UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO

PRETERM-CLEVELAND, INC., *et al.*,	:	
	:	
Plaintiffs,	:	**Case No. 1:19-cv-00360**
v.	:	
	:	
DAVID YOST, *et al.*,	:	**Judge Barrett**
	:	
Defendants.	:	

PLAINTIFFS' REPLY IN FURTHER SUPPORT OF THEIR MOTION FOR PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES II

SUMMARY OF ARGUMENT 1

ADDITIONAL STATEMENT OF FACTS 5

Changes in Plaintiffs' Practice and Continued Fear of Prosecution 5

Length of COVID-19 Pandemic 6

Physicians' Exercise of Their Medical Judgment Under the Director's Order 7

Delaying Abortion Creates Health Risks, Can Force Women to Carry to Term, and Does Not Conserve PPE 9

Delaying Abortion Increases the Risks Associated With the Procedure and May Force Some Women to Carry to Term 9

Forcing a Person to Remain Pregnant, and Forcing them to Carry to Term, Also Increase Health Risks 13

ARGUMENT 15

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claim That the Director's Order, as Interpreted by Defendants to Force Plaintiffs' Patients to Delay Abortion Weeks or Months, Violates the Due Process Clause. 15

A. The Proper Standard of Review is *Casey*'s Undue Burden Test. 15

1. Forcing Patients to Delay Abortion for Weeks or Months Impermissibly Burdens Abortion Access. 15

2. Defendants' Asserted State Interests Are Not Furthered. 18

3. The Burdens Outweigh the Benefits. 21

B. Defendants Are Not Entitled To a Deferential Standard of Review of the Order, But Plaintiffs Are Likely to Prevail Even Under That Standard. 22

II. The Other Preliminary Injunction Factors Weigh in Plaintiffs' Favor. 24

CONCLUSION 26

TABLE OF AUTHORITIES

Cases

Aptheker v. Secretary of State,
378 U.S. 500 (1964) 24

Colautti v. Franklin, 439 U.S. 379 (1979) 18

Cruzan by Cruzan v. Dir., Mo. Dep't of Health,
497 U.S. 261 (1990) 23, 24

Doe v. Bolton,
410 U.S. 179 (1973) 18

In re Cincinnati Radiation Litig.,
874 F. Supp. 796 (S.D. Ohio 1995) 23

Jacobson v. Massachusetts,
197 U.S. 11 (1905) 22, 23, 24

Kanuszewski v. Mich. Dep't of Health & Human Servs.,
927 F.3d 396 (6th Cir. 2019) 23

Korematsu v. United States,
323 U.S. 214 (1944) 24

Little Rock Family Planning Servs. v. Rutledge,
No. 4:19-cv-449-KGB, slip op. (E.D. Ark. Apr. 14, 2020) 20

Lochner v. New York,
198 U.S. 45 (1905) 22

Northland Family Planning Clinic, Inc. v. Cox,
487 F.3d 323 (6th Cir. 2007) 4, 25

Planned Parenthood of Cent. Mo. v. Danforth,
428 U.S. 52 (1976) 18

Planned Parenthood of Se. Pa. v. Casey,
505 U.S. 833 (1992) .... passim

Planned Parenthood of Sw. Ohio Region v. Yost,
375 F. Supp. 3d 848 (S.D. Ohio 2019) 21

Preterm-Cleveland v. Att'y Gen. of Ohio,
No. 20-3365, slip op. (6th Cir. Apr. 6, 2020) .... passim

Robinson v. Marshall,
2:19-cv-365-MHT-JTA, slip op. (M.D. Ala. Apr. 12, 2020) .... passim

Smith v. Avino,
91 F.3d 105 (11th Cir. 1996) 23, 24

Steel Co. v. Citizens for a Better Env't,
523 U.S. 83 (1998) 23

Steffel v. Thompson,
415 U.S. 452 (1974) 4

Trump v. Hawaii,
138 S. Ct. 2392 (2018) 24

United States v. Carolene Prods. Co.,
304 U.S. 144 (1938) 22

Whole Woman's Health v. Hellerstedt,
136 S. Ct. 2292 (2016) .... passim

Workman v. Mingo Cty. Bd. of Educ.,
419 F. App'x 348 (4th Cir. 2011) 23

Statutes

42 U.S.C. § 1988 25

Other Authorities

Am. Coll. of Cardiology & Soc'y for Cardiovascular Angiography and Interventions, *Triage Considerations for Patients Referred for Structural Heart Disease Intervention During the Coronavirus Disease 2019 (COVID-19) Pandemic: An ACC /SCAI Consensus Statement* (Apr. 2, 2020), http://interventions.onlinejacc.org/content/early/2020/04/05/j.jcin.2020.04.001 ... 7

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Am. Dental Ass'n, *ADA Interim Guidance for Management of Emergency and Urgent Dental Care* (Apr. 1, 2020), https://www.ada.org/~/media/CPS/Files/COVID/ADA_Int_Guidance_Mgmt_Emerg-Urg_Dental_COVID19.pdf 7

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Gov. Mike DeWine Corona Virus Update, Mar. 26, 2020, https://www.ideastream.org/gov-mike-dewine-coronavirus-update-march-26-2020 3

Jo Ingles, *Coronavirus in Ohio: State Considering Next Move in Abortion Fight*, WOSU PBS (Apr. 2, 2020), https://radio.wosu.org/post/coronavirus-ohio-state-considering-next-move-surgical-abortion-fight#stream/0 3

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Ohio Dep't of Health, Essential Versus Non-Essential Surgeries COVID-19 Checklist, Apr. 8, 2020, https://coronavirus.ohio.gov/wps/portal/gov/covid-19/checklists/english-checklists/essential-versus-non-essential-surgeries-covid-19-checklist 2

SUMMARY OF ARGUMENT

Plaintiffs, as health care providers, appreciate Defendant Acton's decision to restrict non-essential surgeries that "can be delayed without undue risk to the current or future health of a patient" to allow Ohioans to fight the COVID pandemic. Plaintiffs do not ask for special treatment, but instead only ask to be treated like all other Ohio physicians complying with the Order, and filed this lawsuit only when it was clear that they might be singled out and subject to legal sanctions. Defendants argue that Plaintiffs seek a "blanket exemption" from the Director's Order to allow them to provide all abortions, and Defendants' brief focuses mostly on fighting this straw man. But Plaintiffs have never sought a blanket exemption from the Director's Order. Rather, even prior to the commencement of this case, Plaintiffs followed the Director's Order by making a case-by-case determination about whether to provide a patient with an abortion under the terms of the Director's Order. Plaintiffs have also taken various precautions to reduce the risk of COVID-19 transmission, such as ensuring distance between patients in the waiting room, and Plaintiffs have taken measures to conserve personal protective equipment ("PPE") consistent with CDC recommendations. The changes in their practice under the Director's Order, as well as other actions taken consistent with best practices to reduce the risk of transmitting COVID-19, have led to a decrease in surgical abortions of 33–72%, depending on the provider, in the last three weeks.

