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

WEST ALABAMA WOMEN'S CENTER and WILLIAM J. PARKER, MD, on behalf of themselves and their patients,

Plaintiffs,

v.

DONALD E. WILLIAMSON, MD, in his official capacity as State Health Officer,

Defendant.

CIVIL ACTION

Case No. 2:15cv497-MHT

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

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INTRODUCTION

This is an as-applied challenge seeking a temporary restraining order and/or preliminary injunction against Alabama Administrative Code Rule 420-5-1-.03(6)(b) (the "Regulation"), which mandates that physicians who provide abortions at a licensed abortion clinic obtain staff privileges at a local hospital or, in the alternative, that the clinic obtain a written contract with an outside covering physician who maintains such privileges. As the Court recognized just last year in the related litigation *Planned Parenthood Southeast v. Strange* ("PPSE"), because abortion is so safe, it is impossible for Plaintiff William J. Parker, M.D., to obtain the staff privileges required by law; and due to widespread anti-abortion sentiment, it is impossible for Plaintiff West Alabama Women's Center ("WAWC" or "the Clinic") to find any physician willing to be associated with the Clinic as an outside covering physician. Thus, despite their best efforts to comply, WAWC—the sole licensed abortion clinic in Tuscaloosa, one of only two clinics in the state that provided abortions throughout the second trimester, and the highest-volume clinic in the state—has been forced to suspend patient services. As a result, to get to a licensed abortion clinic, Tuscaloosa women must now travel the very distances—if not further—the *PPSE* Court already held impose a substantial obstacle in the path of a significant number of women seeking abortions in Alabama. And, once again, as the Court previously found, these increased distances will prevent a significant number of women from obtaining a safe abortion; will lead some to resort to unsafe methods of self-abortion rather than be forced to continue their pregnancies against their will; and will delay still other women in their ability to obtain an abortion (subjecting them to unnecessary health risks), and causing significant harms in terms of time, and financial cost.

Indeed the evidence set forth below unmistakably shows the effect of WAWC's closure has been extremely detrimental to [the welfare of women in need of safe and legal abortion services. For example, one Alabama clinic has seen a surge in the number of women who have been delayed in accessing an abortion, reporting that the number of women it must turn away for being past the clinic's gestational limit has increased over 100%, as compared to the same period last year. Likewise, since WAWC has been closed, another clinic has received at least two phone calls every month from women asking for instructions on how to self-induce an abortion because they cannot afford to travel to the clinic. Meanwhile, even though the only clinic left in the state that provides abortions throughout the second trimester is operating at close to its maximum capacity, its increase in patients is but a fraction of the number seen by WAWC during the same period last year. In fact, data suggest a significant drop in the total number of abortions performed in Alabama in 2015, as compared to previous years.

In the face of these ongoing and escalating harms, there is no justification for Defendant Williamson, the State Health Officer and Director of the Alabama Department of Public Health ("DPH"), to continue to enforce the Regulation against Plaintiffs. As demonstrated below, WAWC's policies and protocols for treatment of abortion complications guarantee the same level and quality of care as that provided by the Regulation. Any interest DPH may have in enforcing the Regulation against WAWC is thus vastly outweighed by the harms that have been, and continue to be, caused by the Regulation.

Having exhausted all other options, absent injunctive relief, WAWC will have no choice but to close its doors permanently. Accordingly, because enforcement of the Regulation provides no discernible benefit to Plaintiffs' patients—and has instead caused, and continues to

cause, significant and irreparable to Alabama women, in violation of their constitutional rights—this Court should enjoin enforcement of the Regulation, as applied to Plaintiffs.

STATUTORY AND REGULATORY FRAMEWORK

As the Court recognized in *Planned Parenthood Southeast, Inc. v. Strange*, Alabama's regulation of abortion clinics is "detailed and extensive." 9 F. Supp. 3d 1272, 1276 (M.D. Ala. 2014) ("*PPSE II*") (internal quotation marks and citation omitted). That extensive regulatory regime includes, among many other requirements, licensing criteria for abortion clinics, *see id.* (citing Ala. Admin. Code r. 420–5–1–.01 to –.04); training, credentialing, and competency requirements for physicians who perform abortions, *see id.* (citing Ala. Admin. Code r. 420–5–1–.02(5)(d)(2)); and patient-care requirements, including the requirement that the physician remain at the clinic until the last patient is discharged, and the requirement that the clinic maintain a twenty-four-hour telephone service through which a patient can reach a medical professional, *see id.* (citing Ala. Admin. Code r. 420–5–1–.03(6)(a), (d), and (e)).

At issue here is the application of one provision of that extensive regulatory regime—the Regulation—to WAWC (or a single clinic). According to the Regulation, in order for a facility to be licensed as an abortion or reproductive health center, either (1) the physician performing an abortion must have "staff privileges at an acute care hospital within the same standard metropolitan statistical area as the abortion or reproductive health center is located, that permit him or her to perform dilation and curettage, laparotomy procedures, hysterectomy, and any other procedures reasonably necessary to treat abortion-related complications," or (2) the facility must have a "valid written contract" for the provision of "outside covering physician services" with a physician with the above-listed hospital staff privileges. The Regulation requires that a

contract for covering physician services specify that the covering physician "shall be available" to treat and manage all complications; the protocols for communication between facility staff and the covering physician; the covering physician's fees; and a that the covering physician notify the facility at least "72 hours in advance of any absences" during which neither the covering physician nor an available substitute physician with the requisite hospital staff privileges is available. Ala. Admin. Code. r. 420–5–1–.03(6)(b)(1) – (5). No other physician or facility that performs office-based procedures, even those riskier than abortion, is subject to a similar requirement. *See, e.g.*, Ala. Admin. Code r. 540-X-10-.01 (laying out guidelines for office-based surgical procedures).

HISTORY OF RELATED PROCEEDINGS

In addition to these regulatory requirements is a *statutory* staff-privileges requirement, which was enacted in 2013, *see* Ala. Code § 26–23E–4(c), and subsequently enjoined. This statute essentially eliminated the covering physician alternative and instead mandated that every physician performing an abortion at a licensed abortion clinic must "have staff privileges at an acute care hospital within the same standard metropolitan statistical area as the facility is located that permit him or her to perform dilation and curettage, laparotomy procedures, hysterectomy, and any other procedures reasonably necessary to treat abortion-related complications." *See id.*

On June 11, 2013, three of Alabama's five abortion clinics, not including the plaintiff in this action, WAWC,[1] filed a pre-enforcement constitutional challenge to the statutory staff-privileges requirement against various state officials, including the defendant in this action,

[1] WAWC was not a plaintiff in this earlier lawsuit, because until December 31, 2014, Plaintiff WAWC's physician had local hospital staff privileges and could comply with the statutory staff-privileges requirement, had it gone into effect, as well as the Regulation.

Donald E. Williamson, M.D., seeking injunctive and declaratory relief. *See Planned Parenthood Southeast, Inc. v. Bentley*, 951 F. Supp. 2d 1280, 1283 (M.D. Ala. 2013) ("*PPSE I*"). As in this case, the plaintiffs in *Planned Parenthood Southeast* asserted a substantive due process claim on behalf of women seeking abortions, arguing that enforcement of the staff-privileges requirement would force abortion providers to cease operations and would thereby unduly burden women in need of abortion services. The Court entered a temporary restraining order barring enforcement of the statutory staff-privileges requirement on June 28, 2013, which was extended pursuant to the parties' joint motions and order of the Court, and remains in effect today. *See id.* at 1290-91; *Planned Parenthood Southeast, Inc. v. Strange*, 33 F. Supp. 3d 1330, 1380-81 (M.D. Ala. 2014) ("*PPSE III*").

During May and June 2014, the Court conducted an eleven-day bench trial on the constitutionality of the statutory staff-privileges requirement to evaluate "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." *PPSE III*, 33 F. Supp. 3d at 1337 (internal quotation marks and citation omitted). At trial, the Court heard live testimony from twenty-four witnesses—including eleven expert witnesses—on matters identical and/or substantially similar to those at issue in this case, including the availability and geographic distribution of abortion providers in Alabama; the safety of abortions and the medical standard of care for management of complications; the obstacles that women in Alabama would face as a result of being compelled to travel between cities (including Tuscaloosa, Birmingham, Montgomery, Mobile, and Huntsville) to access abortion services; the extreme difficulties clinics face in attempting to find doctors willing to provide abortions or even to serve as a covering physician in Alabama, and the extraordinary consequences that have befallen doctors who agree to do so; and the

inability of abortion providers in Alabama to obtain staff privileges at local hospitals. *See id.* at 1341–76.

On August 4, 2014, the Court issued a 172-page opinion containing its factual findings and legal conclusions, *see id.* at 1330, which it supplemented in a separate opinion issued on October 20, 2014, *see Planned Parenthood Southeast, Inc. v. Strange*, 33 F. Supp. 3d 1381 (M.D. Ala. 2014) ("*PPSE IV*"). The Court first found that enforcement of the statutory staff-privileges requirement would force the abortion clinics in Birmingham, Mobile, and Montgomery to close because their physicians could not obtain staff privileges, and that—due to factors that included anti-abortion stigma, negative professional consequences that deter physicians from being affiliated with the provision of abortion, and regulatory barriers to entry—it was highly unlikely that new providers would take their place. *PPSE III*, 33 F. Supp. 3d at 1348–55. Looking to quantitative and qualitative evidence concerning high poverty rates among Alabama women seeking abortions, the capacity of low-income women to travel between Tuscaloosa, Birmingham, Montgomery, Huntsville, and Mobile, and the relationship between increased travel distance and abortion access for women, the Court found that reduced abortion access would inflict an array of harms on women seeking abortions. *Id.* at 1355–1363. In particular, the Court found that

> [f]irst, ... [a] significant number of the women would be prevented from obtaining an abortion; others would be delayed in obtaining abortions, exposing them to greater risks of complications; and even the women who are able to obtain abortions would suffer significant harms in terms of time, financial cost, and invasion of privacy. Second, for all Alabama women, the number of abortions that can be performed in the State would be radically diminished, with every indication that the statewide capacity of abortion services would further diminish, rather than increase, in the future. Finally, . . . there is significant risk that women who are unable to procure abortions would turn to unsupervised and unsafe use of abortion-inducing medications.

Id. at 1355; *see also id.* at 1362–1363.

These severe harms, the Court found, far outweighed the "exceedingly weak" justifications for the statutory staff-privileges requirement, including the state's asserted interest in fostering continuity of care. *Id.* at 1378. The Court found that early-term abortions are "extraordinarily safe," that complications from such procedures are "vanishingly rare," and that even among those complications, most do not require hospital treatment. *Id.* at 1364, 1366. The Court further found that of the rare instances when complications do occur, in many cases whether the physician has staff privileges would be irrelevant because complications may arise after the patient has been discharged and gone home, and many patients do not alert the clinic before going to a hospital for treatment. *Id.* at 1367–68. For the remaining cases, including the very rare case of a direct hospital transfer from the clinic, the Court found that the key to continuity of care "is ensuring that a doctor who treats a complication has enough information about the initial procedure to make wise choices about the patient's care." *Id.* at 1371. The Court found that hospital staff privileges are not necessary to provide such care. *See id.* Far from protecting patient safety, the Court found that enforcement of the statute (and the resultant closure of abortion clinics) "would, in reality, do more to inhibit continuity of care than to promote it." *Id.* at 1372. The Court explained:

> [A] woman in one of those three cities [in which clinics would be forced to close] would have to travel to Tuscaloosa, Huntsville, or out of state to obtain an abortion. If she experienced a complication, which would be most likely to occur only after she returned home, she would have to seek treatment close to her home. Neither the doctor who performed the abortion nor the clinic's covering physician would be likely to have staff privileges at any hospital near her home. Furthermore, in light of the challenges that many women face in traveling outside their home cities to secure an abortion, she would almost certainly be more likely to miss a scheduled follow-up visit.

