IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES, *et al.*,

Plaintiffs,

v.

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas, *et al.*,

Defendants.

CIVIL ACTION

Case No. 4:19-cv-00449-KGB

PLAINTIFFS' MOTION FOR EX PARTE TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

Plaintiffs Little Rock Family Planning Services ("LRFP") and Dr. Thomas Tvedten, on behalf of themselves and their patients, hereby move the Court under Federal Rule of Civil Procedure 65 for *ex parte* temporary restraining order and/or preliminary injunction restraining Defendants from eliminating patients' right to freely access surgical-abortion care, *i.e.*, the only type of care available to women who are more than 10 weeks pregnant, as measured from the date of their last menstrual period ("LMP") (the "COVID-19 Abortion Ban" or the "Ban"). On the morning of Friday, April 10, the Arkansas Health Department ("ADH") demanded that clinicians at Plaintiff Little Rock Family Planning ("LRFP") cease providing surgical-abortion care to numerous women who had already assumed the substantial burdens of making an initial trip to the clinic days before to receive the State's mandated (in-person) "informed-consent" information. ADH stated that the provision of surgical abortion "will result in an immediate suspension of [LRFP's] license."[1] Violation of the ADH directive also carries criminal, financial, and licensure penalties, and each day a person or business operates in violation of the guidance would constitute a separate offense.[2]

The issuance of a temporary restraining order without a hearing and without notice to Defendants or providing them an opportunity to respond is warranted. First, Plaintiffs have set forth specific facts in the Supplemental Complaint and in sworn declarations, attached hereto, clearly showing that immediate and irreparable injury, loss, or damage will result to Plaintiffs' patients before Defendants can be heard in opposition. In fact, Plaintiffs have already been forced to turn away a number of women seeking care on Friday. And during the coming week, they are

[1] Ex. 1.

[2] *See* Ark. Code § 20-7-101; Executive Order to Amend Executive Order 20-03 Regarding the Public Health Emergency Concerning COVID-19 for the Purpose of Imposing Further Restrictions to Prevent the Spread of COVID-19, EO 20-13, § 2(a) (Apr. 4, 2020), https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-13._.pdf.

scheduled to provide surgical care to more than 20 women, including at least 12 for whom medication abortion is not an option.[3] These women will all be forced to carry their pregnancies to term against their will or, in the midst of a pandemic, assume the substantial burdens associated with attempting to travel to another State to exercise their constitutional right to access pre-viability abortion care. That is a quintessential example of immediate and irreparable harm. *See* Fed. R. Civ. P. 65(b)(1)(A); *see also Zaxby's Franchising, LLC v. MJM Foods*, LLC, No. 3:16-CV-00137 BSM, 2016 WL 3024074, at *1 (E.D. Ark. May 25, 2016) (granting *ex parte* temporary restraining order to prevent customer confusion before restaurant trademark dispute could be resolved); *Tempur-Pedic Int'l, Inc. v. Waste To Charity, Inc.*, No. 07 2015, 2007 WL 535041, at *5 (W.D. Ark. Feb. 16, 2007) (granting *ex parte* temporary restraining order to prevent the movement or destruction of mattresses).

Second, Plaintiffs attempted to contact counsel for Defendants on April 12, 2020, to resolve this matter without litigation, and expressly informed Defendants that Plaintiffs would be seeking emergency relief if the matter could not otherwise be resolved. These efforts to resolve the matter have been unsuccessful. *See* Godesky Decl., attached hereto, ¶¶ 4–5. This is more than sufficient to satisfy Plaintiffs' obligations to give notice and, given the threat of imminent and irreparable harm, no further notice should be required. *See* Fed. R. Civ. P. 65(b)(1)(B); *see also, e.g.*, *GE Commercial Distribution Fin. Corp. v. Crabtree RV Ctr., Inc.*, 2009 WL 10707170, at *3–4 (W.D. Ark. Apr. 3, 2009) (granting *ex parte* temporary restraining order to protect interest in recreational vehicles even where "*no efforts* have been made to give notice to the Defendant," given the threat of imminent and irreparable harm) (emphasis added); *Ellis v. Jackson Nat'l Life Ins. Co.*. No. 2:11-CV-1064-WKW, 2011 WL 6300608, at *1–2 (M.D. Ala. Dec. 15, 2011) (finding single phone call

[3] Williams Decl. ¶ 40.

to nonmovant's counsel sufficient to grant *ex parte* temporary restraining order).

As more fully explained in the accompanying brief, Plaintiffs satisfy the remaining requirements for a temporary restraining order and a subsequent preliminary injunction because (i) Plaintiffs are likely to succeed on the merits of their claims that the COVID-19 Abortion Ban violates the constitutional rights of Plaintiffs and their patients; (ii) the balance of equities tips strongly in favor of Plaintiffs and their patients; and (iii) the public interest will be served by a temporary restraining order and/or an injunction. Plaintiffs further request that, given the nature of the relief sought and Plaintiffs' limited means, bond be waived should the Court grant injunctive relief.

This Motion is based upon the Supplemental Complaint filed in this case, the exhibits to that Complaint, the brief filed herewith, and the following documents:

1. Attached as **Exhibit 1** is a true and accurate copy of the April 10, 2020 Arkansas Department of Health cease-and-desist order.

2. Attached as **Exhibit 2** is a true and accurate copy of the April 12, 2020 declaration of Lori Williams.

3. Attached as **Exhibit 3** is a true and accurate copy of the April 12, 2020 declaration of Janet Cathey.

4. Attached as **Exhibit 4** is a true and accurate copy of the March 21, 2020 Arkansas Department of Health Elective Surgery Guidance.

5. Attached as **Exhibit 5** is a true and accurate copy of the March 30, 2020 Arkansas Department of Health Guidance Letter.

6. Attached as **Exhibit 6** is a true and accurate copy of the April 2, 2020 Little Rock Family Planning Services Precautions and Protocols in Response to COVID-19 Pandemic.

7. Attached as **Exhibit 7** is a true and accurate copy of the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries.

8. Attached as **Exhibit 8** is a true and accurate copy of Arkansas State Senator Trent Garner's March 29, 2020 tweet.

9. Attached as **Exhibit 9** is a true and accurate copy of the April 6, 2020 *SFGate* article titled *Arkansas Schools Closed for Rest of Year Due to Coronavirus*.