Plaintiffs' and Defendants' positions (articulated for the first time during their recent appeal) seem to agree on the following: 1) if a patient is eligible for both medication abortion and surgical abortion, the provider will provide only a medication abortion; 2) if delaying the abortion would push a patient past the point in pregnancy where she will be unable to obtain an abortion, the provider may perform the surgical abortion; 3) if delay may cause harm to the patient's life or health, the provider may perform the surgical abortion. Where they disgree is

what amount of risk to the patient's health justifies proceeding with the surgery, and who gets to make that determination.

Defendants are unwilling to permit Plaintiffs, like all other health care providers in Ohio, to use their good faith medical judgment to decide whether a particular patient's care can be delayed "without undue risk to the current or future health of a patient." Director's Order at 4. It is Defendants, therefore, that seek a blanket rule delaying almost all surgical abortions under the Director's Order. But that is not how medicine is practiced, either before or after the pandemic. Health care providers always look at an individual patient's unique medical history and current condition, as well as other factors that affect her care. Then, based on these factors, health care providers use their training, skill, and judgment to make a recommendation about a course of treatment. All other providers in Ohio are able to do this under the Director's Order, but not abortion providers. In fact, the Ohio Department of Health's recent guidance explicitly states that "[e]ach situation will be different. It is not necessarily appropriate to cancel every instance of a specific procedure. . . . Decisions remain the responsibility of providers . . . ."[1]

Indeed, unlike other health care providers, Plaintiffs risk being second-guessed by Defendants, upon pain of civil and criminal penalties when they provide care under the Order. Plaintiffs have faced repeated threats that the Director's Order will be enforced specifically against them. Most recently, after their appeal of the TRO was dismissed, a spokesperson for the Attorney General emphasized that she "believed the [Sixth Circuit's] decision allows her office to enforce actions against any physician that 'performs a surgical abortion that could have been

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[1] Ohio Dep't of Health, Essential Versus Non-Essential Surgeries COVID-19 Checklist, Apr. 8, 2020, https://coronavirus.ohio.gov/wps/portal/gov/covid-19/checklists/english-checklists/essential-versus-non-essential-surgeries-covid-19-checklist.

safely postponed or performed with medication.'"[2] And after this Court's TRO, the Attorney General said "the state still wants to stop clinics from performing surgical abortions, despite a federal judge ruling that the order shouldn't be applied to abortion providers."[3]

This is on top of the cease and desist letters sent to Plaintiffs PPSWO, WMCD and Preterm prior to the commencement of this litigation, which have never been withdrawn. Pls' Mot. for TRO and/or Prelim. Inj. and Mem. in Supp., Doc. #42 ("Pls.' Opening Br.") at 2. Shortly thereafter, Governor Mike DeWine at a press conference identified only life-saving abortions as falling within the Order's parameters.[4] That same day, the Attorney General again threatened "quick enforcement action" against clinics that continue to provide surgical abortion care.[5] At the same time, the Department of Heath spent two days inspecting some of Plaintiffs' clinics, and still, to this day, has not informed Plaintiffs PPSWO, WMCD and Preterm of the results of their inspection, though those inspections took place over two weeks ago. Pls.' Opening Br. at 3.

Plaintiffs also fear being second-guessed by Defendants because of Defendants' shifting positions in this case. Indeed, before this case began, the cease-and-desist letters to some

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[2] Kate Smith, *Majority of Abortion Services in Ohio Can Continue, Judges Rule*, CBS News (Apr. 6, 2020), available at https://www.cbsnews.com/news/ohio-abortion-majority-services-judge-rules/.

[3] Jo Ingles, *Coronavirus in Ohio: State Considering Next Move in Abortion Fight*, WOSU PBS (Apr. 2, 2020), https://radio.wosu.org/post/coronavirus-ohio-state-considering-next-move-surgical-abortion-fight#stream/0.

[4] Gov. Mike DeWine Coronavirus Update, Mar. 26, 2020, https://www.ideastream.org/gov-mike-dewine-coronavirus-update-march-26-2020.

[5] Attorney General Yost press release March 26, 2020, Liner Decl. Ex. G (General Yost is "the prosecutor" and ODH is the "police officer" and his office "stands ready to play our role and pursue legal action on behalf of [ODH].").

Plaintiffs seemed to interpret the Director's Order as prohibiting virtually all surgical abortions. Pls.' Opening Br. at 2–3. Then, shortly after the case began, the State was unwilling to take a position at all despite "being given the opportunity in two telephonic conferences to do so." *Preterm-Cleveland v. Att'y Gen. of Ohio*, No. 20-3365, slip op. at 7 (6th Cir. Apr. 6, 2020) (Bush, J., concurring in part and dissenting in part). And now, Defendants apparently take the position that patients who are ineligible for medication abortion (which can only be provided up to 10 weeks LMP) must delay their abortions, in the absence of serious health risks, until they are at the cusp of the legal limit in Ohio, which is 21.6 weeks LMP. Defs.' Resp. to Pls.' Mot. for Prelim. Inj., Doc. #59 ("Defs.' Br.") at 18–19.

Defendants' insistence that they can second-guess the provider who determines that a patient's care cannot be delayed, and their shifting position on the meaning of the Director's Order, enhance the chilling effect on Plaintiffs. *See Robinson v. Marshall*, 2:19-cv-365-MHT-JTA, slip op. at 51 (M.D. Ala. Apr. 12, 2020) ("[T]o proceed with lawful abortions [under an order restricting abortions during the COVID-19 pandemic], providers must be *confident* that their exercise of reasonable medical judgment will not be met with unconstitutional or bad-faith prosecution") (emphasis in original); *see also Northland Family Planning Clinic, Inc. v. Cox*, 487 F.3d 323, 342 (6th Cir. 2007) (holding that the Attorney General's non-binding statements do not assuage credible fear of prosecution). Defendants' position leaves Plaintiffs "between the Scylla of intentionally flouting state law and the Charybdis of forgoing what [t]he[y] believe[] to be constitutionally protected activity in order to avoid becoming enmeshed in a criminal proceeding." *Steffel v. Thompson*, 415 U.S. 452, 462 (1974).

Absent a preliminary injunction, this chilling effect will force providers to push women further into their pregnancies if not deny them care altogether, to the detriment of their health.

Indeed, delaying abortion for weeks or months will increase the risks associated with the abortion procedure, and forcing people to remain pregnant will increase the risks of urgent pregnancy complications. Moreover, forcing patients to delay abortion will not further the state's interest. To the contrary, it will require the use of more PPE and will require more interactions with the health care system. Balancing these burdens on abortion access with the lack of benefits, as required by *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), it is clear that Plaintiffs are likely to succeed on the merits of their claim. Furthermore, the other preliminary injunction factors weigh in Plaintiffs' favor for similar reasons: Plaintiffs' patients will suffer irreparable harm in the form of detrimental consequences to their health, while the state will suffer no harm given that more health care resources will be used if patients are forced to delay abortion.

