IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., on behalf of itself and its patients; *et al*.,

Plaintiffs,

v.

HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; *et al*.,

Defendants.

CASE NO. 3:15-cv-00705

JUDGE FRIEDMAN

MAGISTRATE JUDGE FRENSLEY

MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

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Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs Adams & Boyle P.C., Choices Memphis Center for Reproductive Health ("Choices"), and Planned Parenthood of Tennessee and North Mississippi ("PPTNM"), and proposed Plaintiffs Knoxville Center for Reproductive Health and Dr. Kimberly Looney (collectively "the Providers") move for a temporary restraining order, followed by a preliminary injunction, to enjoin Governor Bill Lee's April 8, 2020, Executive Order No. 25, "An Order To Reduce The Spread Of Covid-19 By Limiting Non-Emergency Health Care Procedures" ("EO-25"), as it applies to procedural abortions in Tennessee. In light of EO-25's broad wording and criminal penalties, all procedural abortion care—that is, *all* abortions after 11 weeks of pregnancy, and all abortions from the *start of pregnancy* for patients who are ineligible for an early method of abortion involving medications alone—is now halted in the state of Tennessee. Every day that this ban remains in place, it forces pregnant people in Tennessee to remain pregnant against their wishes. Unless and until this court grants relief, they will continue to suffer constitutional injury, serious medical risk, and other forms of irreparable harm.

As applied to procedural abortion, EO-25 contravenes guidance issued by leading medical authorities in the wake of COVID-19. The American College of Obstetricians and Gynecologists ("ACOG") and seven other leading medical organizations[1] issued a public statement in response to the COVID-19 health pandemic explaining that abortion is "essential," "time-sensitive" health care that cannot be delayed without risking the health and safety of the patient.

[1] The medical organizations issuing this joint guidance were ACOG, the American Board of Obstetrics & Gynecology, the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine. *See Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

Most urgently, the Providers seek relief on behalf of patients who are particularly burdened by the Executive Order because of the time-sensitive nature of abortion care, including: ***First***, patients who, in the good faith professional judgment of the provider, will likely lose their ability to obtain an abortion in Tennessee if their procedures are delayed until after April 30, 2020. EO-25 will force such patients to either carry an unwanted pregnancy to term, and bear the far greater risks of illness, complications, and risk of death associated with ongoing pregnancy and childbirth, or attempt to seek abortion care out of state, which imposes significant costs, burdens, and emotional distress that the COVID-19 pandemic will exacerbate. ***Second***, patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a lengthier and more complex abortion procedure, which is only available at two clinics in Nashville and Memphis, if their procedures are delayed until after April 30, 2020. These patients will likely have to travel farther for abortion care as a result of EO-25, which increases the costs and burdens of accessing such care and will face greater health risks associated with the more complex procedure. ***Third***, patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a two-day procedure—which is only available at two clinics in Nashville and Memphis, and which requires at least three separate visits to the provider—if their procedures are delayed until April 30, 2020. In making such determinations, providers must be allowed take into account all of the factors bearing on an individual patient's ability to timely access abortion care and medical risk, including the patient's medical history, familial circumstances, and any logistical and financial obstacles faced by the patient.

The Providers' further request that during the pendency of the Executive Order, Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them be temporarily enjoined from enforcing the in-person counseling

requirement under Tenn. Code Ann. § 39-15-202(a)-(h) (the "48-hour Delay Law"), which requires that the physician provide state-mandated information to patients in person, at least 48 hours before the abortion, rather than by telephone (as comparable state laws allow, *see*, e.g., Ga. Code Ann. § 31-9A-3), or other telehealth technologies (as Tennessee Executive Order 15 encourages during the COVID-19 crisis, *see* Exec. Order 15, at 10 (Mar. 19, 2020)).[2] Such relief is necessary because the Delay Law imposes significant burdens on access to care, and requires the Providers to use more PPE than would otherwise be necessary if they were able to provide the same information to patients via telephone videoconference, or other telehealth technologies.

Decades of Supreme Court precedent categorically prohibit states from banning abortion before viability, or imposing burdens on abortion access that exceed the benefits conferred. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846, 871 (1992); *Roe v. Wade*, 410 U.S. 113, 166 (1973). Nor is it a permissible exercise of the state's police power to exploit a health pandemic to ban abortion. *Jacobson v. Mass.*, 197 U.S. 11, 31 (1905) (explaining State's police power may not violate fundamental rights and must serve State's asserted aims). Accordingly, federal district courts in Alabama, Ohio, Oklahoma, and Texas have already granted emergency requests to temporarily restrain those states from banning abortion through COVID-19 executive orders. *See Robinson v. Marshall*, No. 2:19-cv-365, at 28, 30 (M.D. Ala. Apr. 12, 2020) (ECF No. 137) ("Robinson," attached as Exhibit 1); *S. Wind Women's Center v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020), *appeal dismissed*, No. 20-6045 (10th Cir. Apr. 13, 2020) (attached as

[2] Governor Bill Lee, *Executive Order No. 15, An Order Suspending Provisions Of Certain Statutes And Rules And Taking Other Necessary Measures In Order To Facilitate The Treatment And Containment of COVID-19* (Mar. 19, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee15.pdf.

Exhibit 2); *Preterm-Cleveland v. Att'y Gen. of Ohio*, No. 1:19-cv-360 (S.D. Ohio Mar. 30, 2020) (ECF No. 43) ("Preterm-Cleveland," attached as Exhibit 3);[3] *Planned Parenthood Ctr. for Choice v. Abbott*, No. A-20-CV-323-LY, 2020 WL 1815587 (W.D. Tx. April 9, 2020) ("Abbott").[4]

That same relief is warranted here. The Providers have already been forced to cancel dozens of procedural abortion appointments scheduled to take place after EO-25 took effect, including for patients who had already traveled to the Providers' clinics, as required by state law, to receive state-mandated counseling and then returned home to wait at least 48 hours before their abortion. Future appointments are now being cancelled, throwing abortion access into disarray.

Forcing patients to remain pregnant against their wishes for weeks or—as is far more likely given the trajectory of the pandemic, months[5]—*undermines*, rather than advances, EO-25's stated goals of "preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through nonessential patient-provider interaction."

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[3] The State of Ohio filed a motion with the Sixth Circuit to stay the Temporary Restraining Order ("TRO") and Plaintiffs moved to dismiss. The Court held it lacked jurisdiction because the TRO did not threaten to inflict irretrievable harms or consequences before it expires. *See Pre-Term Cleveland v. Att'y Gen. of Ohio*, No. 20-3365, 2020 WL 1673310, at *2 (6th Cir. Apr. 6, 2020) ("*Pre-Term Cleveland II*").

[4] The Fifth Circuit granted in part an administrative stay of the District Court's order, leaving in place the temporary restraining order as to medication abortion and as to "women who would be past Texas's legal limit—22 weeks LMP—for abortion by April 22." *In re Abbott*, No. 20-50296, at 3, 5 (5th Cir. Apr. 13, 2020) (attached as Exhibit 4). Plaintiffs have filed an emergency application with the Supreme Court to vacate the stay. *See* Applicants' Emergency Application to Justice Alito to Vacate Administrative Stay of Temporary Restraining Order Entered by the United States Court of Appeals for the Fifth Circuit, *Planned Parenthood Center for Choice, et al., v. Greg Abbott, Governor of Texas, et al.*, No. 19A1019 (Apr. 11, 2020).

[5] *See, e.g.*, Jake Lowary, *Vanderbilt Health Policy COVID-19 model finds evidence of flattening curve, recommends social distancing policies continue*, VUMC Reporter, Apr. 9, 2020, https://news.vumc.org/2020/04/09/vanderbilt-health-policy-covid-19-model-finds-evidence-of-flattening-curve-recommends-distancing-policies-continue/ (predicting that, in Tennessee, "if the current social distancing policies continue to reduce the spread of the disease, there would be an estimated peak of hospitalizations in mid-June. If the state were to experience additional gains from social distancing, under that more optimistic scenario the peak of hospitalizations could be lower and could be as early as mid-May").

EO 25 at 3. A person who wants to end a pregnancy but is unable to do so will have far more contact with the healthcare system in both the near and long-term, using up significantly more personal protective equipment ("PPE") and health care resources, than if they had been able to obtain an abortion without delay. Declaration of Dr. Kimberly Looney ("Looney Decl.," attached as Exhibit 5) ¶ 31. They will need prenatal care as pregnancy takes an increasing toll on their health, which will involve multiple trips to health care facilities, particularly if the patient has a high-risk pregnancy or underlying health care conditions exacerbated by pregnancy. *Id.* Some patients will have to seek care at an emergency room after experiencing a miscarriage—using not only PPE, but also the hospital's physicians, nurses, and beds, and exposing the patients to the risk of contagion. *Id.* ¶ 35. Patients who must carry a pregnancy to term and deliver will need multiple prenatal visits, screening tests, and, ultimately, a multi-day hospital admission, which is even lengthier if the patient had a cesarean-section. *Id.* ¶ 33.

Alternatively, some patients who have the means will attempt to obtain abortion care by traveling to another state, increasing the risk of COVID-19 transmission but conserving no PPE. Under either scenario, preventing patients from accessing procedural abortions in Tennessee will increase the risks, both to patients and the rest of Tennessee's population, of contracting COVID-19 and result in greater use of PPE and hospital resources—*contrary to the stated goals of EO-25 and to public health*.

The COVID-19 pandemic does not reduce the need for abortions; if anything, it makes timely access to comprehensive reproductive healthcare even more urgent, while raising additional obstacles for individuals seeking care. Absent injunctive relief from this Court, due to the burdens imposed by EO-25, in conjunction with the mandatory 48-hour delay and the backlog that already exists at clinics, many of the Providers' patients will lose their ability to access safe and legal pre-

viability abortion in Tennessee and be forced to carry pregnancies to term against their will. For those patients who are able to access abortion, some will be forced to have longer, more invasive procedures, which requires more PPE. The majority of abortion patients in Tennessee are poor or low-income and already face enormous obstacles in accessing healthcare; these obstacles are exacerbated by the extreme financial and logistical difficulties brought on by the COVID-19 public health crisis. Being delayed or denied a procedural abortion will jeopardize patients' physical health amidst a health crisis that has already overburdened the healthcare system. Moreover, denial and delay of abortion can cause significant emotional, social, and economic harms.

Accordingly, the Providers seek a temporary restraining order and preliminarily injunction to enjoin Defendants, their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them, from enforcing or complying with EO-25 to prohibit procedural abortions prior to viability and preserve the *status quo* for patients who are seeking that care. This relief is critical to prevent irreparable harms to patients' health and ongoing violation of their constitutional rights. This relief will also further the public interest and the public health.

STATEMENT OF FACTS

A. Abortion and Reproductive Healthcare in Tennessee

Legal abortion is a vital, safe, and common form of healthcare.[6] Tr. Vol. 2, 57:18-58:8 (Young);[7] Looney Decl. ¶ 9. Abortions rarely result in complications and do so at rates of no more

[6] Nat'l Acads. of Sci., Eng'g & Med., *The Safety & Quality of Abortion Care in the United States*, 77 (The National Academies Press 2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.") [hereinafter "National Academies Report"].

[7] This Statement of Facts contains numerous references to the prior record in this case in light of the many applicable facts here. References to "Tr." refers to the trial record.

than a fraction of a percent.[8] *Id*. Additionally, every pregnancy-related complication is more common among women having live births than among those having abortions. *Id*. ¶ 10.[9] In fact, a 2012 study found the risk of death for those carrying pregnancies to term is approximately 14 times higher than for those obtaining abortions. *See id*.[10] More recent maternal mortality data in the United States reflect even higher maternal mortality rates, and Tennessee, in particular, has higher maternal mortality rates than national numbers. Tr. Vol. 2, 65:19-12 (Young). While abortion is an extremely safe procedure, the risks increase as pregnancy progresses. Looney Decl. ¶ 10; Tr. Vol. 2, 57:23-58:8 (Young); Tr. Vol. 1, 41:3-8 (Wallett).

There is no typical abortion patient: individuals seek abortion for a multitude of complex reasons, including medical, family, economic, and personal reasons. Tr. Vol. 1, 45:9-46:4 (Wallett); Looney Decl. ¶ 19. Approximately 1 in 4 women will have an abortion in their lifetime. Tr. Vol. 2, 57:18-22 (Young). The majority of the Providers' patients live below or close to the poverty line. Tr. Vol. 2, 91:6-14 (Young); Declaration of Rebecca Terrell ("Terrell Decl.," attached as Exhibit 6)). ¶ 14; Declaration of Corrinne Rovetti, FNP, APRN-BC ("Rovetti Decl.," attached as Exhibit 7) ¶ 19.

There are two methods of abortion care available in Tennessee: medication abortion or in-office procedural abortion (also referred to as "surgical abortion"). Tr. Vol. 2, 57:18-22 (Young); Looney Decl. ¶ 11. For a medication abortion, the patient takes mifepristone in the clinic and then, 24 to 48 hours later, takes misoprostol at a location of her choosing, typically at home. Looney Decl. ¶ 11. The pregnancy is then passed in a process similar to miscarriage. *Id.*; Tr. Vol. 1, 39:15-

[8] National Academies Report at 55, 60, 74-75.
[9] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Am. J. Obstetrics & Gynecology 215, 217 (2012).
[10] *Id.*

11 (Wallett). The use of mifepristone in combination with misoprostol is safe and effective to terminate pregnancies up to 11 weeks LMP (or 77 days). Looney Decl. ¶ 12.

Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as a procedural abortion involves no incision or general anesthesia. Looney Decl. ¶ 14. In the majority of cases, a procedural abortion is performed using the "aspiration" technique, which involves the use of gentle suction to empty the uterus, typically takes about 5-10 minutes, and may at times involve local anesthesia or conscious sedation. *Id.*; Tr. Vol. 1, 40:12-20 (Wallett); Tr. Vol. 2, 58:9-59:1 (Young). Starting at 14-16 weeks, physicians typically use the dilation and evacuation ("D&E") technique, which requires additional skills and equipment to perform, and takes longer, including longer time spent by the patient in the recovery room. Looney Decl. ¶ 14; Tr. Vol. 1, 40:21-8 (Wallett). Starting around 18 weeks LMP, procedural abortion may be performed as a two-day procedure because a patient receives medications to dilate her cervix the day before the procedure itself. Looney Decl. ¶ 14. For some patients, procedural abortion is safer or medically indicated over medication abortion, such as for patients at increased risk of bleeding. *Id*. ¶ 13.

Pregnancy is generally 40 weeks in duration, and abortion care is only available during a limited window of time. *Id*. ¶¶ 15, 31. While patients usually seek abortion as soon as they are able, there are a host of logistical, financial, and legal obstacles that can delay patients who have made the decision to end a pregnancy. *Id*. ¶ 21. For example, patients must contact the clinic and schedule their pre-abortion mandatory counseling visit; they must come up with the necessary funds, as abortion is generally not covered by Tennessee insurance plans or the state Medicaid program; and they must make all of the necessary arrangements including finding transportation, taking unpaid time off work and finding and paying for childcare. *Id.*; Terrell Decl. ¶¶ 12-14;

Rovetti Decl. ¶ 19. Further, Tennessee law requires that patients make an initial counseling visit and then wait at least 48 hours before returning to the health center to obtain abortion care. Terrell Decl. ¶ 11; Rovetti Decl. ¶ 16. For patients who live in rural areas or for whom travel is especially difficult, there is no exception to the mandatory delay and two-trip requirement. Terrell Decl. ¶ 11. Patients under the age of 18 must obtain parental consent before they can obtain an abortion, unless they go to court and obtain a judicial bypass. *Id.* ¶ 12. Nor does Tennessee law permit providers to offer medication abortion—or even perform the mandatory counseling visit—via telemedicine, which could ease the travel and logistical burdens for patients living in rural areas or who must travel long distances to receive abortion care. *Id.*

The COVID-19 public health emergency exacerbates these burdens on the Providers' patients. *Id.* ¶ 15; Looney Decl. ¶ 22; Rovetti Decl. ¶ 17-19. It has caused unprecedented layoffs and other work disruptions, shuttered schools and childcare facilities, and otherwise limited patients' options for transportation and childcare support during a time of recommended social distancing and shelter-in-place orders.[11] Looney Decl. ¶ 22; Rovetti Decl. ¶¶ 17-19. Indeed, during the week ending on April 4, 2020, the number of unemployment claims in Tennessee rose to 116,141 initial claims—a 23,641 increase from the 92,500 initial claims filed the previous week.[12]

Access to abortion in Tennessee is limited by provider availability, with eight providers in only four cities. Tr. Vol. 2, 88:6-19, 89:18-90:7 (Young); Terrell Decl. ¶ 11. 96% of Tennessee

[11] *See* Governor Bill Lee, *Executive Order No. 22, An Order Directing Tennesseans To Stay Home Unless Engaging in Essential Activities To Limit Their Exposure To And Spread Of Covid-19* (Mar. 30, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee22.pdf; Governor Bill Lee, *Executive Order No. 23, An Order Amending Executive Order No. 22 Requiring Tennesseans To Stay Home Unless Engaging in Essential Activity Or Essential Services* (Apr. 2, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee23.pdf.

[12] U.S. Dep't of Labor, *Unemployment Insurance Weekly Claims Report / USDL 20-510-NAT* at 5 (Apr. 9, 2020), https://www.dol.gov/ui/data.pdf.

counties lack an abortion provider, and 63% of Tennesseans live in a county with no provider. Tr. Vol. 2, 88:6-19, 89:18-90:7 (Young). Abortions after 15 weeks are only available at PPTNM's Nashville and Memphis clinics, and only up to 19 weeks, 6 days LMP. Looney Decl. ¶¶ 2, 15.

Because the cost of abortion increases as pregnancy advances, some patients find themselves trapped in a vicious cycle: delaying their abortion care while they attempt to raise the necessary funds, and then having to delay even longer to raise the additional funds needed for a more costly abortion later in pregnancy. Tr. Vol. 2, 93:9-17 (Young). Delay can also increase the costs of travel, childcare, and—for patients who are delayed to the point when abortion becomes a two-day procedure—additional time off work, among other expenses. Rovetti Decl. ¶ 19. This is especially onerous for patients who must travel long distances to reach a clinic because travel requires additional logistical arrangements, including being away from home and work, needing childcare, and potentially needing to inform others of the reasons for appointments. Tr. Vol. 1, 99:17-100:2 (Wallett); Terrell Decl. ¶ 13; Rovetti Decl. ¶ 19. These burdens are compounded by the mandatory 48-hour delay requirement, which forces patients to make at least two separate visits and creates significant delay for patients (far greater than 48 hours) and which some patients are unable to do. Tr. Vol. 1, 286:25-287:8 (Terrell); Looney Decl. ¶ 23; Rovetti Decl. ¶¶ 16, 19, 25.

B. COVID-19 Pandemic and the Governor's Executive Order

In March 2020, the United States and the State of Tennessee declared a state of emergency related to the COVID-19 pandemic.[13] On April 8, 2020, Governor Lee signed EO-25 to "preserv[e]

[13] *See* President Donald J. Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/; *Gov. Bill Lee Issues Executive Order Declaring State of Emergency in Response to COVID-19*, TN Office of the Governor (Mar. 12, 2020), https://www.tn.gov/governor/news/2020/3/12/gov--bill-lee-issues-executive-order-declaring-state-of-emergency-in-response-to-covid-19.html.

personal protective equipment for emergency and essential needs" and prevent "community spread of COVID-19 through nonessential patient-provider interactions." *See* EO-25 at 2.[14] EO-25 provides that "[a]ll healthcare professionals and healthcare facilities in the State of Tennessee shall postpone surgical and invasive procedures that are elective and non-urgent." *Id.* at 2. Elective and non-urgent procedures are defined as "those procedures that can be delayed until the expiration of this Order because they are not required to provide life-sustaining treatment, to prevent death or risk of substantial impairment of a major bodily function, or to prevent rapid deterioration or serious adverse consequences to a patient's physical condition if the surgical or invasive procedure is not performed, as reasonably determined by a licensed medical provider." *Id*. at 2-3. EO-25 took effect at 12:01 a.m., Central Daylight Time, on April 9, 2020, and remains in effect until 12:01 a.m., Central Daylight Time, on April 30, 2020.[15] A violation of an executive order is a class A misdemeanor, and may result in licensure penalties. Tenn. Code Ann. § 58-2-119; *see also* Apr. 10, 2020 Letter from Commissioner Lisa Piercey to Health Care Providers (Exhibit 8).

EO-25 explains that "the American College of Surgeons has recommended that each hospital, health system, and surgeon thoughtfully review all scheduled elective procedures with a plan to minimize, postpone, or cancel electively scheduled operations, endoscopies, or other invasive procedures and to immediately minimize use of essential items needed to care for patients, including, but not limited to, ICU beds, personal protective equipment, terminal cleaning supplies,

[14] EO-25 amends and supersedes the provisions of Executive Order No. 18, dated March 23, 2020, which prevented hospitals and ASTC's from performing non-essential procedures, but explicitly exempted "pregnancy-related visits and procedures" as well as "emergency or trauma-related procedures where postponement would significantly impact the health, safety, and welfare of the patient." *Id*. Executive Order 18 defined non-essential procedures as "any medical procedure that is not necessary to address a medical emergency or to preserve the health and safety of a patient, as determined by a licensed medical provider." *Id*.

[15] EO-25 is likely to be renewed or extended, as experts expect the current crisis to last beyond April 30, into May or June. *See, e.g.*, Lowary, *supra* note 5.

and ventilators." *Id.* at 1. EO-25 defines PPE as including, but not limited to, "medical gowns, N95 masks, surgical masks, TYVEK suits, boot covers, gloves, and/or eye protection." *Id.* at 3.

C. The Providers' Health & Safety Measures in Response to COVID-19

Since the COVID-19 crisis began, the Providers have been diligent in protecting the health of their patients and staff while continuing to provide access to high-quality, timely abortion care. Terrell Decl. ¶¶ 17-27; Looney Decl. ¶¶ 24-30; Rovetti Decl. ¶¶ 8-13. Even before EO-25 was issued, they proactively adopted recommendations and guidelines from the Centers for Disease Control and Prevention ("CDC"), National Abortion Federation to reduce the spread of COVID-19, while continuing to comply with all relevant Tennessee laws and regulations governing abortion. Terrell Decl. ¶ 19; Looney Decl. ¶ 25; Rovetti Decl. ¶ 8.

For example, the Providers have postponed or cancelled non-essential procedures such wellness visits. Terrell Decl. ¶ 26; Looney Decl. ¶ 26; Rovetti Decl. ¶ 8. They screen patients for symptoms over the telephone prior to their appointments and when they arrive at the clinics prior to entering the facilities to ensure that no one experiencing symptoms of COVID-19 enters the clinic. Terrell Decl. ¶¶ 20-21; Looney Decl. ¶ 27; Rovetti Decl. ¶¶ 9, 11. Based on the particularized needs of each facility, the Providers maintain social distancing by, for example, staggering appointments, asking patients to wait outside the clinic until their appointment, prohibiting patients from bringing a support person to their appointment, keeping patients in separate rooms whenever possible, and spacing patients a minimum of six feet apart during their time in the clinic. Terrell Decl. ¶ 22; Looney Decl. ¶ 28; Rovetti Decl. ¶¶ 9, 11-12. At any given time, the Providers have fewer people inside the clinic than they normally had before the COVID-19 pandemic. Terrell Decl. ¶ 23; Looney Decl. ¶ 26; Rovetti Decl. ¶¶ 8-9. Where medically appropriate, several of the Providers have reduced the number of staff in the clinic and restricted the number of staff in the room during procedural abortion to only those who are medically

essential or required by law. Terrell. Decl. ¶¶ 23-24; Rovetti Decl. ¶ 24. Additionally, the Providers continuously disinfect chairs, doorknobs, pens, clipboards, and other frequently touched surfaces throughout the day. Terrell Decl. ¶ 27; Looney Decl. ¶ 28; Rovetti Decl. ¶¶ 8, 12.

Abortion care does not require the use of any hospital resources that may be needed for COVID-19 response such as hospital beds, ICU beds, or ventilators. Looney Decl. ¶ 30. Indeed, procedural abortion takes place in an outpatient setting. *Id.* Procedural abortion involves only minimal use of PPE: typically gloves, a surgical mask or reusable plastic face shield, and either reusable scrubs or a disposable gown or smock. *Id.* ¶ 29; Terrell Decl. ¶¶ 30; Rovetti Decl. ¶ 24. None of the Providers stock the N95 respirators that are in short supply during this COVID-19 pandemic. Looney Decl. ¶ 30; Terrell Decl. ¶ 29; Rovetti Decl. ¶ 24. Procedural abortion after approximately 18 weeks LMP requires more PPE than a procedural abortion at an earlier point in pregnancy, because it is typically a two-day procedure at that stage. Looney Decl. ¶ 50. Nevertheless, as explained *infra*, abortion care requires vastly less PPE than continuing a pregnancy. The provision of abortion care in Tennessee does not deplete hospital resources and the Providers have made every effort to conserve PPE and minimize the spread of COVID-19 while still providing this time-sensitive, essential healthcare to patients. *Id*. ¶¶ 24, 30; Terrell Decl. ¶ 33; Rovetti Decl. ¶ 24.

D. EO-25's Threat to End Abortion Access and Harm Patients While Undermining Its Own Objectives

EO-25 threatens severe harms to patients while undermining its stated goals. These harms will only be exacerbated if, as experts predict, the COVID-19 crisis lasts well past April.

First, some patients will be unable to obtain an abortion at all because they will pass the limit when abortion care is available in Tennessee while EO-25 is in effect, or will be unable to obtain an appointment in Tennessee in time, even after EO-25 is lifted, because of a surge in

demand. Following the expiration of EO-25, there will be a severe backlog of patients seeking access to abortion. Looney Decl. ¶ 46. Only one provider in the state (PPTNM) provides abortions after 15 weeks LMP, and it will not have capacity to care for the number of patients who will need services *Id*. Forcing all of the patients still able to obtain an abortion in Tennessee to attempt to obtain them in the same narrow window of time—after EO-25 expires and before they reach the point in pregnancy at which abortion is no longer available in the state—will create a crush of demand that health centers are unlikely to be able to meet. *Id*.; Terrell Decl. ¶ 46. Further, there will be a cascading effect in which patients at earlier gestational ages will be forced to delay procedures so patients who would otherwise be denied care entirely can be treated first. Terrell Decl. ¶ 46. The 48-hour mandatory delay, in conjunction with this backlog, will push patients to have later procedures with greater risks and expense, or prevent women from accessing abortion in Tennessee entirely. *Id.*; Looney Decl. ¶¶ 47-50.

In addition to violating their fundamental right to determine if, when, and how to have a child or add to their existing families, these patients will face dramatically increased medical risks. Looney Decl. ¶¶ 10, 34-38. A patient who is forced to carry an unwanted pregnancy to term faces increased risk of death. Tr. Vol. 2, 65:19-66:7 (Young); Looney Decl. ¶ 10. More recent maternal mortality data in the U.S. reflect even higher maternal mortality rates, and Tennessee, in particular, has higher maternal mortality rates than the national average. Tr. Vol. 2, 65:19-12 (Young). In contrast, data published by the Centers for Disease Control and Prevention (CDC) concerning mortality associated with abortion confirms that rates are extremely low: 0.6 deaths per 100,000 abortions. Tr. Vol. 2, 66:13-19 (Young).

Even an uncomplicated pregnancy stresses the patient's entire physiology, including the increased risks associated with caesarean or vaginal delivery, which entails risks of hemorrhage,

infections like chorioamnionitis or endometriosis, and increased risks of preeclampsia or eclampsia. Tr. Vol. 2, 66:20-67:15 (Young); Looney Decl. ¶¶ 34, 36. Patients who are forced to carry unwanted pregnancies to term also face increased risks of preterm delivery and premature rupture of membranes. Tr. Vol. 2, 66:20-67:15 (Young); Looney Decl. ¶ 55.

Forcing patients to remain pregnant against their will is also directly at odds with EO-25's stated purposes: it *increases* in-person contact within the health care system and demands far greater quantities of PPE and other medical resources than allowing patients to end their pregnancies without needless delay.[16] Patients who are forced to continue a pregnancy will have to have prenatal visits—typically once a month, or more often for patients with high-risk pregnancies or preexisting conditions—as well as pregnancy-related screenings and tests, including multiple ultrasounds, blood tests, and glucose tests. Looney Decl. ¶ 31. Unlike abortion, for which complications and hospital transfers are extremely rare, *see* Terrell Decl. ¶ 29, Looney Decl. ¶ 9, one in five pregnant women will visit a hospital *prior* to delivery, Looney Decl. ¶ 31. Fifteen to twenty percent of pregnancies end in miscarriage, for which patients will often seek care at a hospital emergency room. Looney Decl. ¶ 35. For all others, the pregnancy will end in childbirth, which typically involves a multi-day hospital admission. Looney Decl. ¶ 33.

Every time a pregnant person presents to the hospital for evaluation prior to labor, which could happen multiple times, they will be interacting with more people and increasing the hospital's use of PPE. *Id*. An actual birth—attended by multiple medical care providers—could involve anywhere from seven to ten gowns, masks, and sterile gloves. *Id.* For an uncomplicated

[16] *See also* Rupsa C. Boelig et al., *Expert Review: MFM Guidance for COVID-19*, Am. J. Obstetrics & Gynecology MFM (Mar. 19, 2020) (recommending that, even during the COVID-19 pandemic, pregnant people should have multiple in-person visits for routine ultrasounds and laboratory work throughout pregnancy).

pregnancy, the patient is going to remain in the hospital at least 24-48 hours; for a caesarean section ("C-section") even longer; and for a more complicated pregnancy, potentially even longer still. *Id.* Again, this means that the patient will require use of a hospital bed or room, and will require the time and attention of hospital staff, who will have to use PPE during interactions with the patient. *Id.* Even an uncomplicated pregnancy can suddenly become life-threatening during labor and delivery and lead to injury. *Id.* ¶ 36. Furthermore, one-third of pregnancies result in a C-section delivery. *Id.* Even though C-section deliveries are relatively common, they are still significant abdominal surgeries that carry risks of hemorrhage, infection and injury to internal organs. *Id.*

Moreover, the COVID-19 crisis has increased the likelihood that pregnant people will be sent to an emergency department. *Id.* ¶ 37. ACOG has recommended that, "given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted."[17] *Id.* Accordingly, ACOG recommends that pregnant women reporting certain potential COVID-19 symptoms—including symptoms that are common during pregnancy for unrelated reasons, such difficulty breathing should "immediately seek care in an emergency department or equivalent unit that treats pregnant women," be isolated if possible, and "adhere to local infection control practices including personal protective equipment." *Id.*[18]

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[17] *See also* Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html (last updated Apr. 3, 2020) (indicating that pregnant women "have changes in their bodies that may increase their risk of some infections" and "have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as influenza.").