Id.[2]

"In light of the severity of the obstacles presented by the requirement and the weakness of the State's justifications," the Court held that "the obstacles imposed by Alabama's staff-privileges requirement are more significant than is warranted by the State's justifications for the regulation." *Id.* at 1378 (internal quotation marks and citation omitted). The Court declared the statutory staff-privileges requirement unconstitutional as applied to the Birmingham, Mobile, and Montgomery clinics, reserving decision on whether that relief would be applied beyond the plaintiffs in the *Planned Parenthood Southeast* litigation and whether injunctive relief is in order. *See id.* at 1380–81. Those matters remain pending before the Court. *See Planned Parenthood Southeast, Inc. v. Strange*, No. 2:13-cv-00405-MHT-TFM, ECF Nos. 250, 256, 257 (briefs on the scope of final relief).

As set forth below, Plaintiff WAWC now finds itself in a similar position to the plaintiff clinics in the *Planned Parenthood Southeast* litigation, in that its new physician (Plaintiff Dr. Parker) cannot obtain staff privileges. However, as described below, because none of the ob-gyns with privileges at the only hospital in Tuscaloosa are willing to serve as the Clinic's covering physician, the Clinic is also unable to comply with the Regulation. As a result, the Clinic cannot provide abortions and brings the present as-applied challenge to the Regulation on behalf of its patients.

[2] The Court likewise found that the state's asserted interest in using the hospital credentialing process to review the quality of physician performance was "weak and speculative" in light of the evidence presented at trial. *PPSE III*, 33 F. Supp. 3d at 1378.

FACTUAL BACKGROUND OF PRESENT ACTION

I. PLAINTIFFS

Plaintiff WAWC, which is located in Tuscaloosa, has provided comprehensive, outpatient reproductive health care services, including first- and second-trimester abortion services, to women from Alabama and surrounding states since 1993. Decl. of Gloria Gray ¶¶ 1, 5 ("Gray Decl."), attached hereto as Exhibit 1. Gloria Gray has been the Clinic's sole administrator, as well as one of the Clinic's owners, throughout this time. *Id.* ¶ 2. WAWC is licensed as an "abortion or reproductive health center" by DPH. *Id.* ¶¶ 6–7. As such, WAWC is subject to and in compliance with extensive regulations, including but not limited to those relating to patient care, infection control, personnel, physician qualifications, fire evacuation plans, emergency communications, recordkeeping, and physical plant requirements. *See* Ala. Admin. Code r. 420-5-1-.01 *et seq.*; *see also* Gray Decl. ¶¶ 7–8. The DPH conducts extensive annual surveys of the Clinic to ensure compliance with the regulations. *See* Gray Decl. ¶ 7. WAWC is, and always has been, the sole licensed abortion clinic in Tuscaloosa. *Id.* ¶¶ 1, 6. There are only four other licensed abortion clinic in the entire state: Reproductive Health Services ("RHS"), in Montgomery; Alabama Women's Center, in Huntsville; Planned Parenthood of Birmingham and Planned Parenthood of Mobile.[3] *Id.* ¶ 6.

WAWC provides medical abortions up to 9 weeks LMP, as measured from the woman's last menstrual period ("LMP"), and surgical abortions up to 21.6 weeks LMP, although the vast

[3] *See* Ala. Dep't. of Pub. Health, *Health Care Facilities Directory (Abortion or Reproductive Health Centers)*, http://dph1.adph.state.al.us/FacilitiesDirectory/(S(wvo3jv55gye12jqcnjcium2y))/Reports/ReportDirectory-2015-07-08-1812108579384.pdf.

majority of women obtain abortions earlier in pregnancy.[4] *Id.* ¶ 5. The only other licensed abortion clinic in Alabama that provides abortions throughout the second trimester is the Alabama Women's Center in Huntsville; the other clinics do not provide abortions past 15 weeks LMP. *See id.* ¶ 6; Decl. of Dalton Johnson ¶¶ 2–3 ("Johnson Decl."), attached hereto as Exhibit 2 ; Decl. of June Ayers ¶¶ 2, 4 ("Ayers Decl."), attached hereto as Exhibit 3; *see also* Abortion Services Search: Mobile Center-Mobile, AL, *Planned Parenthood*, http://www.plannedparenthood.org/health-center/alabama/mobile/36609/mobile-center-2911-90330/abortion; Abortion Services Search: Birmingham Center-Birmingham, AL, *Planned Parenthood*, http://www.plannedparenthood.org/health-center/alabama/birmingham/35205/birmingham-center-3253-90330/abortion. In addition to abortions, WAWC provides, *inter alia*, routine gynecological procedures, birth control, testing and treatment for sexually transmitted infections, pregnancy testing and options counseling, and referrals for prenatal care and adoption. Gray Decl. ¶ 5.

For at least the past three years, prior to the time when WAWC ceased providing abortions in 2015, more women received abortions at WAWC than at any other clinic in the state. In 2012, WAWC performed approximately 39% of the abortions in Alabama (3,503 procedures), more than double the number of procedures performed by the clinic with the second-highest volume (1,451 procedures); in 2013, WAWC performed approximately 44% of the abortions in Alabama (3,710 procedures), more than 2.5 times the number of procedures

[4] Based on published numbers from 2012 and 2013, approximately 80% of WAWC's patients obtain abortions prior to 11 weeks LMP. *See* Ala. Dept. of Pub. Health, *Induced Terminations of Pregnancy by Facility and Probable Postfertilization Age, Alabama, 2013*, http://www.adph.org/healthstats/assets/ITOP_PPFA_2013_rev.pdf; Ala. Dept. of Pub. Health, *Induced Terminations of Pregnancy by Facility and Probable Postfertilization Age, Alabama, 2012*, http://www.adph.org/healthstats/assets/ITOP_PPFA_2012.pdf.

performed by the clinic with the second-highest volume (1,469). *See id.* ¶ 9.[5] And although the DPH has yet to publish statewide statistics for 2014, WAWC performed 4,723 abortions that year—over three times more than any other clinic in Alabama had performed in any prior year for which statistics are available. *See id.* ¶ 9.

Additionally, until its recent closure, WAWC was one of only two clinics in the state that provided abortions after 15 weeks LMP (with the only other such provider located near the Tennessee border in Huntsville), and provided care to far more women in need of second-trimester abortions than any clinic in the state. *See id.* ¶ 6, 10. In 2012 and 2013, WAWC performed more than 60% of the second-trimester abortions in the state, and performed nearly 80% of abortions between 17 and 21.6 weeks LMP (the state's legal limit). *See id.* ¶¶ 5, 10.

Plaintiff Dr. Parker is a highly regarded board certified ob-gyn with subspecialty training in family planning, contraception and abortion. Decl. of Dr. Willie J. Parker ¶¶ 1, 6–12 ("Parker Decl."), attached hereto as Exhibit 4. Dr. Parker has over twenty years of experience in women's health, including as the Director of the Division of Family Planning and Preventive Services at the Washington Hospital Center (Washington D.C.); as the Medical Director of Planned Parenthood of Metropolitan Washington, overseeing clinical and laboratory services at five health care centers in Maryland, Virginia, and the District of Columbia; and as an independent abortion provider at outpatient abortion clinics in Alabama, Georgia, Illinois, Pennsylvania, and Mississippi. *Id.* ¶ 1. He currently provides abortions at RHS when that clinic's primary physician is unavailable and at the sole abortion clinic in Mississippi four to six days per month, and would like to provide abortions at WAWC. *Id.* ¶ 3. Dr. Parker has held numerous faculty positions, including as an Assistant Professor of Obstetrics and Gynecology at the University of

[5] *See also* sources cited *supra* note 4.

Hawaii School of Medicine and as a Clinic Instructor at the University of Michigan Health Systems. *Id.* ¶ 9. He is currently on the faculty of the Northwestern University Feinberg School of Medicine, and holds staff privileges at the Northwestern University hospital. *Id.*

II. PLAINTIFFS' ATTEMPTS TO OBTAIN STAFF PRIVILEGES AND/OR OUTSIDE COVERING PHYSICIAN

The same physician—Dr. Louis Payne—provided abortions at WAWC from its founding in 1993 until his retirement at age 75, on December 31, 2014. Gray Decl. ¶¶ 2, 12, 14. Because Dr. Payne held staff privileges at DCH Regional Medical Center ("DCH") in Tuscaloosa before working at WAWC, and maintained them throughout the entire time he worked at the Clinic, WAWC did not previously experience any difficulty complying with the Regulation. *Id.* ¶¶ 2, 12. In addition, because Dr. Payne always held staff privileges at DCH, WAWC was not required to—and did not ever—enter into a formal written agreement with an outside covering physician, which is the alternative legal requirement under the Regulation. *Id.* ¶ 13.[6]

Late last year, after Ms. Gray learned of Dr. Payne's impending retirement, Ms. Gray and Dr. Parker agreed that Dr. Parker would provide abortions at WAWC. *Id.* ¶¶ 14–15; Parker Decl. ¶ 3. In order to comply with the Regulation, Dr. Parker intended to move to Tuscaloosa and apply for staff privileges to perform, *inter alia*, hysterectomies and laparotomies at DCH. Gray Decl. ¶¶ 15–16; Parker Decl. ¶ 13. Dr. Parker submitted his application for privileges in December 2014. Gray Decl. ¶ 16; Parker Decl. ¶ 13. Because Dr. Parker was willing to move to Tuscaloosa and because DCH is affiliated with the University of Alabama (Dr. Parker has

[6] Dr. Payne was able to maintain his privileges, even after giving up his obstetrical practice to work at WAWC, because he continued to perform non-abortion-related gynecological procedures at the hospital. *Id.* ¶ 12.

substantial academic credentials), both Ms. Gray and Dr. Parker were optimistic that he would be able to obtain privileges. Gray Decl. ¶ 16; Parker Decl. ¶ 14.

On or about February 5, 2015, Dr. Parker met with the Professional Activities Committee ("PAC") at the hospital to discuss his application. Parker Decl. ¶ 16. The PAC is a group consisting of physician representatives from various departments at the hospital, which evaluates all staff privileges applications and then issues a recommendation to the hospital Board of Directors ("the Board") as to whether privileges should be granted. *Id.* At that meeting, Dr. Parker and the PAC discussed the fact that Dr. Parker did not have sufficient records of recent hospital admissions—particularly of hysterectomies and laparotomies—for the PAC to review because he had been providing only outpatient abortions, which are incredibly safe and thus almost never result in hospital admissions, for the past five years. *Id.* ¶¶ 18, 29, 34. For example, in Dr. Parker's entire career, no patient of his has ever suffered a complication from abortion that was so serious that a hysterectomy was required. *Id.* ¶ 26. In fact, none of his patients at RHS or the clinic in Mississippi have ever been transferred to the hospital at all. *Id.* ¶ 34.

In order to address the PAC's concerns, Dr. Parker proposed a proctoring arrangement whereby he would co-manage another ob-gyn practice's patients and they could observe his skills. *Id.* ¶ 18. Proctoring arrangements are not unusual for physicians who are returning to a hospital-based practice after a period of providing solely outpatient care. *Id.* That this arrangement be with a practice separate from the Clinic was essential, however, given that the complication rate for abortion is so low the Clinic alone would never generate enough patients needing hospital-based care to allow the hospital to actually evaluate Dr. Parker performing these procedures. *Id.* ¶ 26; *see also* Gray Decl. ¶ 18.

After the meeting, Dr. Parker received a letter from the PAC dated February 9, stating that the proctoring arrangement was an "outstanding idea." Parker Decl. ¶ 19. The letter requested that Dr. Parker submit something in writing to indicate that another practice was willing to participate in the arrangement. *Id.* On March 2, a group of ob-gyns affiliated with the University sent a letter to the PAC stating that the proctoring arrangement was "a wonderfully innovative gesture" and that they would support the arrangement. *Id.* ¶ 20. The PAC decided that, as part of the proctoring arrangement, Dr. Parker would have to perform ten hysterectomies and ten operative laparoscopies to his proctors' satisfaction. *Id.* ¶ 21. On March 4, Dr. Parker and Ms. Gray learned that the PAC had recommended the Board approve Dr. Parker's application for privileges, and that his application would go before the Board at its meeting on March 10. *Id.*; *see also* Gray Decl. ¶17, 19.