For all of the reasons below and in Plaintiffs' opening brief, this Court should grant the preliminary injunction.

ADDITIONAL STATEMENT OF FACTS

Changes in Plaintiffs' Practice and Continued Fear of Prosecution

Even prior to the Director's Order, Plaintiffs began to change their practices to do their part to flatten the curve and preserve PPE. As a result of those measures, and compliance with the Director's Orders, Plaintiffs' rate of surgical abortions has dropped significantly in the last three weeks. Preterm-Cleveland has experienced a 69% decrease. Suppl. Decl. of Chrisse France ("Suppl. France Decl.") ¶ 6 (attached as Ex. A). Planned Parenthood Southwest Ohio Region has seen a 33% decrease. Suppl. Decl. of Sharon Liner, M.D. ("Suppl. Liner Decl.") ¶ 6 (attached as Ex. B). Planned Parenthood of Greater Ohio has seen a 56% decrease. Suppl. Decl. of Adarsh Krishen ("Suppl. Krishen Decl.") ¶ 5 (attached as Ex. C). Women's Med Center of Dayton saw a 72% decrease. Suppl. Decl. of W.M. Haskell, M.D. ("Suppl. Haskell Decl.") ¶ 6 (attached as Ex.

D). Northeast Ohio Women's Center's surgical abortion rate has dropped 65% in the last three weeks. Suppl. Decl. of David Burkons, M.D. ("Suppl. Burkons Decl.") ¶ 5 (attached as Ex. E). Despite Plaintiffs' compliance with the Director's Order, given Defendants' threats of enforcement discussed *supra*, absent an injunction, Plaintiffs fear that their decisions about whether to delay a particular patient's abortion will be second-guessed by Defendants. Suppl. France Decl. ¶¶ 4–5; Suppl. Liner Decl. ¶ 15; Suppl. Krishen Decl. ¶ 4; Suppl. Haskell Decl. ¶ 5; Suppl. Burkons Decl. ¶ 4.

Length of COVID-19 Pandemic

Although no one knows how long the COVID-19 outbreak will last, the goal in a pandemic is to flatten the curve, such that the same number of people may be infected, but spread out over a longer period of time. Decl. of Alison Norris, M.D., PH.D. ("Norris Decl.") ¶¶ 9–10 (attached as Ex. F). Flatter curves are longer curves. *Id.* ¶ 11. Where people are practicing social distancing, residents will be living with the restricted conditions for a longer time than if they had not taken those measures, and in the long run, more people will survive COVID-19 than if any other approach had been taken. *Id.* Ohio has been taking measures, and achieving results, in flattening the curve for more than 4 weeks already. *Id.* Such measures will continue to be in place for weeks (most conservatively), and more likely, months to come. *Id.* Thus, Ohioans—like all those in areas affected by coronavirus—are in a marathon, not a sprint. *Id.* As is true throughout the country, Ohio was unprepared for the outbreak, and its healthcare resources, including the supply of PPE, has been significantly taxed. *Id.* ¶ 14. Initiatives are underway to ramp up the production of PPE. *Id.* Currently, N-95 masks are in the shortest supply (Plaintiffs generally do not use that type of mask) while gloves are the least scarce. *Id.* ¶ 15 & n.5, 19; Keder Decl.¶ 36.

Physicians' Exercise of Their Medical Judgment
Under the Director's Order

The Director's Order requires physicians to exercise professional judgment to determine which surgeries and procedures can be safely postponed. Medical professional organizations are in agreement that the decision whether to delay a procedure—and for how long—must be based on sound clinical judgment.[6] Even before the COVID-19 pandemic and the Director's Order, physicians have always exercised their professional judgment when caring for patients. And now, given the pandemic, they use their medical training, experience, and professional guidance, as well as patient-specific considerations—including not only her health but also psychosocial factors—to determine whether delaying the surgery could harm the patient. Decl. of Lisa Keder, M.D., M.P.H. ("Keder Decl.") ¶ 31 (attached as Ex. G); Decl. of Craig McKinney, M.D. ¶ 11 (attached as Ex. H).

For example, as Dr. Craig McKinney, a general surgeon, testifies, two patients may seek care for similar symptoms, such as trouble with a gallbladder, but one will need urgent surgery and the other will not. McKinney Decl. ¶¶ 9–11. Although a mass in the gallbladder is neither an

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[6] *See, e.g.*, Am. Coll. of Surgeons, *COVID-19: Elective Case Triage Guidelines for Surgical Car*e (Mar. 24, 2020), https://www.facs.org/covid-19/clinical-guidance/elective-case; Am. Coll. of Cardiology & Soc'y for Cardiovascular Angiography and Interventions, *Triage Considerations for Patients Referred for Structural Heart Disease Intervention During the Coronavirus Disease 2019 (COVID-19) Pandemic: An ACC /SCAI Consensus Statement* (Apr. 2, 2020), http://interventions.onlinejacc.org/content/early/2020/04/05/j.jcin.2020.04.001; Am. Dental Ass'n, *ADA Interim Guidance for Management of Emergency and Urgent Dental Care* (Apr. 1, 2020), https://www.ada.org/~/media/CPS/Files/COVID/ADA_Int_Guidance_Mgmt_Emerg-Urg_Dental_COVID19.pdf; Am. Heart Ass'n, Ass'n of Am. Med. Colls., Children's Hosp. Ass'n & Fed'n of Am. Hosps., *AHA Letter to Surgeon General Re: Elective Surgeries and COVID-19* (Mar. 15, 2020), https://www.aha.org/lettercomment/2020-03-15-aha-letter-surgeon-general-re-elective-surgeries-and-covid-19; COVID-19 Pandemic Breast Cancer Consortium: Am. Soc'y of Breast Surgeons, Nat'l Accreditation Program for Breast Ctrs., Nat'l Comprehensive Care Network, Comm'n on Cancer & Am. Coll. of Radiology, *Recommendations for Prioritization, Treatment and Triage of Breast Cancer Patients During the COVID-19 Pandemic* (Apr. 13, 2020), https://www.facs.org/-/media/files/quality-programs/napbc/asbrs_napbc_coc_nccn_acr_bc_covid_consortium_recommendations.ashx.

emergent condition nor one that is immediately life threatening, there is a risk that it could be cancerous, and if the surgery is delayed and the cancer spreads, other organs such as the liver may become affected. *Id*. ¶ 9. In contrast, another patient with gallbladder problems, and who would have been a candidate for gallbladder removal in non-pandemic times, would not need urgent surgery because the patient's symptoms were manageable until they become more severe. *Id*. ¶ 10.