[18] *See* Am. Coll. of Obstetricians & Gynecologists and Soc. for Fetal-Maternal Med., *Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Apr. 10, 2020), https://www.acog.org/-

Second, EO-25 will delay access to safe, essential, and time-sensitive abortion care for over two weeks, and likely longer if it is extended. *See* Terrell Decl. ¶ 15; Looney Decl. ¶¶ 57-58; Rovetti Decl. ¶¶ 22-23. This conflicts with medical and public health guidance. As ACOG and other leading medical organizations recently emphasized in a joint statement, "Abortion Access During the COVID-19 Outbreak," abortion is an essential procedure that cannot be delayed. Looney Decl. ¶ 20.[19] The statement stresses that: "To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure" because it "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible." *Id.*[20]

The American Medical Association ("AMA"), American Nurses Association, and American Hospital Association also issued a statement "urging the public to #StayHome as we reach the critical stages of our national response to COVID-19," but stressing that "[o]f course, those with urgent medical needs, including pregnant women, should seek care as needed." *Id.*[21] Likewise, the AMA noted its regret that "elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive health care." *Id.*[22] This leading organization of American physicians—the very people on the front lines in fighting the virus—voiced its

/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6.

[19] Am. Coll. of Obstetricians & Gynecologists et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[20] *Id.*

[21] Am. Med. Ass'n, Am. Hosp. Ass'n, and Am. Nursing Ass'n, *AMA, AHA, ANA: #StayHome to confront COVID-19* (Mar. 24, 2020), https://www.ama-assn.org/press-center/press-releases/ama-aha-ana-stayhome-confront-covid-19.

[22] Patrice A. Harris, President, AMA, AMA Statement on Government Interference in Reproductive Healthcare (Mar. 30, 2020), https://bit.ly/2X4OAjT.

opposition to "government intrusion in medical care" at this critical moment in our nation's history, emphasizing that physicians and patients "should be the ones deciding" which medical services "need to be performed, and which ones can wait." *Id.*

Although abortion is extremely safe throughout pregnancy, delay in accessing care may endanger patients' health. *Id.* ¶¶ 20, 49. The timing of when a patient is able to access abortion care is critical, because it determines which procedure(s) a patient may be eligible to receive. *Id.* ¶¶ 14, 50; Tr. Vol. 2, 64:1-14 (Young); Adams Dep. 79:25-80:17. Similarly, timing is important because while abortion is extremely safe throughout pregnancy, the risks increase as pregnancy progresses, and the later in pregnancy a patient accesses a procedural abortion, the more likely she is to experience a rare complication like hemorrhage, uterine perforation, cervical laceration or retained products of conception. Tr. Vol. 2, 64:15-23 (Young); Looney Decl. ¶ 49. Aside from the increased risks of the procedure, it is also distressing for patients to be forced to wait to have a procedure once they are certain of their decision. Tr. Vol. 2, 83:8-24 (Young); Looney Decl. ¶ 49.

Pushing patients to obtain care later in their pregnancies also directly contradicts EO-25's stated goals by *increasing* the duration and frequency of patient interactions with the outside world and the use of PPE, even for patients who are still able to obtain an abortion. Looney Decl. ¶ 50. EO-25 will delay some patients to the point when they must have a more complicated procedural abortion using the D&E technique rather than the aspiration technique, which requires more time in the clinic and a larger number of staff than aspiration abortion. *Id.*; Rovetti Decl. ¶ 23. Other patients will be delayed past 18 weeks LMP and so will need a two-day procedural abortion. *Id.* Patients will have to travel to Nashville or Memphis for these procedures, the only places where such procedural abortions are available. *Id.* ¶¶ 2, 15.

Third, some patients, rather than wait for EO 25 to expire—or because they simply cannot afford to wait—may attempt to travel hundreds of miles out of state to try to obtain an abortion. Looney Decl. ¶ 51; Rovetti Decl. ¶ 25. This requires them to overcome all of the logistical barriers and costs associated with accessing abortion care out-of-state, virtually all of which are exacerbated by the COVID-19 crisis. Looney Decl. ¶ 51. These patients are also likely to obtain abortions later than they would were they able to access care within the state, which—as noted above—entails greater risks and costs than an earlier procedure. *Id.* ¶ 52. And efforts to travel are also likely to expose both patients and other people to additional risk of contagion as patients navigate the childcare, transportation, food, and lodging necessary to make the trip at a time when states, including Tennessee, and public health experts have urged their citizens to reduce travel and stay at home as much as possible in order to reduce the rate of transmission of COVID-19. *Id.* This will only further undermine the State's efforts to contain the virus because these contacts increase the risk of contracting COVID-19 and bringing the virus back to families and communities in Tennessee. *Id.*

Fourth, when patients cannot access services to terminate a pregnancy within the healthcare system, some will find ways to do so outside the healthcare system, not all of which may be safe. Looney Decl. ¶ 56. If attempts to self-induce give rise to additional health problems, some patients may be forced to seek emergent medical care, increasing their interactions with the outside world and further taxing the medical system as it works to respond to the COVID-19 crisis. *Id.*

Failure to comply with EO-25 carries criminal penalties, which may in turn trigger disciplinary action against licensees. *See* Exhibit 7; Tenn. Comp. R. & Regs. 1200-08-10-.03(1); Tenn. Code Ann. § 63-6-214. Absent immediate relief from the Court, EO-25 will continue to ban

virtually all abortions in Tennessee after eleven weeks LMP, and even earlier among patients for whom medication abortion is not appropriate. Patients will experience extreme delays in seeking abortion care, if they are able to access it at all. Terrell Decl. ¶¶ 45-46; Looney ¶¶ 43-44. Some patients with the means to travel will seek abortion care outside the state, risking the spread of COVID-19 to others, to themselves, and to their community, and doing nothing to conserve the use of PPE. Looney Decl. ¶¶ 51-52. All of these severe and ongoing harms will fall hardest on poor and low-income people and families.

ARGUMENT

The Providers seek a temporary restraining order and preliminary injunction to prevent EO-25, as applied to pre-viability procedural abortions, from continuing to violate the constitutional rights of Tennessee patients and causing irreparable harm. In ruling on such a motion, the Court considers four factors, all of which weigh heavily in the Providers' favor: (1) a substantial likelihood of success on the merits; (2) substantial threat of irreparable injury; (3) that the injury to the Providers outweighs any harm the injunction might cause Defendants; and (4) that granting the injunction will not disserve the public interest. *Am. Civil Liberties Union Fund of Mich. v. Livingston Cty.*, 796 F.3d 636, 642 (6th Cir. 2015) (quoting *Bays v. City of Fairborn*, 668 F.3d 814, 818–19 (6th Cir. 2012)).

As several federal district courts have already held when faced with comparable executive orders prohibiting abortion care, the Providers are entitled to injunctive relief. EO-25 effectively bans pre-viability abortions in Tennessee after 11 weeks LMP (and even earlier for some patients), contravening decades of binding Supreme Court precedent. Even under the "undue burden" test that applies to laws regulating (rather than banning) abortion, EO-25 fails: it imposes substantial burdens on patients that outweigh any benefits. Indeed, rather than protecting public health, EO-

25 undermines its stated goals by forcing people to carry unwanted pregnancies to term, seek abortions later in pregnancy, seek abortion care out of state, or attempt to self-induce an abortion, leading to far more person-to-person contact with healthcare providers and greater use of essential resources, including hospital capacity and PPE. Accordingly, a temporary restraining order and injunctive relief is necessary to prevent severe and irreparable harm to the Providers' patients; is consistent with the balance of hardships; and serves the public interest.

I. THE PROVIDERS WILL SUCCEED ON THE MERITS OF THEIR SUBSTANTIVE DUE PROCESS CLAIM.

The Providers are certain to succeed on the merits of their claim that EO-25 violates their patients' liberty rights under the Fourteenth Amendment and does not further its asserted interests. Indeed, several district courts have already rapidly reached that conclusion in similar cases. *See Preterm Cleveland* at 6; *Robinson* at 28; *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2, 5.

1. A COVID-19 ban on pre-viability abortions contravenes decades of U.S. Supreme Court and other precedent.

It is axiomatic that a State may not ban pre-viability abortion. *Casey*, 505 U.S. at 879 (holding that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability"); *see also Roe*, 410 U.S. at 163–64. Nearly a half-century ago, the U.S. Supreme Court recognized that the U.S. Constitution protects a woman's right to abortion, *Roe*, 410 U.S. at 153–54. A state may proscribe abortion only *after* viability, and even then it must allow abortion where necessary to preserve the life or health of the patient. *Id.* at 163–64. *Casey*'s adoption of the "undue burden" standard, under which "a provision of law [restricting pre-viability abortion] is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion," "d[id] not disturb the central holding of *Roe v. Wade*." 505 U.S. at 878-79. The Court again reaffirmed this core principle of constitutional law in 2016. *See Whole Woman's*

Health, 136 S. Ct. at 2299 (stating a law is invalid if it bans abortion "before the fetus attains viability" (quoting *Casey*, 505 U.S. at 878)).

Indeed, the Sixth Circuit has struck down laws that would inhibit "the vast majority of second-trimester abortion," recognizing that it would "clearly have the effect of placing a substantial obstacle in the path of a woman seeking a pre-viability abortion." *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201 (6th Cir. 1997); *see also EMW Women's Surgical Ctr., P.S.C. v. Meier*, 373 F. Supp. 3d 807 (W.D. Ky. 2019) (striking down ban on a second-trimester abortion method). Courts across the nation have come to the same conclusion.[23] This is because the availability of abortions for *some* women "does not [] alter the nature of the burden" that a ban on pre-viability abortion imposes on women who do not fall within an exception to that ban. *Isaacson v. Horne*, 716 F.3d 1213, 1227 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014).

Here, EO-25 operates as a ban on all abortions after 11 weeks LMP, and even earlier for patients ineligible for medication abortion. EO-25 acts as a complete ban on abortions in Tennessee, at minimum, for any person whose pregnancy will be past 19 weeks, 6 days LMP by April 30, 2020, the current expiration date of the Order. But in reality, it will act as a complete

[23] *See, e.g.*, *Edwards v. Beck*, 786 F.3d 1113, 1116 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 895 (2016); *Little Rock Family Planning Servs. v. Rutledge*, 397 F. Supp. 3d 1213 (E.D. Ark. 2019) (enjoining ban on abortions after eighteen weeks of pregnancy), *appeal docketed*, No. 19-2690 (8th Cir. Aug. 9, 2019); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 981 (2016) (ban on abortions after six weeks); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019) (ban on abortions starting at fifteen weeks); *Isaacson v. Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014) (ban on abortions starting at twenty weeks); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996), *cert. denied*, 520 U.S. 1274 (1997) (ban on abortions starting at twenty-two weeks); *Sojourner T. v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992), *cert. denied*, 507 U.S. 972 (1993) (ban on all abortions with exceptions); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69, 1371–72 (9th Cir. 1992), *cert. denied*, 506 U.S. 1011 (1992) (ban on all abortions); *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630–32 (M.D.N.C. 2019) (ban on abortions starting at twenty weeks).

ban for many more as the need for EO-25 is tied to the pandemic, which is expected to last for many more weeks, if not months.[24] Indeed, EO-25 itself supersedes a prior order that was scheduled to end on April 13, 2020.[25] Moreover, even if EO-25 is lifted on April 30, 2020, the backlog of patients will take several weeks to resolve, resulting in an even greater number of patients experiencing delays while trying to access abortion care or unable to get an abortion in Tennessee at all. Looney Decl. ¶¶ 46-48. For all these reasons, EO-25's application to procedural abortion should be struck down as an unconstitutional previability ban. *See Robinson* at 32-33 ("It is abundantly clear that the medical restrictions in the state health order are unconstitutional to the extent that they prevent a woman from obtaining an abortion before viability.").

2. EO-25 imposes an undue burden on people seeking access to abortion after 11 weeks LMP.

Defendants may argue that because of the current crisis, this Court should look to case law applying the "undue burden" balancing test to evaluate abortion *regulations* rather than the uniform precedent striking down pre-viability abortion *bans*. *See Whole Woman's Health*, 136 S. Ct. at 2309. That standard "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309. Even assuming *arguendo* that there could be emergency circumstances that could justify a State forcing people to remain pregnant against their will, the application of EO-25 to pre-viability abortions would be unconstitutional. Banning abortions after 11 weeks of pregnancy during the COVID-19 health and

[24] *See* Denise Grady, *Not His First Epidemic: Dr. Anthony Fauci Sticks to the Facts*, N.Y. Times, Mar. 8, 2020, https://www.nytimes.com/2020/03/08/health/fauci-coronavirus.html.
[25] *See* Governor Bill Lee, *Executive Order No. 18, An Order To Reduce the Spread of COVID-19 By Limiting Non-Emergency Healthcare Procedures* (Mar. 23, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee18.pdf.

economic crisis will undermine the very public health interests EO-25 purports to serve while causing other significant, irreparable harm.

As numerous district courts have already held, enforcing similar COVID-19 executive orders to ban procedural abortion is an "undue burden" on patients seeking to exercise their constitutional right. *Robinson* at 35 (finding it "substantially likely" that the medical restrictions at issue "pose an 'undue burden,' *Casey*, 505 U.S. at 786, that is so extreme that the restrictions effect 'a plain, palpable invasion of rights secured by the fundamental law,' *Jacobson*, 197 U.S. at 31"); *Preterm Cleveland* at 6 ("enforcement creates a substantial obstacle in the path of patients seeking pre-viability abortions"); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2-3 (holding Oklahoma imposed an "undue burden" on abortion access by imposing requirements that effectively deny a right of access to abortion).

EO-25, which operates as a ban on abortion after 11 weeks LMP, imposes severe burdens. The ban is in effect until at least April 30, 2020, and may be extended for weeks or even months, pushing many abortion patients past the date at which abortion care is available in Tennessee. Terrell Decl. ¶ 43; Looney Decl. ¶ 58. These patients will suffer far greater health risks associated with continued pregnancy and childbirth, as well as the emotional and financial burdens of carrying an unwanted pregnancy to term.

Moreover, even if some patients delayed by EO-25 are still eligible to obtain a legal abortion when EO-25 is lifted, many will be forced to undergo a procedure that entails greater risk and is more complicated and more expensive than a procedure available earlier in pregnancy. Looney Decl. ¶ 50. Abortion procedures after 15 weeks of pregnancy are only available at two health centers in the state, and none of the Providers perform abortions beyond 19 weeks and 6 days; patients pushed past this gestational age will not be able to obtain an abortion in the state at

all. Terrell Decl. ¶ 43; Looney Decl. ¶¶ 2, 15, 44. Thus, EO-25 overwhelmingly harms individuals seeking an abortion.

In addition to unnecessarily increasing the health risks to patients, delays caused by EO-25 will impose burden in the form of anxiety, anguish, and pain. *See supra* Section D. Delay can also increase the cost of abortion care, as well as the costs of travel, childcare, and in some cases time off work. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2314-18; *Planned Parenthood of Wis. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015); *McCormack v. Hiedeman*, 694 F.3d 1004, 1016-17 (9th Cir. 2012); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1356-60 (M.D. Ala. 2014). These burdens are exacerbated for poor and low-income patients in Tennessee. *See supra* Section D. The COVID-19 public health emergency deepens these burdens, leaving many people out of work, with children neither in school nor in childcare, and with restricted transportation options and limited or risky access to the support people on whom they might otherwise rely on for transport or childcare. *See supra* section A.

While the Providers share the Governor's commitment to preserving "personal protective equipment for emergency and essential needs" and preventing "community spread of COVID-19," a ban on all abortion care after 11 weeks LMP does not serve those interests. Nearly all abortions in Tennessee are provided in outpatient facilities, not hospitals, and require limited use of PPE. Looney Decl. ¶ 29; Terrell Decl. ¶ 29; Rovetti Decl. ¶ 24. In contrast, under current medical guidelines, even during the COVID-19 emergency, pregnant patients are advised to make multiple trips to healthcare facilities to obtain prenatal care, pregnancy screening, and, ultimately, labor and delivery, and possible C-section procedures, requiring vastly more PPE, hospital resources, and contact than procedural abortion care. *See supra* Section D. By preventing abortions from going

forward, EO-25 will lead to greater use of PPE, not less. *See id.*[26] Indeed, ACOG recommends close monitoring of pregnant patients and immediate hospitalization upon display of common pregnancy symptoms because they could be a manifestation of COVID-19. *Id.* Ultimately, pregnant patients will require care from health care providers using PPE, and much more so if they carry to term. *Id.*

Likewise, delaying patients in accessing abortion ultimately requires increased use of PPE. Even if EO-25 is limited to April 30, 2020, this delay will push patients to have longer and more complex procedures, including in some cases two-day procedures, that require more person-to-person contact and PPE. Looney Decl. ¶ 50; *see Pre-Term Cleveland II*, 2020 WL 1673310, at *2 (noting that a procedural abortion performed later in pregnancy requires more PPE). Alternatively, women will face increased travel and contacts outside of their communities to obtain an abortion in another state, potentially using public transportation, even though public health experts have advised the public to minimize activities outside the home. *See supra* Section D.

Well before EO-25 was issued, the Providers had already implemented extensive precautionary measures to prevent transmission of COVID-19 while continuing to offer essential care. Terrell Decl. ¶¶ 17-27; Looney Decl. ¶¶ 24-30; Rovetti Decl. ¶¶ 8-13. The Providers could make further progress in preserving PPE, as well as reducing overall contagion risks during the pandemic, were Defendants willing to temporarily waive medically unnecessary abortion restrictions that limit the Providers' ability to adapt to this crisis—such as Tennessee's requirement that patients make an extra trip to the health center 48 hours in advance to receive state-mandated

[26] *See, e.g.*, Rupsa C. Boeling, et al., *MFM Guidance for COVID-19*, Am. J. of Obstetrics & Gynecology (*available online* Mar. 19, 2020), https://www.sciencedirect.com/science/article/pii/S2589933320300367 (recommending reduced prenatal visits and increased use of telemedicine where possible, but providing that certain in-person visits, such as ultrasound and lab work, are necessary).

information before returning for an abortion. *See* Tenn. Code Ann. § 39-15-202(a)-(h); Rovetti Decl. ¶¶ 8-13.

In sum, even if banning or restricting abortion during the COVID-19 crisis would result in some small, temporary preservation of PPE at abortion clinics and small, temporary reduction in person-to-person interactions at abortion clinics, it will only be pushing those same pregnant patients into other medical settings where they will need more PPE and have more in-person encounters. Because EO-25 provides no benefit while causing significant harm, it violates the undue burden test.

3. *Jacobson v. Massachusetts* Does Not Require a Different Result.

The State may argue that language plucked from a 1905 case, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), rather than the Supreme Court's articulation in *Roe, Casey,* and *Whole Woman's Health* of the applicable standard when the right to abortion is at stake, governs the determination of whether EO-25's previability ban on abortion is constitutional. Such a suggestion, however, would be premised on a fundamental misunderstanding of *Jacobson*.

Far from granting states unfettered authority, modern constitutional law recognizes *Jacobson* as one of the early cases recognizing a liberty interest in declining medical treatment and treats *Jacobson* as having "balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). Accordingly, when citing *Jacobson* today, courts recognize that it does not supplant the modern substantive constitutional test applied to the right in question. *See, e.g.*, *Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F.3d 396, 419–20 (6th Cir. 2019) (applying strict scrutiny to substantive due process claim, even where the challenged program "may be an example of a state's proper exercise of its *parens-patriae* role" (citing *Jacobson*, 197 U.S. at 38)); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348, 352–

54 (4th Cir. 2011) (assuming strict scrutiny applies to free exercise challenge to vaccination requirement) (citing *Jacobson*, 197 U.S. at 12). The Supreme Court in *Casey* characterized *Jacobson* as "recognizing limits on government power" and cited *Jacobson* in support of its holding that "a State's interest in the protection of life falls short of justifying a plenary override of individual liberty claims." *Casey*, 505 U.S. at 857.

Jacobson itself recognizes that a state's powers to secure the health and safety of the public are limited. Here, EO-25 is not a proper exercise of that power for two reasons: *first*, a state may not, "under the guise of exerting a police power," invade rights guaranteed by the Constitution; *second*, a state may not exercise its police power in an arbitrary manner that fails to actually serve the State's asserted interests. *Jacobson*, 197 U.S. at 25, 28-29, 31 ("[N]o rule prescribed by a state . . . shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument.").

First, the plaintiff in *Jacobson* failed to demonstrate that the challenged mandatory smallpox vaccination violated his constitutional rights under the Fourteenth Amendment. *Id*. at 31.[27] Here however, by banning abortions prior to viability, EO-25 contravenes decades of Supreme Court precedent. Among those "rights secured by the fundamental law" recognized by the Supreme Court since it decided *Jacobson* is the right to reproductive autonomy. The Supreme Court has repeatedly recognized that the right to control one's reproductive life is "central to personal dignity and autonomy," and "central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992). *See* Alabama

[27] The liberty interest against vaccination remains weaker than the liberty interest in abortion. Even outside of the context of crises like the smallpox outbreak in *Jacobson* (i.e., when state police power is heightened), courts have rejected arguments that mandatory vaccinations violate the Constitution's protections for liberty. *See, e.g., Phillips v. City of New York*, 775 F.3d 538, 542 (2d Cir. 2015).

decision f. 10 ("The *Jacobson* Court--writing long before the development of modern substantive-due-process jurisprudence--found no clear invasion of any fundamental right. . . . But here, a fundamental right is clearly at issue."). As discussed at greater length above at Section I.1, under binding Supreme Court precedent, states cannot ban abortion prior to viability. Just four years ago, the Supreme Court reiterated that, because the right to abortion is fundamental, state intrusions on that right are subject to heightened judicial review. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309-10 (2016). Where, as here, the burdens outweigh the benefits, then the state's action constitutes "a plain, palpable invasion of rights" under *Jacobson.* See Alabama decision (holding under either the undue burden or *Jacobson* framework, "the plaintiffs have shown a substantial likelihood that, if read to effect a postponement of any abortion not required to protect the life and health of the mother, the medical restrictions are unconstitutional."); *see also Wong Wai v. Williamson*, 103 F. 1 (N.D. Cal. 1900) (enjoining state action targeting Chinese population because it deprived them of equal protection and liberty).[28]

As to the second limit on a state's police power recognized in *Jacobson*, the Court explained that the "means prescribed by the state" must bear a "real or substantial relation to the protection of the public health and the public safety." *Jacobson*, 197 U.S. at 31; *see also Women's Kansas City St. Andrew Soc'y v. Kansas City*, 58 F.2d 593, 598 (8th Cir. 1932). In other words, the State's action must *actually serve* its asserted interests. In *Jacobson*, the plaintiff sought to avoid smallpox vaccination, alleging harms to his health, but because "most of the members of the medical profession" and "high medical authority" agreed that smallpox vaccination furthered the

[28] Federal courts across the country have refused to abdicate their duty to step in where, as here, states have exercised their police powers to eliminate or unduly burden abortion access. *See S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *5 (citing *Jacobson*, 197 U.S. at 31); *Preterm Cleveland* at 6; *Robinson* at 6.

state's interest in protecting public health and safety, the Court held the statute was a proper exercise of police power. 197 U.S. at 23-24, 31, 35.

Here, however, as discussed *supra* in Section D, EO-25 frustrates, rather than serves, its stated goals of preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through nonessential patient-provider interactions. And unlike *Jacobson*, in the instant case, ACOG and seven other leading medical groups have stated that abortion care constitutes an essential healthcare service that, if delayed or denied, will impose severe health consequences on patients. *See supra* Section D. Likewise, the AMA opposes "government intrusion in medical care" during the COVID-19 crisis, including ""elected officials . . . exploiting this moment to ban or dramatically limit women's reproductive healthcare." *See S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2-3; *cf. Jew Ho v. Williamson*, 103 F. 10 (N.D. Cal. 1900) (holding resolution quarantining the "Chinese Quarter" after reported diagnoses of bubonic plague "had no real or substantial relation" to the purported public health purpose). Accordingly, Plaintiffs are likely to succeed on the merits of their claim that EO-25's ban on abortion after 11 weeks LMP is unconstitutional.

II. THE PROVIDERS' PATIENTS WILL SUFFER IRREPARABLE HARM IF THE BAN IS ENFORCED.

The Providers' patients will suffer serious and irreparable harm in the absence of a temporary restraining order and preliminary injunction. EO-25 prevents Tennessee patients from exercising their fundamental constitutional right to terminate a pregnancy. The Sixth Circuit has made clear that if "a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Am. Civil Liberties Union of Ky. v. McCreary Cty.*, 354 F.3d 438, 445 (6th Cir. 2003) (emphasis added) (*citing Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *accord Mich. State A. Phillip Randolph Inst. v. Johnson*, 833 F.3d 656, 669 (6th Cir. 2016) ("[W]hen constitutional

rights are threatened or impaired, irreparable injury is presumed." (internal citations omitted)); *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012) (same); *see also Taubman Co. v. Webfeats*, 319 F.3d 770, 778 (6th Cir. 2003) ("[T]he loss of constitutional rights for even a minimal amount of time constitutes irreparable harm."). Because EO-25, as applied to procedural abortion care, impairs the Providers' patients' rights guaranteed by the Fourteenth Amendment, it necessarily inflicts irreparable harm and should be enjoined in this application. *See Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 803 (S. D. Ohio 2019) (determining that Ohio's six-week abortion ban "would, per se, inflict irreparable harm" if enforced).

In addition, as many medical professional organizations emphasize, abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[29] Indeed, for some patients, such a delay will deprive them of their liberty and autonomy to choose abortion at all. Forcing patients to forgo abortion care and remain pregnant against their will inflicts serious physical, emotional, and psychological consequences that alone constitute irreparable harm. *See e.g.*, *Elrod*, 427 U.S. at 373–74; *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013). Likewise, a delay in obtaining abortion care causes irreparable harm by "result[ing] in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 832 (7th Cir. 2018) (alteration in original) (quoting *Van Hollen*, 738 F.3d at 796), *petition for cert. filed*, No. 18-1019 (Feb. 4, 2019). This "disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th

[29] ACOG et al., *supra* note 1.

Cir. 2018) (internal quotation marks omitted), *cert. denied sub nom. Andersen v. Planned Parenthood of Kan. & Mid-Mo.*, 139 S. Ct. 638 (Mem.) (2018).

Every district court that has considered this question has found that the deprivation of abortion care for a period of weeks or longer would result in irreparable injury. *Robinson* at 53 (holding that any denial of women's "fundamental right to privacy" constitutes irreparable injury); *Abbott*, 2020 WL 1815587 at *6 ("Plaintiffs and their patients will suffer irreparable harm in the absence of a temporary restraining order"); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *6 ("Plaintiffs here have demonstrated imminent, irreparable harm absent entry of injunctive relief, as their patients will be substantially delayed in or prevented from exercising their right to abortion access."); *Preterm-Cleveland* at 7 ("enforcement would, per se, inflict irreparable harm"). This Court should reach the same conclusion here.

III. THE BALANCE OF HARMS AND PUBLIC INTEREST SUPPORT INJUNCTIVE RELIEF.

The Providers' patients will suffer numerous irreparable harms without an injunction, and the requested relief will simply preserve "the status quo that has been in place for more than 40 years since *Roe* was decided, and some 25 years since *Casey* followed." *Preterm-Cleveland*, 394 F. Supp. 3d at 803. As the Sixth Circuit has made clear, "[w]hen a constitutional violation is likely . . . the public interest militates in favor of injunctive relief because it is always in the public interest to prevent violation of a party's constitutional rights." *Am. Civil Liberties Union Fund of Mich.*, 796 F.3d at 649 (alternations in original) (quoting *Miller v. City of Cincinnati*, 622 F.3d 524, 540 (6th Cir. 2010)); *accord Mich. State*, 833 F.3d at 669 (same); *Am. Freedom Def. Initiative v. Suburban Mobility Auth. for Reg'l Transp.*, 698 F.3d 885, 896 (6th Cir. 2012) ("[T]he public interest is promoted by the robust enforcement of constitutional rights . . . ."); *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994) (same).

Moreover, as set forth more fully above, EO-25 provides no benefits in the context of pregnant patients, who will need medical care in any scenario. And, even if EO-25, as applied to people seeking to end a pregnancy, in fact resulted in a temporary reduction of PPE (which it does not), that benefit would be vastly outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of either continuing an unwanted pregnancy or traveling to other states in search of time-sensitive medical care. *Robinson* at 54-55 (finding that the "substantial" injuries to patients that would result if some women were "forced to carry their pregnancies to term" vastly outweigh any benefits of the state's order, which did "relatively little" to "preserve healthcare resources and prevent close personal contact"); *Preterm-Cleveland* at 7 ("There is no demonstrated "beneficial amount of net saving of PPE…such that the net saving of PPE outweighs the harm of eliminating abortion."); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *6 (holding that the executive order's plain and palpable deprivation of a fundamental right outweighed the injury the public may suffer if those procedures are allowed to occur).

IV. A BOND IS NOT NECESSARY IN THIS CASE.

Plaintiffs respectfully request a waiver of the Federal Rule of Civil Procedure 65(c) bond requirement. *Appalachian Reg'l Healthcare, Inc. v. Coventry Health & Life Ins. Co.*, 714 F.3d 424, 431 (6th Cir. 2013); *see also Moltan Co. v. Eagle-Picher Indus.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (affirming district court decision to require no bond because of "the strength of [the plaintiff's] case and the strong public interest involved"); *Preterm-Cleveland*, 394 F. Supp. 3d at 804 (waiving bond). This Court should use its discretion to waive the bond requirement here, where the relief sought will result in no monetary loss to Defendants.

CONCLUSION

This Court should grant the Providers' motion for a temporary restraining order and/or preliminary injunction to enjoin Defendants and their officers, agents, servants, employees, and

attorneys, and any persons in active concert or participation with them from enforcing or requiring compliance with the EO-25 as applied to procedural abortions. Most urgently, the Providers seek relief on behalf of patients who are particularly burdened by EO-25 because of the time-sensitive nature of abortion care, including: (1) patients who, in the good faith professional judgment of the provider, will likely lose their ability to obtain an abortion in Tennessee if their procedures are delayed until after April 30, 2020; (2) patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a lengthier and more complex abortion procedure, which is only available at two clinics in Nashville and Memphis, if their procedures are delayed until after April 30, 2020; or (3) patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a two-day procedure—which is only available at two clinics in Nashville and Memphis, and which requires at least three separate visits to the provider—if their procedures are delayed until April 30, 2020. Providers must be allowed to consider all relevant factors, including the patient's medical history, familial circumstances, and any logistical and financial obstacles faced by the patient, in making such a determination.

The Providers' further request that this Court Grant such other and further relief as this Court may deem just, proper, and equitable, including that, during the pendency of EO-25, Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them be temporarily enjoined from enforcing the Delay Law's in-person counseling requirement.