10. Attached as **Exhibit 10** is a true and accurate copy of the March 19, 2020 Arkansas Department of Health Directive to Dentists to suspend non-emergent dental care.

11. Attached as **Exhibit 11** is a true and accurate copy of Governor Asa Hutchinson's March 13, 2020 Executive Order (EO 20-05) amending EO 20-03.

12. Attached as **Exhibit 12** is a true and accurate copy of the March 18, 2020 American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology *et al.* Joint Statement on Abortion Access During the COVID-19 Outbreak.

13. Attached as **Exhibit 13** is a true and accurate copy of the March 30, 2020 American Medical Association statement on government interference in reproductive health care.

14. Attached as **Exhibit 14** is a true and accurate copy of the April 4, 2020 *Daily Caller* article titled *World Health Organization: Abortion Is 'Essential' During Coronavirus Pandemic*.

15. Attached as **Exhibit 15** is a true and accurate copy of the March 19, 2020 Ambulatory Surgery Center Association COVID-19 Guidance for ASCs on Necessary Surgeries.

16. Attached as **Exhibit 16** is a true and accurate copy of New Jersey Governor Phil Murphy's March 23, 2020 COVID-19 Press Information.

17. Attached as **Exhibit 17** is a true and accurate copy of the April 2, 2020 Department of Labor Unemployment Insurance Weekly Claims.

18. Attached as **Exhibit 18** is a true and accurate copy of the April 13, 2020 declaration of Leah Godesky.

Dated: April 13, 2020

Respectfully submitted,

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** Motion for admission pro hac vice granted*
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On Behalf of the Arkansas Civil Liberties Union Foundation, Inc.
Attorney for Plaintiffs

EXHIBIT 1

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

April 10, 2020

Little Rock Family Planning
4 Office Park Dr.
Little Rock, AR 72211

RE: Healthcare Facility Complaint Survey
Conducted April 7, 2020

Dear Administrator:

We recently completed an unannounced investigation of your facility following the receipt of a complaint. The investigation was conducted on April 7, 2020, by personnel from Health Facility Services and included a review of medical records and facility staff interviews.

That investigation did not reveal any deficiencies with respect to the rules for abortion facilities in Arkansas.

However, your facility is in violation of the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries. That directive was posted on the ADH's website on April 3, 2020, and a copy was mailed to your facility on Monday, April 6, 2020. The April 3 Directive mandates the postponement of all procedures that are not immediately medically necessary during the COVID-19 emergency. That prohibition applies to surgical abortions that are not immediately necessary to protect the life or health of the patient.

Your facility was found to be performing surgical abortions that are not immediately necessary to protect the life or health of the patient, and your facility is therefore in violation of the April 3 Directive. Your facility is required to postpone such procedures until after the COVID-19 emergency has ended and the April 3 Directive is withdrawn.

Accordingly, your facility is ordered to immediately cease and desist the performance of surgical abortions, except where immediately necessary to protect the life or health of the patient. Any further violations of the April 3 Directive will result in an immediate suspension of your facility's license.

Sincerely,

Becky Bennett

Becky Bennett
Section Chief, Health Facility Services

EXHIBIT 2

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES et al., Plaintiffs, v. LESLIE RUTLEDGE, et al., Defendants.	CIVIL ACTION Case No. 4:19-cv-00449-KGB

DECLARATION OF LORI WILLIAMS, M.S.N, A.P.R.N., IN SUPPORT OF PLAINTIFFS' MOTION FOR AN EX PARTE TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

I, Lori Williams, M.S.N., A.P.R.N., declare under 28 U.S.C. § 1746 and penalty of perjury that the following is true and correct:

1. I am a nurse practitioner and the Clinical Director of Plaintiff Little Rock Family Planning Services ("LRFP").

2. I submit this Declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and/or Preliminary Injunction relating to the State's enforcement of Executive Order 20-13 and the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries to bar all surgical abortion "except where immediately necessary to protect the life or health of the patient" (the "COVID-19 Abortion Ban").

Background and Education

3. I received my bachelor's degree from the University of Arkansas at Fayetteville in 1998, and a Master's degree in science and nursing from Vanderbilt University in 1999.

4. From 2000 to 2004, I worked as a nurse practitioner at Women's Community Health in Little Rock, a clinic that previously provided abortion care in the State. I have worked at LRFP since 2004, and have been the Clinical Director since 2007.

5. As LRFP's current Clinical Director, I am responsible for all aspects of our day-to-day operations, including overseeing patient care in coordination with the physicians and other health-care professionals, supervising the staff, maintaining policies and procedures, interacting with Arkansas Department of Health licensing personnel when they visit to inspect or request information, and ensuring that LRFP complies with all laws and regulations.

6. In 2010, I purchased an ownership interest in LRFP, which I currently share with LRFP Medical Director Dr. Thomas Tvedten and his wife, Natalie Tvedten.

7. I am also currently the National Abortion Federation's ("NAF") Board Chair, and have been on the Board of Directors since 2012. NAF is a professional association of abortion providers including individuals, public and non-profit clinics, Planned Parenthood affiliates, women's health centers, physicians' offices and hospitals. Among other things, NAF provides accredited continuing medical education exclusively in abortion care to advance the clinical skills and update the medical techniques of abortion providers. I previously served on the NAF committee that is responsible for drafting, reviewing, and updating all clinical-policy guidelines, and routinely attend NAF conferences and communicate with NAF members regarding the standards of and developments regarding abortion care.

Abortion Care at LRFP

8. LRFP has operated an abortion clinic in Little Rock since 1973, and has been licensed by the State as an abortion provider since licensing began in the mid-1980s. LRFP also offers procedures that are similar to abortion care for patients whose pregnancies end in

miscarriage, as well as basic gynecological care, including pap smears, STD testing, and contraceptive counseling and services.

9. Abortion is one of the safest medical procedures currently available to women in the United States. It is substantially safer than giving birth, and a host of other common medical procedures, including a tonsillectomy and numerous dental procedures.[1] Complications from abortion are extremely rare, and when they occur they can usually be managed in an outpatient clinic setting, either at the time of the abortion or in a follow-up visit.