Soon after March 10, however, Ms. Gray and Dr. Parker learned that the Board had not approved the application and had, instead, sent it back to the PAC with "additional questions." Parker Decl. ¶ 22; Gray Decl. ¶ 20. Plaintiffs still do not know what those "questions" were. Gray Decl. ¶ 21. Around the same time, Dr. Parker received a phone call from a member of the Board stating he could obtain staff-privileges only if he satisfied the proctoring condition using the Clinic's own patients. Parker Decl. ¶ 24. Then, in a letter dated April 2, the members of the ob-gyn group that had initially agreed to participate in the proctoring arrangement sent a letter to Dr. Parker effectively withdrawing their offer to serve as proctors. *Id.* ¶ 23; Gray Decl. ¶ 21. This letter also added, although it was not relevant to the privileges application, that none of the members of the practice would be able to serve as the Clinic's outside covering physician. Gray Decl. ¶ 21. Taken separately or together, the loss of his potential proctors and the requirement that he perform twenty complex gynecological surgeries patients from the Clinic (for whom

there is only an infinitesimal risk of any complication requiring any hospital-based treatment at all, let alone surgery), means it is impossible for Dr. Parker to obtain the requisite privileges at DCH. Parker Decl. ¶¶ 25–26; Gray Decl. ¶ 21. Ms. Gray is not aware of any other physician in Tuscaloosa (or anywhere else in Alabama) who is willing and able to work at WAWC and could satisfy the hospital's criteria for privileges. Gray Decl. ¶ 22.

Throughout the time that the staff privileges application was pending, Ms. Gray was simultaneously searching for a physician who would be willing to serve as the Clinic's outside covering physician as a means to satisfy the Regulation. Gray Decl. ¶ 23. These efforts have proven similarly fruitless. *Id.* ¶¶ 23–27. To the best of Ms. Gray's knowledge, there are three group ob-gyn practices in Tuscaloosa, including the University-affiliated group discussed above, as well as two solo ob-gyn practitioners in the greater Tuscaloosa area. *Id.* ¶¶ 24–25. None of these physicians is willing to serve as the Clinic's outside covering physician. *Id.* at ¶¶ 21, 24–27.

As noted above, the University-affiliated group stated its refusal to serve as the outside covering physician in the April 2nd letter.[7] *Id.* ¶ 21. At the February meeting with the PAC, a doctor from one of the other private practices informed Dr. Parker to his face that their group was unwilling to do anything to help the Clinic. Parker Decl. ¶ 17; Gray Decl. ¶ 24. The third group practice is headed by a physician whose opposition to abortion is well-known. Gray Decl. ¶ 24. Finally, after multiple unsuccessful attempts to reach one of the solo practitioners, that doctor's secretary explained that the doctor was unwilling to even speak to the Clinic about the

[7] There was a brief period of time during which one of the doctors at this practice *was* willing to serve as the outside covering physician. Gray Decl. ¶¶ 19-20. However, that physician signed the April 2 letter stating that none of the physicians would serve as a covering physician, and thus revoked that agreement. *Id.* ¶ 21.

possibility of serving as the covering physician. *Id.* ¶ 25. The other solo practitioner refused because of concerns about how it would affect that doctor's career. *Id.*

Ms. Gray's failed attempts to find an outside covering physician are not unusual for Alabama. In the *PPSE* litigation, the Court recognized the difficulties clinics face in finding a doctor willing to serve as the outside covering physician, either because of anti-abortion sentiment or because of physicians' well-founded fears that being associated with an abortion clinic – even if only for the purpose of providing post-abortion care, off-site – would be devastating to their practice and careers. For example, "[i]n 1999 and again in 2003, the Montgomery administrator, to comply with state regulations, sent a letter to every OB/GYN in the Montgomery area, seeking a local covering physician to treat any post-abortion complications . . . In both years, she received only negative responses." *PPSE III*, 33 F. Supp. 3d at 1352. And in Huntsville, local anti-abortion protesters destroyed the private ob-gyn practice of the one doctor willing to serve as the clinic's outside covering physician. *See id.* at 1350 ("The local leader of the pro-life movement told Johnson that he would protest Dr. H1's practice for as long as Dr. H1 continued to serve as covering physician for the clinic. Dr. H1 removed her children from their Catholic school due to the publicity surrounding her affiliation with the abortion clinic. She had a mass exodus of patients from her practice. Finally, she was forced to close the obstetric portion of [her] practice.") (internal quotation marks and citation omitted).

Due to the impossibility of compliance with the Regulation, on May 6, 2015, Ms. Gray submitted a request to DPH for a waiver of the Regulation, pursuant to rule 420-1-2-.09 of the Alabama Administrative Code. *Id.* ¶ 28, Ex. C. In support of the request, Ms. Gray provided DPH with copies of WAWC's policies and protocols for managing patient complications and a letter from Dr. Parker explaining the safety of abortion, his extremely low complication rate, and

detailing how the Clinic would respond to a complication or emergency without a covering physician. Gray Decl. ¶ 28; *id.* at Ex. C. On May 12, Ms. Gray supplemented the request with a letter from Dalton Johnson, the owner and administrator of the Huntsville abortion clinic explaining that, during WAWC's closure, his clinic had seen a sizable increase in patients, particularly those later in pregnancy; the limits on his clinic's capacity; and his concerns that an increase in patients will result in a backlog and delayed access to care. Gray Decl. ¶ 29, Ex. D. On May 22, Ms. Gray received a letter from DPH denying the waiver. Gray Decl. ¶ 30; *id.* at Ex. E. The DPH letter did not provide any grounds or justification for the denial, other than to state that the outside covering physician requirement was "essential." *Id.* at Ex. E. The denial did not address any of the supporting materials that had been submitted to DPH along with the request, including the evidence that enforcement of the Regulation was itself causing ongoing harm to women. *Id.*; *see also id.* ¶ 30.

III. SAFETY OF ABORTION AND TREATMENT OF ABORTION COMPLICATIONS

Legal abortion is one of the safest medical procedures performed in the United States. *See* Parker Decl. ¶ 29. Medication abortion, which Plaintiffs intend to offer up to nine weeks LMP, involves the administration of medications to induce an abortion. Gray Decl. ¶ 5; Parker Decl. ¶ 31. This is a nonsurgical option that allows a woman to complete the abortion in the privacy of her own home. Parker Decl. ¶ 31. Medication abortions involve the administration of two medications to induce an abortion. *Id.* The first medication is taken at the clinic. The second medication, which causes bleeding and cramping, is taken at home after the patient has left the clinic. *Id.* Surgical abortion involves the use of instruments to evacuate the contents of the uterus. *Id.* ¶ 32. However, the term "surgical" is somewhat of a misnomer; surgical abortion

involves no incision into the woman's skin or other bodily membrane, and is not what is typically thought of as surgery. *Id.*

Most of the complications associated with abortion – such as bleeding and infection – are not only rare, but also minor and can be (and are) appropriately and safely managed at the clinic. *Id.* Similarly, those complications that may arise after discharge are also minor and very rare. *Id.* ¶¶ 32, 40. A recent peer-reviewed study of first trimester abortions found that only 0.89% of abortion procedures performed by physicians resulted in any complication whatsoever. *Id.* ¶ 33. Complications that require a visit to a local hospital emergency room are even rarer, and situations in which a patient needs to be admitted to the hospital for further treatment, rarer still. The same study discussed above found that only 0.05% of patients suffered a complication requiring hospital-based care. *Id.* Although abortion remains very safe throughout pregnancy, the risk of complications, and cost of the procedure, do increase with gestational age. *Id.* ¶ 53. However, even including second trimester abortions, Dr. Parker's rate of complications requiring hospital-based care is still lower than this already small percentage. *Id.* ¶ 34.

In terms of risk, first- and second-trimester surgical abortion is analogous to other gynecological procedures that also take place in outpatient settings, such as surgical completion of miscarriage or hysteroscopy, a gynecological procedure that uses endoscopy for diagnostic and operative purposes. *Id.* ¶ 37. A gynecologist who performs these non-abortion procedures in his or her office in Alabama is not required to obtain staff privileges to perform complex gynecological surgeries at a local hospital and/or sign a written contract with a local physician who holds such privileges. *See* Ala. Admin. Code r. 540-X-10 *et seq*. In terms of non-gynecological procedures that also take place in outpatient settings, first-trimester surgical abortions are comparable in terms of risks, invasiveness, instrumentation, and duration to

vasectomy; and second-trimester abortions are comparable to gastroenterological procedures such as sigmoidoscopy and colonoscopy. Parker Decl. ¶ 38. A physician who performs one of these procedures in his or her office in Alabama likewise is not required to obtain staff privileges and/or sign a written contract with a local physician who holds such privileges. *See* Ala. Admin. Code r. 540-X-10 *et seq*.

While complications associated with abortion are extremely uncommon, WAWC's protocols ensure patients receive optimal care in the rare event they do occur. *See* Gray Decl. ¶¶ 12, 31, Ex. C; Parker Decl. ¶¶ 39-52.[8] In particular, WAWC's protocols ensure continuity of care in the very rare event a complication requires hospital-based care. Parker Decl. ¶¶ 39-52. The existence (or lack thereof) of a written agreement with an outside covering physician has no impact on the level and quality of care WAWC's patients would receive. *Id.*

There are only two situations in which any clinic would transfer care of the patient from the clinic's physician to an "outside" physician, whomever that may be: (1) if a complication arises after discharge and the clinic refers the patient to her closest emergency room for evaluation and/or treatment; or (2) if a patient is transferred from the clinic to the hospital during the procedure or prior to discharge from the clinic. *Id.* ¶¶ 41-42, 44.

Complications that arise after discharge: As required by law, the Clinic maintains a twenty-four-hour/seven-days-per-week hotline for patients to call with any questions or

[8] Alabama law contains detailed regulations concerning post-operative observation, monitoring, and follow-up care for abortion patients. For example, a physician must sign all discharge orders and must remain on the premises until all patients are discharged. Ala. Admin. Code r. 420-5-1-.03(6)(a). After hours, "[t]he facility must have a 24 hour answering service that immediately refers all calls related to post abortion problems to a qualified registered nurse, nurse practitioner, physician assistant, or physician." Ala. Admin. Code r. 420-5-1-.03(6)(d); *see also PPSE II*, 9 F. Supp. 3d at 1276. WAWC's policies comply with these and other safety regulations. Gray Decl. ¶ 7. These regulations are not at issue in this lawsuit.

concerns. Gray Decl. ¶ 31; Parker Decl. ¶ 41. Any patient who calls the hotline with a medical-related issue will be assessed by the on-call registered nurse. Gray Decl. ¶ 31, Parker Decl. ¶ 41. Most of the time, the patient is not experiencing a complication at all and simply needs assurance that her condition or symptoms are normal. Parker Decl. ¶ 41. The nurse may recommend rest, relaxation, over-the-counter medication such as Tylenol or Aleve, or uterine massage. *Id.* If necessary, the nurse will contact the physician for a consult. *Id.* If the patient requires additional, non-urgent treatment, the patient will be offered an in-clinic appointment within twenty-four hours (or the next available day the Clinic is open). *Id.*; *see also* Gray Decl. ¶ 31. In the very rare instance in which the physician determines the safest course of action is for the patient to be seen at a hospital immediately, he will refer her to her closest emergency room, as medically appropriate. Parker Decl. ¶ 42. Depending on where the patient lives, this hospital may not be in Tuscaloosa. *Id.* ¶ 43. If the physician knows which hospital the patient intends to go to, he will call ahead to the hospital to provide all pertinent details concerning the case and make himself available to the hospital staff if they have any questions. *Id.* ¶ 42. If the physician does not know where the patient is going (or whether the patient will follow his advice and seek immediate care), he will nonetheless ensure that the patient has his contact information and emphasize that she should provide this information to the hospital as soon as she arrives. *Id.*

Patient Transfer: In the extremely rare event of a complication that arises *at the clinic*, the physician, together with other clinic staff, will provide necessary stabilizing treatment to the patient, call 911, alert the hospital to the pending transfer and provide the emergency department with necessary details about the case, and prepare a copy of the patient's medical records and all other pertinent data to go with the patient to the hospital. Parker Decl. ¶ 44.

These protocols are consistent with the standard of care, and do not differ, in practice, from the protocols and procedures followed when a clinic has an outside covering physician. *See* Argument, Section I.B, *infra*. Accordingly, there is nothing in the Regulation that enhances patient care in any way. Compl. ¶¶ 58, 64-73.