Dated: April 13, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Memorandum of Law in Support of Motion for Temporary Restraining Order and/or Preliminary Injunction* has been served on the following counsel of record through the Electronic Filing System on this 13th day of April, 2020:

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/s/ Thomas H. Castelli
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Exhibit 1

IN THE DISTRICT COURT OF THE UNITED STATES FOR THE MIDDLE DISTRICT OF ALABAMA, NORTHERN DIVISION

YASHICA ROBINSON, M.D., et al., on behalf of themselves, their patients, physicians, clinic administrators, and staff,	)	
Plaintiffs,	)	
v.	)	**CIVIL ACTION NO. 2:19cv365-MHT (WO)**
STEVEN MARSHALL, in his official capacity as Alabama Attorney General, et al.,	)	
Defendants.	)	

OPINION

In December 2019, a novel coronavirus, which causes the disease now known as COVID-19, began to spread quickly around the world. On March 13, 2020, the President of the United States and the Governor of the State of Alabama declared the COVID-19 outbreak both a national and state emergency. Following these declarations, Alabama's State Health Officer issued a series of orders suspending certain public gatherings.

One of these orders, published on March 27, mandated the postponement of "all dental, medical, or surgical procedures," with two exceptions: (a) those "necessary to treat an emergency medical condition" and (b) those "necessary to avoid serious harm from an underlying condition or disease, or necessary as part of a patient's ongoing and active treatment." State Health Order of March 27, 2020 (doc. no. 88-1) at 6 ¶ 7.

Plaintiffs Yashica Robinson, M.D., Alabama Women's Center, Reproductive Health Services, and West Alabama Women's Center are abortion providers in Alabama. They seek in this ongoing litigation to enjoin enforcement against them of the State Health Officer's March 27 "Order of the State Health Officer Suspending Certain Public Gatherings Due to Risk of Infection by COVID-19," extended (with identical language as relevant here) on April 3.[1] *See* State Health Order of April 3, 2020 (doc.

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1. This ongoing litigation was initiated in May 2019 to challenge an Alabama statute that imposed criminal liability on abortion providers for nearly all abortions, completed or attempted, regardless of fetal viability.

no. 109-1). The defendants are Steven Marshall, the Attorney General, and Dr. Scott Harris, the State Health Officer.[2]

For the reasons described below, the plaintiffs' motion for a preliminary injunction will be granted in

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See Robinson v. Marshall, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (Thompson, J.). Because the statute contravened clear Supreme Court precedent, the court preliminarily enjoined enforcement of the statute as applied to pre-viability abortion. *See id.* On March 30, 2020, the plaintiffs then moved to supplement their complaint to challenge the March 27 state health order, and the court granted the motion.

2. Additional defendants are the district attorneys of the four counties where the plaintiff clinics are located, the Chairman of the Alabama Board of Medical Examiners, and the Chairman of the Medical Licensure Commission of Alabama. *See* First Amended Complaint (doc. no. 79) at 8-12 ¶¶ 20-28. These defendants were named in the original complaint in this case, *see* Complaint (doc. no. 1) at ¶¶ 18-25, but were voluntarily dismissed without prejudice after they agreed to abide by any relief issued by the court as to the statute originally challenged. *See* Orders (doc. nos. 44, 49). They were were added back in as parties in the amended complaint, *see* First Amended Complaint (doc. no. 79) at 8-12 ¶¶ 20-28, but have not appeared or participated in this phase of the litigation. When the court refers to the defendants in this opinion, the court is referring to only Steven Marshall, the Attorney General, and Dr. Scott Harris, the State Health Officer.

part, denied in part, and held in abeyance in part.[3]

I. BACKGROUND

In light of the ongoing COVID-19 emergency, Alabama's State Health Officer, Dr. Scott Harris, has issued a series of state health orders suspending certain public gatherings and placing limits on the performance of many medical "procedures." How the restrictions on medical procedures apply to abortion was not immediately clear. In part because abortion providers in Alabama operate in an atmosphere of hostility, the plaintiffs sought clarification of whether the restrictions allow the continued performance of abortions. Repeated efforts to

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3. In light of the temporary restraining order issued in *S. Wind Women's Ctr. LLC v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020) (Goodwin, J.), the motion for a preliminary injunction is held in abeyance to the extent that it seeks relief prohibiting application to *all* medication abortions of the medical restrictions of the State Health Officer's March 27, 2020 and April 3, 2020 state health orders (and to any future orders extending the application of the medical restrictions). The court will further consider whether relief is appropriate on this issue.

clarify the application of the medical restrictions to abortion, including by the plaintiffs and by this court, have yielded multiple inconsistent interpretations put forth by the defendants and their attorneys.

The initial state health order, entered on March 19, 2020, delayed "all elective dental and medical procedures." State Health Order of March 19, 2020 (doc. no. 88-4) at 4 ¶ 6. On March 20, an assistant general counsel for the Alabama Department of Public Health confirmed to the plaintiffs' counsel that the department "ha[d] no plans to apply the order to the [abortion] clinics." Decl. of Pls.' Counsel (doc. no. 73) at 46 ¶ 4.

However, on March 27, the State Health Officer amended the restriction on medical procedures in the March 19 state health order, postponing "all dental, medical, or surgical procedures," with two exceptions: (a) those "necessary to treat an emergency medical condition" and (b) those "necessary to avoid serious harm from an underlying condition or disease, or necessary as

part of a patient's ongoing and active treatment." State Health Order of March 27, 2020 (doc. no. 88-1) at 6 ¶ 7.

Counsel for the plaintiffs reached out again to the Alabama Department of Public Health, seeking to confirm that the March 27 state health order would still not be applied to the clinics. *See* Decl. of Pls.' Counsel (doc. no. 73) at 47 ¶ 9-10. As the plaintiffs interpreted the state health order, "medication abortion is not a procedure within the terms of the order and ... surgical abortion procedures fall within the exceptions." *Id.* at 47 ¶ 10. On March 29, the chief counsel to the attorney general stated in response to the questions from the plaintiffs' counsel that "we are unable to provide ... a blanket affirmation that abortions will, in every case, fall within one of the exemptions." *Id*. at 48 ¶ 14. In other words, under this interpretation, the restrictions on medical procedures may prohibit some abortions. Given this, the plaintiffs filed both a motion to file a supplemental complaint and a motion for a temporary restraining order and preliminary injunction, seeking to

immediately enjoin enforcement of the March 27 order against abortion providers and abortion clinics.

During an emergency on-the-record hearing on March 30, this court asked counsel for the defendants whether the State Health Officer had taken a position interpreting the revised March 27 state health order. *See* March 30, 2020, Hr'g Tr. (doc. no. 98) at 5:23-25, 21:17-22:1. Counsel for defendants represented that the State Health Officer had taken a position and had communicated that position to counsel's office. *See id.* at 6:1-7, 20:4-8, 22:2-5. Counsel explained that, per the State Health Officer's own interpretation, the March 27 state health order *did* apply to abortions and that abortions would only meet the exceptions where required to protect the life and health of the mother. *See id.* at 20:22-21:1, 22:6-10. In response to these representations, the court entered a broad temporary restraining order enjoining the application of the March 27 state health order against abortion providers and abortion clinics because the state health order, as so

described by defense counsel, operated as a prohibition on abortion during the pendency of the order. *See Robinson v. Marshall*, 2020 WL 1520243 (M.D. Ala. 2020) (Thompson, J.), *amended by Robinson v. Marshall*, 2020 WL 1659700 (M.D. Ala. 2020), *and appeal dismissed*, No.20-cv-11270-B (11th Cir. 2020).

As requested, the court gave the defendants 48 hours to respond to the plaintiffs' motion for a preliminary injunction and indicated that, upon receipt of the defendants' response, the court would immediately reconsider its decision. The court set the motion for a preliminarily injunction for a fast-track hearing a week later, on April 6.

Late in the day on April 1, before this court could hold a preliminary injunction hearing, the defendants filed a motion to dissolve the temporary restraining order and a motion to stay enforcement of that order pending appeal. In their briefs, the defendants advanced a new interpretation of the March 27 state health order. The defendants explained in a footnote that they actually

"did not mean to suggest that [protecting the life or health of the mother] are the only circumstances where an abortion would fit within one of the two exceptions" in the March 27 order. Defs.' Br. in Support of Mot. to Dissolve (doc. no. 89) at 26 n.30. Instead, the defendants indicated, this was just one example of a range of exceptions, though they did not affirmatively provide any other examples of how the exceptions would permit an abortion to proceed. *See id*. In an accompanying declaration, Dr. Scott Harris, the State Health Officer, explained that while "abortions constitute 'procedures'" under the order and that "no particular type of ... procedure categorically fits within one of the two exceptions," the determination of whether an exception applies "should be made by a doctor using reasonable medical judgment based upon his or her patient's individual circumstances." Decl. of State Health Officer (doc. no. 88-15) at 6 ¶¶ 22-23. But Dr. Harris still did not explain how the restrictions on medical procedures and associated exceptions in the March

27 order applied to abortions. The plaintiffs and the court were still in the dark on this point.

The court held an immediate hearing on April 3 to discuss, among other things, the defendants' revision in their April 1 brief (allowable abortions *not* limited to protecting the life or health of the mother) of their prior interpretation in the March 30 hearing (abortions limited to protecting the life or health of the mother), both of which, according to defense counsel, were made after talking with State Health Officer Harris. *See* March 30, 2020, Hr'g Tr. (doc. no. 98) at 6:1-7, 20:4-8, 22:2-5; April 3, 2020, Hr'g Tr. (doc. no. 123) at 35:9-13, 37:13-14. During the April 3 hearing, the court understood the defendants to make four critical clarifications of the scope of the restrictions on medical procedures and its exceptions. These clarifications, however, were not in the March 27 state health order, the defendants' brief, or Dr. Harris's declaration. As a result, the court reduced the defendants' four April 3 clarifications to writing.

- **First, "[i]n general, for an abortion, like any other procedure, a doctor should examine his or her patient, consider all circumstances, and determine whether one of the exceptions to the March 27 order applies. If they do, the procedure can go forward." *Robinson v. Marshall*, 2020 WL 1659700, at *3 (M.D. Ala. Apr. 3, 2020) (internal quotation marks, alteration, and citation omitted).**
- **Second, "if a healthcare provider determines, on a case-by-case basis in his or her reasonable medical judgment, that a patient will lose her right to lawfully seek an abortion in Alabama based on the March 27 order's mandatory delays ... then the abortion may be performed without delay pursuant to the exceptions in the March 27 order. The provider may examine his or her patient as needed to make the necessary determination regarding the age of the fetus." *Id*. (internal citation omitted).**
- **Third, "[i]f a healthcare provider determines, again**

on a case-by-case basis in his or her reasonable medical judgment, that the abortion cannot be delayed in a healthy way, then the abortion may be performed without delay pursuant to the exceptions in the March 27 order." *Id.* (internal quotation marks, alteration, and citation omitted). "[A] healthcare provider may also examine his or her patient to assess whether or not an abortion can be delayed for two weeks in a healthy way...." *Id.* (internal quotation marks omitted).

- **Fourth, and finally, "[t]he reasonable medical judgment of abortion providers will be treated with the same respect and deference as the judgments of other medical providers. The decisions will not be singled out for adverse consequences because the services in question are abortions or abortion-related." *Id.* (internal citation omitted).**

Based largely upon these clarifications, the court found that its initial March 30 temporary restraining order "swept too broadly," as the April 3 clarifications

"alleviated the court's most serious concerns underlying the issuance of its temporary restraining order." *Id*. The court thus narrowed its temporary restraining order by granting the defendants' motion to stay "to the extent that the court adopts as its order the clarifications agreed upon by the defendants." *Id.* at *4. The court did not stay the temporary restraining order in full because the defendants' clarifications of the state health order were not otherwise binding.[4]

Also on April 3, in the midst of the court's resolution of the motion to stay, the State Health Officer issued a new state health order that extended the relevant restrictions on medical procedures until April

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4. The court did not act on the motion to dissolve the temporary restraining order because it lacked jurisdiction to do so, given that the defendants had filed an appeal from the temporary restraining order to the Eleventh Circuit Court of Appeals. *See* Notice of Appeal (doc. no. 94); *see also Robinson v. Marshall*, 2020 WL 1659700, at *1 (M.D. Ala. 2020) (Thompson, J.). The appeal was later dismissed on April 4 pursuant to the parties' joint motion. *See* Letter from David J. Smith, Clerk of Eleventh Circuit Court of Appeals, to Clerk, Middle District of Alabama (doc. no. 122).

30. *See* State Health Order of April 3, 2020 (doc. no. 109-1). The restrictions on medical procedures in the March 27 order are identical to the restrictions in the April 3 order. As a result, the defendants agreed that "to the extent that any provider could lawfully have considered the April 17 expiration date from the March 27 order, that provider can instead consider the new expiration date of April 30, 2020." Order (doc. no. 113) at 2.

On April 5, counsel for the defendants submitted three additional written clarifications to the court's understanding of their April 3 oral clarifications. *See* Defs.' Notice (doc. no. 120).

- **First, the defendants additionally clarified that "a healthcare provider's assertion that a procedure meets one of the exceptions is not conclusive proof that the procedure meets one of the exceptions." *Id*. at 2.**
- **Second, the defendants additionally clarified that "any healthcare provider would still need to make an**

individualized determination for his or her patient as to whether losing the ability to have a procedure performed would cause serious harm to the patient." *Id*. at 3.

- **Third, the defendants additionally clarified that "the exceptions require that the risk to a patient's health be sufficiently serious." *Id*. at 3 (internal quotation marks, alteration, and citation omitted).**

During the April 6 preliminary injunction hearing, however, the State Health Officer, Dr. Scott Harris, put forth yet another interpretation of the restrictions on medical procedures. First, although the March 19 and March 27 state health orders had been interpreted differently, *see* Decl. of Pls.' Counsel (doc. no. 73) at 46 ¶ 4 ("no plans to apply" March 19 order to abortion clinics); *id.* at 48 ¶ 14 ("unable to provide ... blanket affirmation that abortions will, in every case, fall within one of the exemptions" to the March 27 order), Dr. Harris explained that he meant for the two orders "to have the same effect." April 6, 2020, Hr'g Tr. (doc. no.

133) at 12:17. Second, just as the determination of whether a particular procedure was elective or not in the March 19 order was "left ... to the discretion of the provider," *id*. at 11:8, for the current restrictions on medical procedures "[t]he providers are the ones who determine whether their procedure fits in those exceptions, not the health department." *Id.* at 49:19-21. Third, a provider can consider "whatever factors they would deem ... appropriate" when making a determination of whether the exceptions in a particular circumstance have been satisfied. *Id*. at 15:25–16:8. Fourth, the Department of Public Health does not intend for an abortion provider to necessarily delay even a single procedure as a result of the restrictions on medical procedures. *See id.* at 50:5-14. Fifth, and finally, the Department does not intend to review healthcare providers' decisions. *See id*. at 44:3-14.

To the extent that Dr. Harris's April 6 testimony represents the current interpretation of the restrictions on medical procedures, it reveals substantial common

ground between the two parties. Dr. Harris, for instance, made clear that the order was never intended to establish a blanket ban on abortions, but rather that the order contemplated "case-by-case determination[s]." *Id*. at 18:1-8. Dr. Harris further emphasized that providers, and not the Alabama Department of Health, should decide which factors to consider in deciding whether the order's exceptions apply. *See id.* at 13:18-21, 15:3-16:8. And Dr. Robinson, one of the plaintiffs in this litigation and the medical director of the plaintiff Alabama Women's Center, agreed that providers could delay abortions under certain circumstances. *See, e.g., id.* at 139:20-23 (for patients presenting with COVID-19 symptoms); *id*. at 155:8-10 (acknowledging possibility that at least one abortion could be safely postponed).

Nonetheless, Dr. Robinson testified that the defendants' additional written clarifications on April 5 to the court's understanding of their representations on April 3, caused her serious concern. According to her,

the written clarifications "made it very clear to me that my medical judgment was not the final decision when it came to the care decisions that I was making for my patients. I don't know who that is going to be left up to, but it made it very clear to me ... that [my medical judgment] would not be the final call." *Id*. at 125:7-13.

With all of these varying interpretations of the State's public health orders in mind, including the interpretations provided to the plaintiffs' counsel before the filing of the motion for temporary restraining order, the court now turns to the plaintiffs' motion for a preliminary injunction.

II. LEGAL STANDARDS

For a preliminary injunction to issue, the plaintiffs must establish the following: (1) a substantial likelihood of success on the merits; (2) a substantial threat of irreparable injury if the preliminary injunction is not granted; (3) that the threatened injury to the plaintiffs outweighs the threatened harm that the

injunction may cause the defendants; and (4) that granting preliminary injunctive relief is not adverse to the public interest. *See Ferrero v. Associated Materials, Inc.*, 923 F.2d 1441, 1448 (11th Cir. 1991); *Cate v. Oldham*, 707 F.2d 1176, 1185 (11th Cir. 1983). Further, where a court issues an injunction, "invalidating the statute entirely is not always necessary or justified;" rather, courts "may be able to render narrower declaratory and injunctive relief." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 323 (2006).

III. DISCUSSION

A. Likelihood of Success on the Merits

On March 27, 2020, the State Health Officer released an order that mandated the postponement of "all dental, medical, or surgical procedures," with two exceptions: (a) those "necessary to treat an emergency medical condition" and (b) those "necessary to avoid serious harm from an underlying condition or disease, or necessary as

part of a patient's ongoing and active treatment." State Health Order of March 27, 2020 (doc. no. 88-1) at 6 ¶ 7. On April 3, the State Health Officer entered a new order with identical medical restrictions that extended their expiration date from April 17 to April 30. *See* State Health Order of April 3, 2020 (doc. no. 109-1). As described above, these medical restrictions are susceptible to multiple readings. Over the course of this litigation, the defendants themselves have put forth several divergent interpretations of the medical restrictions, each with dramatically different implications for the plaintiffs.

Under one of the interpretations put forth by the defendants, for all of April, abortions can lawfully proceed without delay *only* when necessary to protect maternal life or maternal health. Based on the record that is now before the court, the medical restrictions, read pursuant to this interpretation, violate the Fourteenth Amendment. The court has no enforceable guarantee that the medical restrictions will *not* be

interpreted in this way by those tasked with their enforcement through 1975 Ala. Code § 22-2-14 or other mechanisms. *See* April 6, 2020, Hr'g Tr. (doc. no. 133) at 44:15-25 (Dr. Harris disclaiming knowledge of how the order might be enforced by others). The plaintiffs and the court also cannot rely on the defendants' non-binding assurances that they will not return to this interpretation. Accordingly, as explained below, the court finds that the plaintiffs have demonstrated a substantial likelihood of success on the merits.

1. Effects of Mandatory Postponement

On March 30, counsel for the defendants represented that, under the medical restrictions, abortions could lawfully proceed without delay only if they were necessary to protect the life and health of the mother. *See* March 30, 2020, Hr'g Tr. (doc. no. 98) at 20:22-21:1, 22:6-10. Under this reading, the medical restrictions would mandate the postponement until at least April 30 of all abortions not performed to protect maternal life

or maternal health.[5]

On the limited record before the court, the precise implications of the medical restrictions, interpreted in this way, remain murky. The COVID-19 crisis leaves the court and the parties in uncharted territory. But this much is clear: for at least some women,[6] a mandatory postponement until April 30 would operate as a

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5. This reading by the defendants is a plausible one. The restrictions allow medical procedures only when "necessary to treat an emergency medical condition" or "to avoid serious harm from an underlying condition or disease." State Health Order of March 27, 2020 (doc. no. 88-1) at 6 ¶ 7. While there are other plausible interpretations, the exception *can* be read to mandate postponement of any abortion not necessary to protect the life or health of the mother. And while the medical restrictions also allow for procedures that are "necessary as part of a patient's ongoing and active treatment," *id.*, the meaning of this provision, and whether and how it applies to abortion, is far from clear.

6. Dr. Robinson acknowledged that, at least hypothetically, it was "possible for there to be at least one abortion that can be safely postponed in [her] judgment." April 6, 2020, Hr'g Tr. (doc. no. 133) at 155:8-10. But "[l]egislation is measured for consistency with the Constitution by its impact on those whose conduct it affects.... The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894.

prohibition **of abortion, entirely nullifying their right to terminate their pregnancies, or would impose a substantial burden on their ability to access an abortion. The court provides examples here, though it cautions that the groups described do not constitute an exhaustive accounting of the medical restrictions' likely effects.**

First, for some group of women, a mandatory postponement will make a lawful abortion literally impossible. Under Alabama law, a woman's window for seeking a lawful abortion is limited: abortion becomes illegal when the probable postfertilization age of the fetus is at least 20 weeks. ***See*** **1975 Ala. Code, as amended, § 26-23B-5. A mandatory postponement until April 30 could thus extend a woman's pregnancy beyond the 20-week boundary imposed by law, making an abortion illegal.** ***See id.; see also*** **Pls.' Mem. in Supp. of a T.R.O. (doc. no. 73-1) at 2 (describing a woman who would be "pushed past the legal limit for abortion in Alabama if she does not obtain an abortion** ***this week*****").**

For other women, a postponement would make securing a lawful abortion far more difficult, or even impossible, including because of major logistical hurdles. Take, for instance, abortions performed after 14 weeks. Only one clinic in Alabama can perform such abortions, *see* April 6, 2020, Hr'g Tr. (doc. no. 133) at 78:4-9, which are normally a very small minority of all abortions performed statewide. *See* Induced Termination of Pregnancy Statistics (doc. no. 88-13) at 10. But if widespread delays to abortions occur, that clinic's limited capacity will likely become a serious barrier that renders lawful abortions entirely unavailable to some women in Alabama. *See* April 6, 2020, Hr'g Tr. (doc. no. 133) at 114:7-116:1. Women in Alabama might also face difficulty traveling to a clinic, *see id.* at 92:16-19, particularly if they live in the far reaches of the State; receiving necessary time off, *see id.* at 92:11-15, or child care, *see id.* at 92:24-93:1; and affording an abortion in the first place, *see id.* at 92:5-10. (In Alabama, an abortion requires two visits, so these obstacles must be navigated

twice. *See, e.g., id.* at 93:2-6.) A mandatory delay would greatly exacerbate many of these difficulties, unseating plans in the midst of a pandemic that has yielded widespread job loss, financial difficulty, and social isolation. *See, e.g., id.* at 113:11-13 (Dr. Robinson noting that "[w]ith each week that the pregnancy is delayed or termination of the pregnancy is delayed, that means there is an increased cost to the patient"); *id.* at 93:7-14 (noting the pandemic's impact on women seeking abortions, apart from the medical restrictions).[7] It is abundantly clear, and the court now finds, that a delay until April 30 will pose a tremendous, and sometimes insurmountable, burden for many women in Alabama.

Further, for some women, a postponement of an abortion may cause serious harm, or a substantial risk of serious harm, to that woman's health. Dr. Robinson

7. The court finds that Dr. Robinson is an expert in obstetrics and gynecology and abortion practice. *See* April 6, 2020, Hr'g Tr. (doc. no. 133) at 72:21-24.

credibly testified that, for at least some women, even a short delay can make an abortion (or the ongoing pregnancy) substantially riskier. *See, e.g.*, April 6, 2020, Hr'g Tr. (doc. no. 133) at 160:11-13 (discussing the increase in risk to patients as time passes); *id.* at 84:10-21 (discussing conditions associated with pregnancy); *id.* at 111:16-18 (noting that "each week that the abortion is delayed, it increases the risk to the patient"); *id.* at 112:18-24 (discussing risks of delay for women at risk of domestic violence or who have experienced rape); *id.* at 111:4-6 (noting that each week of delay "increases the risk of mortality"); *id.* at 107:2-11 (reading from a report concluding that, while complications are rare, the risk of serious complications increases with delay[8]); *id.* at 110:2-5 (summarizing a

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8. Dr. Robinson read from a report admissible as a learned treatise. *See* Committee on Reproductive Health Services: Assessing the Safety and Quality of Abortion Care in the U.S., National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* (2018); *see also* Fed. R. Evid. 803(18).

report concluding that "every week an abortion is delayed increases the risk [of mortality or death in the patient] by approximately 38 percent"[9]; *see generally id.* at 39:17-40:4 (Dr. Harris agreeing regarding Alabama's high rate of childbirth complications and maternal mortality). Abortion is a "very safe" procedure, *id.* at 110:24-25, but, for some patients, the relative risk can dramatically increase in a short time--and for these patients, a mandatory delay would create a substantial and serious risk of harm for many patients.

2. The Medical Restrictions' Constitutionality

The court finds that, in light of these effects, the plaintiffs have shown a substantial likelihood of success on the merits. That is, it is substantially likely that the medical restrictions, when interpreted to allow only

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9. Here, Dr. Robinson was summarizing a section of a learned treatise. *See* Linda A. Bartlett, *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 731, 735 (2004); *see also* Fed. R. Evid. 803(18).

those abortions necessary to protect the life and health of the mother, are unconstitutional. First, to the extent that they are interpreted to *prohibit* certain women from *ever* obtaining a pre-viability abortion--and force them, instead, to carry their pregnancies to term--the medical restrictions are very likely unconstitutional on the record before the court. And, second, to the extent that they impose substantial burdens upon or create serious and substantial health risks for women seeking abortions, they very likely pose an unconstitutional burden.

The plaintiffs and the defendants posit two distinct legal frameworks for this case. The plaintiffs suggest that the substantive-due-process analysis of *Roe v. Wade*, 410 U.S. 113 (1973), *Planned Parenthood of Southeast Pennsylvania v. Casey*, 505 U.S. 833 (1992), and other related cases should govern. The defendants argue that the court should instead turn to the State's emergency powers, as set forth in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905), in reviewing the

order. The court need not decide which legal framework applies, and instead assumes that they can and should be applied together in these circumstances. Under either framework, the plaintiffs have shown a substantial likelihood that, if read to effect a postponement of any abortion not required to protect the life and health of the mother, the medical restrictions are unconstitutional.

In *Jacobson*, amid a smallpox outbreak in Cambridge, Massachusetts, the City (acting pursuant to a state statute) mandated the vaccination of all of its citizens. The Court upheld the statute against a Fourteenth Amendment challenge, clarifying that the State's action was a lawful exercise of its police powers and noting that, "[u]pon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members." *Id.* at 27. Still, while *Jacobson* urges deferential review in times of emergency, it clearly demands that courts enforce the Constitution. *See id* at

28. Indeed, *Jacobson* explicitly contemplates a backstop role for the judiciary: "[I]f a statute purporting to have been enacted to protect the public health, the public morals, or the public safety, has no real or substantial relation to those objects, or is, beyond all question, *a plain, palpable invasion of rights secured by the fundamental law, it is the duty of the courts to so adjudge, and thereby give effect to the Constitution*." *Id.* at 30 (emphasis added); *see also Casey*, 505 U.S. at 857 (citing *Jacobson* for the proposition that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims").

Under *Jacobson*, therefore, a State's emergency response can still be unlawful if it impinges on a fundamental right in a "plain, palpable" way. *Jacobson*, 197 U.S. at 31.[10] Abortion is a fundamental right. *See,*

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10. The *Jacobson* Court--writing long before the development of modern substantive-due-process jurisprudence--found no clear invasion of any fundamental right. "Whatever may be thought of the expediency of

e.g., *Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005) (noting that "[t]he Supreme Court has recognized that fundamental rights include those guaranteed by the Bill of Rights as well as certain 'liberty' and privacy interests," which include the right "to abortion" (internal citation marks omitted)). And so *Jacobson* asks courts to protect it, even in times of emergency.

Here, the contours of the fundamental right at stake are described in *Roe*, *Casey*, and subsequent cases. As the Supreme Court has repeatedly re-affirmed, the Fourteenth Amendment protects a woman's right to terminate her pregnancy. *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) (noting that the Supreme Court "has determined and then redetermined that the Constitution offers basic protection to the woman's right to choose").

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this statute, it cannot be affirmed to be, beyond question, in palpable conflict with the Constitution." *Jacobson*, 197 U.S. at 31. Its inquiry thus ended with deference to the State's chosen policy. But here, a fundamental right is clearly at issue.

Still, the right to an abortion does have limits. As the Court recognized in *Casey*, a State may regulate pre-viability abortion to further its legitimate interests, but only if the laws in question do not place an "undue burden" on a woman's right to end her pregnancy. *Casey*, 505 U.S. at 876–79 (plurality opinion). Further, *Casey* itself held that, as applied to a *prohibition* (rather than a mere regulation) of pre-viability abortion, the State's interests *must* give way to a woman's right to terminate her pregnancy. "Before viability, the State's interests are not strong enough to support a prohibition of abortion ...." *Casey*, 505 U.S. at 846 (opinion of the Court); *see also Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (reiterating that "[b]efore viability, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy" (internal citations and quotation marks omitted)).

It is abundantly clear that the medical restrictions in the state health order are unconstitutional to the

extent that they *prevent* a woman from obtaining an abortion before viability--that is, where they effect a *prohibition* on abortion. Although *Casey* did not consider the interests presented by the defendants here (preserving healthcare resources and reducing close social contact), it plainly holds that the choice to terminate a pregnancy before viability must belong to the woman, not the State.[11] *Casey*, 505 U.S. at 846 (opinion of the Court); *see also Gonzales*, 550 U.S. at 146. To fully prevent this choice (by, for example, mandating that a woman's abortion be delayed until it is illegal) violates *Casey*'s central holding, and thus violates *Jacobson*, too. *See Jacobson*, 197 U.S. at 31; *see also id.* at 25 ("A local enactment or regulation, even if based on the acknowledged police powers of a state, must

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11. Indeed, the underlying logic of *Casey* centers on dignity and autonomy. *See Casey*, 505 U.S. at 852 (noting that, in the abortion context, "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law"). These essential values require the court's protection, even (or, maybe, especially) in an emergency.

always yield in case of conflict ... with any right which [the Constitution] gives or secures."). On the record before the court, even where the State's interests are reviewed with great deference, that violation is "plain, palpable," and constitutionally forbidden.[12] *Id.* at 31.

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12. *Jacobson* also discusses an exception for "[e]xtreme cases," when the police power is exerted "in such circumstances, or by regulations so arbitrary and oppressive in particular cases, as to justify the interference of the courts to prevent wrong and oppression." *Jacobson*, 197 U.S. at 38. *Jacobson* continues: "It is easy, for instance, to suppose the case of an adult who is embraced by the mere words of the act, but yet to subject whom to vaccination in a particular condition of his health or body would be cruel and inhuman in the last degree. We are not to be understood as holding that the statute was intended to be applied to such a case, or, if it was so intended, that the judiciary would not be competent to interfere and protect the health and life of the individual concerned." *Id.* at 38-39. *Jacobson* thus recognizes the need for exemptions to allow individuals to avoid serious, lasting impacts--but, unlike in the case of abortion, it did not face such an impact directly. *See generally In re Cincinnati Radiation Litig.*, 874 F. Supp. 796, 819 (S.D. Ohio 1995) (noting that *Jacobson* "involved minimally invasive procedures with no lasting side effects"). At minimum, this exception makes clear that *Jacobson* does not give blanket authority to the State, even in an emergency.