Similarly, as Dr. Lisa Keder, Director of the Division of General Obstetric and Gynecology at the Ohio State University testifies, some gynecological care is being postponed during the pandemic, but other care continues as physicians make case-by-case determinations that the care is essential. This includes surgical management of ectopic pregnancies and miscarriages, and inpatient diagnostic procedures, such as cone biopsy (to remove abnormal tissue in the cervix) and hysteroscopy for post-menopausal bleeding. (Hysteroscopy is a procedure to view the inside of the uterus for any abnormalities and to sample tissue to evaluate for uterine malignancy.) Keder Decl. ¶ 32. Dr. Keder is unaware of any other surgical procedures that have been specifically forbidden by the State, or any other areas of medicine where the State is second-guessing the considered judgment of physicians who have determined a surgery or procedure essential. *Id.* Indeed, guidance released just last week by Defendant ODH recognizes that decisions under the Director's Order "remain the responsibility of providers and local healthcare delivery systems."[7]

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[7] Ohio Dep't of Health, *supra* n.1.

Delaying Abortion Creates Health Risks, Can Force Women to Carry to Term, and Does Not Conserve PPE

Delaying abortion services increases risks to the patient, without corresponding overall savings in PPE or hospital resources. Norris Decl. ¶ 19. This is true both because an abortion performed later in pregnancy carries increased risks to the patient's health, and because forcing someone to remain pregnant also carries risks. Both also tax health care resources more than early abortion provision. As the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the American College of Surgeons ("ACS") have determined, abortion is a time-sensitive, essential service that should not be delayed. Indeed, ACS deems "pregnancy termination (for medical indication or patient request)" to be a "[s]urger[y] that if significantly delayed could cause significant harm."[8] Keder Decl. ¶ 34. Delaying an abortion can result in rapidly worsening or severe symptoms, permanent dysfunction, or death. For these reasons, delaying an abortion creates undue risks to the patient's current or future health. *Id.*

Delaying Abortion Increases the Risks Associated With the Procedure and May Force Some Women to Carry to Term

Although legal abortion is very safe, the risks of mortality increase as the pregnancy advances. Keder Decl. ¶ 38; Decl. of Sharon Liner, M.D. ¶ 32 (attached as Ex. A to Pls' Mot. for TRO/Prelim. Inj., Doc. 42) ("First Liner Decl."). Overall, the mortality risk from abortion is very low: 0.7 per 100,000 abortions. Keder Decl. ¶ 38. To put that in perspective, there are 14.7 pregnancy-related deaths per 100,000 live births in Ohio. *Id.* The risk of death associated with abortion increases with gestational age—increasing 38% each week. *Id.* The risk of death is

[8] The Ohio Department of Health's new guidance on essential surgeries says that "[f]or additional guidance, it is appropriate to reach out to professional societies and associations in specific specialty areas." Ohio Dep't of Health, *supra* n.1.

lowest earlier in pregnancy: 0.3 per 100,000 abortions at eight weeks or less, 0.5 at 9–13 weeks, 2.5 at 14–17 weeks, and 6.7 at 18 weeks and greater. *Id.* Thus, the mortality risk at 14–17 weeks is more than eight times greater than at eight weeks or less and more than 22 times greater at or after 18 weeks. *Id.*

Similarly, while abortion is a safe procedure, the risk of complications from abortion increases with gestational age. *Id.* The risk of major complication—defined as complications requiring hospital admission, surgery, or blood transfusion—is approximately 2.5 times greater in the second-trimester than in the first. *Id.* ¶ 39. Accesing abortion as early in pregnancy as possible is the single most important factor for ensuring the safety of abortion. *Id.* ¶ 38.

First-trimester abortions are most commonly performed with aspiration only. Suppl. Liner Decl. ¶ 10. Aspiration procedures use only suction and typically take less than ten minutes to complete. *Id.* Around 15 weeks LMP, physicians switch to the dilation and evacuation ("D&E") technique. Keder Decl. ¶ 19; Suppl. Liner Decl. ¶ 10. A D&E has two steps: first, dilation of the cervix and second, removal of the fetus, placenta and uterine lining (decidual tissue) with surgical instruments and suction. Liner Decl. ¶ 10. Depending on the gestational age, dilation procedures are done the same day as the evacuation procedure or the day before. *Id*. By 15–16 weeks, dilation is achieved overnight, making the D&E a two-day procedure. *Id.*

As the number of weeks increases, the invasiveness of the required procedure, the need for fetal demise, and the need for deeper levels of sedation also increase, which carries greater risks to the patient. Keder Decl. ¶¶ 40–41. Because later abortion procedures are more complex, and sometimes require two days to complete, they also consume more PPE than earlier abortion procedures. Norris Decl. ¶ 28. For these reasons, forcing a patient to have an abortion later in

pregnancy not only increases risks to the patient but also increases the complexity, time, and cost of the procedure.

Delaying an abortion will cause emotional and psychological harm for patients, especially those who are in violent relationships or who are forced to continue to carry a pregnancy that is a result of rape. Keder Decl. ¶ 46. Domestic violence is known to have increased during the stay-home orders, which may include sexual violence and coercion. Norris Decl. ¶ 35. For women who experience intimate partner violence, and who are denied an abortion, ongoing contact with the man involved results in continued exposure to violence. *Id*. Having an abortion is associated with a reduction in physical violence from the man involved with the pregnancy. *Id*. Delaying an abortion may also compromise her privacy. At 10 weeks, a pregnancy is usually not visible, but at 22 weeks, the pregnancy is visible to others. Keder Decl. ¶ 47.

Delaying an abortion will also increase the cost of the procedure. Norris Decl. ¶¶ 30–33. Most abortion patients are poor or low income; thus, the inability to obtain an abortion in the first trimester can make the procedure altogether inaccessible. *Id.* ¶ 30. Furthermore, patients may have to take time off from work and/or arrange childcare to make the multiple trips to the provider. Keder Decl. ¶ 46; Norris Decl. ¶ 32. And as pregnancy advances, some patients may get ill, requiring more time off from work. Keder Decl. ¶ 46. Thus, delay will increase the financial burden for some patients.

These economic barriers are compounded for women who have to travel to receive an abortion. Norris Decl. ¶ 32. About half of Ohio women live in a county with no abortion provider. *Id*. These women may need to arrange to take time off work, or borrow a car or gas money, which may increase time to appointment. *Id*. For example, abortion is available in

Columbus only to seventeen weeks and six days. Krishen Decl. ¶ 7. Thus, a patient for whom Planned Parenthood of Greater Ohio's East Columbus health center is their nearest abortion provider and who is forced to remain pregnant to eighteen weeks or later will be required to travel to Cincinnati, Dayton, or Cleveland for care—at least twice—or will have to travel out of state. *Id.*

Forcing patients to travel intra-state and out-of-state is contrary to the goals of pandemic mitigation efforts such as stay-at-home and social-distancing orders. Keder Decl. ¶ 44; Norris Decl. ¶ 33. Furthermore, the COVID-19 pandemic has only exacerbated these burdens on patients seeking abortion care. First Liner Decl. ¶ 34. It has limited public transit availability, caused 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. *Id*. Indeed, jobless claims are soaring due to the virus. *Id*.