IV. IRREPARABLE HARM

The evidence shows that the temporary closure of WAWC—the highest volume clinic in the state and one of only two clinics in Alabama that provides abortions throughout the second trimester—has already caused and will continue to cause significant and irreparable harm to Plaintiffs' patients.

As set forth in greater detail below, *see* Argument, Section I.A.2, *infra*, the evidence shows that increasing the distance women must travel to obtain an abortion harms women by imposing financial and logistical barriers that prevent some women from obtaining a desired abortion at all and that delay others' access to care. *See* Decl. of Dr. Stanley Henshaw ¶¶ 3-8 ("Henshaw Decl."), attached hereto as Exhibit 5; Decl. of Dr. Sheila Katz ¶¶ 16-32 ("Katz Decl."), attached hereto as Exhibit 6. Since it is no longer possible to obtain an abortion in Tuscaloosa, the next closest options for a woman in Tuscaloosa are about fifty-nine miles away at the Planned Parenthood clinic in Birmingham or 100 miles away at Reproductive Health Services ("RHS") in Montgomery. *See* Gray Decl. ¶ 35. Neither of these clinics provides abortions after 15 weeks LMP (as WAWC did), and the only Alabama clinic now providing abortions through the second trimester is Alabama Women's Center in Huntsville. *Id.* ¶¶ 6, 36; Johnson Decl. ¶ 3. Huntsville is more than 100 miles from Birmingham, 150 miles from Tuscaloosa, and nearly 200 miles from Montgomery.

This increased travel has imposed and will continue to impose a tremendous burden on women who would have obtained care at WAWC, 82% of whom are living at or below 110% of the federal poverty level. Gray Decl. ¶ 34. As the declaration of Dr. Sheila M. Katz—a sociologist who specializes in gender and poverty—explains, the burdens of intercity travel are especially onerous for low-income women. Katz Decl. ¶¶ 16-32. Many women living in poverty have no access to a car, and low-income women generally lack the funds to cover the transportation, childcare, lodging, and lost wages that a woman must be able to afford in order to travel to another city to access abortion services. *Id.*; *see also* Ayers Decl. ¶ 7; Gray Decl. ¶¶ 11, 34. Dr. Katz's declaration explains that the elimination of abortion services in Tuscaloosa will prevent many low-income women from being able to obtain an abortion. Katz Decl. ¶¶ 6, 7, 32.

And indeed, over the past six months, WAWC has received numerous phone calls from women and their families, as well as other doctors, nurses, a domestic violence shelter and even multiple county health departments, trying to schedule an abortion at the Clinic. Gray Decl. ¶ 37. Upon being told that the Clinic is temporarily closed, many women have stated that finding transportation to a clinic outside Tuscaloosa will be extremely difficult, if not impossible. *Id.* ¶ 38. The Clinic has also had to turn away desperate women who have shown up at the clinic in person, often under heartbreaking circumstances, who have stated they have no other options. *Id.* ¶¶ 39-41.

The operators of the few remaining clinics in the state have similarly witnessed the harms that the Clinic's closure has imposed on Alabama women. Since WAWC closed, the Alabama Women's Center in Huntsville has experienced a significant increase in the number of women calling from western Alabama, many of whom have expressly stated that they were unable to travel to Huntsville. *See* Johnson Decl. ¶¶ 8-9. At least twice per month since WAWC's

closure, some of these callers have asked Alabama Women's Center staff about the best way for a woman to take matters into her own hands to induce an abortion if she is unable to travel. *See id.* ¶ 9. Moreover, since WAWC's closure, many women who have been able to reach the Huntsville clinic have experienced unwanted delay in obtaining an abortion due to the difficulty of traveling a long distance to reach the clinic. *See id.* ¶¶ 10-11. The Montgomery clinic has likewise experienced a substantial increase in patients for whom the unavailability of abortion services in Tuscaloosa resulted in delayed access to care. *See* Ayers Decl. ¶ 5. In just the first six months of 2015, RHS has seen more than a 100% increase in the number of patients who have sought care at the clinic but who are past the clinic's 15-week gestational cutoff, and has experienced a 50% increase in telephone calls from such women. *See id.* ¶ 6.

Additionally, the evidence shows that there has been a marked drop-off in the number of abortions in Alabama since WAWC closed. Over the first six months of 2014, the Tuscaloosa clinic performed 2,533 abortions. *See* Gray Decl. ¶ 9. By comparison, over the same period in 2015, the Montgomery and Huntsville clinics have increased the number of procedures performed, but the increase does not come close to filling the gap left by WAWC's closure. Specifically, the Montgomery and Huntsville clinics treated 733 more women in the first six months of 2015 than they did during the previous year, which leaves 1,800 procedures performed by WAWC unaccounted for.[9] It is true that these figures do not account for the number of procedures performed at Planned Parenthood in Birmingham. However, that clinic performed

[9] *See* Johnson Decl. ¶ 6, Ex. A (Alabama Women's Center performed 485 more abortions in first six months of 2015 than in the same period in 2014); Ayers Decl. ¶ 8 (Reproductive Health Services performed 248 more abortions in first six months of 2015 than in the same period in 2014).

just 1,154 procedures throughout the entire year in 2013, and 1,342 in 2012,[10] and at least as of May 2015 has had limited availability due to staff schedules. Gray Decl. ¶ 35. Unless the Birmingham clinic performed more than double the number of abortions over the *first six months* of 2015 than it performed *throughout the entire year* in 2012 or 2013—all while operating on a limited schedule—then Alabama has witnessed a pronounced drop-off in the number of abortions since WAWC closed.

Moreover, as noted above, prior to its closure, WAWC was one of just two Alabama clinics performing abortions through the second trimester. *See id.* ¶¶ 6, 36; Johnson Decl. ¶ 3. In the first half of 2014, WAWC performed 179 abortions at or after 16 weeks LMP. *See* Gray Decl. ¶ 10. During the same period, the Huntsville clinic performed thirty-four abortions at or after 16 weeks LMP, and the combined figure for the two clinics in the first half of 2014 was 213. *See* Johnson Decl. Ex. A. By contrast, in the first half of 2015, the Huntsville clinic performed only 112 abortions at or after 16 weeks LMP—meaning that between the two clinics, more than 100 fewer abortions at or after 16 weeks LMP were performed in 2015. *See id.*

The numbers indicate, in short, that far fewer women have been able to obtain abortions in Alabama since WAWC closed. These data are consistent with the statistical and epidemiological research, which establishes that when the distance to access an abortion increases, the abortion rate declines. *See* Henshaw Decl. ¶¶ 3-8, 17-22.

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[10] *See* Ala. Dep't. of Pub. Health, *Induced Terminations of Pregnancy by Facility and Probable Postfertilization Age, Alabama, 2013*, http://www.adph.org/healthstats/assets/ITOP_PPFA_2013_rev.pdf; Ala. Dept. of Pub. Health, *Induced Terminations of Pregnancy by Facility and Probable Postfertilization Age, Alabama, 2012*, http://www.adph.org/healthstats/assets/ITOP_PPFA_2012.pdf.

ARGUMENT

Plaintiffs are entitled to a temporary restraining order and/or preliminary injunctive relief because (1) they are substantially likely to prevail on the merits of their claim; (2) a temporary restraining order and/or preliminary injunctive relief is necessary to prevent irreparable injury to Plaintiffs and their patients; (3) these injuries to Plaintiffs and their patients outweigh any harm to Defendants; and (4) entry of relief in Plaintiffs' favor is in the public interest. *See McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998); *Ingram v. Ault*, 50 F.3d 898, 900 (11th Cir. 1995) (same standard applies to requests for preliminary injunctive relief and temporary restraining orders).

I. PLAINTIFFS ARE SUBSTANTIALLY LIKELY TO PREVAIL ON THE MERITS OF THEIR SUBSTANTIVE DUE PROCESS CLAIM.

Plaintiffs are substantially likely to prevail on the merits of their claim that the enforcement of the Regulation against Plaintiffs imposes a substantial obstacle to their patients' right to obtain an abortion and is therefore unconstitutional. Plaintiffs' as-applied substantive due process claim is governed by the undue burden standard articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and analyzed by the Court in the *PPSE* litigation.

"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." *Casey*, 505 U.S. at 877. In determining whether the obstacles a regulation imposes are "substantial" under this standard, the *PPSE* Court has explained that "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." *PPSE II*, 9 F. Supp. 3d at 1287; *accord Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 914 (9th Cir.

2014) (under the undue burden test, the court must "weigh the extent of the burden against the strength of the state's justification in the context of each individual statute or regulation"); *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) ("*Van Hollen I*") ("The feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous."); *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, --- F. Supp. 3d ----, 2015 WL 1285829, at *10 (W.D. Wis. Mar. 20, 2015) ("*Van Hollen II*") (holding that under the undue burden standard, the court must "weigh legitimate health benefits derived from an abortion regulation against the burdens it places on women seeking access to abortion services.").

At "the heart of [the undue burden] test," the Court recognized, "is the relationship between the severity of the obstacle and the weight of justification the State must offer to warrant that obstacle." *PPSE II*, 9 F. Supp. 3d at 1287 (citations omitted).

> Not every legitimate state interest will justify any and all obstacles (short of outright prohibition). . . . Some obstacles will be so slight that the government need not justify them at all. Other obstacles will be significant enough to require a legitimate justification, but still so modest that even somewhat doubtful or marginal state interests will justify them. However, as the severity of obstacle increases, so increases the requirement that the government establish that the regulation furthers its interests in real and important ways. At some point, the obstacles on the right to obtain an abortion will become so significant that the State cannot justify them at all.

Id. at 1287-88 (internal citations omitted); *accord Humble*, 753 F.3d at 914; *Van Hollen II*, 2015 WL 1285829, at *37 ("Whether the Act presents an undue burden depends on the relative benefits of the Act compared to the imposed burden.").

Under this standard, there can be no question that Plaintiffs are substantially likely to prevail on the merits of their claim, because as applied to Plaintiffs, the Regulation creates severe obstacles to women in need of an abortion that far outweigh the state interests underlying the

application of the Regulation here. *See PPSE II*, 9 F. Supp. 3d at 1287-88. Enforcing the Regulation against Plaintiffs has inflicted, and will continue to inflict, severe harm on women in need of abortion services by permanently shuttering WAWC, and thereby preventing some women from being able to obtain abortions, imposing delays on other women's access to care, and forcing some women unable to access safe and legal abortion services to resort to unsafe self-help measures. In view of these significant obstacles, the state cannot assert a sufficient justification for enforcing the Regulation against Plaintiffs. Indeed, far from advancing the state's interest in patient health, the evidence shows that continued enforcement of the Regulation will only endanger and undermine women's health in Alabama.

A. *Enforcement of the Regulation Will Impose Severe Obstacles to Women Seeking Abortions.*

Turning first to the burdens imposed by the Regulation, the enforcement of the Regulation against Plaintiffs creates severe and in some cases insurmountable obstacles to women seeking abortion services in Alabama. As the *PPSE* Court has explained, "[i]n order to determine the severity of an obstacle that a regulation places on women seeking abortion, the court must examine carefully the effect of the regulation on them, considering the real world circumstances." *PPSE III*, 33 F. Supp. 3d at 1342 (quotation marks and citation omitted). The Court has explained that relevant considerations for analysis include "the means by which the regulation operates on the right to obtain an abortion, the nature and circumstances of the women affected by the regulation, the availability of abortion services, both prior to and under the challenged regulation, the kinds of harms created by the regulation, and [t]he social, cultural, and political context." *Id.* (quotation marks and citation omitted). Applying those considerations here, it is beyond question that continued enforcement of the Regulation against Plaintiffs has

imposed, and will continue to impose, devastating obstacles to women in need of abortion services.

1. *The Effect on WAWC*

As an initial matter, the record makes abundantly clear that the effect of the Regulation has been to close WAWC—the only abortion clinic in Tuscaloosa, the highest-volume abortion provider in the state, and one of only two providers of post-15-week abortions in the state. *See id.* (in evaluating the obstacles imposed by a law, the court must first determine the "effect of the requirement on current and potential abortion providers"). Pursuant to the Regulation, an abortion clinic is barred from providing abortions unless either (1) the physician performing the procedure obtains local hospital staff privileges authorizing the performance of specified gynecological procedures,[11] or (2) the facility obtains a contract with an outside doctor with such privileges to provide covering physician services. *See* Ala. Admin. Code r. 420-5-1-.03(b). As set forth above and as the declarations of Ms. Gray and Dr. Parker make clear, WAWC cannot comply with either component of this requirement for reasons that have nothing to do with the safety of Plaintiffs' medical services.