10. LRFP's patients seek abortions for a variety of personal, medical, financial, and family reasons. Many of our patients already have at least one child and have decided they cannot parent another. Some are young women who feel they are not ready to carry a pregnancy or become a parent. Others are pursuing school or career opportunities and/or they lack the necessary financial resources or a sufficient level of partner or familial support or stability. Other patients seek abortions because continuing with the pregnancy could pose a particular risk to their health, especially if their past pregnancies have been high risk, while others have received a diagnosis of a fetal anomaly. LRFP also provides care for patients who are in abusive relationships, or are pregnant as a result of rape or sexual assault.

11. LRFP provides both medication abortion and surgical abortion. Both methods are safe, effective means to terminate a pregnancy.

12. LRFP offers medication abortion from the point in pregnancy when an intrauterine pregnancy can be confirmed (typically 5-6 weeks from the first day of the patient's last menstrual period ("LMP")) and up to 70 days or 10 weeks LMP. Medication abortion

[1] The Safety and Quality of Abortion Care in the United States, THE NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, MEDICINE, at 74–75 (2018), *available at* https://www.nap.edu/read/24950.

involves taking a combination of two pills, mifepristone and misoprostol, after which the patient expels the contents of the pregnancy in a manner similar to a miscarriage.

13. Despite the name, surgical abortions do not involve what is commonly understood to be "surgery." There are no incisions, and no need for general anesthesia. LRFP provides two types of surgical abortion: (1) aspiration abortion (which primarily involves the use of gentle suction to safely empty the contents of the uterus) from approximately 3-4 weeks LMP through approximately 13 weeks LMP, and (2) a dilation and evacuation ("D&E") procedure typically beginning around 14 weeks LMP through 21.6 weeks LMP, which is the legal limit in Arkansas. A D&E procedure involves the use of surgical instruments in addition to gentle suction, and typically takes longer to perform and requires more time in a recovery room than an aspiration abortion procedure. In addition, D&E procedures performed after 18 weeks LMP at LRFP typically require an additional visit to the clinic to dilate the cervix the day before the procedure is performed.

14. Under current Arkansas law, and the State-mandated abortion-delay requirement, women who seek either medication or surgical abortion care at LRFP must visit the clinic to receive an ultrasound and State-mandated options counseling at least 72 hours before the procedure (LRFP provides additional, non-directive counseling before the procedure itself).

15. In 2019, LRFP provided approximately 1,950 abortions, 1,725 of which were surgical procedures. Of those, nearly half were provided to women beyond 10 weeks LMP for whom medication abortion would not have been an option. From January through March 2020, LRFP provided 526 abortions, 478 of which were surgical procedures, 226 of which were beyond the 10-week cut off for medication abortion care.

16. It is common for a woman who can choose between a medication and surgical abortion (i.e., a woman who is less than 10 weeks LMP) to have a strong preference for a surgical abortion. Although there are many reasons for this (and other women have a strong preference for medication abortion), many women prefer the surgical option because it is shorter in duration, and women are generally able to return to work and other responsibilities shortly afterwards. Other women may have a pre-existing medical condition (e.g., anemia, low hemoglobin or blood-clotting disorders) that makes having a medication abortion contraindicated.

17. LRFP is the only abortion clinic in Arkansas that offers surgical abortions.

18. Surgical abortion does not require extensive personal protective equipment ("PPE"). For the State-mandated ultrasound that must be performed before every abortion, we use only non-sterile gloves. For the procedure itself, the physician uses sterile gloves (one pair per procedure), and a surgical mask (worn throughout the day); the assistant uses only a surgical mask (also worn throughout the day) and gloves. When necessary, LRFP uses reusable gowns and reusable eyewear.

19. While LRFP's patients generally seek abortion as soon as they are able to, a multitude of logistical obstacles cause many of our patients to experience delay in their ability to access abortion care. For example, a substantial percentage of our patients are poor or have low-incomes, and struggle to raise the finances needed to obtain abortion care. Moreover, as the patient's gestational age increases, so does the cost of getting an abortion, which can further prolong her access to care. Some of our patients face issues with unsupportive or abusive partners, or a lack of access to medical care to confirm the pregnancy. Some patients, particularly those who are younger or have irregular periods, may not recognize that they are

pregnant right away. Others may experience difficulties navigating the medical system, including finding a provider and scheduling an appointment.

20. Based on my counseling conversations with patients, I know that the time, money and effort required to make the necessary plans to come to LRFP cause anxiety and stress, which would only be exacerbated by further travel and logistical arrangements. The need to arrange for time off work on multiple days can be very challenging, and many LRFP patients are in low-wage jobs where they likely do not receive vacation or sick days. Taking time off means less pay, which is extremely burdensome for many lower-income women who struggle to raise the funds for abortion care. These women also routinely report that they risk their employment and confidentiality by asking for time off. Patients who already have children must typically arrange and potentially pay for childcare during the time they are traveling to the clinic and receiving care. Patients must also arrange and pay for transportation, which presents a major challenge in rural Arkansas. There are few public-transportation options, and rural residents often live far away from health-care providers.

21. The mandated delays imposed by Arkansas law compound the challenges that women face in obtaining abortion care. Arkansas law forces patients to delay their abortions for at least 72 hours after receiving State-mandated in-person counseling. Similarly, Arkansas law requires that an unemancipated minor patient obtain either parental consent or a judicial order excusing them of that requirement before they can receive abortion care. For those that choose to involve a parent, negotiating a time when a parent (who may have work and other obligations) can accompany them to the clinic may delay them from accessing care. And for those who cannot involve a parent, navigating the judicial system in order to obtain the required order waiving Arkansas's consent requirement likewise causes them to delay their abortion.