For some people, these obstacles will be too much to overcome, and if their ability to access abortion is delayed, they will be forced to carry their pregnancies to term. Moreover, if Plaintiffs delay all surgical abortions until the cusp of the limit of when they see patients, their schedules will be overwhelmed, and they will not be able to see all of their patients, which also creates the risk that some patients will be forced to carry their pregnancies to term. Suppl. Liner Decl. ¶ 14; Suppl. Krishen Decl. ¶ 8; Suppl. Haskell Decl. ¶ 8. Suppl. Burkons Decl. ¶ 7.

Other women might turn to self-managed abortion, possibly using unsafe methods, requiring hospital care. According to data compiled from across the entire world, the frequency of abortion is similar in places that have the most restrictive laws (where abortion is banned outright or allowed only to save the woman's life) as it is in places that have the least restrictive laws (where abortion is allowed without restriction as to reason). Norris Decl. ¶ 34. Indeed, a few

months ago, an Ohio couple was charged with several crimes after inducing labor in pregnancy at 28 or 29 weeks with drugs purchased online. Keder Decl. ¶ 45. These individuals may end up in the emergency department (as this couple did), which will result in even greater PPE use than an earlier, legal abortion. *Id*.

Forcing a Person to Remain Pregnant, and Forcing them to Carry to Term, Also Increase Health Risks

Pregnant individuals are more prone to shortness of breath, blood clots, nausea and vomiting, dehydration, hypertension, urinary tract infections, and anemia (among other complications). Keder Decl. ¶ 13. Pregnant women also are at greater risk of certain infections, and sometimes these conditions require evaluation and occasionally urgent or emergent care to preserve the patient's health or save her life. *Id*. Pregnancy may aggravate a preexisting health condition such as high blood pressure (hypertension), diabetes, kidney disease, autoimmune disorders, and asthma. *Id*. ¶ 14. Other complications may arise during pregnancy, such as preeclampsia, pregnancy-induced hypertension, deep venous thrombosis, and gestational diabetes. *Id*. According to one study, 20% of pregnant patients seek care in the emergency department at least once during pregnancy. *Id*. ¶ 15.

ACOG and the Society for Maternal Fetal Medicine recommend that patients who are at "elevated risk"—that is, those who have severe symptoms consistent with COVID-19—should immediately seek care in the emergency department or an equivalent unit that treats pregnant women. *Id*. ¶ 17. Because pregnant patients experience many of the same symptoms associated with COVID-19, there may be an increase in the number of pregnant patient interactions with the health-care system. *Id*.

If a pregnant patient presents to the emergency department, a nurse and a physician will evaluate the patient. *Id.* ¶ 16. This often includes not only an emergency department physician

but also an obstetrician-gynecologist. *Id*. The evaluation will require non-sterile gloves, and, if a pelvic examination is required, the provider will also use a gown and surgical mask if there is concern regarding respiratory infection. *Id*. Gloves will also be used for any diagnostic testing, such as ultrasound or blood tests. *Id*. A patient who is admitted to labor and delivery would require contact with more staff and PPE will be needed to care for the patient. *Id.*

Pregnant individuals may also experience miscarriage (defined as pregnancy loss before twenty weeks) and preterm premature rupture of membranes. Approximately one in five pregnancies end in miscarriage. *Id*. ¶ 18. Although most miscarriages occur in the first trimester, approximately 20% of miscarriages occur in the second trimester. *Id*. Because miscarriage can result in incomplete explusion of the products of conception, which can lead to hemorrhage or infection, surgical completion of miscarriage is a time-sensitive, essential procedure. *Id*. ¶ 21. This treatment is similar to abortion care, and includes the provision of medication or a surgical procedure called a dilation and curettage ("D&C") (which is the equivalent of an aspiration abortion). *Id*. ¶ 19. Similarly, miscarriages in the second trimester will need to be managed with a surgical procedure: either a D&C or a D&E. *Id*. ¶ 19. Most D&Cs and D&Es are done in the operating room and include multiple staff, including the attending OB/GYN physician, surgical technician, anesthesia personnel, and circulating nurse. *Id*. ¶ 23. All the staff wear a surgical hat, eye protection, mask, shoe covers, and gloves when entering the operating room. *Id*. ¶ 23. A pregnant patient is more likely to experience a miscarriage requiring a surgical procedure to complete it than she is to have a complication from abortion that would require a similar hospital-based procedure. *Id.* ¶ 19.

Of course, if a patient carries a pregnancy to term, a significant amount of PPE and hospital resources are needed throughout the pregnancy—for routine prenatal care, evaluation for

concerns, and labor and delivery, which could include a cesarean section. *Id*. ¶¶ 25–29. Patients with unplanned pregnancies or without an obstetrician are more likely to present to the emergency department for urgent and non-urgent care. *Id.* ¶ 15.

ARGUMENT

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claim That the Director's Order, as Interpreted by Defendants to Force Plaintiffs' Patients to Delay Abortion Weeks or Months, Violates the Due Process Clause.

A. The Proper Standard of Review is *Casey*'s Undue Burden Test.

The proper standard of review is the undue burden test first outlined in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). As the Supreme Court held, "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." 505 U.S. at 877. A restriction that, "while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (quoting *Casey*, 505 U.S. at 877). As the Supreme Court has held, "*Casey* requires courts to consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2298. As discussed below, the burdens of pushing women further into their pregnancy—to the detriment of their health and possibly forcing them to carry to term—outweigh the benefits. Forcing patients to delay abortion for months does not further the state's interests in preserving health care resources.

1. Forcing Patients to Delay Abortion for Weeks or Months Impermissibly Burdens Abortion Access.

Contrary to Defendants' unsupported claim, Defs.' Br. at 19, delaying abortion access for weeks or months imposes a substantial obstacle in the path of women accessing abortion. As

discussed above, although abortion is very safe, and much safer than childbirth, the medical risk associated with abortion increases as the pregnancy progresses. *See supra* at 11. And forcing someone to remain pregnant increases the risk that she will experience a pregnancy complication necessitating hospital care. *See supra* at 13–15. Delaying abortion is also detrimental to survivors of domestic violence or rape. *See supra* at 11. And for some people, delaying the abortion means that they will not obtain an abortion at all, and will be forced to carry their pregnancies to term. *See supra* at 12.

Defendants do not dispute Plaintiffs' evidence that delaying abortion by weeks or months imposes health risks. Defs.' Br. at 30. Nevertheless, they argue that delaying abortion does not impose a substantial obstacle in the path of people seeking abortion, claiming that the delay is "temporary." But as the Sixth Circuit recognized, even a "temporary" delay can deprive "a woman of her right to an abortion during the optimal 15-week period during which the aspriation method can be performed." *Preterm-Cleveland*, No. 20-3365, slip op. at 4. In any event, the the pandemic will likely last months in Ohio, and therefore the delay will not be "temporary."