But even where they operate as a "regulation" of abortion, and not a "prohibition," the medical restrictions, if interpreted to mandate the postponement of any abortion not necessary to protect the life and health of the mother, are very likely unconstitutional. The court finds it substantially likely that they pose an "undue burden," *Casey*, 505 U.S. at 786, that is so extreme that the restrictions effect "a plain, palpable invasion of rights secured by the fundamental law," *Jacobson*, 197 U.S. at 31.

Under the "undue burden" analysis, a regulation of pre-viability abortion cannot survive if the "burdens a law imposes on abortion access" outweigh its benefits. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016). Put another way, "the court must determine whether, examining the regulation in its real-world context, the obstacle is more significant than is warranted by the State's justifications for the regulation." *Planned Parenthood Se., Inc. v. Strange*, 9 F. Supp. 3d 1272, 1287 (M.D. Ala. 2014) (Thompson, J.).

Considered in their real-world context, the medical restrictions will pose a substantial obstacle to many women in Alabama. In general, even a brief delay causes serious challenges: a 24-hour waiting period, though upheld in *Casey*, posed a close question for the Supreme Court. As this court later noted, the one-day wait "seems to have fallen just on the other side of the line from being a substantial obstacle." *Planned Parenthood Se., Inc. v. Strange*, 9 F. Supp. 3d 1272, 1286 (M.D. Ala. 2014) (Thompson, J).

Here, counted from the initial imposition of the medical restrictions, a delay could exceed *one month*--even if the restrictions are not extended--and the lengthy postponement period sweeps in many women.[13] The

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13. The defendants have admitted that the course of the pandemic could last three or four months, beginning in early March. *See* April 6, 2020, Hr'g Tr. (doc. no. 133) at 37:21-22. The medical restrictions could certainly be extended beyond April 30. *See, e.g., id.* at 104:11-14 (Dr. Robinson explaining that she understands the medical restrictions could be extended past April 30).

possible implications of a postponement, applied across the board, are varied and deeply troubling, as the court discussed above. The medical restrictions would amplify existing challenges, pose severe health risks, and render abortions functionally unavailable for at least some women. Most importantly, however, if the restrictions are read to delay any abortion not necessary to protect the life and health of the mother, then abortion providers would be categorically unable to even *consider* these factors in determining whether an abortion can or should be postponed.

These extensive burdens must be balanced against the interests put forth by the defendants: the preservation of healthcare resources (including personal protective equipment) and the prevention of close social contact.[14]

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14. In *Casey* and its progeny, regulations of abortions are typically justified by two legitimate interests: "preserving and promoting fetal life," *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007), and protecting the health of the woman, *see id.* at 146. Here, the court assumes that the defendants' interests in preserving healthcare resources and preventing social

***See, e.g.*, April 6, 2020, Hr'g Tr. (doc. no. 133) at 10:19:11:1 (describing the interests motivating the restrictions); *id.* at 8:3-9:3 (describing the State's interest in conserving personal protective equipment); *id.* at 9:16-10:2 (social distancing); Decl. of State Health Officer (doc. no. 88-15) at ¶ 24 (discussing reasons for mandating delay of abortions). The court recognizes the urgency and breadth of the State's COVID-19 response. But compared to the serious burdens imposed by the medical restrictions, the benefits to the State and the public fall far short.**

First, most abortions and related appointments require a limited amount of personal protective equipment (PPE), and a delayed abortion does not erase even the patient's short-term need for medical care. For instance, the defendants have stated that normal prenatal visits and mandatory pre-abortion examinations can

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contact may legitimately support a regulation of abortion during an emergency.

proceed as scheduled under the medical restrictions. *See, e.g.*, April 3, 2020, Hr'g Tr. (doc. no. 123) at 42:4-16; *see also Robinson v. Marshall*, 2020 WL 1659700, at *3 (M.D. Ala. 2020) (Thompson, J.) (court memorializing this); Defs.' Clarifications (doc. no. 120) at 2-3 (not disputing it).

Beyond those appointments, abortions themselves require only a limited amount of PPE.[15] *See* Corr. Robinson Decl. (doc. no. 99-1) at 13 ¶ 30 (discussing the PPE required for a medication abortion); April 6, 2020, Hr'g Tr. (doc. no. 133) at 54:14-55:2 (same); Corr. Robinson Decl. (doc. no. 99-1) at 13 ¶ 30 (discussing the

15. Indeed, the State Health Officer conceded that administering a medication abortion "may not itself" require the use of PPE. Decl. of State Health Officer (doc. no. 88-15) at ¶ 24. He justified delaying medication abortions based on the risk of possible complications requiring a surgical abortion or emergency medical care. Decl. of State Health Officer (doc. no. 88-15) at ¶ 24. However, the rate of such complications is extremely low, a fact that Dr. Harris admitted he did not know when he made the decision that medication abortions should be postponed. *See, e.g.*, April 6, 2020, Hr'g Tr. (doc. no. 133) at 79:2-15 (discussing the rate of complications); *id.* at 55:23-56:1.

PPE required for procedural/surgical abortions); April 6, 2020, Hr'g Tr. (doc. no. 133) at 132:10-18 (same). Further, the risk of a serious complication of abortion is extremely low. *See id.* at 78:11-16. For some delays, therefore, some amount of PPE will be conserved; for other delays, a very small amount of PPE (if any) will be conserved; and for other delays, any PPE conserved will simply be re-routed to routine prenatal visits or, often, appointments required to address the complications of pregnancy.[16] *See, e.g., id.* at 51:6-8 (Dr. Harris's expectation that a pregnant woman should continue to receive prenatal care under the medical restrictions). Indeed, as to hospital resources more generally, the medical restrictions are very unlikely to make a significant difference: the rate of abortions that require hospitalization is extremely low. *See, e.g.*, April 6, 2020, Hr'g Tr. (doc. no. 133) at 79:2-23

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16. With respect to any PPE that *is* conserved, the defendants have not put forward evidence regarding how it might be used or re-directed to hospitals that are experiencing shortages.

(discussing the rate of complications and noting that most complications can be managed in an outpatient setting). Put simply, even when measured on a very short time horizon, the benefits of the medical restrictions as applied to abortions, are limited, particularly compared to the burdens that they impose.

Further, if an abortion is delayed and then does *not* proceed, the medical restrictions may backfire over time: PPE usage will often be higher and provider-patient contact will likely increase. A typical uncomplicated pregnancy will require *multiple* prenatal appointments and delivery, each of which require PPE, even if there are no unforeseen complications. *See* Corr. Robinson Decl. (doc. no. 99-1) at 13 ¶ 32; April 6, 2020, Hr'g Tr. (doc. no. 133) at 125:19-126:5 (Dr. Robinson); *see also id.* at 51:6-8 (Dr. Harris's expectation that a pregnant woman should receive prenatal care). A complicated pregnancy would require far more. *See* Corr. Robinson Decl. (doc. no. 99-1) at 13 ¶ 32. At least some of these needs will emerge before the restrictions expire, especially if they

are further extended.

Thus, assuming that the defendants' interests posited here may be considered and granting them substantial deference, the court finds that the burden imposed by the medical restrictions is undue. Indeed, it is substantially and plainly undue--enough that to impose it impinges the right to an abortion in a "plain, palpable" fashion. *Jacobson*, 197 U.S. at 31.[17]

Finally, the defendants also rely upon *Smith v. Avino*, 91 F.3d 105, 109 (11th Cir. 1996), *abrogated on unrelated grounds by Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83 (1998), arguing that it supersedes the *Casey* framework and imposes far more deferential review. In *Avino*, reviewing an evening curfew imposed in the wake of Hurricane Andrew, the Eleventh Circuit held that, "when a curfew is imposed as an emergency measure in

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17. As discussed above, the court assumes that *Jacobson* applies and dictates substantial deference to the state. If only *Casey* applies, the analysis here remains valid and comes to the same conclusion--albeit even more firmly, because the defendants' stated interests would be considered with greater scrutiny.

response to a natural disaster, the scope of review in cases challenging its constitutionality is limited to a determination whether the [executive's] actions were taken in good faith and whether there is some factual basis for the decision that the restrictions ... imposed were necessary to maintain order." *Avino*, 91 F.3d at 109 (internal citations, alteration, and quotation marks omitted). But unlike the instant case, *Avino* addressed only temporary, partial restrictions on certain fundamental rights, *see id.*, and explicitly addressed times "when a *curfew* is imposed ... in response to a *natural disaster*." *Id.* (emphasis added). This court declines to extend it beyond those contexts.[18]

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18. Further, in arguing that *Avino* should be extended to state actions that impact fundamental rights in other contexts, including where such rights may be permanently denied, the defendant's argument proves too much. In an emergency, the defendants suggest, a reviewing court may investigate only "whether the executive's actions were taken in good faith and whether there is some factual basis for the decision that the restrictions imposed were necessary to maintain order." *Avino*, 91 F.3d at 109 (internal citations, alteration, and quotation marks omitted). But under this logic, with only "good faith" and "some factual basis," government actors in any

Notably, the court's conclusions come despite the substantial deference to the State that *Jacobson* and *Avino* recommend. In light of the ongoing emergency, the court gives great weight to the State's interests: preventing social contact, preserving personal protective equipment, and preserving other healthcare resources. But the court must nonetheless intervene. A fundamental right is at stake; that right, for some women, is subject to a possible *permanent denial*, not a mere delay or temporary denial; and, based on the Supreme Court's clear holdings on the right to an abortion, the State's asserted interests, even when viewed with a tremendous degree of deference, cannot support the accompanying deprivation of a Fourteenth Amendment right.

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emergency could permanently curtail nearly *any constitutional right*. *Id.* That assertion, which flows directly from the State's argument, is extreme, and plainly false; *Avino* should not be read to stand for such a broad proposition. *Compare id.* (asserting that fundamental rights may be "temporarily limited or suspended" in emergencies, citing *Korematsu v. United States*, 323 U.S. 214 (1944)) *with Trump v. Hawaii*, 138 S. Ct. 2392, 2423 (2018) (noting that "*Korematsu* was gravely wrong the day it was decided").

The plaintiffs have, therefore, demonstrated a likelihood of success on the merits.

3. Appropriate Remedy

Still, the medical restrictions' constitutional problems do not justify the plaintiffs' requested remedy: an injunction of the medical restrictions, as applied to abortion providers, in their entirety. The court declines to use a sledgehammer where a scalpel will do. *Cf. Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 323 (2006) (holding that "invalidating the statute entirely is not always necessary or justified" when "lower courts may be able to render narrower declaratory and injunctive relief"). Accordingly, rather than enjoin the medical restrictions in full, the court will enjoin them only to prevent those applications of the medical restrictions that are inconsistent with the mandates of the Constitution, as described above.

The defendants have put forward multiple interpretations of the medical restrictions. Based upon

the defendants' most recent clarifications, the medical restrictions grant substantial leeway to providers acting in their reasonable medical judgment (in contrast to the previous interpretation, described above, which was far more restrictive). For instance, the defendants have clarified that the medical restrictions allow providers to consider a range of factors in determining whether a procedure can lawfully proceed as scheduled. When asked *which* factors, Dr. Harris pointed only to providers' clinical judgment. "[T]he clinician should use their clinical judgment and consider *whatever factors they would deem would be appropriate* to make that determination [of whether a procedure falls within one of the order's exceptions]." April 6, 2020, Hr'g Tr. (doc. no. 133) at 16:3-5 (testimony of Dr. Scott Harris) (emphasis added). Ultimately, "[t]he providers are the ones who determine whether their procedure fits in [the order's] exceptions, not the health department." *Id.* at 49:19-21.

By the State Health Officer's telling, then, an

abortion provider is permitted to consider all of those factors that he or she reasonably deems relevant in deciding whether an abortion can be delayed. As Dr. Robinson credibly testified (and as the court now finds), an abortion provider might reasonably consider many factors, including: whether the woman's abortion would become riskier because of a substantial delay, *see* April 6, 2020, Hr'g Tr. (doc. no. 133) at 105:22-23; the patient's "socioeconomic factors, her medical history, [or] the circumstances surrounding her decision to proceed with an abortion," *id.* at 158:21-23; and the "logistics of getting back to the clinic, taking the time off of work, [and] coordinating care for their children," *id.* at 114:1-2. Where these considerations (or others) are relevant to a provider's determination under the medical restrictions, that provider may lawfully consider them, and Dr. Harris explicitly disclaimed any interest in second-guessing those decisions. *See* April 6, 2020, Hr'g Tr. (doc. no. 133) at 44:3-10.

The court assumes that, if they were only read in

this way, the medical restrictions *would not* constitute an unlawful prohibition of any woman's abortion. Rather, they would allow a provider to consider whether a patient's abortion must proceed as scheduled because that patient will not, or likely will not, be able to terminate her pregnancy if it is postponed.

Still, the plaintiffs have expressed a lingering reticence to trust the representations of the defendants, particularly with respect to non-binding interpretations that emerged after multiple days of litigation. The court finds these concerns warranted: "Mid-litigation assurances are all too easy to make and all too hard to enforce, which probably explains why the Supreme Court has refused to accept them." *W. Alabama Women's Ctr. v. Williamson*, 900 F.3d 1310, 1328 (11th Cir. 2018) (affirming an injunction despite a non-binding clarification from the State), *cert. denied sub nom. Harris v. W. Alabama Women's Ctr.*, 139 S. Ct. 2606 (2019); *see also Stenberg v. Carhart*, 530 U.S. 914, 940 (2000) (cautioning against accepting an Attorney General's

non-binding interpretation of a state law). Despite the defendants' most recent clarifications, therefore, an injunction must issue.

A clear, enforceable standard is especially essential given the long history of anti-abortion sentiment in Alabama and nationwide. *See, e.g.*, *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1334 (M.D. Ala. 2014) (Thompson, J.), *as corrected* (Oct. 24, 2014), *supplemented*, 33 F. Supp. 3d 1381 (M.D. Ala. 2014), *and amended*, No. 2:13-cv-405-MHT, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014). Said history is no secret to any abortion provider in Alabama--it is evident "when she opens the newspaper, drives by a group of protesters at a clinic, or learns that another piece of legislation concerning abortion has been enacted." *Id.*[19] As the court noted, this observation "does not imply that such

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19. Just last year, this court preliminarily enjoined a law that imposed a "near-total ban on abortion." *Robinson v. Marshall*, 415 F. Supp. 3d 1053, 1055 (M.D. Ala. 2019) (Thompson, J.).

activities are illegal, improper, or morally wrong; indeed, the right to express deeply held beliefs is of the utmost importance." *Id.* But these events have inarguably yielded a "climate of violence, harassment, and hostility," *id.*, that pervades the day-to-day work of abortion providers in Alabama.[20]

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20. These challenges clearly persist. As one example, Dr. Robinson regularly receives threatening and harassing messages online and in person because she is an abortion provider, including a recent social media message expressing "hope" that she contracts COVID-19. *See* Suppl. Robinson Decl. (doc. no. 110-1) at 3 ¶ 8; Attachment 2 (doc. no. 110-2). Anti-abortion advocates, including another physician, have also filed complaints against Robinson with the Board of Medical Examiners. *See* Suppl. Robinson Decl. (doc. no. 110-1) at 3 ¶ 8-9; April 6, 2020, Hr'g Tr. (doc. no. 133) at 168:20-169:13. Although these complaints have never been substantiated, they have triggered investigations, which Dr. Robinson must now report each time she renews her medical license. *See* Suppl. Robinson Decl. (doc. no. 110-1) at 3 ¶ 8; April 6, 2020, Hr'g Tr. (doc. no. 133) at 169:14-19. Protesters have also filed complaints against AWC with the Alabama Department of Public Health, which reliably lead to investigations of the clinic, disrupting the clinic's practice though never leading to a finding of any wrongdoing. *See id.* at 122:13-25. Dr. Robinson testified that these tactics of protesters "keep[] me and my staff constantly feeling on edge, I mean, wondering from day to day what the next attack is going to be and how effective they will be." *Id.* The court finds Dr. Robinson's testimony credible.

In this environment, a provider might reasonably fear that prosecutions under the medical restrictions will proceed despite the defendants' on-the-record interpretations.[21] But to proceed with lawful abortions, providers must be *confident* that their exercise of reasonable medical judgment will not be met with unconstitutional or bad-faith prosecution. That is, physicians acting lawfully cannot be left to "the tender mercies of a prosecutor's discretion and the vagaries of a jury's decision," *W. Alabama Women's Ctr.*, 900 F.3d at 1329, or wrongly deterred from performing lawful procedures in the first place. *See generally Colautti v. Franklin*, 439 U.S. 379, 396 (1979) ("The prospect of

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21. These fears are justified by, among other things, recent events. Dr. Robinson testified that, since the medical restrictions went into effect, protestors have called the police asking them to "come and check on us," "thinking that we were supposed to be shut down" and urging investigations from the police and the Department of Public Health. April 6, 2020 Hr'g Tr. (doc. no. 133) at 121:3-21. The police have responded in person at least once since the pandemic began. *See id.* at 121:22-122:9. In general, these efforts (and others like them) keep Dr. Robinson and her staff "constantly feeling on edge." *Id.* at 122:23.

such disagreement, in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination ..., could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment.").

Given these realities, guaranteeing practical, reliable flexibility to abortion providers requires an injunction. But the court's injunction will be limited in scope. It will essentially reduce to an order the most recent representations made by the defendants (and, in particular, by Dr. Scott Harris), rendering them enforceable and locking them into place. To the extent that the state health order is applied in a fashion inconsistent with this mandate, and *only* to that extent, it will be enjoined.

B. Irreparable Harm

The plaintiffs have demonstrated that the medical restrictions, if left in place, would result in imminent,

irreparable harm to some, though not all, of their patients. The medical restrictions are clearly susceptible to an interpretation that would permanently prevent or impose plainly undue burdens upon abortions for some women, denying those women their fundamental right to privacy. As the Eleventh Circuit has held, any denial of that right constitutes "irreparable injury." ***Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville, Fla.,*** **896 F.2d 1283, 1285 (11th Cir. 1990). The effects of such a denial are particularly severe in the abortion context: the Seventh Circuit recently noted that a "delay in obtaining an abortion can result in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal."** ***Planned Parenthood of Wisconsin, Inc. v. Van Hollen*****, 738 F.3d 786, 796 (7th Cir. 2013). For those women approaching 20 weeks of pregnancy, such harms are especially acute. As described above, in the instant case, these harms include an increase in medical risk,** ***see*** **April 6, 2020, Hr'g Tr. (doc. no. 133) at 105:19-23,**

106:17-107:11, 109:20-25, and serious logistical challenges, *id.* at 112:25-114:4, including substantial travel, *see, e.g., id.* at 92:16-19.

Moreover, the plaintiffs have demonstrated that, despite the defendants' clarifications stated on the record, they remain at serious risk of prosecution, including because, without an injunction, the defendants would retain the option to revise their interpretation of the medical restrictions. Such enforcement also poses a threat of imminent harm.

C. The Balance of Hardships

The plaintiffs have shown that, with no injunction in place, some women would very likely be forced to carry their pregnancies to term; others would face serious obstacles that render obtaining an abortion very difficult. Further, they have demonstrated a meaningful risk of unwarranted prosecutions that deter abortion providers and, in turn, create a substantial obstacle for women seeking abortions. These injuries are substantial.

In contrast, the state health order, as applied to abortion providers, contributes relatively little to the State's efforts to preserve healthcare resources and prevent close personal contact. (The court describes and weighs these benefits in detail above.) As importantly, the court's injunction is narrow, minimizing harm to the defendants by embracing recent clarifications made on the record by the State Health Officer. In sum, the court finds that the balance of hardships tips towards the plaintiffs.

D. The Public Interest

The court also finds that a narrow preliminary injunction serves the public interest. The defendants have described serious and urgent conditions--conditions that merit an equally serious and urgent response. But, based on the current record, the defendants' efforts to combat COVID-19 do not outweigh the lasting harm imposed by the denial of an individual's right to terminate her pregnancy, by an undue burden or increase in risk on

patients imposed by a delayed procedure, or by the cloud of unwarranted prosecution against providers.

Still, the court recognizes the demands of the ongoing crisis. By issuing a narrowly tailored injunction, the court simultaneously insists, on the one hand, that abortion providers shoulder some of the burden of the State's widespread response--and protects, on the other, the right to privacy guaranteed by the United States Constitution.

****

In accordance with this opinion, the court will issue an appropriate injunction separately. The bond requirement of Fed. R. Civ. P. 65(c) will be waived.

DONE, this the 12th day of April, 2020.

/s/ Myron H. Thompson
UNITED STATES DISTRICT JUDGE

Exhibit 2

FILED
United States Court of Appeals
Tenth Circuit

April 13, 2020

Christopher M. Wolpert
Clerk of Court

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

SOUTH WIND WOMEN'S CENTER LLC, d/b/a Trust Women Oklahoma City, on behalf of itself, its physicians and staff, and its patients; LARRY A. BURNS, D.O, on behalf of himself and his staff and his patients; COMPREHENSIVE HEALTH OF PLANNED PARENTHOOD GREAT PLAINS INC., on behalf of itself, its physicians and staff, and its patients,

Plaintiffs - Appellees,

v.

J. KEVIN STITT, in his official capacity as Governor of Oklahoma; MICHAEL HUNTER, in his official capacity as Attorney General of Oklahoma; DAVID PRATER, in his official capacity as District Attorney for Oklahoma County; GREG MASHBURN, in his official capacity as District Attorney for Cleveland County; GARY COX, in his official capacity as Oklahoma Commissioner of Health; MARK GOWER, in his official capacity as Director of the Oklahoma Department of Emergency Management,

Defendants - Appellants.

THE AMERICAN CENTER FOR LAW AND JUSTICE; SIXTY-TWO MEMBERS OF THE OKLAHOMA SENATE AND OKLAHOMA HOUSE OF REPRESENTATIVES; STATE OF UTAH; STATE OF ALABAMA; STATE

No. 20-6045
(D.C. No. 5:20-CV-00277-G)
(W.D. Okla.)

OF ALASKA; STATE OF ARKANSAS; STATE OF IDAHO; STATE OF INDIANA; STATE OF KENTUCKY; STATE OF LOUISIANA; STATE OF MISSISSIPPI; STATE OF MISSOURI; STATE OF MONTANA; STATE OF NEBRASKA; STATE OF OHIO; STATE OF SOUTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF TEXAS; STATE OF TENNESSEE; STATE OF WEST VIRGINIA; DISTRICT OF COLUMBIA; STATE OF CALIFORNIA; STATE OF COLORADO; STATE OF CONNECTICUT; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF MAINE; STATE OF MASSACHUSETTS; STATE OF MINNESOTA; STATE OF NEVADA; STATE OF NEW MEXICO; STATE OF NEW YORK; STATE OF OREGON; STATE OF PENNSYLVANIA; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; ARCHDIOCESE OF OKLAHOMA CITY; CATHOLIC CONFERENCE OF OKLAHOMA; OKLAHOMA BAPTISTS; OKLAHOMA FAITH LEADERS; ROMAN CATHOLIC DIOCESE OF TULSA

Amici Curiae.

ORDER AND JUDGMENT*

* After examining the appellate filings, this panel has determined unanimously that oral argument would not materially assist in the determination of this appeal. *See* Fed. R. App. P. 34(a)(2); 10th Cir. R. 34.1(G). The case is therefore ordered submitted without oral argument. This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

Before **LUCERO**, **BACHARACH**, and **MORITZ**, Circuit Judges.

In connection with the current COVID-19 pandemic, the Governor of Oklahoma issued an Executive Order ("EO") on March 24 declaring a state of emergency and stating that "Oklahomans and medical providers in Oklahoma shall postpone all elective surgeries, minor medical procedures, and non-emergency dental procedures until April 7." Fourth Am. Exec. Order 2020-07, ¶ 18, *South Wind Women's Ctr. LLC v. Stitt*, No. 5:20-cv-00277-G (W.D. Okla. Mar. 30, 2020), ECF No. 1-1. The EO was amended on April 1 to extend the postponement of elective surgeries and minor medical procedures until April 30. The EO did not elaborate on the specifics of "elective surgeries" or "minor medical procedures." But a press release by the Governor on March 27 stated that the postponement of elective surgeries and minor medical procedures referenced in the EO applied to "any type of abortion services as defined in 63 O.S. § 1-730(A)(1) [that] are not a medical emergency as defined in 63 O.S. § 1-738.1[A] or otherwise necessary to prevent serious health risks to the unborn child's mother." Mar. 27, 2020 Press Release, "Governor Stitt Clarifies Elective Surgeries and Procedures Suspended Under Executive Order," *South Wind Women's Ctr.*, No. 5:20-cv-00277-G (W.D. Okla. Mar. 30, 2020), ECF No. 1-2.

Plaintiffs-Appellees ("Appellees") are three of the four providers of abortion services in Oklahoma, and they promptly brought suit in the Western District of

Oklahoma against the Governor and various other state officials ("Appellants"), challenging the suspension of abortion services as unconstitutional. They filed a Motion for Temporary Restraining Order and/or Preliminary Injunction on March 31. The district court granted the motion for a temporary restraining order ("TRO") in part on April 6, ordering that: (1) "The prohibition on surgical abortions may not be enforced with respect to any patient who will lose her right to lawfully obtain an abortion in Oklahoma on or before the date of expiration of the Executive Order; and" (2) "The prohibition on medication abortions may not be enforced." Mot. to Stay, Attach. G at 13. Appellants appealed that order on April 7 and then filed two motions with this court—an emergency motion for stay pending appeal and a motion to expedite the appeal. On expedited review, we dismiss the appeal for lack of jurisdiction and deny the emergency motion for stay pending appeal as moot.

"Because the district court's order took the form of a temporary restraining order, we must address our own jurisdiction. Temporary restraining orders are not ordinarily appealable, but preliminary injunctions are appealable." *Tooele Cty. v. United States*, 820 F.3d 1183, 1186 (10th Cir. 2016); *see also Populist Party v. Herschler*, 746 F.2d 656, 661 n.2 (10th Cir. 1984); 16 Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, Federal Practice and Procedure § 3922.1 (3d ed. 2014) ("The general rule is that orders granting, refusing, modifying, or dissolving temporary restraining orders are not appealable under [28 U.S.C.] § 1292(a)(1) as orders respecting injunctions."); 15A Charles Alan Wright, Arthur R. Miller & Edward H. Cooper, Federal Practice and Procedure § 3914.3 (2d ed. 1992) ("It long

has been settled as a general matter that § 1292(a)(1) permits appeal from decisions with respect to preliminary injunctions, but not from temporary restraining order decisions.").

But this court has noted two exceptions to the general rule that denial of a TRO is not appealable under 28 U.S.C. § 1292(a)(1): (1) "when the order in reality operates as a preliminary injunction" and (2) "when the order is appealable as a final order under 28 U.S.C. § 1291." *Populist Party*, 746 F.2d at 661 n.2 (internal quotation marks omitted). The second exception does not apply here; this TRO is clearly not appealable as a final order. Which leaves us to decide whether this TRO in reality operates as a preliminary injunction and is therefore appealable within the first exception.

> For an interlocutory order to be immediately appealable under § 1292(a)(1), . . . a litigant must show more than that the order has the practical effect of refusing an injunction. Because § 1292(a)(1) was intended to carve out only a limited exception to the final-judgment rule, we have construed the statute narrowly to ensure that appeal as of right under § 1292(a)(1) will be available only in circumstances where an appeal will further the statutory purpose of permitting litigants to effectually challenge interlocutory orders of serious, perhaps irreparable, consequence. Unless a litigant can show that an interlocutory order of the district court might have a serious, perhaps irreparable, consequence, and that the order can be effectually challenged only by immediate appeal, the general congressional policy against piecemeal review will preclude interlocutory appeal.

Carson v. Am. Brands, Inc., 450 U.S. 79, 84 (1981) (citation and internal quotation marks omitted). In *United States v. State of Colorado*, 937 F.2d 505, 507-08 (10th Cir. 1991), this court relied on *Carson* in applying a three-part test to evaluate whether an order refusing to approve modification of a consent decree had the

practical effect of an injunction. To sustain appellate jurisdiction under that test, the government must show (1) the interlocutory order has "the practical effect of denying an injunction"; (2) "the order [has] irreparable consequences"; and (3) the order "can be effectively challenged only by immediate appeal." *Id*.

Appellants argue[1] that irreparable harm will result from the TRO and that "even two weeks of undermining the state's response to the pandemic would be truly irremediable." Mot. to Stay TRO at 1 (internal quotation marks omitted). Appellees maintain that Appellants have not shown irreparable harm or that the only means of effectively challenging the TRO is by immediate appeal.

To support their position that irreparable harm will result from the TRO and that, alone, warrants treating this order as an appealable injunction, Appellants cite *Duvall v. Keating*, 162 F.3d 1058, 1062 (10th Cir. 1998). *Duvall* was a death penalty case in which a death row prisoner appealed the denial of a TRO that was requested to stop an imminent execution. In that context, this court acknowledged that, although a TRO is not generally appealable, it would exercise jurisdiction based on an exception that applies when "an appellant will suffer irreparable harm absent immediate review."[2] *Id*. The irreparable harm in that case was the appellant's

[1] In their motion to expedite the appeal, Appellants propose that the arguments in their stay motion and the attached exhibits stand as their opening appellate brief. We grant the motion to expedite and therefore rely on Appellants' stay motion and exhibits, Appellees' response opposing the stay motion, and Appellants' reply in deciding the appeal.

[2] *Duvall* relied on an Eleventh Circuit case, *Ingram v. Ault*, 50 F.3d 898, 900 (11th Cir. 1995), for this exception. *Ingram* also involved an imminent execution.

execution, and the threat of that harm was established with evidentiary certainty. So it followed from the nature of the irreparable harm and its evidentiary certainty that the TRO could not be effectively challenged absent immediate appeal; otherwise, the appellant would have been executed. Not only is the nature of the irreparable harm urged by Appellants quite distinguishable from the impending execution that persuaded the *Duvall* court to exercise appellate jurisdiction, but it also lacks the evidentiary certainty of the harm established in *Duvall*.

The TRO entered in this case is of short duration; it expires April 20, which brings it squarely within the confines of Fed. R. Civ. P. 65(b)(2). Further, immediate review is not the only means of effectively challenging the district court's action here, and Appellants' rights will not be irretrievably lost absent immediate review. In fact, the matter remains pending before the district court in Appellees' request for a preliminary injunction. And the deadlines reflected on the district court docket give every indication that the court intends to promptly rule on the request for a preliminary injunction. These circumstances combine to support the conclusion that the district court's order operates as what it purports to be—a TRO. As such, the order is not appealable.

See id. ("Because the district court denied Ingram's motion for a TRO, he faces execution in less than twenty-four hours. The requirements of irreparable harm and need for immediate appeal are therefore satisfied.").