22. Every day that one of our patients remains pregnant, she experiences additional financial, emotional, and physical consequences. For example, as a pregnancy progresses, the costs associated with abortion care increase. An abortion performed prior to 11 weeks LMP typically costs around $700, whereas abortion care nearing 21 weeks LMP can cost nearly three times that much in view of the relative complexity of the procedure. Thus, forcing a woman to delay her abortion may push a patient past the point at which she is able to afford care. And while abortion is one of the safest medical procedures currently available, the risks associated with the procedure increase as the pregnancy progresses. Delay may also worsen any health conditions that either pre-exist the pregnancy or are brought on by the pregnancy. Delay can likewise affect the type of abortion a patient can receive, such as by forcing a patient who would have received an aspiration abortion (available up to approximately 13 weeks LMP) to undergo a D&E abortion (available up to 21.6 weeks LMP). If pushed past 18 weeks LMP, delay will also likely require a patient to visit the clinic an additional time on the day before the procedure to dilate her cervix, further exacerbating the challenges discussed above. And delay can push a patient beyond the point at which abortion is available in the State (i.e., 21.6 weeks LMP), and prevent her from accessing abortion care at all, thereby forcing her to carry to term against her will.

Arkansas's COVID-19-Related Actions
With Regard To Abortion Care, and LRFP's Response

23. In recent months, governments around the world have implemented orders and directives relating to the public-health crisis arising from the spread of COVID-19. In Arkansas, the Arkansas Department of Health ("ADH") issued a guidance letter on March 21, 2020 relating

to elective surgeries.[2] The stated goals were to "preserve staff, personal protective equipment (PPE), and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic."[3] The ADH's guidance letter recommended that "[p]rocedures … that can be safely postponed shall be rescheduled to an appropriate future date" but stated that "time-sensitive care will continue."[4] The ADH's guidance exempted "small rural hospitals under 60 beds," and circumstances that would increase the "threat to the patient's life if the procedure is not performed," risk of "progression of staging of a disease or condition if surgery is not performed," or "there is a risk that the patient's condition will rapidly deteriorate if surgery is not done."[5]

24. The ADH's guidance was reiterated in another letter issued on March 30, 2020.[6]

25. In the meantime, beginning in mid-March 2020, LRFP began to put in place measures to protect its patients and staff by reducing the spread of infection while ensuring that patients in need of time-sensitive abortion care could continue to access our services. LRFP determined that it would cease providing basic gynecological care—i.e., pap smears, STD testing, and contraceptive counseling and services—and that, where possible and permitted by law, prescriptions would be administered over the phone. LRFP also began performing enhanced telephonic and in-person screening of patients for COVID-19 symptoms, and

[2] A copy of the ADH's March 21, 2020 guidance letter is accessible at https://www.healthy.arkansas.gov/images/uploads/pdf/Elective_Surgery_Guidance_3.21.20final.pdf

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] A copy of the ADH's March 30, 2020 guidance letter is accessible at https://www.healthy.arkansas.gov/images/uploads/pdf/ADH_elective_procedures_letter.pdf

staggering patient appointment times to reduce the number of patients at the facility at any given time, minimizing possibilities for exposure.

26. LRFP then expanded upon and formalized these precautions in its April 2, 2020 COVID-19 Response Protocol ("LRFP Protocol").[7] That protocol sets forth detailed information about (1) postponement of LRFP services for which delay would not risk harm to the patient (i.e., certain gynecological care); (2) screening patients for symptoms of infection, both telephonically and on site; (3) staggering appointment times in order to minimize in-person contact and shorten the time patients spend in clinical space; (4) spacing individuals at least 6 feet apart in waiting areas to comply with the State's and CDC's "social distancing" guidelines; (5) limiting visitors and support people by requiring that they sit in cars or return home until patients are ready to be picked up; (6) performing temperature checks on all individuals entering the building (including staff); and (7) enhancing infection control protocols with frequent clinic sanitization and education of patient etiquette.[8] Given these changes, LRFP has only 6-8 patients in the waiting area at any given time, patients undergoing treatment are in individual rooms, and patients are never within 6 feet of each other, including during recovery. In addition, and where applicable, LRFP counsels its patients to seek care at a clinic closer to their home in order to minimize the patient's travel and risk of exposure during the COVID-19 pandemic.

27. The LRFP Protocol also states that "LRFP is aware of the PPE shortage our healthcare system is currently facing," and "is committed to using only the PPE that is necessary to protect [its] patients and staff."[9] As explained above, neither LRFP, nor abortion care in

[7] Ex. 1.

[8] *Id.*

[9] *Id.*

general, requires extensive PPE. LRFP is self-sustaining in terms of PPE for the next several months, and is prepared to switch to cloth/reusable masks should it become necessary. LRFP placed an order for additional PPE through NAF earlier this month, but that order has not yet been filled. LRFP has no intention of utilizing any State PPE stockpiles or resources.

28. At LRFP, the use of N-95 masks, the PPE that appears to be in shortest supply in battling the COVID-19 pandemic, is limited to two staff members who self-sourced their masks and have underlying conditions or live with someone who does. Likewise, because all our procedures are performed in our own outpatient facility, we are not using any hospital resources that may be needed for COVID-19 response—no hospital staff or supplies, no hospital beds (let alone ICU beds), and no ventilators.

29. LRFP is adhering rigorously to the LRFP Protocol in order to protect its patients and staff, and to aid in decreasing the spread of COVID-19.

30. On April 1, 2020, representatives from the ADH twice called LRFP to inquire about what the clinic was doing to reduce non-essential services, preserve PPE, and protect against the spread of COVID-19. On both occasions, I summarized the practices outlined in the LRFP Protocol discussed above. At no point during either conversation did the ADH representatives suggest that LRFP was not complying with the State's elective-surgery guidance, and on April 1, 2020, LRFP received a letter confirming our compliance with "applicable provisions of the Rules and Regulations for Licensure."[10]

31. On April 3, 2020, the ADH issued a Directive reiterating the goals and instructions from the ADH's March 21, 2020 guidance (the "April 3 ADH Directive").[11] When

[10] Ex. 2.

[11] A copy of the April 3 ADH Directive is available at www.healthy.arkansas.gov/images/uploads/pdf/Elective_Procedure_Directive_April_3.pdf.

Governor Asa Hutchinson was asked about the April 3 Directive during an April 6, 2020 press conference, State Health Director Dr. Nate Smith explained that it is "not intended to replace a physician's judgment," and reiterated that the April 3 Directive encompasses only procedures that can "be safely deferred."[12] At no point during the conference did the Governor or Dr. Smith suggest that surgical abortion is not permissible under the April 3 Directive.