Nor does the Supreme Court's decision to uphold a mandatory waiting period in *Casey*, 505 U.S. at 885–86, help Defendants. Defs.' Br. 17. The 24-hour delay upheld in *Casey* is markedly different than a delay of weeks or months in terms of the health risks discussed above. Indeed, the Court considered even a 24-hour delay a "close[] question" and noted that the evidence on the requirement's effects was "troubling," but held that "we cannot say that the waiting period imposes a real health risk." 505 U.S. at 885–86. By contrast, the Supreme Court more recently held in *Whole Woman's Health* that three-week wait times for an abortion

appointment would impose a burden on people seeking access to abortion. 136 S. Ct. at 2318; *see also id*. at 2313 (acknowledging that longer wait times for abortion burden patients).[9]

Furthermore, for some women, delaying their abortion may mean, in practice, that they are forced to carry their pregnancies to term, because they will not be able to travel again to the clinic, they may not be able to afford the abortion later in pregnancy, or the clinic's schedule may not be able to accomodate everyone seeking an appointment. *See supra* at 12. Such an effect plainly violates those patients' right to access that constitutionally protected care. *See, e.g.*, *Casey*, 505 U.S. at 879 ("[A] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.").

Plaintiffs must be able to use their medical judgment and consider all factors to determine whether the patient's abortion can be delayed under the Director's Order. The Ohio Department of Health has explicitly said that both physical and mental health are among the factors that health care providers should consider when determining whether the surgery can be delayed.[10] But, unlike other health care providers, Defendants have indicated that they will not defer to an abortion provider's judgment. *See supra* at 7–8.

Defendants' position is not only in contrast to the Department of Health's guidance but it is also contrary to Supreme Court precedent. Indeed, the Supreme Court has repeatedly held that health care providers must have the discretion to use their medical judgment when interpreting laws that restrict access to abortion. For example, in *Doe v. Bolton*, 410 U.S. 179, 191–92

[9] Furthermore, the *Casey* Court found that the burden imposed by the 24-hour mandatory waiting period was outweighed by the state interests in potential life given that it was "calculated to inform the woman's free choice, not hinder it." 505 U.S. at 877. Here, as discussed below, the Order does not actually further a valid state interest.

[10] Ohio Dep't of Health, *supra* n.1

(1973), the Court underscored the importance of affording physicians adequate discretion in exercising medical judgment in a vagueness challenge to a Georgia statute requiring that a physician's decision to perform an abortion must rest upon "his best clinical judgment." The Court found it critical that that judgment "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." *Id.* at 192; *see also Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64 (1976) (holding that, in the context of a statute that restricted abortion after viability, determining viability must be a matter for the judgment of the responsible attending physician, not politicians); *Colautti v. Franklin*, 439 U.S. 379, 396–97 (1979) (same).

2. Defendants' Asserted State Interests Are Not Furthered.

The explicit purposes of the Order are preserving "PPE and critical hospital capacity and resources within Ohio." Order at 1. Defendants also assert that the Order "helps reduce the number of individuals present in its hospitals and other medical facilities." Defs.' Br. at 14. The importance of these interests is not in dispute—indeed, Plaintiffs are doing everything they can to assist in these efforts, *see* Pls.' Opening Br. at 7–8—but while these interests might be served by delaying other medical care, they are not furthered by delaying abortions until the patient is at or near the legal limit. *See Whole Woman's Health*, 136 S. Ct. at 2311 ("nothing in Texas' record evidence . . . shows that, compared to prior law . . ., the new law advanced Texas' legitimate interest in protecting women's health.").

As Plaintiffs have already explained, surgical abortion uses minimal PPE overall and almost none of the PPE that is in short supply. *See* Pls.' Opening Br. at 7–8; Suppl. Haskell Decl. ¶ 7. Plaintiffs have also instituted social distancing measures that reduce the number of individuals in the clinic and in the exam room. *See* Pls.' Opening Br. at 7–8. Additionally, following the Director's Order, Plaintiffs have been using their professional judgment and

providing care only if it could not safely be delayed "without undue risk to the patient's current or future health." Suppl. Liner Decl. ¶ 4; Suppl. France Decl. ¶ 4; Suppl. Haskell Decl. ¶ 4; Suppl. Krishen Decl. ¶ 4; Suppl. Burkons Decl. ¶ 4. As a result of all of these measures, the number of surgical abortions Plaintiff clinics perform has declined dramatically. Suppl. Liner Decl. ¶ 6; Suppl. France Decl. ¶ 6; Suppl. Haskell Decl. ¶ 6; Suppl. Krishen Decl. ¶ 5; Suppl. Burkons Decl. ¶ 5. Moreover, Plaintiffs perform abortions in an outpatient setting, not in hospitals. *See* Pls.' Opening Br. at 19. Thus, Plaintiff clinics are minimizing the burden on hospitals by ensuring that essential time-sensitive outpatient procedures do not become urgent or emergent hospital procedures. *See* Keder Decl. ¶¶ 11, 13, 15.

Contrary to what Defendants' suggest, Defs.' Br. at 21–22, delaying abortions until the patient is at or near the legal limit will not preserve significant PPE in the "immediate near-term" nor will it change the "cumulative effect" of the Director's Order. Defendants completely ignore the incontestable fact that pregnancy is a constantly progressing condition that requires health care, regardless of whether a person is seeking to terminate that pregnancy or attempting to carry that pregnancy to term. Keder ¶¶ 25–29 (describing medical care needed when carrying a pregnancy to term); *see also Preterm-Cleveland*, Case No. 20-3365, slip op. at 6 (Bush, J., concurring in part and dissenting in part) ("abortion is a unique medical procedure under both Ohio and federal law"). Pregnancy carries inherent risks, including risk of miscarriage, that are more likely to lead to the need for medical care, including urgent and emergency care, which uses still more PPE and more hospital resources than a person who obtains a timely abortion. Keder ¶¶ 12–24. Thus, PPE is not "cumulative[ly] saved, even in the "immediate near-term," just shifted to another provider. *See* Keder ¶ 11; *Robinson*, 2:19cv365-MHT-JTA, slip op. at 38 ("a delayed abortion does not erase even the patient's short-term need for medical care").

In any case, this Court should, like the Sixth Circuit, be skeptical of Defendants' urging that it only consider the "immediate near-term." *See Preterm-Cleveland*, Case No. 20-3365, slip op. at 4. The Order has no end date, instead stating that it will "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." Order at 4. Thus, Defendants are not suggesting that patients be delayed days or weeks, but indefinitely and likely for months. *See* Norris Decl ¶¶ 11, 36; McKinney Decl. ¶ 13. As explained *infra*, such delay will not conserve PPE or hospital resources in the short, medium or long term. Keder ¶ 11.