We grant the motion to expedite the appeal, as well as the motion for leave to file an amicus brief filed on April 10 by the Roman Catholic Diocese of Oklahoma, et al. We dismiss the appeal for lack of jurisdiction, and we deny as moot the emergency motion for stay pending appeal.

Entered for the Court
Per Curiam

20-6045, South Wind Women's Center v. Stitt (Lucero, J., concurring).

I am fully in agreement with the per curiam order of the court. I write separately to concur on one point.

As noted, we must determine whether the temporary restraining order has the practical effect of a preliminary injunction under Rule 65(a). The second factor of the three-part test we apply is determined under United States v. Colorado, 937 F.2d 505 (10th Cir. 1991). We ask whether the district court's order has irreparable consequences. Id. at 507, 508. The State of Oklahoma contends that the consequence of allowing the temporary restraining order to remain in effect pending resolution of the request for a preliminary injunction is irreparable. Our per curiam order mentions in passing that this claimed irreparable injury lacks "evidentiary certainty." Assuredly, that is correct. I would add that the district court carefully analyzed the need for reducing abortion procedures in different scenarios, weighed this against the harm resulting from the denial of abortion services, and tailored its temporary relief accordingly.

Appellants advance suggested situations in which hospitals would turn away COVID-19 patients because they need to treat women with complications resulting from abortions, or in which abortion procedures would cause shortages in personal protective equipment. But these hypothetical scenarios are just that—hypothetical. Appellants' presentation is devoid of evidence that there is a risk these scenarios would occur if we do not exercise jurisdiction over the temporary restraining order.

Because of that failure, I conclude that Appellants have not established that the district court's temporary restraining order has irreparable consequences.

Exhibit 3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

Preterm-Cleveland, et al.,	:	
Plaintiffs,	:	Case No. 1:19-cv-00360
vs.	:	Judge Michael R. Barrett
Attorney General of Ohio, et al.,	:	
Defendants.	:	

TEMPORARY RESTRAINING ORDER

This matter is before the Court on Plaintiffs' Motion for a Temporary Restraining Order and/or Preliminary Injunction. (Doc. 42). This matter is also before the Court on Plaintiffs' Motion to File a Supplemental Complaint. (Doc. 41).

I. BACKGROUND

Plaintiffs—a collection of reproductive healthcare clinics and physicians providing abortion care—filed their Initial Complaint in this matter in May 2019. The Initial Complaint includes one count against Defendants challenging the constitutionality of Ohio Senate Bill 23 of the 133rd General Assembly ("S.B. 23") also known as the "Heartbeat Protection Act." (Doc. 1). Plaintiffs also filed a Motion for a Temporary Restraining Order and/or Preliminary Injunction enjoining the enforcement of S.B. 23. (Doc. 2). In July 2019, the Court granted Plaintiffs' Motion for a Preliminary Injunction and enjoined Defendants from enforcing or complying with S.B. 23 pending further Order of this Court. (Doc. 29). That Order remains in effect.

Pertinent to the current Order, on March 9, 2020, the Governor of Ohio declared a State of Emergency via Executive Order in light of COVID-19. (Doc. 41-1, PageID 698-701). "COVID-19 is a respiratory disease that can result in serious illness or death, is caused by the SARS-CoV-2 virus, which is a new strain of coronavirus that had not been previously identified in humans and can easily spread person to person." *Id.*

On March 17, 2020, Defendant Director of the Ohio Department of Health, Amy Acton, issued an order titled "RE: Director's Order for the Management of Non-essential Surgeries and Procedures throughout Ohio" ("Director's Order"). *Id.* The Director's Order states, inter alia, that:

> 1. Effective 5:00 p.m. Wednesday March 18, 2020, all non-essential or elective surgeries and procedures that utilized P[ersonal protective equipment ("PPE")] should not be conducted.
>
> 2. A non-essential surgery is a procedure that can be delayed without undue risk to the current or future health of a patient. Examples of criteria to consider include:
>
> a. Threat to the patient's life if surgery or procedure is not performed;
> b. Threat of permanent dysfunction of an extremity or organ system;
> c. Risk of metastasis or progression of staging; or
> d. Risk of rapidly worsening to severe symptoms (time sensitive).
>
> 5. . . . This Order shall remain in full force and effect until the State of Emergency Declared by the Governor no longer exists, or the Director of the Ohio Department of Health rescinds or modifies this Order.

Id. Defendant Acton states that the Order's purposes are to "prevent[] the spread of contagious or infectious diseases" and "preserv[e PPE] and critical hospital capacity and resources within Ohio." *Id.* A violation of the Director's Order is a second-degree misdemeanor. *See* Ohio Rev. Code. § 3701.352.

On March 20, 2020 and March 21, 2020, Defendant Attorney General of Ohio, Dave Yost, sent letters to Plaintiffs Planned Parenthood Southwest Ohio Region,

Preterm-Cleveland, and Women's Med Group Professional Organization citing the Director's Order and stating that "[t]he Ohio Department of Health has received a complaint that your facility has been performing or continues to offer to perform surgical abortions, which necessarily involve the use of PPE." (Doc. 42-1, PageID 807); (Doc. 42-2, PageID 820); (Doc. 42-4, PageID 845). Defendant Yost ordered Plaintiffs "to immediately stop performing non-essential and elective surgical abortions." *Id.* Defendant Yost concluded that, "[i]f you or your facility do not immediately stop performing non-essential or elective surgical abortions in compliance with the attached order, the Department of Health with take all appropriate measures." *Id.*

On March 30, 2020, Plaintiffs filed their Motion to File a Supplemental Complaint and Motion for a Temporary Restraining Order and/or Preliminary Injunction. (Docs. 41, 42). The proposed Supplemental Complaint seeks to add a constitutional challenge to the Director's Order as applied to surgical abortion procedures. (Doc. 42-1). The Motion for a Temporary Restraining Order and/or Preliminary Injunction requests that the Court temporarily enjoin Defendants from enforcing the Director's Order in a way that would ban surgical abortion in Ohio. (Doc. 42).

The Court held two informal telephone conferences on March 30, 2020 pursuant to S.D. Ohio Civ. R. 65.1 and Plaintiffs advised the Court of their preference for an immediate ruling on their Motion for a Temporary Restraining Order as they have scheduled surgical abortion surgeries this week.

II. ANALYSIS

a. Standard of Review

i. Motion to File Supplemental Complaint

Rule 15(d) of the Federal Rules of Civil Procedure governs supplemental pleadings and permits a party to move to file, and the Court to permit, "a supplemental pleading setting out any transaction, occurrence, or event that happened after the date of the pleading to be supplemented." FED. R. CIV. P. 15(d). "Rule 15(d) aims 'to give the court broad discretion in allowing a supplemental pleading.'" *Ne. Ohio Coal. for the Homeless v. Husted*, 837 F.3d 612, 625 (6th Cir. 2016) (citing FED. R. CIV. P. 15(d) advisory committee's note to 1963 amendment).

ii. Motion for Temporary Restraining Order

Under Federal Rule of Civil Procedure 65, the purpose of a temporary restraining order is to preserve the status quo so that a reasoned resolution of a dispute may be had. *See, e.g.*, *Procter & Gamble Co. v. Bankers Trust Co.*, 78 F.3d 219, 227 (6th Cir. 1996).

In the Sixth Circuit, the standard for obtaining a temporary restraining order and the standard for obtaining a preliminary injunction are the same. *Workman v. Bredesen*, 486 F.3d 896 (6th Cir. 2007). In determining whether to grant or deny a temporary restraining order or a preliminary injunction, the Court must consider four factors: "(1) whether the movant has a strong likelihood of success on the merits; (2) whether the movant would suffer irreparable injury without the injunction; (3) whether issuance of the injunction would cause substantial harm to others; and (4) whether the public interest would be served by issuance of the injunction." *City of Pontiac Retired Emps. Ass'n v. Schimmel*, 751 F.3d 427, 430 (6th Cir. 2014) (per curiam) (en banc) (internal quotation

marks omitted). Due to the urgency of the situation, the Court will decide whether temporary injunctive relief is warranted based on Plaintiffs' Motion (Doc. 42), along with the affidavits and documents filed in the record as of the date of this Order, and the two telephonic conferences held on March 30, 2020. *See* FED. R. CIV. P. 65.

b. Holdings

i. Motion to File Supplemental Complaint

The facts in Plaintiffs' Initial Complaint (Doc. 1) are sufficiently related to the facts in Plaintiffs' proposed Supplemental Complaint (Doc. 41-1) such that the Court will allow Plaintiffs' supplemental pleading. *See Ne. Ohio Coal. for the Homeless*, 837 F.3d at 625. The Court finds that the combination of the overlapping subject matter, the Court's familiarity with that subject matter, and the Court's prior entry of a Preliminary Injunction related to that subject matter favor allowing the supplemental pleading. *See id.*

ii. Motion for Temporary Restraining Order

The Court concludes, for the reasons required under Federal Rule of Civil Procedure 65(d), that Plaintiffs have shown (1) a likelihood of success on the merits of at least one of its claims; (2) that Plaintiffs and their patients will suffer irreparable harm if an injunction is not issued; (3) that the balance of harm favors Plaintiffs; and (4) that the public interest weighs in favor of granting a temporary restraining order. *See Hoover Transp. Servs., Inc. v. Frye*, 77 F. App'x 776, 781 (6th Cir. 2003) ("If [plaintiffs] can show a likelihood of success on the merits of any of the claims, an injunction may issue, subject to consideration of the other factors.").

The law is well-settled that women possess a fundamental constitutional right of access to abortions. *Roe v. Wade*, 410 U.S. 113, 153-54 (1973). Yet the right to terminate

a pregnancy is not absolute: "[A] state may regulate abortion *before viability* as long as it does not impose an 'undue burden' on a woman's right to terminate her pregnancy." *Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436, 443 (6th Cir. 2003) (quoting *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 876 (1992) (emphasis added)). "[T]here 'exists' an 'undue burden' on a woman's right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the '*purpose or effect*' of the provision 'is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'" *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016) (quoting *Casey*, 505 U.S. at 878 (emphasis added in *Hellerstedt*)).

Defendant Yost's letters to Plaintiffs suggest his determination that surgical abortions are non-essential surgeries and thus are subject to the Director's Order. *See* (Doc. 42-1, PageID 807); (Doc. 42-2, PageID 820); (Doc. 42-4, PageID 845). Defendant Yost's statements and order in those letters, without more guidance, implicate Plaintiffs' patients' Fourteenth Amendment rights. In balancing the four relevant factors and at this stage in the proceedings, Plaintiffs have shown a likelihood of success on the merits on its claim that enforcement of the Director's Order as applied to surgical abortion procedures will result in an unconstitutional deprivation of Plaintiffs' patients' Fourteenth Amendment right to substantive due process because enforcement creates a substantial obstacle in the path of patients seeking pre-viability abortions, thus creating an undue burden on abortion access.

Turning to the factor of irreparable harm, Plaintiffs argue that their patients will suffer serious and irreparable harm in the absence of a temporary restraining order and/or preliminary injunction, as the Director's Order prevents Ohio women from exercising their

constitutional right to reproductive freedom as protected by the Fourteenth Amendment.[1] (Doc. 42). Inasmuch as this Court has determined that the Director's Order likely places an "undue burden" on a woman's right to choose a pre-viability abortion, and thus violates her right to privacy guaranteed by the Fourteenth Amendment, the Court further determine that its enforcement would, per se, inflict irreparable harm.

With regard to the remaining factors concerning harm to others and the public interest, Plaintiffs assert that their patients will suffer numerous irreparable harms without injunctive relief and, given the indeterminate length of the Director's Order, some could be forced to forgo an abortion entirely and carry an unwanted pregnancy to term. (Doc. 42). Defendants have not demonstrated to the Court, at this point, that Plaintiffs' performance of these surgical procedures will result in any beneficial amount of net saving of PPE in Ohio such that the net saving of PPE outweighs the harm of eliminating abortion. These favors weigh in Plaintiffs' favor. *See Am. Freedom Def. Initiative v. Suburban Mobility Auth. for Reg'l Transp.*, 698 F.3d 885, 896 (6th Cir. 2012); *Jackson Womens' Health Org. v. Currier*, 940 F. Supp. 2d 416, 424 (S.D. Miss. 2013).

Accordingly, a temporary restraining order is proper. In that regard, and understanding the novel intersection between the foregoing legal precedent in *Roe*, *Casey*, and *Hellerstedt* that emphasizes the Fourteenth Amendment's guarantee of the right to reproductive freedom and Ohio's interest in protecting its citizens during the evolving COVID-19 emergency, the Court holds that Plaintiff healthcare providers are to determine if a surgical abortion procedure can be safely postponed during the pre-viability

[1] While clinics and physicians do not possess a constitutional right to perform abortions, they have standing to assert constitutional challenges on behalf of their patients in the abortion context. *See Planned Parenthood of Greater Ohio v. Hodges*, 917 F.3d 908 (6th Cir. 2019).

stage to maximize healthcare resources to combat the COVID-19 pandemic. If a healthcare provider determines, on a case-by-case basis, that the surgical procedure is medically indicated and cannot be delayed, based on the timing of pre-viability or other medical conditions, said procedure is deemed legally essential to preserve a woman's right to constitutionally protected access to abortions.

III. CONCLUSION

For the foregoing reasons, it is hereby **ORDERED** that Plaintiffs' Motion to File a Supplemental Complaint (Doc. 41) is **GRANTED**. It is further **ORDERED** that Plaintiffs' Motion for a Temporary Restraining Order and/or Preliminary Injunction (Doc. 42) is **GRANTED IN PART,** to the extent that it seeks a temporary restraining order, **and HELD IN ABEYANCE IN PART,** to the extent that it seeks a preliminary injunction. Specifically, it is hereby **ORDERED** that Defendant; Defendant's officers, agents, servants, employees, and attorneys; and those persons in active concert or participation with them who receive actual notice of the order are **TEMPORARILY RESTRAINED** from enforcing the Director's Order against Plaintiffs as described above.

This Temporary Restraining Order is effective upon entry and expires fourteen (14) days thereafter unless dissolved earlier or extended by the Court. There is no bond requirement. *See Molton Co. v. Eagle-Picher Indus., Inc.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (district court has discretion to issue preliminary injunction with no bond).

IT IS SO ORDERED.

_s/ Michael R. Barrett_____
Michael R. Barrett, Judge
United States District Court

Exhibit 4

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 20-50296

In re: GREG ABBOTT, in his official capacity as Governor of Texas; KEN PAXTON, in his official capacity as Attorney General of Texas; PHIL WILSON, in his official capacity as Acting Executive Commissioner of the Texas Health and Human Services Commission; STEPHEN BRINT CARLTON, in his official capacity as Executive Director of the Texas Medical Board; KATHERINE A. THOMAS, in her official capacity as the Executive Director of the Texas Board of Nursing,

Petitioners

On Petition for Writ of Mandamus to
the United States District Court
for the Western District of Texas

Before DENNIS, ELROD, and DUNCAN, Circuit Judges.

PER CURIAM:

On April 10, 2020, Petitioners filed an emergency motion to stay the district court's order (Doc. 63) temporarily restraining executive order GA-09, pending our consideration of their mandamus petition. Having addressed emergency motions concerning GA-09 more than once in the past week, we refer readers to our description of this fast-moving litigation elsewhere. *See In re Abbott*, --- F.3d ---, 2020 WL 1685929, at *2–4 (5th Cir. Apr. 7, 2020) (*Abbott II*). For present purposes, suffice it to say that GA-09 is an emergency public health measure, issued by the Governor of Texas on March 22, 2020, that postpones non-essential surgeries and procedures until April 22 in the face of

the COVID-19 pandemic. *Id.* at *2–3. GA-09 applies to a broad range of procedures, does not mention abortion, and contains exceptions for procedures immediately necessary to preserve the life or health of patients. *Id.* at *3, 9-10. GA-09 is enforceable by both criminal and administrative penalties and is currently set to expire after 11:59 p.m. on April 21, 2020. *Id.* at *3.

On March 30, the district court entered a TRO against GA-09 as applied to all abortion procedures. *Planned Parenthood Ctr. for Choice et al. v. Abbott*, 2020 WL 1502102, at *4 (W.D. Tex. Mar. 30, 2020) (*Abbott I*). We administratively stayed that TRO on March 31 and, on April 7, we issued a writ of mandamus directing the district court to vacate its TRO. *Abbott II*, 2020 WL 1685929, at *2. In doing so, we explained that the challenge to GA-09 must be analyzed under the controlling legal standards set forth in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11 (1905). *See Abbott II*, 2020 WL 1685929, at *2. We emphasized that our decision was based only on the record before us, and that both sides would presumably have a chance to present evidence concerning narrower remedies at a preliminary injunction hearing then scheduled for April 13. *Id.* at *2.

The next day, April 8, the district court vacated its TRO and cancelled the April 13 preliminary injunction hearing. Doc. 54. The district court stated it "anticipates that the governor will extend or amend and extend [GA-09] to a date past April 21, 2020," and that "[i]t makes no sense to take up the request for [a] preliminary injunction until the parties and the court have the benefit of any subsequent order." Doc. 58 at 3. The district court therefore ordered the parties to confer and agree to a schedule and procedures for the yet-undetermined preliminary injunction hearing. *Id.*

That same day Respondents sought another TRO, which the district court granted the next day, April 9, following a brief telephone hearing at which Petitioners were not allowed to present evidence or file an opposition.

Transcr. of 4/9/20 Tel. Conf. at 14:39; *Planned Parenthood Ctr. for Choice v. Abbott*, 2020 WL 1815587 (W.D. Tex. Apr. 9, 2020) (*Abbott III*). The April 9 TRO prevents GA-09 from applying, until April 19, to three categories of abortion: (1) medication abortions; (2) abortions for women who would be more than 18 weeks LMP ("last menstrual period") by April 22 and unable to reach an ambulatory surgical center; and (3) abortions for women who would be past Texas's legal limit—22 weeks LMP—for abortion by April 22. *Abbott III*, 2020 WL 1815587, at *7. On April 10, Petitioners sought another writ of mandamus from our court, as well as an emergency stay. Later that day, we granted a partial administrative stay of the TRO, except as to the part applying to women who would be 22 weeks LMP by April 22. We expedited briefing on both the emergency stay motion and the mandamus petition.

We now consider Petitioners' motion for emergency stay of the April 9 TRO as it applies to the provision of medication abortions. Four factors guide our analysis: (1) whether Petitioners have made a strong showing of entitlement to mandamus; (2) whether Petitioners will be irreparably harmed absent a stay; (3) whether other parties will be substantially harmed by a stay; and (4) the public interest. *See Nken v. Holder*, 556 U.S. 418, 426 (2009); *ODonnell v. Goodhart*, 900 F.3d 220, 223 (5th Cir. 2018). "The first two factors are the most critical." *ODonnell*, 900 F.3d at 223 (citing *Barber v. Bryant*, 833 F.3d 510, 511 (5th Cir. 2016)).

The first inquiry is whether Petitioners have made a strong showing they are entitled to mandamus. *Nken*, 556 U.S. at 426. To be entitled to mandamus relief, Petitioners must demonstrate, *inter alia*, "a clear abuse of discretion that produces patently erroneous results." *In re JPMorgan Chase & Co.*, 916 F.3d 494, 500 (5th Cir. 2019) (cleaned up). We have serious concerns about whether the district court's April 9 TRO adhered to our order in *Abbott II*. For example, despite citing the decision once, the TRO does not discuss or apply

"the framework governing emergency public health measures like GA-09," established by the Supreme Court in *Jacobson*. *Abbott II*, 2020 WL 1685929, at *1. Nor does the TRO appear to "careful[ly] pars[e] . . . the evidence," *id.* at *11, developed after a hearing at which "all parties [would] presumably have the chance to present evidence on the validity of applying GA-09 in specific circumstances," *id.* at *2—something our decision emphasized.[1] Finally, the TRO persists in "usurp[ing] the state's authority to craft emergency health measures" by "substitut[ing] [the court's] own view of the efficacy of applying GA-09 to abortion." *Id.* at *1; *cf. Abbott III*, 2020 WL 1815587, at *4 (finding "delaying access to abortion will not conserve [personal protective equipment]" "[b]ecause individuals with ongoing pregnancies require more in-person healthcare . . . than individuals who have previability abortions").

Conversely, however, we have doubts about Petitioners' showing as to medication abortions. As to that category, Respondents argue that medication abortions are not covered by GA-09 because neither dispensing medication nor ancillary diagnostic elements (such as a physical examination or ultrasound) qualify as "procedures." Guidance by the Texas Medical Board may support this interpretation of the order.[2] Furthermore, the parties' helpful written responses to our questions did not settle whether GA-09 applies to medication

[1] *See*, *e.g.*, *id.* at *2 (noting "[t]he district court has scheduled a telephonic preliminary injunction hearing for April 13, 2020," after which the court could "make targeted findings, based on competent evidence, about the effects of GA-09 on abortion access"); *id.* at *12 (noting that the question of a narrowly tailored injunction could be pursued by "the parties . . . at the preliminary injunction stage"); *id.* at *13 (noting that "Respondents will have the opportunity, of course, to present additional evidence" on pretext "in conjunction with the district court's preliminary injunction hearing scheduled for April 13, 2020").

[2] *See* Texas Medical Board, Frequently Asked Questions Regarding Non-Urgent, Elective Surgeries and Procedures During Texas Disaster Declaration for COVID-19 Pandemic (Mar. 29, 2020), http://www.tmb.state.tx.us/idl/59C97062-84FA-BB86-91BF-F9221E4DEF17 (explaining "[a] 'procedure' [under GA-09] does not include physical examinations, non-invasive diagnostic tests, the performing of lab tests, or obtaining specimens to perform laboratory tests").

abortions. Given the ambiguity in the record, we conclude on the briefing and record before us that Petitioners have not made the requisite strong showing of entitlement to mandamus relief. Because a failure on that first inquiry is sufficient to deny the stay, we need not proceed to the remaining prongs.

We express no ultimate decision on the ongoing mandamus proceeding or on the remaining aspects of the emergency stay motion.

***

IT IS ORDERED that Petitioners' emergency motion to stay the district court's April 9 TRO is DENIED as to medication abortions. We also DISSOLVE the temporary administrative stay as it applies to medication abortions.

JAMES L. DENNIS, Circuit Judge, concurring.

I concur in the majority's conclusion that the petitioners have failed to make a strong showing that they are entitled to mandamus with respect to medication abortions. The petitioners' stated desire to enforce GA-09 against medication abortions despite the executive order's apparent inapplicability is a strong indication that the enforcement is pretextual and does not bear a "'real or substantial relation' to the public health crisis" we are experiencing. *In re Abbott*, --- F.3d ---, 2020 WL 1685929, at *7 (5th Cir. Apr. 7, 2020) (quoting in *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 31 (1905).

I disagree, however, with the majority's unnecessary critique of the district court's decision. I believe the district court properly exercised its inherent authority "to manage [its] own affairs so as to achieve the orderly and expeditious disposition of cases" in choosing to issue a second TRO rather than to immediately proceed to a hearing on a preliminary injunction as the majority suggested in its last mandamus opinion. *Chambers v. NASCO, Inc.*, 501 U.S. 32, 43 (1991) (quoting *Link v. Wabash R. Co.*, 370 U.S. 626, 630–631 (1962)). Further, far from "usurp[ing] the state's authority to craft emergency

health measures" by "substitut[ing] [the court's] own view of the efficacy of applying GA-09 to abortion," I believe the court properly considered the evidence to determine whether "beyond question, GA-09's burdens outweigh its benefits" when applied to medication abortions, as the majority previously instructed. *Abbott*, 2020 WL 1685929, at *1, 9 (internal quotations omitted).

Accordingly, I concur only in the denial of the petitioner's emergency motion as it applies to medication abortions and to the corresponding dissolving of the administrative stay.

United States Court of Appeals

FIFTH CIRCUIT
OFFICE OF THE CLERK

LYLE W. CAYCE
CLERK

TEL. 504-310-7700
600 S. MAESTRI PLACE,
Suite 115
NEW ORLEANS, LA 70130

April 13, 2020

MEMORANDUM TO COUNSEL OR PARTIES LISTED BELOW:

No. 20-50296 In re: Greg Abbott, et al
USDC No. 1:20-CV-323

Enclosed is an order entered in this case.

Sincerely,

LYLE W. CAYCE, Clerk

Amanda Sutton-Foy

By: _____
Amanda Sutton-Foy, Deputy Clerk
504-310-7670

Ms. Jeannette Clack
Mrs. Molly Rose Duane
Ms. Heather Gebelin Hacker
Mr. Kyle Douglas Hawkins
Ms. Beth Ellen Klusmann
Mr. Richard Muniz
Ms. Julie A. Murray
Mr. Patrick J. O'Connell
Ms. Jennifer Sandman
Ms. Rupali Sharma
Ms. Hannah Swanson
Mrs. Natalie Deyo Thompson
Ms. Stephanie Toti

Exhibit 5

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., INC., on behalf of itself and its patients *et al.*, Plaintiffs, v. HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity, *et al.*, Defendants.	CIVIL ACTION CASE NO. 3:15-cv-00705 JUDGE FRIEDMAN MAGISTRATE JUDGE FRENSLEY

DECLARATION OF KIMBERLY LOONEY, M.D.

Kimberly Looney, M.D., declares and states the following:

1. I am an obstetrician and gynecologist ("OB/GYN") licensed to practice in the state of Tennessee, and I have been practicing since 2002. I earned my medical degree from the University of Tennessee at Memphis Health Sciences Center in 2002 and completed my residency in obstetrics and gynecology at the University of Illinois at Chicago Medical Center in 2006. I subsequently received a Master of Public Health degree from Emory University and did a Family Planning and Reproductive Health Fellowship at Emory University School of Medicine. I have been certified by the American Board of Obstetrics and Gynecology since 2013. I first started providing care, including abortions, at Planned Parenthood Tennessee and North Mississippi

("PPTNM") in 2008 and have been the Chief Medical Officer of PPTNM since 2019.[1] I have taught, researched, and given presentations about reproductive healthcare, including abortion.

2. PPTNM is a not-for-profit corporation operating health centers in Tennessee and Mississippi. In Tennessee, PPTNM operates four health centers: in Nashville, Knoxville, and two in Memphis. All provide a wide range of reproductive and sexual health services to patients, including services such as well-woman exams, cancer screenings, birth control counseling, Human papillomavirus (HPV) vaccines, annual gynecological exams, pregnancy care, contraception, adoption referral, and miscarriage management. We provide medication abortion through 11 weeks, 0 days, as measured from the first day of a patient's last menstrual period ("LMP") at our four health centers in the state. Two of our health centers (in Nashville and Memphis) also provide procedural abortions, sometimes called "surgical" abortions, through 19 weeks, 6 days LMP.

3. As the Chief Medical Officer at PPTNM, I provide oversight and leadership on all medical services we provide, including abortion services. I am responsible for promulgating and ensuring adherence to medical protocols for all of our services, and for general quality assurance. I also provide abortion care and family planning services at the Nashville health center and one of our Memphis health centers.

4. I submit this declaration in support of Plaintiffs' motion for temporary restraining order and/or preliminary injunction, which seeks to enjoin the enforcement of Executive Order 25 ("EO 25") to ban procedural abortions. I am familiar with the directives of EO 25, and understand that I face severe penalties, including criminal penalties for violating it. Therefore, while I believe that my abortion patients will suffer severe harm if they are delayed in obtaining procedural

[1] Prior to 2018, I provided care at Planned Parenthood of Middle and East Tennessee ("PPMET"). In 2018, PPMET consolidated with Planned Parenthood of the Greater Memphis Region to form PPTNM.

abortion care, and that many will be prevented from accessing abortion care entirely if forced to delay their abortions for the duration of EO 25, absent an order from this Court, I cannot risk continuing to perform procedural abortions.

5. Since EO 25 went into effect, PPTNM has had to cancel patients scheduled for procedural abortions and will have to continue doing so without relief from this Court. Under the extremely narrow language of EO 25, we cannot provide any procedural abortions at this time.

6. Although we have already been forced to cancel patients scheduled for procedural abortions, upon relief from the Court, we will be able to call these patients quickly and reschedule them for the next available appointments.

7. The facts and opinions included here are based on my education, training, practical experience, information, and personal knowledge I have obtained as an OB/GYN and an abortion provider; my attendance at professional conferences; review of relevant medical literature; and conversations with other medical professionals. If called and sworn as a witness, I could and would testify competently thereto.

8. My curriculum vitae, which sets forth my experience and credentials more fully, is attached as Exhibit A.

Legal Abortion in the United States and PPTNM's Provision of Abortion Care

9. Legal abortion is one of the safest medical procedures in the United States and is substantially safer than childbirth.[2] Complications from abortion are rare, and when they do occur, they can usually be managed in an outpatient setting, either at the time of the abortion or in a follow-up visit. Major complications—defined as complications requiring hospital admission,

[2] Nat'l Acads. of Scis., Eng'g & Med., *The Safety & Quality of Abortion Care in the United States* 77–78, 162–63 (2018).

surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester procedural abortion cases, and in 0.41% of procedural abortion cases in the second trimester or later.[3] Abortion-related emergency room visits constitute just 0.01% of all emergency room visits in the United States.[4]

10. The risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion, and every pregnancy-related complication is more common among patients giving birth than among those having abortions.[5]

11. There are two main methods of abortion: medication abortion and procedural abortion (sometimes referred to as "surgical abortion"). Both methods are safe, effective means of ending a pregnancy.[6] Medication abortion involves a combination of two pills: mifepristone and misoprostol.[7] The patient takes the mifepristone in the clinic and then, twenty-four to forty-eight hours later, takes the misoprostol at a location of their choosing, most often at their home, after which they expel the contents of the uterus in a manner similar to a miscarriage. Medication abortion is neither a "surgery" nor a "procedure."

12. Current medical evidence demonstrates that medication abortion is safe and effective through 11 weeks LMP.

13. After 11 weeks, 0 days LMP, patients will generally need a procedural abortion. Additionally, some patients with pregnancies less than 11 weeks, 0 days LMP will have a

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[3] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015).
[4] Ushma Upadhyay, et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16:88 BMC Med. 1, 1 (2018).
[5] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215 (2012).
[6] Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester,* 126 Obstetrics & Gynecology 22, 22 (2015).
[7] Nat'l Acads., *supra* note 2, at 51.

procedural abortion for various reasons, including because of an underlying medical condition, such as an increased risk of bleeding, that makes this the safer option.[8]

14. While sometimes referred to as "surgical abortion," a procedural abortion is not what is commonly understood to be "surgery"; it involves no incision, no need for general anesthesia, and no requirement of a sterile field. Up to fourteen to sixteen weeks LMP, physicians use the aspiration abortion technique, which involves dilating the natural opening of the cervix using medications and/or small rods, inserting a narrow tube into the uterus, and gently emptying the uterus through suction. This procedure typically takes five to ten minutes and may involve local anesthesia or conscious sedation to make the patient more comfortable. To perform abortions after that gestational point in pregnancy, physicians must dilate the cervix further and use a combination of instruments and suction to empty the uterus, which is called the dilation and evacuation ("D&E") technique. This technique generally takes longer than an aspiration procedure, and results in the patient spending more time in the recovery room. Later in the second trimester, typically starting around eighteen weeks LMP, the physician begins cervical dilation the day before the procedure itself, meaning that the abortion procedure requires two visits to the clinic one day apart.