32. On April 4, 2020, by Executive Order 20-13, Governor Asa Hutchinson declared the State of Arkansas "a disaster area."[13] He declined, however, to issue a stay-home order to all Arkansas residents,[14] and all businesses, manufacturers, construction companies, and places of worship in the State are open and operational so long as they adhere to certain social-distancing guidelines.[15] The Executive Order also states that a violation of a directive from the Secretary of Health "is a misdemeanor offense, and upon conviction thereof is punishable by a fine of not less than one hundred ($100) nor more than five hundred dollars ($500) or by imprisonment not exceeding one (1) month, or both."[16]

33. There are on-site protestors at LRFP nearly every day that we provide women with care. Between April 4 and 10, 2020, however, the harassment and intimidation from on-site

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[12] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 6, 2020), https://www.youtube.com/watch?v=KS2Kb4V8U3I.

[13] *See* Executive Order To Amend Executive Order 20-03 Regarding The Public Health Emergency Concerning COVID-19 For The Purpose Of Imposing Further Restrictions To Prevent The Spread Of COVID-19 ("EO 20-13"), *available at* https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-13._.pdf. EO 20-13 supersedes the Directives set out in two prior Executive Orders: EO 20-03, issued March 11, 2020, and EO 20-10, issued March 26, 2020.

[14] *Arkansas Gov. Asa Hutchinson on why he hasn't issued a stay-at-home order* (Apr. 8, 2020) *available at* https://www.pbs.org/newshour/show/arkansas-gov-asa-hutchinson-on-why-he-hasnt-issued-a-stay-at-home-order.

[15] *See* EO 20-13.

[16] *Id.*

protestors significantly increased. During that period, protestors summoned the police to the clinic on two occasions. And on Friday, April 10, 2020, a crowd of roughly 15 protestors gathered outside LRFP—none of whom abided by the State's social-distancing guidelines—to harass the clinic's staff and patients, and post pictures of their cars and license plates online. I am also aware of social-media complaints directed at the clinic beginning in March 2020, including some specifically requesting action by the Governor and state legislators to stop the provision of abortion care. For example, on March 29, 2020, state senator Trent Garner announced in a tweet that he had "asked the Governor to [ban abortions] in Arkansas …. We shouldn't expose women to the risk of the Wuhan COVID-19 virus for an unnecessary elective procedure, and we could save the unborn babies."[17]

34. On April 7, 2020, ADH inspectors performed an unannounced in-person inspection at LRFP. At no point during the inspection, which occurred on a day during which both surgical and medication abortions were provided, did the ADH representatives suggest that LRFP was not complying with the State's April 3 Directive.

35. On April 8, 2020, the Governor gave an interview to PBS during which he discussed Arkansas's "targeted" approach to managing risks relating to COVID-19. When asked whether he thinks "that by not requiring or ordering people to stay home, unless they have to be out, is not putting other people at risk," the Governor responded "No."[18] He elaborated that "as long as they do what they're supposed to do, which is social distance, wear a mask when

[17] *E.g.*, Ex. 3.

[18] *Arkansas Gov. Asa Hutchinson on why he hasn't issued a stay-at-home order* (Apr. 8, 2020) *available at* https://www.pbs.org/newshour/show/arkansas-gov-asa-hutchinson-on-why-he-hasnt-issued-a-stay-at-home-order.

you're out, this accomplishes the purpose."[19] The Governor further said that currently in the State, there are "a lot of hospitals that are empty right now and health care workers that are empty," presumably meaning that they are available to provide care.[20]

36. On April 9, 2020, the Governor and Dr. Smith were asked at a press conference if "elective surgeries" are still permitted in the State, and Dr. Smith responded that judgments at surgical centers would be left primarily to the providers.[21] At no point during the conference did the Governor or Dr. Smith suggest that surgical abortion care is not permissible under the April 3 Directive.[22]

37. Around 10am CST, on April 10, ADH inspectors hand delivered a cease-and-desist order to LRFP (the "C&D Order").[23] It stated that the April 7 inspection "did not reveal any deficiencies with respect to the rules for abortion facilities in Arkansas," but that LRFP was "in violation of the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries."[24] The C&D Order stated that the April 3 Directive "mandates the postponement of all procedures that are not immediately medically necessary during the COVID-19 emergency," and thus, according to ADH, the "prohibition applies to surgical abortions that are not immediately necessary to protect the life or health of the patient."[25] The C&D Order ordered LRFP to "immediately cease and desist the performance of surgical abortions, except where

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[19] *Id.*

[20] *Id.*

[21] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 9, 2020), https://www.youtube.com/watch?v=Kg-qMqmycAM.

[22] *Id*.

[23] Ex. 4.

[24] *Id.*

[25] *Id.*

immediately necessary to protect the life or health of the patient."[26] The C&D Order also stated that "[a]ny further violations of the April 3 Directive will result in an immediate suspension of [LRFP's] license."[27]

38. On April 10, LRFP was scheduled to provide surgical-abortion care to 8 patients whom LRFP had to turn away, including one patient at 17 weeks LMP. These patients were devastated and extremely frightened about what the C&D Order meant for their ability to access care.

39. Later on April 10, the Governor and Dr. Smith held a press conference regarding COVID-19.[28] Dr. Smith admitted that he "can't say with certainty" how long the C&D Order against LRFP will be in place, and when a reporter pressed a question regarding whether the C&D Order means that "some of [the women who would otherwise visit LRFP] are going to have a baby," the Governor responded by asking "Is there a question remotely"?[29]

40. LRFP has 26 patients scheduled to receive surgical abortion care the week of April 13, 2020, including:

- 12 who are more than 10 weeks LMP (i.e., patients who are not candidates for a medication abortion, assuming it is not contraindicated);
- 8 who are more than 12 weeks LMP, and will soon require a D&E instead of an aspiration abortion to terminate their pregnancy if their abortion is delayed; and
- 3 who are more than 17 weeks LMP, and will soon require a two-day procedure

[26] *Id.*

[27] *Id.*

[28] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 10, 2020), https://www.youtube.com/watch?v=X2v1SIesdyc.

[29] *Id*.

instead of a one-day procedure, and in short order be past Arkansas's legal limit for abortion care.