Because for the past five years Dr. Parker has provided outpatient abortion exclusively, which is extremely safe, he essentially has no recent record of past inpatient cases for the hospital to review. Parker Decl. ¶¶ 14, 18, 25-26; *see also PPSE III*, 33 F. Supp. 3d at 1344 (finding ob-gyn with only abortion practice cannot obtain staff privileges because he is "unable to provide documentation of 25 non-abortion-related procedures"). As such, the hospital has required that he demonstrate proficiency in the specific procedures in which he has requested

[11] The required procedures are "dilation and curettage, laparotomy procedures, hysterectomy, and any other procedures reasonably necessary to treat abortion-related complications." Ala. Admin. Code r. 420-5-1-.03(b).

privileges by finding a physician to proctor him and then performing ten hysterectomies and ten operative laparotomies at the hospital *on his own patients* to his proctor's satisfaction. Parker Decl. ¶¶ 18-26; *see also PPSE III*, 33 F. Supp. 3d at 1143 ("[M]any hospitals require that a doctor with active-staff or courtesy-staff privileges admit a certain number of patients or perform a certain number of procedures on a regular basis . . . . [in order for] the hospital's medical staff to evaluate a doctor's clinical skills."). However, because abortion is so safe, this is simply impossible. Parker Decl. ¶ 26; Gray Decl. ¶ 12; *cf. Van Hollen I*, 738 F.3d at 792-93 ("Pretext aside, a common and lawful criterion for granting admitting privileges . . . is the number of patient admissions a doctor can be expected to produce for the hospital—the more the better, as that means more utilization of hospital employees and resources and hence more fees for the hospital. But the number of patient admissions by doctors who perform abortions is likely to be negligible because there appear to be so few complications from abortions and only a fraction of those require hospitalization—probably a very small fraction."); *PPSE III*, 33 F. Supp. 3d at 1344 (finding ob-gyns performing abortions exclusively are unlikely to meet hospitals' minimum admissions requirement due to safety of procedure). Indeed, none of Dr. Parker's patients—let alone ten patients in a single year—has ever suffered a complication from abortion so severe that a hysterectomy was warranted. Parker Decl. ¶ 26; *see also PPSE III*, 33 F. Supp. 3d at 1366 ("It is extremely rare that either hysterectomy or laparotomy would be necessary following an abortion, even a later-term abortion. Indeed, with approximately 9,000 abortions performed in Alabama each year, in most years not a single early-term abortion in the State would require either procedure.").[12] Plaintiffs thus cannot comply with the staff privileges component of the Regulation.

[12] Even if it were possible to generate the number of patients required by the hospital, no

Moreover, despite exhaustive efforts, Plaintiffs have not been able to satisfy the covering physician component of the Requirement. Specifically, over the past few months, Plaintiffs have reached out to each and every qualified group ob-gyn practice and solo practitioner in Tuscaloosa with staff privileges at DCH they could think of that might be willing to sign a contract to serve as a covering physician for the Clinic. All of these requests were rejected either because of anti-abortion sentiment or fear of being publicly associated with an abortion clinic. *See* pp. 15-16, *supra*; *see also PPSE III*, 33 F. Supp. 3d at 1348 (recognizing that "some, and perhaps many" physicians have "deeply held religious and ethical convictions" against abortion); *id.* at 1349 ("Even among doctors who do not view abortion doctors negatively, a phenomenon that Dr. Freedman names the 'cautionary tale' is a barrier to recruiting new abortion providers: Doctors who may consider performing abortions are warned, explicitly or by example, of the negative consequences past abortion doctors have faced for providing abortions in a particular community.").

Having exhausted all other options to comply with the Regulation, Plaintiffs filed an application for a waiver of its requirements, pursuant to Alabama Administrative Code rule 420-1-2-.09, from DPH on May 6. *See* Gray Decl. ¶ 28. As described *supra*, the request was denied, with little explanation, on May 22, 2015. *Id.* ¶ 30.

Plaintiffs have, in sum, made every possible effort to comply with the Regulation but cannot satisfy its requirements, due in large part to the inherent safety of outpatient abortion and the fact that an abortion provider's ability to comply turns on the willingness of local qualified

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physician associated with the hospital is willing to serve as Dr. Parker's proctor. Parker Decl. ¶ 25; *see also PPSE III*, 33 F. Supp. 3d at 1345 (citing testimony from abortion provider in Birmingham that "she did not know of a doctor at any of those hospitals who would agree to affiliate with her for the purpose" of her staff privileges application and "keeping the Planned Parenthood clinic open"); *id.* at 1346 (citing similar testimony from Mobile abortion provider).

ob-gyns to voluntarily assist the clinic and no such physician is forthcoming. The record is therefore plain that the "effect of the [Regulation] on current and potential abortion providers" has been the outright elimination of abortion services in Tuscaloosa and of one of the only two providers of abortions throughout the second trimester in the state.[13] *PPSE III*, 33 F. Supp. 3d at 1342.

2. *The Effect on Women Seeking Abortions*

As set forth in detail below, the elimination of abortion services at WAWC has imposed, and will continue to impose, severe and in many cases insurmountable obstacles to women who would otherwise have been able to obtain abortions at the Clinic. These burdens are already proving devastating to low-income women, who made up the vast majority of Plaintiffs' patients and who are least able to overcome the obstacles that the elimination of abortion services at the Clinic has imposed.

As a starting point, the closure of WAWC decimates "the availability of abortion services" for many women in Alabama. *PPSE II*, 9 F. Supp. 3d at 1288. Until its closure, WAWC was the only abortion clinic in Tuscaloosa throughout its twenty-two years of operation. *See* Gray Decl. ¶ 1. But WAWC is much more than the only abortion provider in one of the state's largest cities. Since 2012—when DPH first started to publish statistics showing the number of abortions performed at individual abortion facilities—WAWC has consistently been the highest-volume abortion provider in the state by a substantial margin. *See id.* ¶¶ 9-10. In

[13] As Plaintiffs' experience reaching out to potential qualified covering physicians makes plain, the "social, cultural, and political context" concerning abortion provision in Tuscaloosa gives no reason to believe that "gaps in service created by the regulation will be filled in the future." *PPSE II*, 9 F. Supp. 3d at 1289. There has never been another abortion clinic in Tuscaloosa, *see* Gray Decl. ¶ 1, and in light of the barriers that WAWC has to this point been unable to overcome, in the absence of relief from this Court, there is every reason to think that there never will be.

each of the last two years for which there are published statistics, WAWC provided approximately 40% or more of the abortions in the state, two-to-three times more (depending on the year) than any other clinic in the state. *Id.* And although DPH has yet to publish statewide statistics for 2014, WAWC performed 4,723 abortions that year—over three times more than any other clinic in Alabama had performed in any prior year for which statistics are available. *See id.*

Additionally, until its recent closure, WAWC was one of only two clinics in the state that provided abortions after 15 weeks LMP (with the only other such provider located near the Tennessee border in Huntsville), and provided care to far more women in need of second-trimester abortions than any clinic in the state. *See id.* ¶¶ 6, 10; *see also PPSE II*, 9 F. Supp. 3d at 1289 (explaining that "the kinds of abortion procedures that are used and their relative frequency of use" is relevant to the analysis of the obstacles a regulation imposes); *accord Van Hollen II*, 2015 WL 1285829, at *37 (emphasizing particularly severe obstacles imposed by law that would close the state's only provider of abortions after 18.6 weeks LMP). In 2012 and 2013, WAWC performed more than 60% of the second-trimester abortions in the state, and nearly 80% of abortions between 17 and 21.6 weeks LMP (the state's legal limit). *See* Gray Decl. ¶ 10.

At issue here, then, are the obstacles imposed by the forced closure of the abortion provider that has served a greater number of women than any other clinic in the state; the primary provider of second-trimester abortions in the state; and the only abortion facility in one of the state's largest cities. As was the case in *PPSE III*, eliminating access to abortions at WAWC imposes three types of obstacles to women in need of abortion services: (1) the burdens of being forced to travel much longer distances to obtain an abortion (resulting in some women's inability to reach a provider, others' delayed access to care, and other harms); (2) significantly

diminished capacity of abortion services in the state; and (3) the significant risk that women unable to surmount those obstacles will resort to unsafe methods of attempted self-abortion. *PPSE III*, 33 F. Supp. 3d at 1355. Indeed, the obstacles here are in many ways even more significant than were the burdens at issue in the related litigation.

a. *Travel Burden*

First, the elimination of abortion access in Tuscaloosa imposes significant travel burdens on women that cause an array of significant harms, including the outright prevention of women's ability to obtain abortions. *See PPSE II*, 9 F. Supp. 3d at 1289 (recognizing a broad range of harms in evaluating the severity of the obstacle); *accord PPSE III*, 33 F. Supp. 3d at 1355. Prior to the forced closure of WAWC, women in and around Tuscaloosa could obtain an abortion without having to travel outside the city. Now, however, a woman in Tuscaloosa seeking a first-trimester abortion is faced with the burden of traveling nearly sixty miles one way to the closest provider in Birmingham, or over 100 miles to the next-closest provider in Montgomery. *See* Henshaw Decl. ¶¶ 19-22. As the declaration of Dr. Stanley Henshaw, an expert in reproductive epidemiology, establishes, the statistical evidence is clear that when women are faced with comparable increases in travel distance to access an abortion, abortion rates decline markedly because the travel burden prevents many women from reaching a provider. *See id.* ¶¶ 4-8, 17-22. Indeed, that was the court's precise factual finding in *PPSE II* concerning the severe impact of the additional sixty-mile travel burden between Tuscaloosa and Birmingham. *See PPSE III*, 33 F. Supp. 3d at 1358 (finding that "when a clinic closes, the largest effects are actually felt by women who, prior to the closure, needed to travel only short distances, less than 50 miles"); *id.* at 1359-60 ("[T]he additional burden on a woman in Birmingham, who previously could obtain an abortion within the city and now would need to travel at least 59 miles to Tuscaloosa, is quite

severe."). The Regulation imposes the identical travel burden of additional travel between Tuscaloosa and Birmingham here.

But that is only the tip of the iceberg in considering the travel-related obstacles that the forced closure of WAWC imposes. As described above, WAWC was, until its recent closure, by a large margin the highest-volume provider of post-15-week abortions in Alabama. *See* Gray Decl. ¶ 10. In the wake of WAWC's closure, the only abortion clinic performing abortions after 15 weeks LMP is in Huntsville, in the northernmost part of the state. *See id.* ¶ 6; Johnson Decl. ¶ 3. A Tuscaloosa woman in need of a post-15-week abortion, who previously could obtain an abortion in her home city, is now confronted with the burden of traveling more than 150 miles one way to Huntsville. *See* Gray Decl. ¶ 36; Henshaw Decl. ¶ 21. Moreover, the harms are not confined to women in and around Tuscaloosa. Women in Montgomery and Birmingham in need of post-15-week abortion services previously had to travel to Tuscaloosa, which would already have been a formidable (and for some women, insurmountable) obstacle, but one that at least some women were able to overcome. *See* Henshaw Decl. ¶ 21; Ayers Decl. ¶ 7. The only option now available to women in Montgomery and Birmingham seeking a post-15-week abortion is to travel to Huntsville, which is nearly 200 miles from Montgomery and more than 100 miles from Birmingham. *See* Henshaw Decl. ¶ 21. The statistical evidence, and the Court's prior findings, make clear that for a substantial number of women, this is no option at all, due to the obstacles that such additional travel imposes. *See id.* ¶¶ 17-26; *PPSE III*, 33 F. Supp. 3d at 1358-60; *cf. Van Hollen II*, 2015 WL 1285829, at *37 (finding undue burden where women would have to travel an additional eighty-five miles in order to access an abortion at 18.6 weeks LMP or later).