If Defendants are allowed to force providers to delay patients until they are at or near the legal limit for abortion in Ohio, providers will need to use more PPE, procedures will require longer and more frequent instances of physical contact between patients and their healthcare team, and patients will be more likely to need to utilize hospital resources. Suppl. Liner Decl. ¶¶ 9, 12; Keder Decl. ¶¶ 37, 42–43; *see also* Pls.' Opening Br. at 20–21; *Little Rock Family Planning Servs. v. Rutledge*, No. 4:19-cv-449-KGB, Doc. 141, slip op. at 14 (E.D. Ark. Apr. 14, 2020) ("abortion is safer and does not burden hospitals as much as continued pregnancy, miscarriage management and childbirth."). As an initial matter, forcing patients to delay their terminations unnecessarily subjects them to extended exposure to the inherent risks of pregnancy complications described above. Second, delaying surgical patients until later in the second trimester will require providers to use at least twice the amount of PPE per patient than if they had been able to provide care earlier in pregnancy. Suppl. Liner Decl. ¶ 9; Keder ¶ 43. In the first and early second-trimester, surgical abortion is performed using the aspiration method, which can be done in a single day with the procedure lasting less than 10 minutes. Suppl. Liner Decl. ¶ 10. Comparatively, second-trimester abortion requires the more complicated D&E method and

must often be done over a period of two days to allow for adequate dilation. *Id.*; *see also Preterm-Cleveland*, Case No. 20-3365, slip op. at 3–4 (noting D&E can require "more time in the clinic and uses more PPE" than aspiration). Additionally, though abortion is very safe, risks increase as pregnancy progresses. Suppl. Liner Decl. ¶ 11–13; Keder Decl. ¶¶ 38–41. This is especially true in Ohio, where, starting at 18 weeks, providers are required to attempt a fetal demise procedure, which alone carries risks, before they can provide D&E abortion. Suppl. Liner Decl. ¶ 12–13 ; Keder Decl. ¶ 41; *see also Planned Parenthood of Sw. Ohio Region v. Yost*, 375 F. Supp. 3d 848, 869 (S.D. Ohio 2019) (finding fetal demise procedures pose risk to patients). Thus, delaying abortion until later in the second trimester also increases the risks of complications that could necessitate further medical care. Suppl. Liner Decl. ¶ 12; Keder Decl. ¶¶ 11, 39.[11] Moreover, as Plaintiffs have explained, *see* Pls.' Opening Br. at 20, denying patients abortion care unless and until their condition deteriorates will result in more patients arriving at the hospital in need of emergency procedures. *See* Keder ¶ 15 (patients with comorbidities are more likely to seek emergency care).

3. The Burdens Outweigh the Benefits.

The final step in the undue burden analysis "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. Here, the Order would severly burden access to abortion—by forcing

[11] As explained *supra* at 12, forcing patients to delay procedures until they are at or near the legal limit will likely result in some patients being denied abortion entirely. Some patients may be forced to travel out of state, thus increasing their exposure to the virus. Keder Decl. ¶ 44; *see also* Pls.' Opening Br. at 20. Others may be forced to carry to term, necessitating the use of even more PPE. Keder Decl. ¶ 48; *see also* Suppl. Liner Decl. ¶ 14; Pls.' Opening Br. at 20–21. And still others may take matters into their own hands and try to terminate the pregnancy without medical assistance, which may lead to the need for emergency and other follow-up medical care. Keder Decl. ¶ 45; *see also Robinson v*, 2:19-cv-365-MHT-JTA, slip op. at 41("[I]f 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.").

patients to delay abortion by weeks or months, or deny them in-state care altogether, to the detriment of their health—but would not further the State's interest in protecting health care resources.

B. Defendants Are Not Entitled To a Deferential Standard of Review of the Order, But Plaintiffs Are Likely to Prevail Even Under That Standard.

Defendants claim that the constitutionality of the Director's Order should be evaluated under a deferential standard of review in an attempt to give themselves *carte blanche* to restrict constitutional rights during this urgent time in our country. But the cases that they cite, *Jacobson* and *Avino*, do not stand for this proposition. Indeed, the Supreme Court in *Jacobson* repeatedly cautioned that the state has authority to "safeguard the public health and the public safety," but that authority is extended "only to the condition that no rule prescribed by a state. . . shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument." *Jacobson v. Massachusetts*, 197 U.S. 11, 25 (1905).

Jacobson stands for the basic premise that the state can exercise police power in an emergency, subject to constitutional limitations.[12] *Jacobson* was decided decades before the Court developed heightened standards of scrutiny for laws violating constitutional rights, *see United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938), as well as modern substantive due process doctrine. To say that *Jacobson* was intended to bypass higher standards of scrutiny for violations of constitutional rights is anachronistic at best. Indeed, rather than affirming that *Jacobson* allowed the state to suspend the constitutional right to bodily integrity

[12] *Jacobson* was decided in 1905, the same year as *Lochner v. New York*, 198 U.S. 45 (1905), at a time when courts were called on to address whether particular enactments were "within the police power of the state." *Id.* at 57. In today's jurisprudence, *Jacobson*'s holding is unremarkable, in that a state is assumed to have the power to enact laws for the public health that are reasonable and as limited by the Constitution.

during a pandemic, the Supreme Court has since characterized *Jacobson* as "*balanc[ing]* an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan by Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (emphasis added); *see also Casey*, 505 U.S. at 857.

As is evident from the discussion of *Jacobson* in modern case law, the case did not upend the level of scrutiny that would otherwise apply to the underlying constitutional right at issue, nor is the case primarily a case about emergency powers. *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). Furthermore, as other courts have noted, *Jacobson* "involved minimally invasive procedures with no lasting side effects" and does not extend to more lasting encroachments on people's liberty interests. *In re Cincinnati Radiation Litig.*, 874 F. Supp. 796, 818–19 (S.D. Ohio 1995) (holding patients subjected to non-consensual medical experiments had due process right to bodily integrity sufficiently well-established to overcome qualified immunity).

Nor does Defendants' other primary case, *Avino*, set the standard for constitutional encroachments during time of emergency. *Avino* is a context-specific holding on curfews during time of natural emergencies. *Smith v. Avino*, 91 F.3d 105, 109 (11th Cir. 1996), *abrogated by Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83 (1998). No court has ever extended *Avino* beyond the context of curfews, and this Court should reject Defendants' suggestion that it do so

here.[13] *See Robinson*, 2:19-cv-365-MHT-JTA, slip op. at 43 (holding that *Avino* "addressed only temporary, partial restrictions on certain fundamental rights," and recognizing no court has extended *Avino* beyond cases involving temporary curfews).

