 F.3d 888, 904 (8th Cir. 2009); *United States v. Tucker*, 78 F.3d 1313, 1322-24 (8th Cir. 1996)—and such bias is not present here. The State did not move to recuse below, nor has it introduced any evidence of bias into the record.

To the extent the State objects to the grant of plaintiff-appellees' motion for consolidation, this Court lacks jurisdiction over that question, as explained in plaintiff-appellees' motions to dismiss. In any event, the State has provided no basis for its accusation that the consolidation order was the product of improper ex parte wrangling, Br. 3; the only support it cites is a run-of-the-mill e-mail to plaintiff-appellees' counsel from the district court's law clerk asking whether the State had been served. *Id.*; *see* DE28-1. There is no mention—let alone substantive discussion—of plaintiff-appellees' motion to consolidate. Finally, "[t]he consent of the parties is not required by the rule to accomplish" consolidation. Charles A. Wright et al., Federal Practice & Procedure § 2383 (3d ed. Aug. 2019 update).

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.[23]

Respectfully submitted,

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[23] In accordance with Eighth Circuit Rule 28A(h), counsel states that this brief has been scanned for viruses and is virus-free.

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CERTIFICATE OF COMPLIANCE

Under Federal Rule of Appellate Procedure 32(a)(7)(B), I hereby certify that the foregoing brief of the plaintiff-appellees complies with (1) the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5)(A) because it was written in Times New Roman, 14-point font and (2) the type-volume limitations contained in Federal Rule of Appellate Procedure 32(a)(7)(B)(i), because it contains 12,946 words, excluding those parts of the brief excluded from the word count under Federal Rule of Appellate Procedure 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that the foregoing was electronically submitted with the Clerk of the Court for the U.S. Court of Appeals for the Eighth Circuit using the CM/ECF system on December 30, 2019. Service on all participants will be accomplished by the CM/ECF system. A paper copy will be served on participants in the case by U.S. Mail, postage prepaid, within five days of the Court's notice that the brief has been reviewed and filed.

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