15. In Tennessee, PPTNM performs medication abortions up to 11 weeks, 0 days LMP and procedural abortions up to 19 weeks, 6 days LMP. We are the only provider in the state that provides procedural abortions after 15 weeks LMP.

16. In 2019, PPTNM performed 4,742 abortions in Tennessee. Of those, 2,390 were procedural abortions and 1,314 occurred beyond eleven weeks LMP, when medication abortion is not an option.

[8] *Id.* at 51–52.

17. In January through March 2020, PPTNM performed 1,700 abortions in Tennessee, 917 of which were procedural abortions and 536 of which occurred beyond eleven weeks LMP, when medication abortion is not an option.

18. Typically, only a small number of procedural abortions are performed as two-day procedures. For example, in 2019, only ninety-nine abortions were two-day procedures. Of course, this number will increase if patients are delayed and pushed later into gestational age.

19. Individuals seek abortion for a multitude of complicated and personal reasons. By way of example, some patients have abortions because they conclude it is not the right time to become a parent or have additional children, they desire to pursue their education or career, or they lack the necessary financial resources or a sufficient level of partner or familial support or stability. Other patients seek abortions because continuing with the pregnancy could pose a greater risk to their health, especially if their past pregnancies have been high-risk.[9] Nationwide, most abortion patients already have children,[10] and the vast majority—seventy-five percent—are poor or low-income.[11]

20. Although abortion is a very safe medical procedure, the associated health risks increase as pregnancy advances.[12] The ability to access abortion even one week earlier disproportionately reduces health risks, including the (already extremely low) risk of death.[13] As

[9] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13 BMC Women's Health 7 (2013).
[10] Guttmacher Inst., Induced Abortions in the United States 1 (2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; *see also* Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Inst., Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, at 6, 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.
[11] Guttmacher Inst., Induced Abortions in the United States 1, *supra* note 10.
[12] Nat'l Acads., *supra* note 2, at 77–78, 162–63.
[13] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004).

the American College of Obstetricians and Gynecologists (ACOG) and other well-respected medical professional organizations have observed, abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[14] And the American Medical Association has stressed that patients "with urgent medical needs, including pregnant women, should seek care as needed,"[15] and noted that "elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive healthcare."[16]

21. Patients generally seek abortion care as soon as they are able, but many face logistical obstacles that can delay access. Some patients may not discover they are pregnant until later in their pregnancies; others may experience difficulties navigating the medical system, including finding a provider and scheduling an appointment. Many of our patients have low incomes, which means that coming up with the money to pay for an unexpected and time-sensitive health care procedure is a struggle. Patients often need time to gather the resources to pay for the abortion and related costs, figure out transportation to a clinic, arrange for time off of work (which is often unpaid, as many patients lack paid time off or sick leave), and, for the vast majority of patients seeking abortions who already have children, arrange and pay for childcare.[17]

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[14] ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[15] Am. Med. Ass'n, Am. Hosp. Ass'n, and Am. Nursing Ass'n, *AMA, AHA, ANA: #StayHome to confront COVID-19* (Mar. 24, 2020), https://www.ama-assn.org/press-center/press-releases/ama-aha-ana-stayhome-confront-covid-19.

[16] Patrice A. Harris, President, AMA, AMA Statement on Government Interference in Reproductive Healthcare (Mar. 30, 2020), https://bit.ly/2X4OAjT.

[17] Jerman et al., *supra* note 10 at 8–10; Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*,

22. The COVID-19 pandemic has only exacerbated these obstacles for patients seeking abortion care.[18] It has shuttered schools and businesses and dramatically limited most peoples' financial resources and childcare options during a time of recommended social-distancing and economic turbulence.[19] Indeed, jobless claims are soaring due to the virus.[20]

23. On top of all of this, Tennessee imposes unnecessary restrictions that only serve to further delay patients. Tennessee requires that all abortion patients make two separate trips to the health center, at least forty-eight hours apart, in order to first receive certain state-mandated information prior to the abortion.[21] This means patients who struggle to navigate getting time off work and coordinating transportation or childcare must do so on two separate occasions. The additional appointments also make it difficult for providers to schedule patients on a timely basis,

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11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

[18] Organizations across the country that provide financial and logistical assistance to women seeking abortion care have reported enormous increases in the volume of requests they receive, due to the widespread economic hardship caused by the pandemic. Paige Alexandria, *Paying for an Abortion Was Already Hard. The COVID-19 Economic Downturn Has Made It Even Harder*, Rewire, Mar. 27, 2020, https://rewire.news/article/2020/03/27/paying-for-an-abortion-was-already-hard-the-covid-19-economic-downturn-has-made-it-even-harder/.

[19] Kirstie Crawford, *Coronavirus in TN: State Board of Education Passes COVID-19 Emergency Rules*, WATE (Apr. 10, 2020, 12:29 AM), https://www.wate.com/news/education/coronavirus-in-tn-state-board-of-education-passes-covid-19-emergency-rules/; Rebekah Pewitt, *Gov. Lee Orders Statewide 'Safer-at-Home' Order Closing Nonessential Businesses amid COVID-19*, NewsChannel5 Nashville (last updated Mar. 31, 2020, 9:10 AM); WTVF, Gov. Lee Loosens Restrictions for Childcare Facilities During COVID-19 Outbreak, NewsChannel5 Nashville (last updated Mar. 31, 2020, 8:09 AM), https://www.newschannel5.com/news/gov-lee-loosens-restrictions-for-childcare-facilities-during-covid-19-outbreak; *see also* White House, *The President's Coronavirus Guidelines for America* (Mar. 16, 2020), https://www.whitehouse.gov/wp-content/uploads/2020/03/03.16.20_coronavirus-guidance_8.5x11_315PM.pdf; Rebecca Shabad, *Fauci Predicts Americans Will Likely Need to Stay Home for at Least Several More Weeks*, NBC News, Mar. 20, 2020, https://www.nbcnews.com/politics/donald-trump/fauci-predicts-americans-will-likely-need-stay-home-least-several-n1164701.

[20] Travis Loller, *Tennessee Unsure How Soon New Unemployment Benefits Coming*, *Nashville Tennessean* (Apr. 8, 2020, 7:06 PM), https://www.tennessean.com/story/money/2020/04/08/tennessee-unsure-how-soon-new-unemployment-benefits-coming/2974700001/.

[21] Tenn. Code Ann. 39-15-202(a)–(h).

often meaning that patients are delayed for far more than forty-eight hours after their initial state-mandated counseling appointment. And patients who are minors must obtain parental consent before they can have an abortion, unless they first go to court and get a judicial bypass. Tennessee also does not allow us to provide medication abortion using telemedicine.

PPTNM's Efforts to Prevent COVID-19 Spread and Conserve Needed Resources

24. PPTNM is committed to doing its part to reduce the spread of COVID-19 and to otherwise help ensure that our public health system has sufficient resources to meet the challenge of responding to a potential surge of illness.

25. Since the COVID-19 outbreak, and even before the Governor issued EO 25, PPTNM was taking steps to preserve medical resources and help prevent the spread of COVID-19 in the communities where we offer services, following the guidelines of major medical organizations such as the Centers for Disease Control and Prevention.

26. For example, we reduced our patient volume to ensure that we comply with current social-distancing recommendations, including by making individualized determinations as to which patient appointments should be postponed or rescheduled in light of these recommendations. In addition, although in normal times we welcome support companions accompanying abortion patients, we made the difficult decision not to allow such companions (except parents accompanying minors) to enter our health centers in order to limit the number of people in the clinic at any given time.

27. We have also made changes to the flow of our patient care. When patients call to make an appointment and when they come to the health center, we screen them for COVID-19 symptoms. We also posted signs on the front doors and throughout our health centers that inform patients that they will be screened and of the common symptoms associated with COVID-19

(fever, cough, shortness of breath, sore throat, or flu-like symptoms) and request that if they have been experiencing those symptoms, they not enter the building and instead call the clinic for instructions.

28. Once the patient enters the clinic, they are sent to our waiting area, where we are making sure to separate our patients so they are all at least six feet apart. We removed all the magazines, books, and other objects from both the waiting rooms and exam rooms, and have sanitizer stations located throughout the health center. As is our standard practice, we also disinfect the waiting room, exam rooms and recovery rooms, and all frequently touched surfaces, on a continuous basis throughout the day.

29. In general, the procedural abortions PPTNM provides are straightforward outpatient procedures requiring little personal protective equipment ("PPE"). Typically, during the mandatory initial informed consent visit, our clinicians use gloves when they are drawing any necessary labs or performing an ultrasound. On the day of the procedure itself, physicians use a mask (which they use all day, unless it becomes soiled or contaminated). Gloves are used during the procedure and then discarded.

30. The overwhelming majority of procedural abortions are performed during a single clinic visit. PPTNM's providers have not used N95 respirators, which I understand are the PPE in shortest supply during the COVID-19 pandemic. Likewise, all of our procedures are performed in our own outpatient facilities, so we are not using any hospital resources that may be needed for COVID-19 response: no hospital staff or supplies, no hospital beds, let alone intensive care unit (ICU) beds, and no ventilators.

31. Caring for pregnant patients who are continuing their pregnancies requires significantly more patient interaction with the healthcare system and significantly more PPE. A

typical pregnancy is generally forty weeks in duration. Even an uncomplicated pregnancy requires a minimum of one prenatal appointment per month, along with additional appointments to complete labs and ultrasounds. Each separate encounter with a health care provider will likely require the use of gloves, a face mask, and other forms of PPE. For a complicated or high-risk pregnancy, the number of visits may be significantly higher; indeed, starting at twenty-six weeks LMP, patients with high-risk pregnancies are often coming in twice a week for routine monitoring visits, which may also involve an ultrasound and non-stress test (NST) evaluations. During each of these visits, the clinician will be wearing gloves *at a minimum*; with COVID-19, many may also be wearing masks for both their protection and the protection of the patient. Additionally, approximately one in five pregnant women will visit a hospital during pregnancy, prior to delivery.[22]

32. A procedural abortion, by contrast, requires only a *maximum* of two to three visits—and would generally be completed in only one visit but for Tennessee's mandatory two-trip requirement.

33. Furthermore, every time a pregnant person presents to the hospital for evaluation prior to labor, which could happen multiple times,[23] they will be interacting with more people and increasing the hospital's use of PPE. An actual birth—attended by multiple medical care providers, including, but not limited to, nursery personnel, a labor and delivery nurse, an OB tech, a physician,

[22] Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 24 Acad. Emergency Med. 940, 942 (2017).

[23] Cunningham et al., *supra* note 22 at 940 (finding that twenty-nine percent of pregnant patients who visited the emergency department during pregnancy did so twice or more); *see also* Urania Magriples et al., *Prenatal Health Care Beyond the Obstetrics Service: Utilization and Predictors of Unscheduled Care*, 198 Am. J. of Obstetrics & Gynecology 75.e1 (2008) (in a smaller study, half of pregnant patients had at least one unscheduled visit to the emergency department during pregnancy, and two-thirds had at least one unscheduled visit to labor and delivery before birth).

and an anesthesiologist—could involve anywhere from seven to ten gowns, masks, and sterile gloves. For an uncomplicated pregnancy, the patient is going to remain in the hospital at least twenty-four to forty-eight hours, for a cesarean-section ("C-section") even longer, and for a more complicated pregnancy, potentially even longer still. Again, this means that the patient will require a use of a hospital bed or room and will require the time and attention of hospital staff, who will have to use PPE during interactions with the patient.

34. While many families are overjoyed by pregnancy, even an uncomplicated pregnancy poses challenges to a pregnant person's entire physiology and stresses most major organs. For example, during pregnancy patients' lungs are working harder, while their ability to breathe in the first place is hampered by the fetus growing in the abdomen, leaving most pregnant patients feeling chronically short of breath. Every organ in the abdomen—e.g., intestines, liver, spleen—is increasingly compressed throughout pregnancy by the expanding uterus; for this and other reasons, many pregnant patients experience gastrointestinal distress, such as diarrhea, nausea, or vomiting, throughout their pregnancy. And a patient is at greater risk for certain infections and other conditions such as blood clots or thrombosis.

35. Moreover, there is a fifteen to twenty percent risk of miscarriage present in every pregnancy. Complications from miscarriage can lead to infection, hemorrhage, surgery, and even death, and such complications are greater during miscarriage than after an abortion.[24] Pregnant

[24] The risk of death with miscarriage is 2.1 times that with legal abortion, and the risk of death with miscarriage after twenty weeks LMP (also known as fetal death) is nearly 170 times that with legal abortion. David A. Grimes, *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999*, 194 Am. J. Obstetrics & Gynecology 92 (2006). Additionally, the rate of infection following miscarriage is approximately 2 to 3%, compared to a rate of 0.0 to 0.4% for procedural abortions. J Trinder et al., *Management of Miscarriage: Expectant, Medical, or Surgical? Results of Randomised Controlled Trial (Miscarriage Treatment (MIST) Trial)*, 332 BMJ (2006); Kari White, Erin Carroll & Daniel Grossman, *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422

patients experiencing a miscarriage—typically manifesting as severe, unexpected bleeding—often present to hospital emergency departments for care.

36. Even an uncomplicated pregnancy can suddenly become life-threatening during labor and delivery. Furthermore, one-third of pregnancies nationally and thirty-two percent in Tennessee[25] result in a C-section delivery. Even though a C-section delivery is a relatively common occurrence, it is still a significant abdominal surgery that carries risks of hemorrhage, infection like chorioamnionitis or endometriosis, increased risk of preeclampsia or eclampsia, and injury to internal organs. And even a vaginal delivery can lead to injury, such as injury to the pelvic floor.

37. Much is currently unknown about COVID-19. ACOG[26] has recommended that, "given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted." Accordingly, ACOG recommends that pregnant people reporting certain potential COVID-19 symptoms—including symptoms that are common during pregnancy for unrelated reasons, such as difficulty breathing—should "immediately seek care in an emergency department or equivalent unit that treats pregnant women," be isolated if possible, and "adhere to local infection control practices regarding personal protective equipment."

(2015); *see also* Diana Taylor et al., *Standardizing the Classification of Abortion Incidents: the Procedural Abortion Incident Reporting and Surveillance (PAIRS) Framework*, 96 Contraception 1 (2017).

[25] Nat'l Ctr. for Health Statistics, Cesarean Delivery Rate by State (2019), https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm.

[26] *See* Am. Coll. of Obstetricians & Gynecologists and Soc. for Fetal-Maternal Med., *Patient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Mar. 2020), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6.

38. In sum, forcing a patient to carry an unwanted pregnancy to term will not only increase the risks to their health and well-being, but will also increase the duration and frequency of their interactions with medical clinicians and the amount of PPE expended on their care, which may inhibit public health officials' ability to further reduce transmission of COVID-19 and the current strain on the medical system.

Executive Order 25

39. On April 8, 2020, Governor Bill Lee signed EO 25, which took effect at 12:01 a.m. on April 9, 2020 and is currently set to expire on April 30, 2020.

40. EO 25 mandates that "[a]ll healthcare professionals and healthcare facilities in the State of Tennessee shall postpone surgical and invasive procedures that are elective and non-urgent." EO 25 at 2. "Elective and non-urgent procedures" are further defined as "those procedures that can be delayed until the expiration of this Order because they are not required to provide life sustaining treatment, to prevent death or risk of substantial impairment of a major bodily function, or to prevent rapid deterioration or serious adverse consequences to a patient's physical condition if the surgical or invasive procedure is not performed, as reasonably determined by a licensed medical provider." *Id.* at 2–3.

41. As part of the justification for these measures, EO 25 states that "limiting the dental and medical procedures that may be performed during the current state of emergency serves the joint goals of preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through nonessential patient-provider interactions."[27]

[27] Elsewhere in EO 25, personal protective equipment is listed to include "medical gowns, N95 masks, surgical masks, TYVEK suits, boot covers, gloves, and/or eye protection." EO 25 at 3.

42. The EO does not specify penalties for noncompliance. However, it is my understanding that physicians may face severe penalties including potentially being charged with a class A misdemeanor for violating executive orders like this one, and that enforcement actions can be taken against facilities as well.

Harms Caused by EO 25

43. As ACOG, the leading national authority on women's health care, has explained, abortion services are "time-sensitive" and "essential" health care, and delaying such care can jeopardize patients' health. Nevertheless, I and the other PPTNM providers cannot provide procedural abortions given the extremely restrictive language of EO 25, as we risk criminal penalties if the State disagrees with our medical judgment. Accordingly, PPTNM has been forced to cancel all procedural abortions at our Tennessee health centers. To be clear, while I believe our abortion patients will be greatly harmed by having their procedural abortions significantly delayed, and some will be prevented from having an abortion altogether (thus facing the far greater risks associated with continued pregnancy and childbirth), with criminal penalties on the line, I and other PPTNM providers simply cannot risk providing this care under EO 25.

44. Some patients who are currently close to PPTNM's limit at 19.6 weeks LMP—generally the latest point at which abortion services are available in Tennessee—will be prevented from obtaining an abortion in the state entirely if they have to delay their abortions while EO 25 is in effect.

45. And EO 25 will also delay many patients who are not as close to the point at which procedural abortions are unavailable in Tennessee because, even assuming that EO 25 will expire at the end of April, there will only be three physicians in the state who can provide procedural abortions until 19.6 weeks LMP at that time. While PPTNM normally has additional providers

to provide later abortions, these providers are unable to travel to the clinic at this time due to the COVID-19 crisis.

46. Whenever EO 25 expires, all of the patients still able to legally obtain an abortion in Tennessee will attempt to obtain this care at the same time, before they reach the point in pregnancy at which abortion is no longer available in the state. This will create a crushing demand that health centers are unlikely to be able to meet. As the only provider in the state that provides care after 15 weeks LMP, PPTNM will be especially hard-hit if patients are forced to delay their abortion care later into the second-trimester of their pregnancies. There is simply no way that I and two other doctors will have the capacity to care for the large number of Tennessee patients who will need our services if, as a result of the delay imposed by EO 25, PPTNM becomes the only provider in the state where many patients can come for care.

47. Patients, of course, will also be delayed due to the state's forty-eight-hour mandatory delay, two-trip requirement. For this reason, too, I do not believe we will be able to meet all patient demand after EO 25 is lifted.

48. All of this will result in patients facing significant delays when attempting to schedule appointments after EO 25 expires. And some will be pushed past 19.6 weeks LMP and will no longer be able to obtain an abortion.

49. Patients delayed in accessing abortion will suffer increased risks to their physical health from remaining pregnant for longer against their will.[28] While abortion is extremely safe throughout pregnancy, the risks increase as pregnancy progresses, and the later in pregnancy a patient accesses a procedural abortion the more likely she is to experience a rare complication like hemorrhage, uterine perforation, cervical laceration or retained products of conception. These

[28] Nat'l Acads., *supra* note 2, at 77–78.

pregnant patients may also suffer heightened emotional distress or anxiety as a result of this public health crisis, which has pushed hospitals and the medical professional to a breaking point; they may be concerned that if they face issues with their pregnancy, a medical facility or hospital may struggle to accommodate them and their partners or support people, or that (by virtue of seeking the extensive medical care, including hospital-based care, associated with pregnancy) they may be exposed to COVID-19.

50. For those patients still able to obtain abortions after EO 25 expires, many will face increased financial and health costs related to abortion, as they will have been pushed later into pregnancy, when abortion is more expensive[29] and the procedure is more complicated, and thus carries with it greater risks. Pushing patients to obtain care later in their pregnancies will not only risk harm to their physical and mental health and financial well-being; it will also increase the duration and frequency of patient interactions with the outside world and the use of PPE, precisely the opposite of the Executive Order's stated goals. For example, patients may need more complicated procedural abortions using the D&E technique rather than the aspiration technique. The D&E technique requires more time in the clinic and a larger number of staff than aspiration abortion—which increases both the exposure risks that patients and staff face, as well as the amount of PPE that must be used. Some of these patients will be delayed to the point that they must have a two-day D&E procedure (which is necessary starting at eighteen weeks LMP), rather than a one-day procedure. This will likewise require more contact and use of PPE.

[29] At PPTNM health centers, the cost of procedural abortion goes up as pregnancy advances and the procedure becomes more complex and requires more staff time and resources. For example, a two-day procedure, starting at eighteen weeks LMP, is $500 more expensive than a procedural abortion at eleven weeks LMP.

51. Other patients, rather than wait for EO 25 to expire—or because they simply cannot afford to wait, given where they are in their pregnancies—may attempt to travel hundreds of miles out of state to try to obtain an abortion. This requires them to overcome all of the logistical barriers associated with accessing abortion discussed above, including finding and paying for transportation and (if needed) childcare, and trying to obtain time off work. And, as explained above, all of this may be more difficult and costly in the midst of the current COVID-crisis, given the effects it has had on unemployment rates and shutting down childcare options.

52. Moreover, given the logistical hurdles of traveling out-of-state, particularly during the COVID-19 pandemic, these patients also are likely to obtain abortions later than they would were they able to access care within the state, which—as noted above—entails greater risks and costs than an earlier procedure. And efforts to travel are also likely to expose both patients and other people to additional risk of contagion, because such travel will require patients to have contacts with many individuals to obtain childcare, transportation, food, and lodging necessary to make the trip at a time when states, including Tennessee, and public health experts have urged their citizens to reduce travel and stay at home as much as possible in order to reduce the rate of transmission of COVID-19. This will only further undermine the State's efforts to contain the virus because these contacts increase the risk of contracting COVID-19 and bringing the virus back to families and communities in Tennessee.

53. For other patients, travel to another state will simply not be possible, particularly during the pandemic. As stated above, many of our patients at PPTNM are poor or low-income

and already struggle to raise the money to afford an abortion, and to afford transportation, childcare, and lost wages for missed work.

54. Finally, as I noted above, some patients, including those who are unable to overcome the logistical and financial barriers associated with accessing care out of state, and those foreclosed from accessing abortion at all given their stage of pregnancy, will be forced to carry to term against their will. As a result, these patients will have to seek out and obtain prenatal care and will eventually go into labor and give birth which, as discussed above, only increases their interactions with the health care system and requires *more* health care resources, not less.

55. Moreover, studies have shown that patients who are denied a wanted abortion (in contrast to those able to obtain abortion care) face serious consequences, including greater likelihood of living in poverty, staying in abusive relationships, and experiencing mental health issues.[30] They and their newborns are also at risk of negative health consequences such as reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes, such as increased risk of preterm delivery.[31] Additionally, patients who seek abortion care but are unable to access that care face large and persistent negative consequences for their financial well-being, as compared to their counterparts who received wanted abortions.[32]

56. We know from experience that when patients cannot access the services they need to terminate a pregnancy within the healthcare system, some will find ways to do so outside the

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[30] Advancing New Standards in Reproductive Health, *Turnaway Study* (2020), https://www.ansirh.org/research/turnaway-study.

[31] A.P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson, Michael A. Koenig & Michelle J. Hindin, *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Family Plan. 18 (2008).

[32] Sarah Miller, Laura R. Wherry & Diana Greene Foster, Nat'l Bureau of Econ. Res. (NBER), NBER Working Paper No. 26662, *The Economic Consequences of Being Denied an Abortion* 26 (Jan. 2020), *available at* https://www.nber.org/papers/w26662.pdf (finding that the impact of

healthcare system, not all of which may be safe. If attempts to self-induce give rise to additional health problems, some of these patients may be forced to seek emergent medical care, thereby increasing their interactions with the outside world and further taxing the medical system as it works to respond to the COVID-19 crisis.

57. In sum, if EO 25 remains in effect, even for just a few more weeks, it will not only inflict extreme harm on our patients, it will also risk exacerbating the COVID-19 crisis, thereby undermining the stated purpose of the EO itself.

58. Although EO 25 indicates that it will expire on April 30, 2020, I fear it is likely to be extended. Certainly, it is clear that the pandemic is likely to continue beyond this period.[33] If that happens, many more of my patients will be forced to remain pregnant and give birth against their will. Not only would that be profoundly harmful for them, but it would force them into the hospital system, putting them at further risk and further depleting the PPE, personnel and facilities needed to fight this pandemic and mitigate its deadly impact. Using this crisis as a justification for banning procedural abortions is one of the most irrational, and frankly dangerous, public health arguments I have ever encountered.

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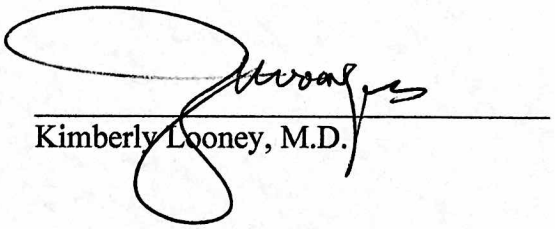
being denied an abortion on unpaid bills being reported to collection agencies is as large as the effect of being evicted, and "the impact on unpaid bills is several times larger than the effect of losing health insurance.").

[33] *See, e.g.*, Quint Forgey, *Social Distancing Guidelines Will Likely Be in Place Beyond April, Surgeon General Says*, Politico (Apr. 1, 2020, 10:28 AM), https://www.politico.com/news/2020/04/01/jerome-adams-coronavirus-social-distancing-guidelines-158998.
Denise Grady, *Not His First Epidemic: Dr. Anthony Fauci Sticks to the Facts*, N.Y. Times (Mar. 8, 2020), https://www.nytimes.com/2020/03/08/health/fauci-coronavirus.html (federal officials and medical professionals expecting the pandemic to last for a year or eighteen months).

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed on April 12, 2020, in Nashville, Tennessee.



Kimberly Looney, M.D.

EXHIBIT A

CURRICULUM VITAE

KIMBERLY R. LOONEY, MD, FACOG

Work Address - Main
Planned Parenthood of TN and North MS
412 Dr. D. B. Todd, Jr. Boulevard
Nashville, TN 37203
Main: (866) 711-1717
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Work Address - Other
Planned Parenthood of TN and North MS
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Memphis, TN 38112
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Direct: (901) 725-1717
Fax: (615) 725-3030
Email: klooney@pptnm.org

PAST ACADEMIC RANK AND POSITION

Assistant Professor
Director of Family Planning Services
Director of Kenneth J. Ryan Residency Training Program
Residency Program Director
Department of Obstetrics & Gynecology
Meharry Medical College
Nashville, TN

EDUCATION

Jul 2006 – Jul 2008	**Department of Gynecology & Obstetrics** **Emory University School of Medicine, Atlanta, GA** *Family Planning & Reproductive Health Fellowship* **Emory University Rollins School of Public Health, Atlanta, GA** *Masters of Public Health in Global Health*
Jun 2005 – Jun 2006	**University of Illinois at Chicago Medical Center, Chicago, IL** *Residency in Obstetrics & Gynecology, Chief Resident*
Jun 2002 – Jun 2005	**University of Illinois at Chicago Medical Center, Chicago, IL** *Residency in Obstetrics & Gynecology*
Aug 1997 – Jun 2002	**University of Tennessee at Memphis Health Sciences Center, Memphis, TN** *Doctorate of Medicine*
Aug 1992 – May 1996	**Fisk University, Nashville, TN** *Bachelors of Arts in Chemistry, Magna cum laude*

BOARD CERTIFICATION

2013	American Board of Obstetrics & Gynecology Active: 9012705. Expiration: 12/31/2020.

MEDICAL LICENSURES

2008	Tennessee State Board of Medical Examiners Active: 43920. Expiration: 01/31/2022.
2006	Georgia Composite State Board of Medical Examiners Active: 058274. Expiration: 01/31/2020.
2005	Illinois Division of Professional Regulations Inactive: 36114016. Retired: 07/31/2014.
2005	Controlled Substance Registration Certificate Status: Active. Expiration: 03/31/2021.

OTHER PROFESSIONAL CERTIFICATIONS

2019	**Advanced Cardiac Life Support** Expiration: 11/19/2021
2016	**Basic Life Support** Expiration: 09/30/2020
2018	**Advanced Techniques in Minimally Invasive Gynecological Surgery (MIGS): Reduced Port, Hand Access & Specimen Extraction Course** Applied Medical, Nashville, TN
2017	**Neonatal Resusitation Program** Expiration: 11/30/2019
2016	**Total Laparoscopic Hysterectomy Course** Ethicon Medical, Houston, TX
2011	**Nexplanon Training Program - Master Faculty** Merck Medical
2006	**Implanon Training Program - Master Faculty** Organon USA, Inc.
2005	**Essure Certification** Conceptus, Inc.

WORK EXPERIENCE

Apr 2019 – current	**Chief Medical Officer** Planned Parenthood of Tennesee and North Mississippi, Memphis, TN
Dec 2018 – current	**Contracted Physician,** *Department of Obstetrics & Gynecology* OB Hospitalist Group/TriStar Centennial Women's Hosptial, Nashville, TN
Oct 2008 – Jun 2019	**Contracted Physician,** *Department of Surgery, Gynecology Division* Veterans Affairs Hospital- York Campus, Murfreesboro, TN
Jul 2016 – Dec 2018	**Residency Program Director,** *Obstetrics & Gynecology* Meharry Medical College School of Medicine, Nashville, TN
Aug 2008 – Dec 2018	**Assistant Professor,** *Department of Obstetrics & Gynecology* **Director,** *Family Planning Services* **Director,** *Kenneth J. Ryan Residency Training Program* Meharry Medical College School of Medicine, Nashville, TN
Nov 2008 – Nov 2017	**Contracted Physician** **Director & Clinical Faculty,** *Kenneth J. Ryan Residency Training Program* Planned Parenthood of Middle & Eastern TN, Nashville, TN
Feb 2015 – Jun 2016	**Associate Residency Program Director,** *Obstetrics & Gynecology* Meharry Medical College School of Medicine, Nashville, TN
Jul 2006 – Jul 2008	**Fellow Clinical Instructor,** *Department of Obstetrics & Gynecology* Emory University School of Medicine, Atlanta, GA
Jul 2006 – Jul 2008	**Contracted Physician** Feminist Women's Health Center, Atlanta, GA
Apr 2005 – May 2006	**Chief Administrative Resident**, *Department of Obstetrics & Gynecology* University of Illinois at Chicago Hospital, Chicago, IL
Jun 1999 – May 2000	**Math & Science Instructor** *(Chemistry, Physics & Pre-Calculus)* Upward Bound Program, LeMoyne-Owen College, Memphis, TN
Oct 1996 – Aug 1997	**Intramural Research Training Award Pre-Doctoral Fellow** National Institutes of Health, Bethesda, MD
Summer 1996, 1997	**Tissue Procurement Team** Tennessee Donor Services, Nashville, TN
Feb 1996 – Jun 1996	**Substitute Teacher** Nashville Metropolitan School System, Nashville, TN
Aug 1994 – Jun 1996	**Pharmacy Technician** Walgreen's Pharmacy, Nashville, TN

OTHER PROFESSIONAL WORK EXPERIENCE

2017	**Consultant – Intrauterine System (IUS) Cross Training Workshop** Bayer Women's Healthcare
2013	**Consultant – Intrauterine System Peer Education Video** Bayer Women's Healthcare
2012 – 2013	**Consultant – Long-acting Reversible Contraception Advisory Board** Bayer Women's Healthcare
2011 – 2015	**Speakers Bureau – Mirena IUS/Skyla IUS** Bayer Women's Healthcare
2006 – current	**Speakers Bureau and Training Faculty – Short and Long-Acting Contraception (Nuvaring/Implanon/Nexplanon) and Gardisil-9** Merck Pharmaceuticals

POSTGRADUATE TRAINING

2015 – 2016	**CREOG School for Program Directors – 16th Term** Council of Resident Education in Obstetrics & Gynecology
2015	**Sex and Gender Medical Education Summit** Mayo Clinic, Rochester, MN
2007	**Policy, Advocacy, Legislation and Media (PALM) Training** Reproductive Health Technologies Project, Washington, D.C.
2006 – 2007	**Leadership Training Initiative** Physicians for Reproductive Health and Choice, New York, NY
2002	**Mission Trip to Nigeria, Africa,** *OB and Primary Care Elective* Nnamdi Azikiwe Teaching Hospital, Nnewi, Nigeria

RESEARCH EXPERIENCE

Research Thesis **2006 - 2008**

Emory University, Family Planning Division, Department of Gynecology & Obstetrics, Atlanta, GA

Advisor Carrie A. Cwiak, M.D., MPH. "Continuation rates of short-term hormonal methods (pill, patch, depo provera) after abortion." A secondary analysis of a survey study assessing birth control continuation rates after abortion.