COVID-19 And The Abortion-Care Recommendations Of Leading Medical Organizations

41. The continuation of abortion care—including surgical abortion care—alongside measures to protect patients and the public in view of COVID-19—is consistent with the recommendations of leading medical organizations. As ACOG and other well-respected medical professional organizations have observed, abortion "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible." ACOG et al., *Joint Statement on Abortion Access During the COVID-19 Outbreak* ("ACOG Statement").[30]

42. The conclusion of these leading health care authorities is that abortion cannot be classified as non-urgent or non-essential care during the COVID-19 outbreak:

> To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, *abortion should not be categorized as such a procedure*. Abortion is an essential component of comprehensive health care. It is also a *time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible*. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.[31]

43. On April 4, 2020, the World Health Organization ("WHO") issued a similar statement concluding that "[a]bortion is considered an essential service during the coronavirus

[30] Ex. 5. *Available at* https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

[31] *Id*.

pandemic" and that "services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak."[32]

44. The American Medical Association ("AMA")—the country's largest medical organization and one of its foremost authorities on medical and public health matters—concurs with this conclusion. The AMA's March 30, 2020 *Statement on Government Interference in Reproductive Health Care* disapproves of efforts "to ban or dramatically limit women's reproductive health care" during the COVID-19 outbreak by "labeling procedures as 'non-urgent.'"[33]

45. The national Ambulatory Surgical Center Association similarly issued guidance on March 19, 2020, which states that consideration of whether delay of a surgery is appropriate must account for the risk to the patient of delay, which in the context of the current pandemic includes "the expectation that a delay of 6-8 weeks or more may be required to emerge" into an environment with less COVID-19 prevalence.[34] A delay of 6-8 weeks (and in many instances a far shorter delay) would prevent many of our patients from obtaining abortions altogether, and would subject others to enhanced medical risk. For example, in the first three months of 2020, LRFP has provided abortion care to approximately 59 patients at and after 16 weeks LMP. A delay of 6 weeks would have pushed all of them past the point when abortion is legal in Arkansas, blocking all of them from being able to obtain an abortion here at all. And there is, of course, as Dr. Smith noted during the April 10, 2020 press conference, no assurance that the COVID-19 Abortion Ban will be lifted within a 6- to 8-week period.

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[32] A summary of the WHO's statement is accessible at https://dailycaller.com/2020/04/04/who-abortion-essential-coronavirus-covid-19/.

[33] Ex. 6.

[34] Ex. 7.

The Effect of the COVID-19 Abortion Ban On LRFP and Its Patients

46. COVID-19 only exacerbates the above-described challenges that women already face in obtaining abortion care in this State. As a result of COVID-19, patients have been laid off work or furloughed, rendering the financial costs of accessing and paying for abortion care even more daunting. Because the outbreak has also led to school closures throughout Arkansas, patients with childcare obligations face even greater obstacles in accessing care. And due to the limited number of persons able to congregate in one place, public transit companies like Ozark have capped the number of people on any bus to 10—i.e., 9 passengers and the driver.[35] Restrictions like these further intensify the struggle of accessing care for all patients.

47. Many women therefore may not be able to make the logistical and financial arrangements necessary to arrive at LRFP for care before 10 weeks LMP and obtain a medication abortion (assuming that the procedure is not contraindicated). Those women will be forced to attempt to travel substantial distances amid a public health crisis to attempt to obtain care. This is no small feat. For example, on Friday, April 10, 2020, LRFP was forced to turn away a surgical abortion patient at 17 weeks LMP. To the best of my knowledge, the next-nearest clinic currently providing care up to 21.6 weeks LMP is in Granite City, Illinois, which is more than 700 miles (roundtrip) from Little Rock, Arkansas. To the best of my knowledge, a clinic in Shreveport, Louisiana (a 420-mile roundtrip drive from Little Rock, Arkansas, and more than 600-miles roundtrip from Fayetteville, Arkansas, where many of our patients live) is continuing to provide care up to 16.6 weeks LMP. I am, however, aware of continuing threats against Louisiana abortion providers, and the clinic may not continue to provide care long

[35] *See* Ozark Regional Transit, *available at* https://www.ozark.org/.

term.[36] Given the substantial distances one must travel from Arkansas to obtain surgical abortion care, some women will be unable to obtain care outside Arkansas at all, and will be forced to carry to term against their will.

48. Without knowing how long the COVID-19 Abortion Ban will last, it is impossible to estimate how many women will lose their ability to abortion care as a result. As stated, women whose pregnancies exceed 21.6 weeks LMP during the ban will necessarily lose their right to access care under Arkansas law. Additionally, women who do not exceed 21.6 weeks LMP during the Ban's pendency may nonetheless lose access to abortion care as a result of a backlog in abortion procedures not performed while the Ban is in place. LRFP's capacity to see surgical abortion patients is approximately 20 to 25 patients per day. Thus, for each day that the COVID-19 Abortion Ban remains in effect, roughly two dozen women that would have otherwise received care are added to an ever-growing "waitlist" that will far exceed LRFP's immediate capacity.

49. Providing pregnant women with immediate access to abortion care is more critical now in the face of this pandemic. Every day that one of our patients remains pregnant, she not only experiences emotional and physical consequences, but also risks contracting the COVID-19 virus, jeopardizing her ability to visit a clinic and receive time-sensitive care. In addition, the longer a woman is forced to remain pregnant—and especially if forced to carry a pregnancy to term—the heavier a burden she becomes on an already threatened healthcare system. Pregnant women need continuing prenatal care consisting of regular hospital visits, medical attention, and increased use of PPE, all of which increase her exposure to COVID-19 and contradict social

[36] Gov. Edwards Confirms Investigation of Louisiana Abortion Clinics For Coronavirus Shutdown Violations (Apr. 9, 2020), *available at* https://www.wwno.org/post/gov-edwards-confirms-investigation-louisiana-abortion-clinics-coronavirus-shutdown-violation.

distancing guidelines. Eventually, these patients will go into labor and give birth, requiring hospital rooms, hospital beds, more attention from medical professionals, and of course, *more* PPE.