Indeed, it is not only the statistical research but the evidence that has been playing out in real time in Alabama since WAWC's closure that confirms that these obstacles are having a

severe impact on abortion access in the state. As set forth at pp. 23-24, *supra*, the Huntsville and Montgomery clinics have treated more patients over the first six months of 2015 than they did over the same period in 2014 when WAWC was open, but the increase does not come close to filling the gap left by WAWC's closure. Specifically, WAWC performed 2,533 abortions during the first half of 2014, *see* Gray Decl. ¶ 9, and the Huntsville and Montgomery clinics have combined to perform 733 more procedures in 2015 than they performed in 2014, *see* Johnson Decl. ¶ 6, Ex. A; Ayers Decl. ¶ 8. Some of this 1,800 gap has presumably been filled by Planned Parenthood in Birmingham. But given that the Birmingham clinic performed just 1,154 procedures in total throughout *all of* 2013, it is highly implausible that the clinic has made up for anything but a small share of the significant gap left by WAWC's closure. *See* Ala. Dep't. of Pub. Health, *Induced Terminations of Pregnancy by Facility and Probable Postfertilization Age, Alabama, 2013*, http://www.adph.org/healthstats/assets/ITOP_PPFA_2013_rev.pdf. Indeed, as Dalton Johnson, the owner and administrator of the Huntsville clinic, recounts in his declaration, since WAWC closed, he has experienced a significant increase in the number of calls from women, including many women from Tuscaloosa, stating that they are utterly unable travel to Huntsville—women whom he has never heard from again. *See* Johnson Decl. ¶¶ 8-9; *see also* Ayers Decl. ¶ 5.

The impact of these obstacles is particularly extreme here due to the very high poverty rates among WAWC's patients.[14] *See PPSE II*, 9 F. Supp. 3d at 1288 (holding that "the nature

[14] As the court explained in *PPSE III*:

> For these women, going to another city to procure an abortion is particularly expensive and difficult. Poor women are less likely to own their own cars and are instead dependent on public transportation, asking friends and relatives for rides, or borrowing cars; they are less likely to have internet access; many already have children, but are unlikely to have regular sources of child care; and they are more

and circumstances of the women affected by the regulation . . . that may serve to amplify the harms imposed by the regulation" are important for evaluating the severity of an obstacle); *accord Van Hollen I*, 738 F.3d at 796 ("Some patients will be unable to afford the longer trips they'll have to make to obtain an abortion when the clinics near them shut down—60 percent of the clinics' patients have incomes below the federal poverty line."). More than 82% of WAWC's patients live at or below 110% of the poverty line. *See* Gray Decl. ¶ 34. For many low-income women, it is simply not possible to arrange for transportation to and from another city to access an abortion, given the multitude of hurdles such intercity travel poses. *See* Katz Decl. ¶¶ 16-22; *see also supra* at pp. 21-22. Indeed, numerous women have expressly said as much to WAWC staff since the Clinic has been closed. *See* Gray Decl. ¶¶ 37-40. And as prevalent as indigence is among abortion patients in general, low-income women are particularly likely to need second-trimester abortion services such as those previously offered at WAWC—

> likely to work on an hourly basis with an inflexible schedule and without any paid time off or to receive public benefits which require regular attendance at meetings or classes. A woman who does not own her own car may need to buy two inter-city bus tickets (one for the woman procuring the abortion, and one for a companion) in order to travel to another city. Without regular internet access, it is more difficult to locate an abortion clinic in another city or find an affordable hotel room. The additional time to travel for the city requires her to find and pay for child care or to miss one or several days of work. Furthermore, at each juncture, a woman may have to tell relatives, romantic partners, or work supervisors why she is leaving town: to procure an abortion. And, in light of the pervasive anti-abortion sentiment among many in Alabama, such disclosures may present risks to women's employment and safety. Finally, as Dr. Katz testified, many low-income women have never left the cities in which they live. The idea of going to a city where they know no one and have never visited, in order to undergo a procedure that can be frightening in itself, can present a significant psychological hurdle. "[T]his psychological hurdle is as serious a burden as the additional costs represented by travel." Katz Rep., PX 56 at ¶ 24.

PPSE III, 33 F. Supp. 3d at 1357; *accord* Katz Decl. ¶¶ 16-32.

and those women will be hit especially hard by the substantially increased travel burdens at issue here. *See* Henshaw Decl. ¶ 15; *see also* Gray Decl. ¶ 34.

Finally, as was true in *PPSE II* and *III*, for women who are not prevented from obtaining an abortion as a result of the travel burdens, the closure of WAWC inflicts other significant harms, including delayed access to care. *See PPSE II*, 9 F. Supp. 3d at 1289 ("The court does not understand the term 'obstacle' in *Casey* to refer only to a direct barrier standing between a woman and access to an abortion. Rather, 'obstacle' refers to the whole array of harms that a regulation may impose on women seeking abortions."); *PPSE III*, 33 F. Supp. 3d at 1356-57; *see also Van Hollen II*, 2015 WL 1285829, at *36 ("Additional costs will include more time away from work and childcare. In addition to these out-of-pocket costs, there are other less quantifiable, albeit real costs that would be amplified if women were to travel to Chicago or other areas to seek abortions, like stress of travel to an unfamiliar area, and difficulties encountered in trying to keep the reason for the travel confidential from a boss, co-workers or an abusive partner.") (citation omitted). Although abortion is very safe throughout pregnancy, the rate of complications increases as pregnancy advances. *See* Parker Decl. ¶ 53. Moreover, the cost of the procedure increases significantly the longer in pregnancy a woman is delayed in obtaining an abortion. *See* Henshaw Decl. ¶¶ 24-25.

As Dr. Henshaw's declaration explains, the relevant research establishes that financial and logistical obstacles associated with travel are significant causes of unwanted delay for women seeking abortions, and these obstacles play a heightened role for second-trimester abortion patients who experience unwanted delay. *See id.* ¶¶ 9-16, 24-26; *accord PPSE III*, 33 F. Supp. 3d at 1356 (finding that "increased travel distance causes delays for women who do secure abortions"). Once again, this evidence is borne out by the experience on the ground in Alabama

since WAWC closed. Since January 2015, the Huntsville clinic has experienced a marked increase in the number of women reporting that they were delayed in trying to obtain an abortion due to difficulty in traveling to the clinic, with many patients expressly reporting that they experienced such travel-related delays since WAWC's closure. *See* Johnson Decl. ¶¶ 10-11. Likewise, the Montgomery clinic has seen a sizable increase in the number of patients coming to the clinic who are already past the gestational limit and, therefore, must be referred to Huntsville. Ayers Decl. ¶ 6.

In sum, the forced closure of the Tuscaloosa clinic has imposed, and will continue to impose, significant travel-related obstacles to women who would have obtained abortions at WAWC, including preventing some women from accessing an abortion at all and delaying other women's ability to get the procedure.

b. *Capacity Problems*

The forced closure of WAWC—historically the highest-volume provider of abortions in Alabama—has likewise stretched the capacity of the state's other abortion providers to the limit, with obvious implications for women seeking timely abortion services throughout the state. *See PPSE II*, 9 F. Supp. 3d at 1289 (court should consider the capacity of other providers to fill gaps imposed by the regulation); *accord PPSE III*, 33 F. Supp. 3d at 1361-62. Simply put, even if all of WAWC's patients could make the trip to one of the other providers in the state, the other providers would not be able to accommodate this substantial influx of patients. *See* Johnson Decl. ¶¶ 12-15; Ayers Decl. ¶ 8.

At the Alabama Women's Center in Huntsville—the lone remaining provider of post-15-week abortions in the state—the clinic has experienced a more than 50% increase in the number of women seeking abortions between January and June 2015 as compared with the same period

last year, and has seen more than triple the number of post-15-week patients. *See* Johnson Decl. ¶ 6, Ex. A. The increase in the number of second-trimester abortions has a significant impact on the Huntsville clinic's capacity, Mr. Johnson explains in his declaration, because later procedures can take significantly longer to complete than a first-trimester abortion, and scheduling more of these more time-consuming procedures reduces the clinic's capacity to treat the increasing volume of patients. *See id.* ¶ 14. With the increase in the number of patients seeking abortions, and the increase in patients seeking second-trimester abortions in particular, the Huntsville clinic is operating near its capacity. *See id.* ¶¶ 14-15. As Mr. Johnson's declaration makes clear, if the number of women seeking the clinic's services continues to increase, his clinic will be forced to institute a waiting list, thereby further contributing to the delays in access to care that women are already experiencing. *See id.* Similarly, RHS in Montgomery has expanded its services to two days per week, but is unable to expand further due to staffing constraints and is thus operating at its maximum capacity. *See* Ayers Decl. ¶ 8.

Where, as here, a regulation so reduces the supply of abortion services that there is a substantial risk of insufficient capacity and attendant delays in access to care, the obstacle to women seeking abortions is unquestionably severe. *See PPSE III*, 33 F. Supp. 3d at 1361-62; *accord Van Hollen II*, 2015 WL 1285829, at *35 ("Even if not out of the zone of pre-viability, the delay may result in some women not being able to have an abortion until the second trimester, when abortions are not only more expensive, but past the point where some women are comfortable having an abortion.").

c. *Unsafe Self-Abortions*

As the Court held in *PPSE II*, the dangers posed by travel- and capacity-related obstacles are "compounded by the threat that women who desperately seek to exercise their ability to

decide whether to have a child would take unsafe measures to end their pregnancies." *PPSE III*, 33 F. Supp. 3d at 1363; *accord Van Hollen II*, 2015 WL 1285829, at *25 n.31 (explaining that "[e]pidimologic data indicate an inverse relationship between the availability of legal abortion and resorting to illegal abortion associated with remarkable increased risks of death or morbidity, which includes septic abortion, uterine infection, pelvic abscess, loss of uterus and/or ovaries [and] infertility") (quotation marks omitted); *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, No. 14-50928, 2015 WL 3604750 (5th Cir. June 9, 2015), *stay granted Whole Woman's Health v. Cole*, No. 14A1288, 2015 WL 3947579 (U.S. June 29, 2015) (finding that "the act's possible connection to observed increases in self-induced abortions" is among the factors that "almost certainly cancel out any potential health benefit associated with the requirement").

Given the severe obstacles that WAWC's forced closure imposes on a woman in need of an abortion—including a woman in need of post-15-week abortion services—the risk of self-abortion is at least as substantial here as it was in *PPSE III*. Indeed, providers are witnessing the manifestation of that risk in the wake of WAWC's closure, including a woman who recently presented at the Tuscaloosa clinic who was unable to travel to another clinic for care and who was so desperate that she threatened to take measures into her own hands. *See* Gray Decl. ¶¶ 37-41. And since WAWC's closure, staff at Alabama Women's Center in Huntsville have received at least two calls per month from women who have expressly stated that because they cannot travel to Huntsville, they will be forced to take matters into their own hands to terminate the pregnancy—these callers have asked the Huntsville clinic staff what pills they can take to cause a self-abortion. *See* Johnson Decl. ¶ 9.

* * *

In sum, as was the case in the *PPSE* litigation, the elimination of abortion services in Tuscaloosa has imposed, and will continue to impose, severe and in some cases insurmountable obstacles to women in need of an abortion. *See PPSE III*, 33 F. Supp. 3d at 1363.

B. *Enforcement of the Regulation Has No Health Benefit and is Detrimental to Women's Health and Safety*

Next, this 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." *PPSE II*, 9 F. Supp. 3d at 1287; *see generally Jackson Women's Health Organization v. Currier*, 760 F.3d 448, 458 (5th Cir. 2014) (holding the undue burden analysis must consider "the entire record and factual context in which the law operates"). Where, as here, plaintiffs "challenge[] as unconstitutional a regulation of the manner in which abortions were performed which threatened to reduce access and which the State justified by reference to protecting the health of the woman," the State must provide "more than general statements of concern and claims that the regulations conceivably might, in some cases, lead to better health." *PPSE III*, 33 F. Supp. 3d at 1340-41 (citing *Doe v. Bolton*, 410 U.S. 179 (1973)). Rather, the State must be able to show "persuasive data" to show that the regulation actually advances its interests. *Bolton*, 410 U.S. at 195. Indeed, "the more severe the obstacle a regulation creates, the more robust the government's justification must be, both in terms of how much benefit the regulation provides towards achieving the State's interests and in terms of how realistic it is the regulation will actually achieve that benefit." *PPSE III*, 33 F. Supp. at 1337 (internal citation omitted); *see also Humble*, 753 F.3d at 912; *Van Hollen I*, 738 F.3d at 798; *PPSE II*, 9 F. Supp. 3d at 1296-97.