Principal Investigator **2006 - 2008**

Emory University, Family Planning Division, Department of Gynecology & Obstetrics, Atlanta, GA

Preceptor Carrie A. Cwiak, M.D., MPH. "Mirena after medical abortion: the MAMA Trial." A randomized control trial of immediate vs. delayed LNG-IUS placement following medical abortion.

Research Investigator **2005 - 2006**

University of Illinois at Chicago, Dept. of Obstetrics & Gynecology, Chicago, IL

Preceptor Gloria Elam, M.D., MPH. A retrospective, comparative study to evaluate if the time in which sexual education is introduced influences the timing of first intercourse and contraception use in female teenagers.

Intramural Research Training Award Pre-Doctoral Fellow **1996 - 1997**

National Institutes of Health/National Cancer Institute, Bethesda, MD

Preceptor Ernest Hamel, M.D., Ph.D. Assayed the cytotoxicity of various anti-mitotic agents for potential cancer therapy.

Research Assistant **1996**

Meharry Medical College, Dept. of Obstetrics & Gynecology/MEDTEP, Nashville, TN

Administered survey seeking to determine the effects of short hospitalization on the health of mother and newborn, long-term costs, and satisfaction of service received.

Co-op/Student Investigator **1995**

HOWMEDICA, Inc. /Division of Pfizer Pharmaceutical, Rutherford, NJ

Preceptor D.C. Sun, Ph.D. Evaluated the degradation of various plastics by UV sterilization for prosthetic implants.

Summer Research Fellow **1994**

Harvard Medical College, Summer Honors Undergraduate Research Program, Boston, MA

Preceptor Geoffrey Ginsburg, M.D., Ph.D. [1]Investigated the regulation of the cholesterol ester transfer protein (CETP) gene by cholesterol. Work awarded.

Research Assistant **1992**

Fisk University, Department of Biology, Nashville, TN

Preceptor M. Gunasakaren, Ph.D. Studied the development of micro-organisms for use as organic, biological insecticides.

Mentorship/Student Investigator **1988, 1990 – 1992**

Meharry Medical College, Department of Physiology, Nashville, TN

Preceptor H.K. Rucker, Ph.D. Participated in the study of IMID through auditory brainstem response and multi-unit recording via the auditory system. Work awarded.

Mentorship/Student Investigator **1989 – 1990**

Meharry Medical College, Department of Pharmacology, Nashville, TN

Preceptor A. Maleque, Ph.D. Conducted an invasive study on the effects of mescaline and atropine on the eye of male albino rats. Work awarded.

FORMAL TEACHING AND LECTURESHIPS

Professional Programs:

2016 – 2018 **Obstetrics & Gynecology Departmental Educational Retreat**
Meharry Medical College, Nashville, TN

2013	**LARC and Essure Clinical Skills Teaching Instructor** National Medical Association National Meeting, Toronto, CA
2008 – current	**Implanon/Nexplanon Training Master Faculty and Speaker** Merck, Meharry Medical College and Nashville Metro Areas, TN
2007 – 2008	**Implanon Training Master Faculty and Speaker** Organon USA, Inc., Emory and Atlanta Metro Areas, GA
2006 – 2007	**Intrauterine Device (IUD) Insertion Instructor** Contraceptive Technology Conference, Atlanta, GA
2003	**Paragard Insertion Clinical Instructor** FEI Women's Health Update on Paragard, Chicago, IL

Postgraduate Lectureships and Simulation Modules:

2017	"Current Epidemiology of STDs." Meharry Medical College, Nashville, TN
2016 – 2018	Surgical Approaches to Postpartum Hemorrhage Simulation, Meharry Medical College, Nashville, TN
2016 – 2018	"Professional Development: Understanding ABOG Certification." Meharry Medical College, Nashville, TN
2016	"Perinatal Conference: Amniotic Band Sequence." Meharry Medical College, Nashville, TN
2015 – 2018	"Physician Wellness: Recognition of Burnout." Meharry Medical College, Nashville, TN
2012 – 2018	Essure Simulation, Meharry Medical College, Nashville, TN
2010 – current	Basic Surgical Techniques Simulation, Meharry Medical College, Nashville, TN
2010 – current	"Early Pregnancy Loss Resolution." Meharry Medical College, Nashville, TN
2009 – current	Manual Vaccuum Aspiration (MVA) Papaya Simulation, Meharry Medical College, Nashville, TN
2008 – current	Long-acting Reversible Contraception (LARC) Simulation Part II – Intrauterine Contraception, Meharry Medical College, Nashville, TN
2008 – current	Long-acting Reversisble Contraception (LARC) Simulation Part I – Subdermal Contraception, Meharry Medical College, Nashville, TN
2008 – current	"Comprehensive Contraception Care." Lecture series (5 part). Meharry Medical College, Nashville, TN
2006 – 2008	"Contraception and Abortion." Emory University, Atlanta, GA

School of Medicine Curriculum:

2014 – 2018	"Spontaneous Abortion and Ectopic Pregnancy." Meharry Medical College, Nashville, TN
2013 – 2015	"Breast Disorders." Meharry Medical College, Nashville, TN
2008 – 2018	"Comprehensive Contraception Care Quickstart." Meharry Medical College, Nashville, TN

Other:

1999 – 2000	**Math & Science Instructor** (Chemistry, Physics & Pre-Calculus) Upward Bound Program, LeMoyne-Owen College, Memphis

Presentations - National Meetings:

- "Contraception Updates." Guest Lecturer. National Medical Association. Obstetrics & Gynecology Section. Oahu, HI. August 2014.
- "LARC Updates and Clinical Scenarios." Guest Lecturer. National Medical Association. Obstetrics & Gynecology Section. Toronto, CA. Aug 2013.
- "Intrauterine Device Management: Challenging Cases." Guest Lecturer. Contraception Technology: Quest for Excellence. Atlanta, GA. October 2009.
- "Continuation rates of short-term hormonal methods after abortion." Oral presentation. ARHP National Conference. Washington, D.C. September 2008.
- "Contraceptive Implants and General Hysteroscopy" and "Contraception Updates." Guest Lecturer. National Medical Association Annual Meeting. Atlanta, GA. July 2008.
- "Intrauterine Contraception Management Issues: A Case-Based Approach." Guest Lecturer. Contraception Technology: Quest for Excellence. Atlanta, GA. November 2007.
- Undergraduate Presenter in Biomedical & Molecular Chemistry. National Institute of Science/ Beta Kappa Chi Joint Annual Meeting, Greensboro, NC. March 1996.
- Undergraduate Presenter. National Science Foundation Annual Meeting, Washington, D.C. December 1992.

Grand Rounds & Other Lectureships:

- "Womens Health & Prevention – General Concerns." Guest Speaker. Health Watch Radio Broadcast. WFSK 88.1 FM. Fisk University. Nashville, TN. September 2016.
- "LARCs and Other Contraception Updates." Guest Speaker. Health Watch Radio Broadcast. WFSK 88.1 FM. Fisk University. Nashville, TN. August 2014.

- "Breastfeeding: The Organic Milk." Lecturer. James Research Symposium. Meharry Medical College, Department of Obstetrics & Gynecology. Nashville, TN. April 2014.

- "IUD Updates: Introducing Skyla." Grand Rounds. University of Tennessee at Knoxville, Department of Obstetrics & Gynecology. Knoxville, TN. August 2013.

- "New Approaches to Unintended Pregnancy Prevention: Emergency Contraception in Primary Adolescent Care." Grand Rounds. Meharry Medical College. Nashville, TN. November 2012.

- "Cervical Cancer Prevention and Updates." Guest Speaker. Health Watch Radio Broadcast. WFSK 88.1 FM. Fisk University. Nashville, TN. January 2012.

- "Cervical Cancer." Guest Lecturer. Davidson County Health Department. Nashville, TN. November 2007.

- "Techniques in Medical Abortion and Manual Vacuum Aspiration." Grand Rounds. Vanderbilt University SOM, Department of Obstetrics & Gynecology. Nashville, TN. October 2010.

- "Clinical Updates in IUD Contraception." Grand Rounds. Meharry Medical College, Department of Obstetrics & Gynecology. Nashville, TN. March 2009.

- "Intrauterine contraception management issues: A case-based approach." Emory University SOM, Family Planning Lecture Series. Atlanta, GA. January 2008.

- "IUD insertion after medical abortion." Emory University School of Medicine, Family Planning Lecture Series. Atlanta, GA. July 2007.

- "The invisible patient: Providing quality healthcare for our GLBTQ patients." Emory University SOM, Family Planning Lecture Series. Atlanta, GA. January 2007.

- "Counseling patients for medical abortion." Emory University School of Medicine, Family Planning Lecture Series. Atlanta, GA. August 2006.

- "The CREOG series for gynecology." University of Illinois- Chicago, Resident directed 7-week lecture series. Chicago, IL. December 2005 – January 2006.

- "The grasshopper series." University of Illinois- Chicago, Resident directed 6-weeks lecture series. Chicago, IL. March 2005 – April 2006.

PROFESSIONAL AND SOCIETY MEMBERSHIPS

- American Congress of Obstetrics & Gynecology
- Association of Professors of Gynecology & Obstetrics
- National Medical Association
- Society of Family Planning
- Association of Reproductive Health Professionals
- Physicians for Reproductive Choice and Health
- Alpha Kappa Alpha Sorority, Inc.

INSTITUTIONAL AND DEPARTMENTAL COMMITTEE MEMBERSHIPS

2017	**Graduate Medical Education Ad Hoc Committee,** *Chair*
2017 – 2018	**Strategic Planning Committee,** *School of Medicine*
2015 – 2018	**Graduate Medical Education Committee**
2015 – 2018	**Program Evaluation Committee,** *Department of Obstetrics & Gynecology*
2013 – 2015	**James Symposium Planning Committee,** *Dept. of Obstetrics & Gynecology*
2012 – 2018	**Committee of Education and Life Long Learning,** *Co-chair*
2011 – 2018	**Clinical Competency Committee,** *Department of Obstetrics & Gynecology*

HONORS AND AWARDS

2018	**10 Year Service Award** *Metropolitan Nashville Hospital Authority*
2017, 2018	**Distinquished Faculty Presenter – Match Day** *Meharry Medical College School of Medicine*
2017	**Alpha Omega Alpha Honor Medical Society** *Meharry Medical College, Gamma Chapter*
2013	**Fellow** *American Congress of Obstetrics & Gynecology*
2013	**Gold Humanism Honor Society** *Meharry Medical College School of Medicine*
2011	**Council on Resident Education in Obstetrics & Gynecology (CREOG) Faculty Teaching Award** *Meharry Medical College*
2006	**PGY-4 Resident Teaching Award** *University of Illinois at Chicago Hospital*
2005	**Association of Professors of Gynecology and Obstetrics (APGO) Scholars Resident Teaching Award**
1999 – 2002	**Imhotep Leadership Society** *University of Tennessee at Memphis Health Sciences Center*
1999	**Keynote Commencement Speaker** *King Magnet HS for Health Sciences & Engineering, Nashville, TN*

RESEARCH INTERESTS

My research interests include utilization of long-acting reversible contraception and means of improving health literacy & education.

RESEARCH AND TRAINING GRANTS AWARDED

2008 Kenneth J. Ryan Residency Training Program Grant
Bixby Center for Global Reproductive Health, U. of California – San Francisco

BIBLIOGRAPHY

- Ladson, G.M., Looney, K.R., Jackson, S.A. (2017). Disability of Pregnancy. (Book chapter)
- Smith, K., Sanket, N., Rana, T., Archibong, A. & Looney, K.R. (2018) Do progestin-only contraceptives contribute to the risk of developing depression as implicated by reduced levels of beta-arrestin 1 protein in mononuclear leukocytes? A pilot study. *Contraception*. (submitted)

PERSONAL INTERESTS

Hobbies include collecting music, art/interior design, exploring new places & cultures and volleyball.

Exhibit 6

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., on behalf of itself and its patients; et al., Plaintiffs, v. HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; et al., Defendants.	)	CASE NO. 3:15-cv-00705 JUDGE FRIEDMAN MAGISTRATE JUDGE FRENSLEY

DECLARATION OF REBECCA TERRELL IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

REBECCA TERRELL hereby declares under penalty of perjury that the following statements are true and correct:

1. I am the Executive Director of CHOICES: Memphis Center for Reproductive Health, an independent healthcare clinic in Memphis, Tennessee ("CHOICES"). Memphis Center for Reproductive Health, the nonprofit organization that runs CHOICES, is a plaintiff in this case.

2. CHOICES opened in Memphis in 1974. Its mission is to provide patient-centered medical care and to champion sexual and reproductive rights. We serve stigmatized populations in the community and provide holistic, comprehensive reproductive health care that integrates

abortion and family planning care into mainstream medical practice rather than isolating those services and the patients who need them.

3. Prior to the COVID-19 crisis, CHOICES provided the full spectrum of reproductive healthcare, including abortion up to 15 weeks of pregnancy (as measured from patients' last menstrual period, or "LMP"), gynecological care, birth control and family planning, testing and treatment for sexually transmitted infections, HIV testing and referrals, LGBTQ services (including hormone therapy for transgender patients), and pregnancy-related and midwifery care. This includes pregnancy testing, preconception counseling, pregnancy options counseling, adoption referral, ultrasound services, prenatal care, birthing services at home or in the hospital, and postpartum care.

4. I have been the Executive Director of CHOICES for over ten years. As Executive Director I oversee all aspects of the clinic's work, including day-to-day clinic operations. I supervise the medical director, director of finance and operations, and director of external affairs. I am familiar with all aspects of abortion clinic operations and patient care.

5. I am also currently overseeing the construction of a new health center that will house the first licensed birthing center in Memphis, Tennessee, with a midwifery practice for patients seeking out-of-hospital birthing services, along with all of the other services currently provided at CHOICES. The new health center is currently scheduled to open in June of 2020.

6. I am offering this declaration in support of Plaintiffs' Motion for Temporary Restraining Order and/or Preliminary Injunction against Executive Order 25 ("EO 25"), as it applies to procedural abortions in Tennessee. EO 25 prevents CHOICES from providing essential and time-sensitive abortion care to any patients who are beyond 11 weeks LMP and any patients earlier than 11 weeks LMP who are ineligible for medication abortion care.

7. Since EO 25 was issued on April 8, 2020, CHOICES has already had to cancel appointments for a number of patients who were scheduled for in-person procedural abortions and were not eligible to obtain medication abortions, and there are many more who will not be able to obtain procedural abortions at the clinic until EO 25 expires, whenever that may be. As a result, I fear that many of our patients will be prevented altogether from making the decision to end a pregnancy.

8. I base these facts on my experience, my extensive and close interaction with CHOICES' staff members who work directly with patients, my review of CHOICES' business records, and other information and personal knowledge I have acquired over the course of my time at CHOICES. If called and sworn as a witness, I could and would testify competently to all of the facts set out in this declaration.

Provision of Abortion Care at CHOICES

9. CHOICES provides two types of abortion care: medication abortion and in-clinic procedural abortion. Up until recently we have offered medication abortion for patients up to 10 weeks LMP and procedural abortion (using aspiration) up to 15 weeks LMP. However, in light of the COVID-19 crisis and in order to meet increased patient need while conserving the use of personal protective equipment ("PPE"), we have begun offering medication abortion for patients up to 11 weeks LMP, consistent with evidence showing the safety and efficacy of these medications up to 77 days of pregnancy.

10. In 2019, CHOICES provided 2792 abortion procedures, of which 1654 (approximately 60%) were procedural abortions.

11. Even before the COVID-19 pandemic, patients seeking abortion in Tennessee faced a number of obstacles to receiving care. Access to abortion care in the state is limited to begin

with, with only eight providers in four cities. Every patient seeking an abortion (with limited exceptions only for "medical emergencies," and no exceptions for patients who live in rural areas or must travel long distances to reach the clinic) must first make an additional trip to the clinic at least 48 hours in advance in order to attend an in-person appointment with the physician, and to receive certain state-mandated information that could otherwise be given by phone, videoconference, or website. The patient must then leave the clinic and wait a minimum of 48 hours before she can return to the clinic and obtain her abortion.

12. Tennessee imposes several other targeted restrictions on abortion services. Although Tennessee specifically encourages the use of telemedicine for other types of care, state law prohibits the provision of medication abortion through the use of telemedicine, as well as the provision of the mandatory in-person counseling appointment. Tennessee law also makes it illegal for anyone other than a physician (such as a nurse practitioner or nurse-midwife) to prescribe or dispense the medications for medication abortion. The state prohibits Medicaid and insurance coverage of abortion in any state exchanges established by the Affordable Care Act. And patients who are under the age of 18 cannot obtain an abortion in Tennessee without parental consent unless they go to court to obtain a judicial bypass.

13. Against this backdrop of legal restrictions, patients face numerous financial and logistical obstacles to obtaining abortion care. In addition to covering the costs of the abortion, patients must take (often unpaid) time off work and arrange for transportation and childcare. Because of the mandatory 48-hour delay, patients must overcome these financial and logistical hurdles for two separate appointments, compounding these costs and burdens. This is especially onerous for patients who have to travel longer distances to obtain care, as this requires additional, costly logistical arrangements, including being away from home and work for longer, needing

more childcare, and possibly needing to inform others of the reasons for the appointments. Due to these obstacles, women are already frequently delayed much more than 48 hours in obtaining abortion care.

14. These burdens are felt most harshly by our poor and low-income patients, who can ill afford these additional costs. TennCare, the State's Medicaid program, is prohibited by state law from covering abortions, and health insurers often do not cover abortion procedures. Thus, most patients are forced to pay out of pocket or seek private financial assistance. Approximately 80% of CHOICES' patients are at or below 110% of the federal poverty level.

15. The obstacles our patients face are only exacerbated by the COVID-19 pandemic. In addition to trying to keep themselves and their families safe, our patients are dealing with lost jobs, increased financial insecurity, loss of childcare, loss of support networks, such as extended family or friends, and limitations on travel. But their need for timely access to abortion care remains despite the pandemic. Prior to EO 25, we routinely heard from patients who were terrified that because of the COVID-19 crisis, we would be shut down and unable to provide them the care they need. Now, because of EO 25, we are forced to tell patients seeking procedural abortions that we cannot provide them care for over two weeks, and likely longer if EO 25 is extended, as is widely expected.

16. The patients who come to CHOICES seeking abortion care do so for a variety of medical, familial, financial, and personal reasons. Most of our patients are already parents, and most are poor or low-income. Some patients seek abortion care because they face serious health issues that make it dangerous to carry a pregnancy to term. Others are in abusive relationships and fear for their safety. These concerns, if anything, are magnified in the context of the COVID-19 crisis.

CHOICES' Response to the COVID-19 Outbreak

17. The safety of CHOICES' staff, employees, and patients is of utmost concern to me and to CHOICES during the COVID-19 outbreak. As is true across the nation, the healthcare professionals at CHOICES are committed to protecting our patients' access to safe, high-quality, timely abortion care during this unprecedented crisis.

18. My clinic staff and I are extremely concerned about the COVID-19 outbreak and its impact on our patients and their families. As the COVID-19 pandemic became increasingly serious across the country, CHOICES began to take several steps to do our part to minimize the risk of spread between patients and staff, and we have continued to revise and refine our COVID-19 protocols as the situation evolves, while continuing to comply with all relevant Tennessee laws and regulations governing abortion.

19. Since the start of the COVID-19 crisis, CHOICES has been monitoring and is abiding by the recommendations and guidelines published by the Centers for Disease Control & Prevention, the National Abortion Federation, the World Health Organization, and the Centers for Medicare and Medicaid Services regarding COVID-19. We are taking strict steps to enforce cleanliness, handwashing, and social distancing.

20. We have been screening patients for any COVID-19 symptoms over the phone twenty-four hours before their appointment. We are also screening all patients (and any essential guests) when they arrive for their appointment, prior to entering the facility. This includes checking their temperature prior to entering the clinic.

21. Any person reporting or exhibiting any fever or other symptoms of COVID-19 is not permitted into the clinic. The patient would be permitted to return for their appointment only

after they are medically cleared to safely do so. However, to date, to the best of my knowledge no patient or staff member at the clinic has exhibited symptoms of COVID-19.

22. We are maintaining social distancing during the check-in and waiting process, meaning all patients in the waiting room are separated by at least six feet at all times, and the staff is separated from patients by a glass partition. We have rearranged our waiting room furniture to ensure a sufficient distance between each person and have stopped allowing patients to bring a support person inside the clinic with them unless they are essential, such as a minor with a guardian. Non-patient visitors are required to wait in their cars outside the clinic.

23. We have reduced the number of staff in the clinic by requiring all staff who can work from home to do so. All staff members who are at higher risk for complications from COVID-19 are working from home if they can or staying home on paid leave. This includes four members of our clinical staff (including one of our two physicians), who are at higher risk for infection due to age and underlying health conditions. Accordingly, we have had to cut back our schedule to seeing patients four days a week, rather than our usual five.

24. We have also reduced the number of staff present in the procedure rooms for procedural abortions to only those staff members who are medically essential or mandated by law.

25. CHOICES has also cancelled all volunteer activities, including doulas, and internships at the clinic and has either rescheduled meetings with outside visitors or shifted them to video or teleconference.

26. We have cancelled or rescheduled all wellness appointments, which can be postponed without increasing patient health risks, for non-pregnant patients. Additionally, to reduce in-person contacts, we are conducting follow-up appointments with patients over the phone

whenever possible. We are also conducting patient education sessions virtually, and have switched to using telehealth as much as possible for our non-abortion services.

27. CHOICES has significantly increased the frequency with which we disinfect surfaces in the clinic, including all high-touch areas, such as doorknobs, exam room tables, exam and recovery room chairs, counters, phones, clip boards, pens, and patient chart covers. We require all staff to clean and disinfect their work areas and all patient areas at least three times per day.

CHOICES' Minimal Use of PPE

28. EO 25 cites the American College of Surgeons' recommendation that providers "immediately minimize use of essential items needed to care for patients, including, but not limited to, ICU beds, personal protective equipment, terminal cleaning supplies, and ventilators." EO 25 at 1. However, the prohibition of abortion care at CHOICES does not further this goal.

29. CHOICES provides only outpatient care, and we do not have any hospital beds or ventilators. We do not have any N95 respirator masks in our inventory. Abortion care is very safe, and in the rare circumstance that a complication arises, it can usually be managed in the clinic. It is extremely rare for CHOICES to transfer a patient from the clinic to the hospital.

30. Abortion care generally involves very minimal PPE. For procedural abortions, the physicians generally wear reusable scrubs, one pair of sterile surgical gloves to perform the procedure, and sometimes a disposable smock. If the patient has chosen conscious sedation (generally at later gestations) and a Certified Respiratory Nurse Anesthetist ("CRNA") is present, the CRNA also wears reusable scrubs, a hair cover, and one pair of non-sterile gloves. There is also one medical assistant present in the procedure room, who wears one pair of non-sterile gloves.

31. Abortion is not surgery, since it does not involve any incisions, and is not required to be performed in a sterile environment. CHOICES uses non-sterile exam gloves whenever

possible, consistent with medical standards for abortion care. I understand these types of gloves are not generally used by hospitals.

32. Medical assistants trained as ultrasound technicians typically perform an ultrasound prior to all abortions, and the technicians wear reusable scrubs and one pair of non-sterile gloves for each ultrasound exam. Medical assistants also draw blood and take vital signs prior to all abortions, and they wear non-sterile gloves there as well.

33. In response to COVID-19, we are taking additional steps to protect our staff and patients that involve the limited use of additional PPE (drawn wholly from our existing limited inventory). For example, clinicians seeing patients and staff members performing ultrasounds or blood draws are now wearing surgical masks (not N95 masks) to limit the risk of COVID-19 transmission when closely interacting with patients. Many staff members are disinfecting these masks per CDC guidelines. Other staff members have brought their own masks, both store-bought and homemade, to wear for their protection and that of others. We have encouraged the use of personal safety materials, such as homemade cloth masks, so that we can conserve our clinic resources as much as possible in order to continue to provide safe, high-quality, timely care to our patients. We are using a miniscule amount of PPE compared to a hospital, or even other ambulatory surgical treatment centers performing more complicated, invasive procedures.

Impact of Executive Order 25 on CHOICES and its Patients

34. I have reviewed EO 25 and I understand that it directs "[a]ll healthcare professionals and healthcare facilities in the State of Tennessee" to "postpone surgical and invasive procedures that are elective and non-urgent." EO 25 at 2. Elective and non-urgent procedures are defined as "procedures that can be delayed until the expiration of this Order because they are not required to provide life-sustaining treatment, to prevent death or risk of substantial impairment of

a major bodily function, or to prevent rapid deterioration or serious adverse consequences to a patient's physical condition if the surgical or invasive procedure is not performed, as reasonably determined by a licensed medical provider." *Id.* at 2-3. EO 25 is effective and enforceable until 12:01 AM on April 30, 2020.

35. Although EO 25 does not specify penalties for noncompliance, it is my understanding that physicians may face criminal penalties for violations of executive orders.

36. Abortion is time-sensitive, essential healthcare, and delaying care can cause significant harm to patients. Indeed, some patients, if forced to delay care until EO 25 expires on April 30, 2020 (assuming it is not extended or renewed), will be denied care altogether. However, because of the extremely restrictive language of EO 25, coupled with the risk of criminal penalties, CHOICES cannot risk providing patients procedural abortion care while EO 25 is in effect.

37. Thus, EO 25 prevents CHOICES' patients from accessing pre-viability abortions in Tennessee after 11 weeks LMP, and may force some of them to carry pregnancies to term against their will.

38. As a consequence of EO 25, CHOICES was forced to cancel procedural abortions for thirteen patients scheduled for April 9 and 10 who were past 11 weeks LMP and therefore not eligible to obtain medication abortions, all of whom had already traveled to the clinic once to complete their mandatory in-person counseling appointments 48 hours in advance. CHOICES also currently has 156 patients scheduled for their mandatory in-person counseling appointments between now and April 22. At least some of those patients will be prevented by EO 25 from obtaining abortion care at CHOICES altogether, because they will be past 11 weeks LMP and thus unable to obtain medication abortions. I understand that all outpatient abortion providers in

Tennessee have ceased providing procedural abortion care in the State as a result of EO 25, and so CHOICES cannot even refer these patients to other providers in the State.

39. The effect of EO 25's ban on the provision of procedural abortion care has been devastating to our patients. Because EO 25 was implemented overnight, we were unable to reach all of our patients scheduled for procedures on April 9, and several of them arrived at the clinic only to be told that we could not perform their abortions. Patients have been deeply distressed and have expressed fear that they will be unable to obtain abortion care at all, or will be forced to travel out of state, which many of them cannot afford and which they fear will expose them to increased risk of contracting COVID-19.

40. One patient, a minor, came into the clinic with her mother last Thursday to obtain a procedural abortion. When we told them we could not perform the procedure because of EO 25 (and she was not eligible for a medication abortion), they were devastated. They told us they had saved up all their money for the past few days to obtain the procedure and had gone without food to do so. They were terrified that the patient would not be able to receive her abortion anywhere, because they could not afford to travel long distances out of state to obtain care.

41. Those patients who can afford it may attempt to travel out of state to obtain abortion care. Those who do so, potentially using public transportation, place themselves at increased risk of contracting the virus at a time when public health experts have advised the public to minimize travel and activities outside the home. In-person contact with others is unavoidable when patients are traveling hundreds of miles and navigating food, lodging, and transportation. These contacts increase the risk that patients will be exposed to COVID-19 and return to Tennessee with the virus. This possibility is not theoretical; in recent weeks CHOICES has received calls from patients in neighboring states such as Texas, where the provision of abortion services has been sharply

curtailed. And although the closest out-of-state provider is in Little Rock, Arkansas, I understand that abortion access is also threatened there, making it even more difficult for patients to locate a clinic that is open and offering services.

42. But many patients, lacking financial resources to travel, will have no choice but to wait for EO 25 to be lifted to seek abortion care. CHOICES only provides abortion care until 15 weeks LMP, and many patients will be past that gestational age when EO 25 is lifted.

43. If the delay caused by EO 25 pushes patients past 19 weeks, 6 days LMP they will be unable to obtain an abortion in Tennessee at all, as I am not aware of any outpatient provider that provides abortion care in the state past 19 weeks, 6 days LMP (and only two clinics in the state provide care up to that point). In general, when patients come to us past 19 weeks, 6 days LMP we have to refer them out of state for care.

44. Other patients may choose to self-manage their abortion rather than wait for EO 25 to be lifted. And some patients, if unable to obtain abortion care in Tennessee, will be forced to carry their pregnancies to term against their will.

45. Even if some patients are able to wait until April 30, 2020, when EO 25 currently scheduled to expire, forced delay will add to the complexity, cost, and risk of abortion for some, if not all, of these patients. In any event, the more likely scenario is that the COVID-19 pandemic will last well beyond April 30 and the ban will be extended several weeks or even months, preventing numerous patients from accessing abortion care at all.