50. In short, enforcement of the COVID-19 Abortion Ban would be devastating, with life-altering consequences for the women and families who come to us in a time of need (e.g., forcing a woman to carry an unwanted pregnancy to term). It would also be an untenable situation for the physicians and staff at LRFP, including myself, who are dedicated to providing compassionate and nonjudgmental health care to our patients.

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

Executed this 13th day of April, 2020.

Lori Williams, M.S.N., A.P.R.N.

EXHIBIT 1

LRFP's Precautions and Protocols in Response to COVID-19 Pandemic[1]

LRFP's patients, visitors, and staff are our highest priority. We are working hard to reduce and prevent the spread of COVID-19 and protect the health and safety of our patients and staff by implementing the following protective measures consistent with the recommendations set forth by the CDC, Arkansas Department of Health and other professional medical organizations and public health authorities:

Patient and Staff Screening:

Prior to scheduling an appointment and upon arrival at LRFP, all individuals are asked the following screening questions:

- Do you have a fever (99.5 degrees or greater), cough, shortness of breath, sore throat, nausea, diarrhea, or fatigue not associated with pregnancy?
- Have you been in contact with someone who has these symptoms or has tested positive for COVID-19?
- Have you traveled outside the United States in the last 21 days?

Patients who answer YES to any of the above questions are instructed to return to their car and call the front desk. A member of the LRFP staff will then provide each such patient with individualized instructions based on their needs and circumstances.

Staff are also required to report any contact with an individual known or suspected to have COVID-19, and must immediately report to the MD or APRN if they experience a cough or any combination of symptoms listed above. Any staff member with suspected symptoms will be referred to the University of Akansas for Medical Sciences (UAMS) for screening. If tested, they will not be permitted to work until a negative test is confirmed. If the staff member tests positive, they will not be permitted to return to LRFP until 2 negative tests are confirmed, or at least 72 hours after resolution of symptoms.

[1] The precautions and protocols described herein are not intended to be exhaustive and are consistently changing in order to best respond to the evolving COVID-19 pandemic.

Temperature Check:

Every individual (including staff) entering LRFP must undergo a temperature check upon arrival. If an individual's temperature is confirmed to be greater than 99.5, an MD or APRN will be immediately notified.

Postponement of Services:

We have evaluated the services and procedures offered by LRFP and have postponed any that are not time-sensitive and for which delay would not risk harm to the patient.

Social Distancing:

The CDC recommends that individuals "socially distance" themselves, which is defined as 6 feet distance from other individuals. As a result, patient appointments will be staggered to decrease the number of persons in the clinic and waiting area at any given time. Patients will also be spaced at least 6 feet from one another while seated in the waiting area. In addition, all LRFP staff and healthcare professionals will work efficiently to discharge patients as soon as medically appropriate to shorten the overall time patients spend in our clinic.

Visitor Policy:

LRFP is limiting the visitors/support people that may accompany patients. Only patients will be admitted into the building at this time. Support people may wait outside, sit in their cars, or return home until patients are ready for pickup. Essential support people (e.g., parents of minors) are permitted but must follow "social distancing" practices in the waiting area. Should it become necessary, LRFP may ask patients to wait in their cars until they can be seen by a healthcare professional.

Cleaning and Infection Control:

- Consultation rooms are thoroughly cleaned and disinfected between each patient.
- Bathrooms, waiting areas, and "high-touch" surfaces (door handles, counseling pages, pens, chairs, tables, etc.) are thoroughly cleaned and sanitized frequently.
- Chairs are spread out to ensure patients can appropriately socially distance themselves in the waiting area.

- All books, magazines, toys, and other items regularly displayed in the waiting areas have been removed.
- All persons entering the building are required to hand sanitize.
- Hand sanitizer is accessible to all patients for use while at the clinic and upon departure.
- Patients are encouraged to practice appropriate cough and tissue disposal etiquette.

Preservation of Personal Protective Equipment (PPE):

LRFP is aware of the PPE shortage our healthcare system is currently facing. In order to aid in combatting this shortage, LRFP is committed to using only the PPE that is necessary to protect our patients and staff. LRFP does not utilize the N-95 respirators (masks) that are critical for first responders fighting COVID-19.

We are all in this together. LRFP is in close communication with various agencies and organizations to stay on top of the evolving COVID-19 situation. For more information on how to protect yourself, please visit the CDC website:
https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html

EXHIBIT 2

Arkansas Department of Health

5800 West Tenth St. Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

April 1, 2020

Lori Williams, Administrator
Little Rock Family Planning Services, PLLC
#4 Office Park Drive
Little Rock, AR 72211

RE: Licensure Abortion Clinic Complaint Survey
Conducted 04/01/2020

Dear Ms. Williams:

Little Rock Family Planning Services, PLLC is considered to be in compliance with applicable provisions of the Rules and Regulations for Licensure. We appreciate the cooperation of the facility staff during the survey.

If you have any questions, please call (501) 661-2201.

If we may be of assistance at any time, please call (501) 661-2201.

Sincerely,

Becky Bennett

Becky Bennett, Section Chief
Health Facility Services
Arkansas Department of Health

/LS

EXHIBIT 3

Trent Garner For Senate
@Garner4Senate

I asked the Governor to do this in Arkansas last week. We shouldn't expose women to the risk of the Wuhan COVID-19 virus for an unnecessary elective procedure, and we could save the unborn babies lives. #arpx #arleg #ARNews lifenews.com/2020/03/27/okl…

Oklahoma Gov Orders Abortion Businesses…
Add Oklahoma to the list of states where the governor has made it clear that abortion businesses must stop kiling babies in abortions
lifenews.com

♡ 8 9:28 AM - Mar 29, 2020

See Trent Garner For Senate's other Tweets

EXHIBIT 4

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

April 10, 2020

Little Rock Family Planning
4 Office Park Dr.
Little Rock, AR 72211

RE: Healthcare Facility Complaint Survey
Conducted April 7, 2020

Dear Administrator:

We recently completed an unannounced investigation of your facility following the receipt of a complaint. The investigation was conducted on April 7, 2020, by personnel from Health Facility Services and included a review of medical records and facility staff interviews.

That investigation did not reveal any deficiencies with respect to the rules for abortion facilities in Arkansas.