The *PPSE* Court identified a non-exhaustive list of factors with which to evaluate the strength of the state's justification, including the extent of the anticipated benefit and the likelihood that the challenged regulation will achieve that benefit. *See PPSE II*, 9 F. Supp. 3d at 1289-90. As demonstrated below, applying these factors in this case shows that the outside covering physician requirement would confer no discernible benefit on WAWC's patients. To the contrary, as set forth above, it undermines women's health. *See* Argument, Section I.A, *supra*.

The only conceivable health justification for the covering physician requirement is that it furthers continuity of care for a woman who experiences an actual or suspected complication arising from an abortion.[15] However, the evidence submitted by Dr. Parker and Ms. Gray demonstrates that, with proper policies and protocols like those in place at WAWC for handling a complication are in place—including policies and protocols concerning the transfer of information from the physician who performed the abortion to the physician who handles the complication—the outside covering physician requirement provides no advantage to the patient.

As an initial matter, in order to assess whether the outside covering physician requirement furthers continuity of care, it is important to understand the limited contexts in which a covering physician may be utilized. First, as, described above, *see* pp. 17-19, *supra*, the risk that a patient even experiences a complication that requires hospital-based care is extremely

[15] In the previous litigation, the defendants argued that the other prong of the Regulation—the staff privileges requirement—served a "credentialing function, both as an initial screening mechanism and by providing ongoing review of physician quality." *PPSE III*, 33 F. Supp. 3d at 1363. That argument was unpersuasive in the staff privileges context, *see id.* at 1373-76, 1378, but is simply irrelevant as a justification for the covering physician requirement—the very point of which is to transfer care from the physician who provided the abortion to someone else altogether. And, as the *PPSE* Court held, the State may not justify a purported health restriction that reduces access by asserting its interest in protecting *fetal* life. *See PPSE II*, 9 F. Supp. 3d at 1298.

low (.05%); *see also PPSE III*, 33 F. Supp. at 1370 n.23 ("[C]linics do not make frequent use of their covering physicians because the procedures they perform are extremely safe and because, where possible, the clinics themselves provide complication care."). Dr. Parker's own record reflects an even lower rate of complications. Parker Decl. ¶ 34.

Second, the Regulation does not actually mandate that the clinic actually involve the outside covering physician in the event of a complication. In other words, a clinic is in compliance with the Regulation if it has an agreement with a covering physician, regardless of whether the clinic ever calls upon the outside covering physician to treat one of its patients. *See e.g.*, *Van Hollen II*, 2015 WL 1285829 at *20 (finding state justifications for admitting privileges requirement weak where the law "does *not* require the physician who performs the abortion accompany his or her patient to the hospital, treat the patient at the hospital, communicate with the hospital, or facilitate the hand-off of the patient to hospital physicians" or "require the physician to admit or attempt to admit patients who need hospitalization at a hospital where the physician has admitting privileges.") (emphasis in original); *see also PPSE III*, 33 F. Supp. 3d at 1368. Moreover, given that the Regulation mandates the covering physician have staff privileges at a hospital local to the clinic, the covering physician requirement is entirely irrelevant for those patients who experience a complication after-hours and live outside the Tuscaloosa area. Thus, for purposes of the Court's analysis in this case, the Court must not simply weigh the relative benefit (if any) of the outside covering physician requirement; it must weigh the relevant benefit the requirement provides *to the tiny percentage of patients who may ever come in contact with that physician* (which could be zero) against the effect of eliminating any abortion services in Tuscaloosa (and the state's highest-volume abortion clinic and one of only two providers of abortions after 15 weeks LMP) altogether. *See, e.g.*, *Humble*, 753 F.3d at 914-15; *PPSE III*, 33

F. Supp. 3d at 1363; *PPSE II*, 9 F. Supp. 3d at 1290 ("The court should consider whether . . . the State can offer only weak reasons to believe the regulation will achieve the anticipated benefit, or any benefit at all."). Neither can be considered in a vacuum.

Even assuming *arguendo* that a clinic utilizes its outside covering physician, where possible, the State still cannot meet its burden. The evidence shows that for the tiny number of women who fall into one of the two categories of patients for whom the outside covering physician requirement may be relevant—(1) patients who are transferred from the clinic to the hospital where the outside covering physician has privileges, and (2) patients who contact the clinic's after hours hotline with a suspected complication and are referred to the hospital where the outside covering physician has privileges—it is doubtful that the requirement confers any benefit. This is because, with policies and protocols such as WAWC's, a clinic can ensure comparable continuity of care regardless of whether care is transferred to an outside covering physician or to the on-call ob-gyn at the hospital.

As described in Dr. Parker's declaration, and reflected in the copies of WAWC's policies, in the extremely rare event of a patient transfer, Dr. Parker would, together with other clinic staff, provide necessary stabilizing treatment to the patient, call 911, alert the hospital to the pending transfer and provide the emergency department with necessary details about the case, and prepare a copy of the patient's medical records and all other pertinent data to go with the patient to the hospital. This is consistent with the standard of care. *See* Parker Decl. ¶¶ 39-52; Gray Decl., Ex. C; *see also* p. 20, *supra*.

With respect to suspected complications that arise after the patient has been discharged, every patient is provided with a twenty-four-hour telephone number through which to reach the Clinic. Parker Decl. ¶ 41; Gray Decl. ¶ 31. Medical staff (a registered nurse and, if appropriate,

Dr. Parker) will assess every medically related call to this after-hours hotline. *Id.* If, in Dr. Parker's determination, the safest course of action is for the patient to be seen at a hospital, he will refer her to her closest emergency department, as is medically appropriate. Parker Decl. ¶ 42-43. If he knows where she intends to go, he will call ahead to the hospital to provide them with pertinent details concerning the case; if not, he will verify that the patient has his contact information and emphasize that she should provide this information to the hospital as soon as she arrives and ask them to contact him. *Id.* at ¶ 42.[16]

These policies will ensure the same level and quality of care as would a policy to involve a specific outside covering physician in the patient's care. Compare, for example, two hypothetical Alabama abortion clinics, both of which follow the same policies and protocols as WAWC, except Clinic A has a written contract with an outside covering physician who has staff privileges at the local hospital, and Clinic B does not.

If Clinic A needs to transfer a patient from the clinic to the hospital, it will observe the following protocol: it will stabilize the patient, call 9/11, explain the emergency to the dispatcher and prepare the patient for transfer (including making a copy of the patients' medical records). The clinic would also contact the outside covering physician and, assuming the physician can be reached explain the situation and relay any necessary medical information about the patient and the circumstances. That physician would then call the emergency room, alert them of the arriving patient, and relay any relevant information about the patient. If the outside covering physician cannot be reached the very moment that the patient is being transferred, or if it seems that the ambulance would arrive at the hospital before the outside covering physician has a

[16] Under WAWC's policies, in the event of an absence from Tuscaloosa, Dr. Parker will stop providing abortions seventy-two hours prior to his departure. *See* Gray Decl., Ex. C.

chance to contact the emergency room, the clinic may simply call the hospital itself and relay the same information directly to the hospital that it would have relayed to the outside covering physician. Upon arrival at the hospital, the patient would be assessed and triaged by the emergency room physicians and staff. Assume for the sake of this hypothetical that the emergency room determines that the complication is best handled by an ob-gyn, not another specialist. If contact with the outside covering physician has been made and that physician can get to the hospital in time, the outside covering physician will take over the patient's care—based on his or her own evaluation of the patient, as well as on the information provided by the clinic and the emergency room. If the outside covering physician cannot be reached or cannot drop everything (including treatment of the doctor's own patients) to get to the hospital by the time the clinic's patient arrives, the on-call ob-gyn at the hospital would treat the patient—based on his or her own evaluation of the patient as well as on the information provided by the clinic and the emergency room. At all times throughout this process, the physician who provided the abortion and/or the clinic is available for additional consult. Although the clinic has a contract with the outside covering physician, unless that physician also happens to be this particular abortion patient's personal ob-gyn, there would be no prior doctor-patient relationship between the two. The outside covering physician would have been completely uninvolved in the abortion procedure itself and would treat the patient for the first time at the hospital.

Now, take Clinic B, which does not have a written contract with an outside covering physician. If Clinic B needs to transfer a patient from the clinic to the hospital, it would observe the following protocol: it will stabilize the patient, call 911, explain the emergency to the dispatcher and prepare the patient for transfer (including making a copy of the patients' medical records). Clinic B would also contact the hospital directly, alert them of the arriving patient, and

relay all relevant information about the patient.[17] Upon arrival at the hospital, the patient would be assessed and triaged by the emergency room physicians. Assume for the sake of this hypothetical that the emergency room determines that the complication is best handled by an ob-gyn, not another specialist. The on-call ob-gyn at the hospital would then treat the patient—based on his or her own evaluation of the patient, as well as on the information provided by the clinic and the emergency room. At all times, the physician who provided the abortion is available for additional consult. Unless the on-call ob-gyn happens to the abortion patient's personal ob-gyn, there would be no prior doctor/patient relationship between the two. The on-call ob-gyn would have been completely uninvolved in the abortion procedure itself and would treat the patient for the first time at the hospital.

It is thus abundantly clear that, in practice, the outside covering physician requirement adds *nothing* to the patient's care. In both situations, the patient is assessed and triaged by the emergency room and then, if necessary, treated by the first qualified ob-gyn or specialist who is available, as needed. *See, e.g.*, *Van Hollen II*, 2015 WL 1285829, at *20 ("Emergency rooms operate by triaging patients depending on the seriousness of their condition, not based on whether a physician accompanies a patient or whether the outpatient provider has admitting privileges. . . . Emergency room physicians are trained to manage obstetric-gynecological complications, and will consult with an ob-gyn when appropriate."); *see also* Parker Decl. ¶¶ 46-50. In both situations, the clinic transfers care for the patient to another ("outside") doctor—a

[17] *See, e.g.*, *PPSE III*, 33 F. Supp. 3d at 1368 ("Although Dr. Roe has never, in ten years of providing abortions, needed to transfer a patient directly to the hospital during a procedure, she described the protocols she would use in such a situation. She would assess and stabilize the patient, while clinic staff secure an ambulance. Then, she would ensure that the medical records were complete and send a copy of the patient's medical records with the ambulance staff. Finally, she would call the emergency room to ensure that the doctors there were prepared for the patient and 'could pick up the care where we ha[d] left off.'") (internal citations omitted).

doctor who does not know the patient and did not provide the abortion—who will treat the patient in the hospital. In both situations, the clinic provides the accepting doctor all the information that doctor needs to assume care of the patient. There is no evidence that a prior written agreement between the clinic and that "outside" doctor affects, let alone improves, care in any way.[18] Indeed, as the Seventh Circuit already recognized, the predominant practice in medicine today is for an outpatient physician to transfer care of a patient in need of hospital-based care to the hospital itself, not to another outpatient physician who would then meet the patient at the hospital and admit the patient him- or herself. *See Van Hollen I,* 738 F.3d at 793 ("The trend in the hospital industry is for the hospital to require the treating physician to hand over his patient who requires hospitalization to physicians employed by the hospital."); *see also Van Hollen II*, 2015 WL 1285829 at *20 ("For doctors who provide services on an outpatient basis, '[if] their patients need to be admitted, they are admitted [to] a hospital with someone who has chosen to spend their entire day in the hospital taking care of those patients.'") (quoting testimony of hospital administrator); *id.* (recognizing that in the event of a complication, care for a patient would be turned over from an outpatient physician to "a surgeon at the hospital or the ER doctor to manage"). As such, because the Clinic's existing policies and protocols already ensure high-quality care for WAWC's patients in the rare case of complications, the state's interest in the outside covering physician requirement cannot possibly justify the tremendous burdens its application imposes here. *See PPSE III*, 33 F. Supp. 3d at 1342; *Van Hollen II*, 2015 WL 1285829 at * 37-38.