46. Further, when this emergency order is eventually lifted, there will be a long waitlist of patients who have waited to obtain care for weeks and are now more advanced in their pregnancies, and CHOICES will likely be unable to immediately serve all of the patients seeking abortion care at the clinic. Prior to EO 25 appointment availability at CHOICES was already

limited because one of our physicians is at high-risk for COVID-19 infection and was unable to continue working in the clinic. After EO 25 expires, demand will be even greater than it was previously. Because patients will have been pushed to later points in pregnancy, they are more likely to request sedation, which requires our CRNA to participate in the abortion procedure. Our CRNA is only able to be on site one day per week. In addition, in order to fit in all of the patients who have been pushed close to 15 weeks LMP by the delay imposed by EO 25, CHOICES will likely be forced to delay patients at earlier points in pregnancy. Once patients are finally able to seek abortion care, the mandatory 48-hour delay will force them to wait even longer, exacerbating the increased risks, costs, and burdens already imposed by EO 25. For these reasons, EO 25 will have a cascading effect, forcing numerous patients to delay their procedures so that CHOICES can provide care first to patients who will otherwise not be able to access care at all.

47. I have seen firsthand how Tennessee's current abortion laws already present numerous challenges to CHOICES' patients and make it extremely difficult to keep CHOICES open. EO 25, by delaying patients' access to essential and time-sensitive abortion care, will only exacerbate the challenges our patients face.

I declare under penalty of perjury that the foregoing is true and correct, and that this declaration was executed this 13th day of April, 2020 in Memphis, Tennessee.

REBECCA TERRELL
Executive Director
Memphis Center for Reproductive Health (CHOICES)

Exhibit 7

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., on behalf of itself and its patients; *et al*.,	
Plaintiffs,	CASE NO. 3:15-cv-00705
v.	JUDGE FRIEDMAN
HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; *et al.*,	MAGISTRATE JUDGE FRENSLEY
Defendants.	

DECLARATION OF CORINNE ROVETTI, FNP, APRN-BC
IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

Corinne Rovetti, FNP, APRN-BC, declares and states as follows:

1. I am a Family Nurse Practitioner and Co-Director of the Knoxville Center for Reproductive Health ("KCRH"), a non-profit reproductive health center in Knoxville, Tennessee, that has been providing high-quality reproductive health care services to patients since 1975. KCRH brings this litigation on its own behalf and on behalf of its patients, physicians, and staff.
2. KCRH provides a range of reproductive health services, including cancer screenings, testing and treatment for sexually transmitted infections, procedural abortion care (sometimes called "surgical abortions") up to 14 weeks and 6 days of pregnancy, as dated

from the first day of the patient's last menstrual period ("LMP"), and medication abortion care up to 10 weeks and 6 days LMP.

3. I perform both clinical services and management and administrative functions for KCRH. In my capacity as a Family Nurse Practitioner, I provide virtually all of KCRH's routine gynecological and family planning services, such as pap smears, insertion of long-acting intrauterine contraceptive devices, and testing and treatment for sexually transmitted infections. As needed, I also perform ultrasound services for abortion patients and provide patient counseling.

4. In my capacity as Co-Director of KCRH, I jointly oversee clinical operations and protocols, hire and supervise staff, engage in advocacy efforts relating to the clinic's mission and values, and take on countless other tasks—from answering phones to recordkeeping—at our small clinic to keep operations running smoothly and safely and ensure that we can continue to provide our patients with excellent care. I have spent more than three decades of my life serving KCRH's patients.

5. I write this declaration in support of Plaintiffs' motion for a temporary restraining order and preliminary injunction enjoining the Tennessee Governor's Executive Order No. 25 ("the Order"), which requires all healthcare providers to "postpone surgical and invasive procedures" except in extremely narrow circumstances. Given the language of the Order and the severe, including criminal, penalties that apply to anyone found in violation, KCRH's physicians cannot risk providing *any* procedural abortions while it is in effect. The Order therefore bans procedural abortions—*i.e.*, bans abortions from the very start of pregnancy for patients who are ineligible for a medication abortion, and bans all abortion after 11 weeks of pregnancy.

6. The facts I state here are based on my experience, my extensive and close interactions with KCRH's staff, physicians, and patients, my review of KCRH's business records, and other information and personal knowledge I have acquired in the course of my duties at KCRH. If called and sworn as a witness, I could and would testify competently to all of the facts set out in this declaration.

7. Over the past month, my Co-Director and I, as well as the clinic's Medical Director and KCRH's long-time physician abortion provider, have worked together to adapt KCRH's policies and protocols to respond to the COVID-19 public health crisis.

8. In accordance with public health guidelines, including from the Centers for Disease Control and Prevention and the National Abortion Federation, we have taken stringent measures to limit non-essential services and enforce social distancing, handwashing, and sanitization. For instance, we have voluntarily suspended *all* in-person visits for non-abortion family planning and gynecological services. We have prohibited anyone other than patients, including partners and support persons, from entering the clinic for abortion services. We have also removed 10 of the 14 chairs in our waiting room and the remaining chairs are positioned at least six feet apart.

9. Patients are screened by phone for COVID-19 when they first call to schedule an appointment, again when we call to remind them of their appointment, and yet again when they arrive at the health center. If the patient reports any suspicious symptoms, our policy is to cancel their appointment until they are medically cleared and encourage them to contact the Tennessee Department of Health for testing. We are not accepting walk-in appointments.

10. In addition, while we have not had any staff report symptoms of COVID-19, our policy is that, in such an event, the staff member would be placed on a 14-day medical leave.
11. When a scheduled patient first arrives at the clinic, one of our staff members meets them at their car to take their temperature and provide them with all necessary paperwork, which they complete outside. Before they enter the clinic, the staff member provides each patient with a perfectly clean, homemade cloth mask to wear at all times; these are for single-use only and the patient takes it home with them after their visit. The staff member then escorts the patient inside—carefully opening every door for the patient, who touches nothing—and brings them directly to the bathroom, where they are required to wash their hands for 20 seconds.
12. All staff members wear cloth masks at all times. Several staff members wear gloves, depending on how closely they interact with patients, and everyone else washes their hands for 20 seconds after each patient interaction, no matter how fleeting. We rigorously sanitize any item patients or staff touch immediately after each use; disinfect all common surfaces on a continuous basis throughout the day; and, of course, thoroughly disinfect our procedure room between patients.
13. In short, we take very seriously our commitment to our patients, our physicians, our staff, and the broader community to do our part to mitigate the spread of this virus while ensuring that patients can still access essential, time-sensitive health care.
14. I am aware that on April 8, 2020, the Tennessee Governor issued the Order, which took effect at midnight the same day, banning all "elective and non-urgent surgical and invasive procedures." As a result, beginning on Thursday, April 9, 2020, KCRH

immediately ceased providing procedural abortions, because we could not risk potential criminal and other penalties.

15. For perspective, I note that KCRH performed 1,366 abortions in 2019, 827 (60 percent) of which were procedural abortions.

16. We had six procedural abortions scheduled for that Thursday. Because the Order took effect virtually instantaneously overnight, we were not able to reach all of these patients by phone before they arrived at our clinic for care. Notably, because Tennessee law forces patients to be counseled by their abortion provider, in person, at least 48 hours before obtaining an abortion, all of these patients had *already* endured the costs and burdens of traveling to our clinic once before.

17. Two of these patients were early enough in pregnancy to obtain medication abortion care instead, so we did not have to turn them away. But the other four were not eligible for medication abortion care, so we were unable to provide them abortions. Instead, we had to refer them to an abortion clinic in Atlanta, a round-trip of approximately 420 miles that would take six hours to drive. They were devastated—crying and expressing serious concerns about whether and how they would be able to make that journey and if they would ultimately get their abortion. Indeed, I understand that the clinics in Atlanta where we refer patients are experiencing significant capacity constraints and currently have multi-week waitlists for appointments.

18. One of these patients, who lives in Knoxville, had initially attempted to obtain a medication abortion at the local Planned Parenthood clinic only to learn that she was too far along in pregnancy. She was then referred to us for a procedural abortion, and had already come to our clinic once for her counseling visit. But on Thursday morning, we

had to inform her—just an hour before her second appointment at our clinic, and her third appointment total—that because of the Executive Order, she would have to make yet *another* trip before she could obtain this care, and that there would be no way for her to get an abortion in Knoxville at all: she will be past 14 days, 6 weeks, our clinic's limit, by the end of the month. Instead, she has two options: she can attempt to travel out of state, or she can wait to see if the Executive Order is, in fact, lifted at the end of the month, and then hope that she can get an appointment in Nashville or Memphis before she reaches 20 weeks of pregnancy. We felt horrible about delivering this news. If the Court grants our request for relief, this is one of the first patients we will call to try to quickly reschedule.

19. It is important to note that most of our abortion patients are very low-income. Indeed, 60 percent of our patients have incomes at or below 110 percent of the federal poverty level. At the best of times, traveling to our clinic twice, as already required by Tennessee's 48-hour mandatory delay law, is expensive and difficult for these patients. Many tell us how they struggled to borrow a car and pay for gas or arrange public transportation. They describe how difficult it was to take time off work when they lack paid sick leave, and how they cannot afford the lost wages. They relay the difficulties of arranging and paying for emergency childcare. And that is all *before* the COVID-19 global pandemic, stay-at-home orders, and economic recession that has closed businesses and schools and cost so many their livelihood and their childcare.

20. When these four patients learned that they would now have to make yet another trip in order to end their pregnancies—in this case, a six-hour round-trip journey out-of-state—many were sobbing and panicked, both about their ability to ultimately obtain an abortion and about having to undertake such extensive travel during this public health crisis.

21. We have had to make similarly painful phone calls to patients scheduled to come to our clinic next week for a procedural abortion—patients who cry when we tell them that the next nearest location where they can obtain this care is Atlanta. We have also had to contact dozens of patients scheduled for a counseling visit in the next two weeks to inform them that they may not be able to get the abortion itself if this Order remains in effect and if they are too far along for medication abortion. And, of course, we continue to receive new calls from people seeking abortion care, who are extremely upset to learn that, if their pregnancy is past 11 weeks, or they are ineligible for medication abortion, they will not be able to get an abortion in Tennessee for a minimum of nearly three weeks—in reality, for the foreseeable future.

22. Forcing KCRH to turn away people who need procedural abortions for as long as this Order (which is likely to be extended, given the estimated length of the pandemic) remains in effect makes no clinical sense. Our patients will be forced to stay pregnant for longer, which increases the health risks of pregnancy and increases their exposure to the medical system as a whole. If they can get an abortion at all, it will be significantly delayed, which increases the health risks associated with abortion.

23. In addition, some patients may be pushed to the point in pregnancy when they need a more complicated procedure than we offer at KCRH. At our clinic, our physician provides all procedural abortions up to 14 weeks, 6 days of pregnancy (our clinic's limit) using the vacuum aspiration technique, in which a small tube is inserted through the cervix into the uterus, and a manual or electric pump attached to the tube evacuates the contents of the uterus with gentle suction. It generally takes 5 minutes to complete. However, because of the Order, instead of promptly obtaining this quick and extremely

safe procedure at our clinic, our patients will be forced to delay their abortion by weeks, if not months, at which point—if they can obtain an abortion at all—their pregnancies may be too advanced for this aspiration method. Instead, they will have to attempt to travel to another city to obtain a more complicated abortion procedure. It is never easy for our patients to upend their lives and arrange and pay for travel and childcare on short notice, and particularly not now in the midst of the financial, emotional and logistical stresses caused by the pandemic. Being forced to travel to another city for care will exacerbate the burdens and costs of obtaining an abortion, and simply be impossible for some of the patients we serve.

24. Moreover, I understand that the Order's stated goal is to preserve personal protective equipment ("PPE"). But KCRH's procedural abortion practice uses only minimal amounts of PPE. First, we do not use or have any supply of N95 masks, which I understand is the PPE in highest demand. Second, we perform procedural abortions only two days per week. On procedure days, our doctor and surgical assistant each use one surgical mask per day—a grand total of four surgical masks per week—and no disposable protective eyewear; instead, our doctor wears a face shield over his surgical mask that he thoroughly disinfects between patients, consistent with national guidelines. While anyone in the procedure room changes gloves and gowns between patients, we have revised our policies so that there are only two people in with the patient—the doctor and the surgical assistance—so the quantities of PPE we are using are extremely minimal.

25. In order to have the greatest impact on reducing the spread and transmission of COVID-19, instead of forcing our patients to stay pregnant or to travel out of state for abortion care, the State could remove other targeted abortion restrictions that unnecessarily

increase in-person encounters. For instance, waiving the 48-hour mandatory delay law and allowing patients to receive the counseling on the day of their abortion, or allowing our physician to perform the counseling by phone or videoconference, would *halve* the travel time for patients as well as the potential exposure time for patients, our physician, and staff.

26. When we informed our patients that procedural abortions are banned in Tennessee at least until the end of this month, most indicated that they would attempt to access this care out of state instead of remaining pregnant indefinitely, forced to hope, against all evidence, that the COVID-19 crisis will end in a few weeks and they will still be able to get an abortion somewhere in Tennessee. Such out-of-state travel will exacerbate, not mitigate, the spread of COVID-19 in our state and be hugely burdensome on our patients, including by increasing their risk of contagion.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 13, 2020

__/s/ Corinne Rovetti____

Corinne Rovetti, FNP, APRN-BC

EXHIBIT A

increase in-person encounters. For instance, waiving the 48-hour mandatory delay law and allowing patients to receive the counseling on the day of their abortion, or allowing our physician to perform the counseling by phone or videoconference, would *halve* the travel time for patients as well as the potential exposure time for patients, our physician, and staff.

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I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 13, 2020

Corinne Rovetti, FNP, APRN-BC

Exhibit 8

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
Andrew Johnson Tower, 5th Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

BILL LEE
Governor

LISA PIERCEY, MD, MBA, FAAP
Commissioner

April 10, 2020

Dear Health Care Providers:

The Tennessee Department of Health would like you to review the newly released Executive Order 25 regarding the limitation of close medical interaction; delaying elective, non-urgent procedures, and limiting attendance at surgeries and invasive procedures in order to preserve personal protective equipment (PPE).
https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee25.pdf

The intent of Executive Order 25 is to protect the health care providers, staff, patients, and the community from the transmission of COVID-19 and prevent the unnecessary use of the PPE resources that are in extremely short supply, especially N95 masks. Specifically, the Executive Order addresses the following:

- Helps ensure that PPE is preserved, and community spread through close medical interaction is limited during the upcoming weeks in which cases/hospitalizations are expected to increase;

- Expands Executive Order 18 to more specifically cover all procedures that are elective and non-urgent and can be delayed until after the Order without risking serious adverse consequences to a patient; and

- Limits attendance at surgeries and invasive procedures to essential personnel to preserve PPE to the greatest extent possible

We appreciate the concerns and feedback expressed by health care providers during this challenging time. We also encourage you to take these actions seriously as not only do our physical and economic health depend on it, but please be advised that failure to comply is a Class A misdemeanor and may result in possible disciplinary action by your respective board.

Sincerely,

Lisa Piercey, MD, MBA, FAAP
Commissioner

LP/BC

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., on behalf of itself and its patients; *et al.*, Plaintiffs, v. HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; *et al.*, Defendants.	CASE NO. 3:15-cv-00705 JUDGE FRIEDMAN MAGISTRATE JUDGE FRENSLEY

[PROPOSED] ORDER GRANTING MOTION FOR A TEMPORARY RESTRAINING ORDER

This matter having come before the Court on a Motion for a Temporary Restraining Order and/or Preliminary Injunction brought by Plaintiffs Adams & Boyle P.C., Choices Memphis Center for Reproductive Health ("Choices"), and Planned Parenthood of Tennessee and North Mississippi ("PPTNM"), and proposed Plaintiffs Knoxville Center for Reproductive Health and Dr. Kimberly Looney (collectively "the Providers"), and for good cause shown, it is hereby ORDERED that the Providers' motion is GRANTED.

The Providers seek to enjoin Governor Bill Lee's April 8, 2020, Executive Order No. 25, "An Order To Reduce The Spread Of Covid-19 By Limiting Non-Emergency Health Care Procedures" ("Executive Order" or "EO-25"), as it applies to procedural abortions in Tennessee. EO-25 requires that "[a]ll healthcare professionals and healthcare facilities in the State of Tennessee" "postpone surgical and invasive procedures that are elective and non-urgent." EO-25 at 2. Elective and non-urgent procedures are defined as "procedures that can be delayed until the expiration of this Order because they are not required to provide life-sustaining treatment, to

prevent death or risk of substantial impairment of a major bodily function, or to prevent rapid deterioration or serious adverse consequences to a patient's physical condition if the surgical or invasive procedure is not performed, as reasonably determined by a licensed medical provider." *Id*. at 2-3. The stated goals of EO-25 are "preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through non-essential patient-provider interactions." *Id*. at 2. A violation of EO-25 is a Class A misdemeanor and may also result in professional disciplinary action. Letter from Lisa Piercey, Tenn. Dep't of Health, to Health Care Providers (Apr. 10, 2020). EO-25 took effect at 12:01 AM on April 9, 2020. EO-25 at 3.

The Providers offer two methods of abortion care. Medication abortion involves the prescription and dispensing of two medications and is available only through 11 weeks of pregnancy, as dated from the first day of a patient's last menstrual period ("LMP"). Medication abortion is not a "surgical [or] invasive procedure[]" and therefore does not fall within the terms of EO-25. Procedural abortion (sometimes referred to as "surgical abortion") is the only option from the start of pregnancy for patients for whom medication abortion is contraindicated, and the only option available after 11 weeks LMP for all patients.

In light of EO-25's broadly worded ban on "surgical and non-urgent procedures," and the threat of criminal penalties for a violation thereof, after EO-25 took effect on April 8, 2020, the Providers promptly cancelled all procedural abortion appointments—including for patients who had already traveled to the Providers' clinics once before, as required by state law, to receive state-mandated counseling at least 48 hours before their abortion (Tenn. Code Ann. § 39-15-202(a)-(h), the "Delay Law"). While EO-25 remains in effect, all abortion after 11 weeks of pregnancy (and, for patients ineligible for medication abortion, all abortion at any point in pregnancy) is effectively banned in the state of Tennessee.

The Providers have established all four factors weighing in favor of a temporary restraining order: (1) substantial likelihood of success on the merits; (2) substantial threat of irreparable injury; (3) that the injury that they and their patients face outweighs any harm the injunction might cause Defendants; and (4) that granting the injunction will not disserve the public interest. *Am. Civil Liberties Union Fund of Mich. v. Livingston Cty.*, 796 F.3d 636, 642 (6th Cir. 2015) (quoting *Bays v. City of Fairborn*, 668 F.3d 814, 818–19 (6th Cir. 2012)). Accordingly, I find that temporary injunctive relief is proper.

Likelihood of Success on the Merits

Decades of Supreme Court precedent categorically prohibits states from banning abortion before fetal viability, or imposing burdens on access that exceed the benefits conferred. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846, 871 (1992); *Roe v. Wade*, 410 U.S. 113, 166 (1973). Consistent with recent decisions by district courts across the country, I find that the Providers are likely to succeed in proving that EO-25, as applied to procedural abortions, is an unconstitutional violation of the Providers' patients' substantive due process rights. *See Pre-Term Cleveland v. Att'y Gen. of Ohio*, No. 1:19-cv-360 (S.D. Ohio Mar. 30, 2020) ("Pre-Term Cleveland"), *appeal dismissed*, 2020 WL 1673310, *2 (6th Cir. Apr. 6, 2020);[1] *Robinson v. Marshall*, No. 2:19-cv-365, at 28, 30 (M.D. Ala. Apr. 12, 2020) (ECF No. 137) ("Robinson"); *S. Wind Women's Ctr. v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020) ("S. Wind Women's Ctr."), *appeal*

[1] The State of Ohio filed a motion with the Sixth Circuit to stay the Temporary Restraining Order ("TRO") and Plaintiffs moved to dismiss. The Court held it lacked jurisdiction because the TRO did not threaten to inflict irretrievable harms or consequences before it expires. *Pre-Term Cleveland v. Att'y Gen. of Ohio*, No. 20-3365, 2020 WL 1673310, *2 (6th Cir. Apr. 6, 2020).

dismissed, No. 20-6045 (10th Cir. Apr. 13, 2020).[2]

EO-25 bans pre-viability abortions beginning at 11 weeks LMP for all patients, and earlier for some, for as long as it remains in effect—as currently written, until April 30, 2020. It will burden all pregnant people seeking a procedural abortion in Tennessee by delaying their care and increasing their health risks, and pose particular harm to three groups of patients:

(1) Patients who, in the good faith professional judgment of the provider, will likely lose their ability to obtain an abortion in Tennessee if their procedures are delayed until after April 30, 2020. EO-25 will force such patients to either carry an unwanted pregnancy to term, and bear the far greater health risks and risk of death associated with ongoing pregnancy and childbirth, or attempt to seek abortion care out of state, which imposes significant costs, burdens, and emotional distress that the COVID-19 pandemic will exacerbate.

(2) Patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a lengthier and more complex abortion procedure, which is only available at two clinics in Nashville and Memphis, if their procedures are delayed until after April 30, 2020. These patients will likely have to travel farther for abortion care as a result of EO-25, which increases the costs and burdens of accessing such care, and will face greater health risks associated with the more complex procedure.

(3) Patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a two-day procedure—which is only available at two clinics in Nashville and

[2] A challenge was also filed in the state of Iowa. There, plaintiffs have voluntarily dismissed their claim following a clarification from the state that it does not interpret its Executive Order to prevent all surgical abortions or those abortion procedures that "could not be delayed without undue risk" to the health of patients. *See Planned Parenthood of the Heartland Inc., v. Reynolds*, No. CVCV981717, at 2 (Ia. Dist. Ct. Apr. 1, 2020).

Memphis, and which requires at least three separate visits to the provider—if their procedures are delayed until April 30, 2020.

A number of factors bear on an individual patient's ability to timely access abortion care and medical risk, including the patient's medical history, familial circumstances, and any logistical and financial obstacles faced by the patient.

Patients are further burdened by the Delay Law's in-person counseling requirement, which requires the physician to provide state-mandated information to patients in person at least 48 hours before the abortion, rather than by telephone (as comparable state laws allow, *see, e.g.*, Ga. Code Ann. § 31-9A-3), or through other telehealth technologies (as the Tennessee Governor's Executive Order 15 encouraged during the COVID-19 crisis, *see* Exec. Order 15, at 10 (Mar. 19, 2020))[3]. The Delay Law imposes significant burdens on access to care and requires the Providers to use more personal protective equipment ("PPE") than would otherwise be necessary if they were able to provide the same information to patients via telephone, videoconference, or other telehealth technologies.

On the other hand, the State's asserted interests in "preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through non-essential patient-provider interactions," EO-25 at 2, are unlikely to be served by compelling people who are pregnant to remain pregnant against their wishes. This is because a person who remains pregnant is likely to need far more health care, in both the near- and long-term, than a person who has a desired abortion. They will need prenatal care as pregnancy takes

[3] Governor Bill Lee, *Executive Order No. 15, An Order Suspending Provisions Of Certain Statutes And Rules And Taking Other Necessary Measures In Order To Facilitate The Treatment And Containment of COVID-19* (Mar. 19, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee15.pdf.

an increasing toll on their health, which will involve multiple trips to health care facilities, particularly if the patient has a high-risk pregnancy or underlying health care conditions exacerbated by pregnancy. Some patients will have to seek care at an emergency room after experiencing a miscarriage—using not only PPE, but also the hospital's physicians, nurses, and beds, and exposing the patients to the risk of contagion. Patients who must carry a pregnancy to term and deliver will need multiple prenatal visits, screening tests, and, ultimately, a multi-day hospital admission, which is even lengthier if the patient has a cesarean section. Moreover, the American College of Obstetricians and Gynecologists ("ACOG") is recommending that pregnant patients experiencing certain potential COVID-19 symptoms, such as difficulty breathing, be "immediately" evaluated in an emergency room—further burdening hospital resources.[4] By contrast, the Providers offer abortion services on an outpatient basis, and their patients seldom experience complications, and very rarely require hospital care. EO-25 will also force some patients who cannot obtain a procedural abortion in Tennessee to attempt to obtain such care out-of-state instead in contravention of public health guidelines, both jeopardizing the patient's health and safety and risking further spread of the virus within Tennessee upon the patient's return.

In short, EO-25 unconstitutionally prevents some patients "from making the ultimate decision to terminate [their] pregnancy before viability." *Casey*, 505 U.S. at 879; *see also Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201 (6th Cir. 1997) (law that blocks "the vast majority of second trimester abortion . . . clearly ha[s] the effect of placing a substantial obstacle in the path of a woman seeking a pre-viability abortion" and is therefore unconstitutional); *EMW*

[4] *See* Am. Coll. of Obstetricians & Gynecologists and Soc. for Fetal-Maternal Med., *Patient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Apr. 10, 2020), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6.

Women's Surgical Ctr., P.S.C. v. Meier, 373 F. Supp. 3d 807 (W.D. Ky. 2019) (striking down ban on a safe and common abortion method); *Isaacson v. Horne*, 716 F.3d 1213, 1227 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014) (medical emergency exception insufficient to save ban on abortions after 20 weeks from constitutional infirmity). Moreover, because ongoing pregnancy requires more health care, including hospital resources and PPE, and involves more person-to-person healthcare interactions than abortion, the Providers are likely to succeed in proving that EO-25 imposes burdens that outweigh any benefits to the State. *Whole Woman's Health*, 136 S. Ct. at 2310. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), does not demand a different result. *Jacobson*, a 1905 decision upholding a mandatory smallpox vaccination, expressly recognizes that a State's powers to secure the health and safety of the public are limited by the Constitution. 197 U.S. at 25 ("[N]o rule prescribed by a state . . . shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument."); *see also id.* at 29, 31; *Casey*, 505 U.S. at 857 (describing *Jacobson* as "recognizing limits on governmental power"). And courts have recognized that *Jacobson* does not supplant the modern substantive constitutional test applied to laws infringing a fundamental right. *See, e.g.*, *Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F. 3d 396, 419–20 (6th Cir. 2019) (applying strict scrutiny to substantive due process claim, even where the challenged program "may be an example of a state's proper exercise of its *parens-patriae* role" (citing *Jacobson*, 197 U.S. at 38)); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348, 352–54 (4th Cir. 2011) (assuming strict scrutiny applies to free exercise challenge to vaccination requirement (citing *Jacobson*, 197 U.S. at 12)).

Moreover, even when analyzed under *Jacobson's* language, EO-25 is not a proper exercise of Tennessee's police powers for the reasons outlined above. Applying EO-25 to bar procedural abortions does not bear a "real or substantial relation to the protection of the public health and the

public safety," *Jacobson*, 197 U.S. at 28, 31, because patients with continuing pregnancies will need more health care resources (including more PPE) and have more person-to-person health care encounters than people who have abortions. In addition, because it bans pre-viability abortions and imposes burdens that outweigh any state benefits, EO-25 "infringe[s]" on the Providers' patients' fundamental rights under the Fourteenth Amendment, which is beyond the State's police powers. *Jacobson*, 197 U.S. at 25, 29, 31.

I therefore find that the Providers are likely to succeed on the merits.

Irreparable Harm

The Providers have established that EO-25, as applied to procedural abortions, is causing irreparable harm to their patients. The Sixth Circuit has made clear that if "a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Am. Civil Liberties Union of Ky. v. McCreary Cty.*, 354 F.3d 438, 455 (6th Cir. 2003) (*citing Elrod v. Burns*, 427 U.S. 347, 373 (1976)). The Providers are likely to succeed in proving that EO-25 impairs their patients' substantive due process rights, and a finding of irreparable harm necessarily follows. *See Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 803 (S.D. Ohio 2019) (determining that Ohio's six-week abortion ban "would, per se, inflict irreparable harm" if enforced).

In addition, EO-25 will jeopardize patients' health. As ACOG and other leading medical associations recently stated, abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[5] Patients who are forced to remain pregnant against their will suffer an array of

[5] The medical organizations issuing this joint guidance were ACOG, the American Board of Obstetrics & Gynecology, the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the

serious physical, emotional, and psychological consequences that constitute irreparable harm. *See e.g.*, *Elrod*, 427 U.S. at 373–74; *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013). Likewise, a delay in obtaining abortion care causes irreparable harm by "result[ing] in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 832 (7th Cir. 2018) (alteration in original) (quoting *Van Hollen*, 738 F.3d at 796), *petition for cert. filed*, No. 18-1019 (Feb. 4, 2019). This "disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) (internal quotation marks omitted), *cert. denied sub nom. Andersen v. Planned Parenthood of Kan. & Mid-Mo.*, 139 S. Ct. 638 (Mem.) (2018). Accordingly, every district court that has considered this question has found that the deprivation of abortion care for a period of weeks or longer would result in irreparable injury. *Pre-Term Cleveland* at 7; *Robinson* at 53; *S. Wind Women's Ctr.* at 12.

Balance of Harms and Public Interest

While the Providers' patients will suffer numerous irreparable harms without an injunction, the requested relief will simply preserve "the status quo that has been in place for more than 40 years since *Roe* was decided, and some 25 years since *Casey* followed." *Preterm-Cleveland*, 394 F. Supp. 3d at 803. As the Sixth Circuit has made clear, "[w]hen a constitutional violation is likely . . . the public interest militates in favor of injunctive relief because it is always in the public interest

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Society of Family Planning, and the Society for Maternal-Fetal Medicine. *See Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

to prevent violation of a party's constitutional rights." *Am. Civil Liberties Union Fund of Mich.*, 796 F.3d at 649 (alterations in original) (quoting *Miller v. City of Cincinnati*, 622 F.3d 524, 540 (6th Cir. 2010)); *accord Michigan State A. Philip Randolph Inst. v. Johnson*, 833 F.3d 656, 669 (6th Cir. 2016) (same). Moreover, EO-25 does not serve its stated purposes in the context of pregnant patients, who will need medical care in any scenario, and is causing significant harm by eliminating abortion access in the midst of a pandemic. *See, e.g.*, *Pre-Term Cleveland* at 7; *Robinson* at 10; *S. Wind Women's Ctr.* at 12. Temporary injunctive relief thus serves the public interest.

IT IS THEREFORE ORDERED that Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them, are TEMPORARILY RESTRAINED from enforcing or requiring compliance with Executive Order 25 as applied to procedural abortions. This Temporary Restraining Order is effective upon entry and shall expire on [DATE] unless extended by the Court for good cause shown or by agreement of the parties.

IT IS FURTHER ORDERED that, during the pendency of EO-25, Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them, are TEMPORARILY RESTRAINED from enforcing the Delay Law's in-person counseling requirement, which requires that the physician provide state-mandated information to patients in person, at least 48 hours before the abortion, rather than by telephone, videoconference, or other telehealth technologies.

IT IS FURTHER ORDERED that the bond requirement of Fed. R. Civ. P. 65(b) is waived, and that this injunctive relief is effective upon service.

Entered this ____ day of _____, 2020.

_____
UNITED STATES DISTRICT JUDGE