Plaintiffs do not disagree that a state's unique interests during a time of emergency can be considered by the Court, but such consideration must be done in the context of the existing framework for analyzing the constitutional right to abortion under existing abortion jurisprudence. As the Supreme Court recognized in *Cruzan*, *Jacobson* applied a balancing test, which involved "balanc[ing] an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan*, 497 U.S. at 278. This framework is similar to the Court's approach in *Casey* and *Whole Woman's Health*, where the Court instructed that the state's interests (the benefits of the law) must be balanced against the burdens the law imposes. Accordingly, for the same reasons that the Order, as applied by the State to abortions, violates the *Casey* and *Whole Woman's Health* balancing test, as discussed above, it also violates the balancing dictated by *Jacobson*. Indeed, as discussed above, delaying abortion for weeks or months "has no real or substantial relation to the protection of the public health and the public safety." *Jacobson*, 197 U.S. at 31.

II. The Other Preliminary Injunction Factors Weigh in Plaintiffs' Favor.

As discussed in Plaintiffs' opening brief, Pls.' Opening Br. at 23, Plaintiffs' patients will suffer irreparable harm without an injunction, and Defendants will not suffer any harm given that

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[13] Defendants fail to acknowledge that *Avino* relies on *Korematsu v. United States*, 323 U.S. 214 (1944), which "was gravely wrong the day it was decided," *Trump v. Hawaii*, 138 S. Ct. 2392, 2423 (2018), and *Aptheker v. Secretary of State*, 378 U.S. 500 (1964), which struck down a law that "too broadly and indiscriminately restricts the right to travel," *id.* at 505, for the proposition that the right of travel and free speech may be limited in an emergency. *Avino*, 91 F.3d at 109. The Court here should not extend that proposition, built on such shaky foundations, to permit the state to curtail abortion rights.

delaying abortion will actually consume more health care resources, not preserve them, *see supra* at 18–21. Moreover, as described above, and contrary to Defendants' claim, Defs.' Br. at 32, Plaintiffs are not asking for special treatment; to the contrary, they seek to be treated like all other health care professionals who are entitled to make these medical decisions based on their own judgment. But given Defendants' multiple threats of enforcement of the Director's Order against Plaintiffs, and Defendants' shifting interpretations of it, Plaintiffs need the protection of a preliminary injunction so that they are not caring for patients with the Sword of Damocles hanging over their heads. And, although the parties agree on some aspects of the interpretation of the Director's Order, Plaintiffs need the protection of an injunction and cannot rely on Defendants' litigation-inspired position. *Northland Family Planning Clinic*, 487 F.3d at 341–43 (holding that attorney general opinion did not moot the case because it was developed in response to litigation and was not binding); *Robinson*, 2:19-cv-365-MHT-JTA, slip op. at 51–52 ("In this environment, a provider might reasonably fear that prosecutions under the medical restrictions will proceed despite the defendants' on-the-record interpretations... Given these realities, guaranteeing practical, reliable flexibility to abortion providers requires an injunction.").

Lastly, Defendants claim that a preliminary injunction will cause them harm because Plaintiffs may seek attorneys' fees, but they cite no case supporting the proposition that a government actor can violate the Constitution and then seek to escape a preliminary injunction by citing the possibility of an attorneys' fee award as potential harm. That proposition would upend the purpose of 42 U.S.C. § 1988, and would mean that no civil rights plaintiff could obtain a preliminary injunction. Moreover, Plaintiffs tried multiple times to understand the contours of the Director's Order prior to filing suit, and only sued when Defendants threatened to enforce the

Director's Order against them by sending cease-and-desist letters, threatening enforcement against them in the press, and inspecting Plaintiffs' clinics for two days. Even after the instant action was filed, Defendants refused to articulate their interpretation of the Order to this Court. Defendants' argument is particularly incredible given that they leapfrogged this Court in an attempt to litigate this case in the Sixth Circuit in the first instance, forcing Plaintiffs to expend resources to defend a frivolous emergency motion to stay.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' motion for a preliminary injunction and prohibit Defendants from enforcing the Director's Order to bar Plaintiffs from performing or otherwise penalize Plaintiffs for performing an abortion when Plaintiffs determine, based on their good faith medical judgment, that a surgical abortion cannot be delayed because of "undue risk to the current or future health of a patient," based on the following factors: (1) whether the procedure is essential to preserve the patient's exercise of the constitutionally protected right to abortion; (2) whether the procedure is needed to protect the patient's health or life; (3) the gestational age of the fetus, as determined by the healthcare provider, as it relates to the increased risk of the abortion procedure as the pregnancy progresses; (4) the medical history and physical and mental health conditions of the patient; and (5) economic, social and logistical factors that may impact the patient's ability to obtain an abortion if it is delayed.

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Respectfully Submitted,

/s/ B. Jessie Hill
B. Jessie Hill #0074770
Trial Attorney for Plaintiffs
Cooperating Counsel for the American Civil

Liberties Union of Ohio Foundation
American Civil Liberties Union of Ohio
4506 Chester Ave.
Cleveland, OH 44103
(216) 368-0553
(216) 368-2086 (fax)
bjh11@cwru.edu
Counsel for Plaintiff Preterm-Cleveland

Elizabeth Watson*
Rachel Reeves*
Brigitte Amiri*
American Civil Liberties Union Foundation
125 Broad Street, 18th Floor
New York, NY 10004
(212) 549-2633
(212) 549-2650 (fax)
ewatson@aclu.org
rreeves@aclu.org
bamiri@aclu.org
Counsel for Plaintiff Preterm-Cleveland

Carrie Y. Flaxman*
Richard Muniz*
Planned Parenthood Federation of America
1110 Vermont Ave NW, Suite 300
Washington, DC 20005
(202) 973-4800
(202) 296-3480 (fax)
carrie.flaxman@ppfa.org
richard.muniz@ppfa.org
Counsel for Plaintiffs Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, and Sharon Liner, M.D.

Jennifer L. Branch # 0038893
Alphonse A. Gerhardstein # 0032053
Gerhardstein & Branch Co. LPA
441 Vine Street, Suite 3400
Cincinnati, OH 45202

(513) 621-9100
(513) 345-5543 (fax)
jbranch@gbfirm.com
agerhardstein@gbfirm.com
Counsel for Plaintiffs Planned Parenthood Southwest Ohio Region, Planned Parenthood of Greater Ohio, Sharon Liner, M.D., Women's Med Group Professional Corporation and Capital Care Network of Toledo

Freda J. Levenson #0045916
American Civil Liberties Union of Ohio Foundation
4506 Chester Avenue
Cleveland, OH 44103
(614) 586-1972 x 125
(216) 472-2210 (fax)
flevenson@acluohio.org
Counsel for Plaintiff Preterm-Cleveland

* *Admitted pro hac vice*

CERTIFICATE OF SERVICE

I hereby certify that on April 15, 2020 a copy of the foregoing was filed electronically. Notice of this filing will be sent to all parties for whom counsel has entered an appearance by operation of the Court's electronic filing system. Parties have access to this filing through the Court's system.

/s/ B. Jessie Hill
B. Jessie Hill