* * *

[18] Indeed, an outside covering physician would be called upon so infrequently, that it would not be reasonable to suggest that that physician gains some sort of "experience" handling complications from abortion that the on-call ob-gyn at the hospital might not possess. *Cf. PPSE III*, 33 F. Supp. 3d 1367-68, 1370 n.23.

Coming to the heart of the undue burden test, the question for this Court is not whether there is any theoretical benefit to a covering physician arrangement. Indeed, as noted above, this is a post-enforcement, as-applied challenge: neither WAWC's policies and protocols, nor the effect of its closure, is hypothetical. Thus, the question here is whether the likelihood and extent that the outside covering physician requirement benefits WAWC's patients at all outweighs the actual harm that results from the alternative: shutting down WAWC altogether. *See PPSE II*, 9 F. Supp. 3d at 1287 ("[T]he heart of this [undue burden] test is the relationship between the severity of the obstacle and the weight of the justification the State must offer to warrant that obstacle."). Because it is plain that WAWC's existing policies and protocols achieve virtually the same level of care as a contract with an outside covering physician, and because it is plain that closing WAWC (Tuscaloosa's only abortion clinic, the highest volume abortion provider in the state, and one of only two clinics that provide abortions throughout the second trimester) imposes significant harms on the women of Alabama, the answer to that question is overwhelmingly, No. *See, e.g.*, *PPSE III*, 33 F. Supp. 3d. at 1372 (holding health justifications for statutory staff privileges requirement insufficient because, *inter alia*, the requirement "would, in reality, undermine the State's goal of continuity of care" by eliminating local abortion access in three cities); *id.* at 1355 (recognizing that eliminating abortion access leads to increase in numbers of women prevented from obtaining abortion and, forced to obtain later abortions, and additional costs and burdens; diminishes statewide capacity of abortion; and increases risk that women would attempt to self-abort). Accordingly, this Court should enjoin enforcement of the Regulation as applied to WAWC.

II. CONTINUED ENFORCEMENT OF THE REGULATION WILL IRREPARABLY HARM PLAINTIFFS AND THEIR PATIENTS.

Plaintiffs readily satisfy the second requirement for injunctive relief: Continued enforcement of the Regulation against Plaintiffs will inflict irreparable harm on Plaintiffs and their patients for which there is no adequate remedy at law.[19]

Having exhausted all other non-litigation options for keeping the Clinic open, absent injunctive relief from this Court, Ms. Gray will be forced to lay off all her staff and permanently close a clinic that has provided critical health care services to tens of thousands of women for over two decades. *See* Gray Decl. at ¶¶ 4, 9-10. This in and of itself constitutes irreparable harm. *See also PPSE I*, 951 F. Supp. 2d at 1289 (finding irreparable harm where statute would force clinic owner to "close her business altogether"); *ABC Charters, Inc. v. Bronson*, 591 F. Supp. 2d 1272, 1307 (S.D. Fla. 2008) (finding irreparable harm where plaintiffs would "be forced to close their businesses," thus depriving plaintiffs of sole source of income and means of retirement); *Mid–Fla Coin Exchange v. Griffin,* 529 F. Supp. 1006, 1030 (M.D. Fla.1981) (finding irreparable harm where plaintiffs' "businesses face virtual extinction if they are forced to comply with the legislation").

Furthermore, the evidence demonstrates that the elimination of the only licensed abortion clinic in Tuscaloosa, and the closure of the highest-volume licensed abortion clinic in the state and one of only two licensed clinics in Alabama that provides abortions throughout the second trimester, is causing irreparable harm to Plaintiffs' patients' health and wellbeing by causing undue delay and, for some, forcing them to continue their pregnancies to term—regardless of risk—against their will. *See* pp. 22-24, 31-40, *supra*; *see also PPSE I*, 951 F. Supp. 2d at 1289

[19] This is particularly true where, as here, Plaintiffs are barred from seeking retroactive damages from defendants because of Eleventh Amendment immunity. *Clark Constr. Co., Inc. v. Pena,* 930 F. Supp. 1470, 1479–80 (M.D. Ala. 1996).

(finding irreparable harm where "women who carry unwanted pregnancies to term are at increased risk of death and childbirth complications" and delay in seeking abortion "also carries an heightened risk of medical complication"); *Van Hollen I*, 738 F.3d at 795-96; *Harris v. Bd. of Supervisors*, 366 F.3d 754, 766 (9th Cir. 2004) (plaintiffs established likelihood of irreparable harm where evidence showed they would experience pain, complications, and other adverse effects due to delayed medical treatment). Indeed, the evidence before this Court demonstrates that since WAWC has been closed there has been a sharp drop in the number of abortions performed in Alabama, and that more women are obtaining abortions at later gestations because of the increased travel burdens imposed by WAWC's closure. *See* pp. 21-24, 38-39, *supra*. Thus, by subjecting Plaintiffs' patients to forced childbirth and/or increased medical risks, enforcement of the Regulation inflicts ongoing irreparable harm as a matter of law.

Finally, continued enforcement of the Regulation violates the "constitutionally protected privacy of the plaintiffs' patients," which further supports a determination of irreparable harm. *PPSE I*, 951 F. Supp. 2d at 1289; *see also Touchston v. McDermott*, 234 F.3d 1133, 1159 n.4 (11th Cir. 2000) (noting "we have presumed irreparable harm to a plaintiff when certain core rights are violated" and "cannot be undone through monetary remedies"). The Eleventh Circuit has recognized that "an on-going violation [of the constitutional right to privacy] constitutes irreparable injury" because "invasions of privacy, because of their intangible nature, could not be compensated for by monetary damages; in other words, plaintiffs could not be made whole." *Ne. Florida Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville, Fla.*, 896 F.2d 1283, 1285 (11th Cir. 1990) (internal citations omitted), *overturned on other grounds*, 508 U.S. 656 (1993); *Women's Medical Ctr. of Nw. Houston v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001) (affirming district court's finding of irreparable harm based on threat to women's

constitutional right to privacy); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (Unit B. 5th Cir. 1981) (finding of irreparable injury is mandated where constitutional right to privacy is being threatened or impaired). As set forth *supra*, enforcement of the Regulation against WAWC imposes an undue burden on their patients' constitutionally protected right to have an abortion.

Accordingly, injunctive relief (as applied to Plaintiffs) is necessary to prevent irreparable harm.

III. THE BALANCE OF EQUITIES WEIGHS HEAVILY IN PLAINTIFFS' FAVOR.

In view of the demonstrated harms resulting from the continued enforcement of the Regulation against Plaintiffs, there is no doubt that the balance of the equities tips sharply in favor of injunctive relief. *See, e.g.*, *Canal Auth. of Fla. v. Callaway*, 489 F.2d 567, 576 (5th Cir. 1974) ("If the currently existing status quo itself is causing one of the parties irreparable injury, it is necessary to alter the situation so as to prevent the injury.").[20] Every day that WAWC remains closed, more and more women are being harmed because they are being forced to access abortions later in pregnancy, or being forced to continue their pregnancies to term against their will. Yet, in defense of this undeniable and ongoing harm, the best Defendants can conceivably argue is that there is a *theoretical* benefit to the covering physician requirement in the "infrequent event that a patient experiences a complication during an abortion procedure requiring an immediate visit to a hospital emergency department." Gray Decl., Ex. D. But even

[20] The Eleventh Circuit has "adopted as binding precedent all decisions of the former Fifth Circuit handed down prior to October 1, 1981." *Dir., Office of Worker's Comp. Programs, U.S. Dep't of Labor v. Hamilton*, 890 F.2d 1143, 1143 n. * (11th Cir. 1989).

that argument must fail because, as Dr. Parker's declaration explains, Plaintiffs' protocols provide the same level and quality of care in the event of a complication as does the covering physician required by the Regulation. *See* Parker Decl. ¶¶ 50-52. Indeed, given that there is no requirement that any clinic with a covering physician ever involve that physician in the care of one of its patients, it is apparent that that there is no practical difference between Plaintiffs' protocols and the Regulation.[21] Thus, whatever theoretical benefits the outside covering physician requirement might hold, these cannot outweigh the concrete and ongoing harms that are resulting from enforcement of the Regulation. *See Scott v. Roberts*, 612 F.3d 1279, 1297 (11th Cir. 2010); *KH Outdoor, LLC v. City of Trussville*, 458 F.3d 1261, 1272 (11th Cir. 2006).

Because the equities tip sharply in favor of granting a temporary restraining order and/or preliminary injunction while the constitutionality of the Regulation (as applied to Plaintiffs) is decided, Plaintiffs satisfy the third criteria for injunctive relief.

IV. INJUNCTIVE RELIEF IS IN THE PUBLIC INTEREST.

Finally, the interests of Plaintiffs and the general public are aligned in favor of a temporary restraining order and/or preliminary injunction in this case. The public interest is not served by allowing the ongoing and unconstitutional application of the Regulation. *See Scott*, 612 F.3d at 1297; *KH Outdoor*, 458 F.3d at 1272. Particularly where civil rights are at stake, an injunction *serves* the public interest because the injunction "would protect the public interest by protecting those rights to which it too is entitled." *Nat'l Abortion Fed'n v. Metro. Atlanta Rapid Transit Auth.*, 112 F. Supp. 2d 1320, 1328 (N.D. Ga. 2000). Furthermore, without an injunction,

[21] Indeed, the only apparent difference is that the Regulation requires finding a local non-abortion providing physician willing to affiliate him or herself (even if in name only) with the clinic. *Cf.* Compl. ¶¶ 66-69.

the sole licensed abortion clinic in Tuscaloosa and the highest-volume abortion clinic in Alabama would be forced to close permanently, causing Plaintiffs' patients to suffer a significantly reduced ability to access constitutionally protected abortion services. Ensuring continued access to constitutionally protected health care services is undoubtedly in the public interest. Thus, Plaintiffs satisfy the fourth and final requirement for injunctive relief.

V. A BOND IS NOT NECESSARY IN THIS CASE.

The Court should waive the Federal Rule of Civil Procedure 65(c) bond requirement. As the Eleventh Circuit held in *Bell South Telecomm., Inc. v. MCIMetro Access Transmission Servs., LLC*, "it is well-established that 'the amount of security required by the rule is a matter within the discretion of the trial court . . . [, and] the court may elect to require no security at all.'" 425 F.3d 964, 971 (11th Cir. 2005) (citing *City of Atlanta v. Metro. Atlanta Rapid Transit Auth.*, 636 F.2d 1084, 1094 (5th Cir. 1981)); *see also AFC Enterprises, Inc. v. THG Rest. Grp., LLC*, 416 F. App'x 898, at *1 (11th Cir. 2011) (affirming that the court does not have to require a bond). The Court should use its discretion to waive the bond requirement in this case, as the temporary restraining order and/or preliminary injunction will not result in a monetary loss for Defendants. Moreover, Plaintiffs are healthcare providers dedicated to serving women in low-income and underserved communities, and a bond would strain the providers' already-limited resources.

CONCLUSION

Accordingly, for the reasons set forth above, this Court should enter a temporary restraining order and/or preliminary injunction, enjoining enforcement of the Regulation as to Plaintiffs.

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Respectfully submitted,

Randall C. Marshall
ASB-3023-A56M
ACLU FOUNDATION OF ALABAMA, INC.
P.O. Box 6179
Montgomery, AL 36106-0179
rmarshall@aclualabama.org
(334) 420-1741

Alexa Kolbi-Molinas*
New York State Bar No. 4477519
Andrew Beck*
New York State Bar No. 4740114
Jennifer Lee*
New York State Bar No. 4876272
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, 18th Floor
New York, NY 10004
akolbi-molinas@aclu.org
abeck@aclu.org
jlee@aclu.org
(212) 549-2633

Attorneys for Plaintiffs

**Pro hac vice motions to be filed*

CERTIFICATE OF SERVICE

I, Randall Marshall, do hereby certify that a true and correct copy of the foregoing will be perfected upon the following counsel of record via e-mail and hand delivery on this 10th day of July, 2015:

P Brian Hale
brian.hale@adph.state.al.us
Alabama Department of Public Health
P.O. Box 303017
Montgomery, AL 36130

Randall C. Marshall