However, your facility is in violation of the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries. That directive was posted on the ADH's website on April 3, 2020, and a copy was mailed to your facility on Monday, April 6, 2020. The April 3 Directive mandates the postponement of all procedures that are not immediately medically necessary during the COVID-19 emergency. That prohibition applies to surgical abortions that are not immediately necessary to protect the life or health of the patient.

Your facility was found to be performing surgical abortions that are not immediately necessary to protect the life or health of the patient, and your facility is therefore in violation of the April 3 Directive. Your facility is required to postpone such procedures until after the COVID-19 emergency has ended and the April 3 Directive is withdrawn.

Accordingly, your facility is ordered to immediately cease and desist the performance of surgical abortions, except where immediately necessary to protect the life or health of the patient. Any further violations of the April 3 Directive will result in an immediate suspension of your facility's license.

Sincerely,

Becky Bennett

Becky Bennett
Section Chief, Health Facility Services

EXHIBIT 5

Categories

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Medical Education News
Membership and Fellowship
Patient Education
Practice Management
Advocacy and Health Policy
Events and Meetings

Sources

News Releases
President's Blog

Clinical | Mar 18, 2020

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Joint Statement on Abortion Access During the COVID-19 Outbreak

The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, released the following statement:

"As hospital systems, clinics, and communities prepare to meet anticipated increases in demand for the care of people with COVID-19, strategies to mitigate spread of the virus and to maximize health care resources are evolving. Some health systems, at the guidance of the CDC, are implementing plans to cancel elective and non-urgent procedures to expand hospitals' capacity to provide critical care.

"While most abortion care is delivered in outpatient settings, in some cases care may be delivered in hospital-based settings or surgical facilities. To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure. Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.

"The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, do not support COVID-19 responses that cancel or delay abortion procedures. Community-based and hospital-based clinicians should consider collaboration to ensure abortion access is not compromised during this time."

Topics: Coronavirus | COVID-19 | Delivery of health care | Health services accessibility | Induced abortion | Medical societies | Obstetric surgical procedures | Organizations | Virus diseases | Women's health services

Latest Clinical News

ACOG Releases Updated Guidance on Exercise in Pregnancy and Postpartum, Includes Recommendations for Athletes
Mar 26, 2020

Joint Statement on Elective Surgeries
Mar 16, 2020

ACOG Updates on Novel Coronavirus Disease 2019 (COVID-19)
Mar 6, 2020

ACOG Statement on "Virginity Testing"
Nov 7, 2019

View More

EXHIBIT 6

AMA STATEMENTS

AMA statement on government interference in reproductive health care

MAR 30, 2020

Statement attributed To:
Patrice A. Harris, M.D., M.A.
President, American Medical Association

"While many physicians and health care workers are on the front lines in the COVID-19 pandemic, it is unfortunate that elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive health care, labeling procedures as 'non-urgent.'

"The AMA will always defend shared decision making and open conversations between patients and physicians, and fight government intrusion in medical care. At this critical moment and every moment, physicians – not politicians – should be the ones deciding which procedures are urgent-emergent and need to be performed, and which ones can wait, in partnership with our patients."

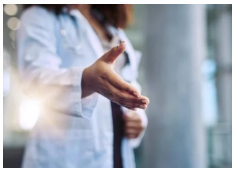
Media Contact:

AMA Media & Editorial
ph: (312) 464-4430
media@ama-assn.org

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises and, driving the future of medicine to tackle the biggest challenges in health care.

AMA Press Center | Coronavirus (COVID-19) | Female Population Care



PHYSICIAN HEALTH

COVID-19 front line: Mount Sinai keeps physician well-being in focus

PUBLIC HEALTH

COVID-19: Rebalancing your staff workload to meet care needs

PHYSICIAN RETIREMENT

Retired doctors hear COVID-19 battle call, look for ways to help

EXHIBIT 7

COVID-19: Guidance for ASCs on Necessary Surgeries

Updated March 19, 2020

In response to government guidance that hospitals and ambulatory surgery centers postpone elective surgeries during the COVID-19 pandemic, the Ambulatory Surgery Center Association (ASCA) has consulted with clinical leaders to solicit recommendations on how and when facilities should proceed with cases that, for clinical reasons, should not be postponed. A surgery may be deemed urgent and necessary if the treating physician decides that a months-long delay would increase the likelihood of significantly worse morbidity or prognosis for the patient.

First and foremost, if a procedure can be safely postponed without additional significant risk to the patient, it should be delayed until after the pandemic. The current and ongoing efforts to isolate our population and create social distancing are essential steps in saving lives by shortening and ultimately ending the COVID-19 pandemic. The health and safety of patients, along with preventing the spread of COVID-19, must be our highest priority. We concur with the American College of Surgeons that “the risk to the patient should include an aggregate assessment of the real risk of proceeding and the real risk of delay, including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent.”

Physicians should engage with patients and families to make care decisions that minimize potential risks to patients while ensuring they receive necessary care that cannot be safely delayed. Physicians should consider the potential of post-surgical complications that could place stress on the local hospital that may lack capacity for transfers. To that end, facilities should reach out to local hospitals to establish a line of communication that ensures coordination in managing care during the pandemic.

In addition, ASCs should develop explicit controls on how to manage the infection risks of all non-patient visitors (patient caregivers, vendors, contractors, etc.) who present themselves inside the facility and should strictly prohibit all non-essential visitors. Additional social distancing policies should be employed.

Examples of cases that might still need to proceed with surgery at this time include:

- Acute infection
- Acute trauma that would significantly worsen without surgery
- Potential malignancy
- Uncontrollable pain that would otherwise require a hospital admission
- A condition where prognosis would significantly worsen with a delay in treatment

Also, ambulatory surgery centers need to be prepared for the possibility that the pandemic may proceed to a point that strains the system such that hospitals will need to shift necessary surgeries to ASCs and/or ASCs and their resources will be required to serve the communities and the healthcare system in a different capacity. Additional guidance from regulatory agencies would govern those situations.

Finally, facilities need to recognize that the pandemic and its impact could create situations when ASCs may need to temporarily suspend services, such as:

- When a patient, staff or physician who has been in the ASC is suspected or subsequently diagnosed with COVID-19
- When there is a significant shortage of PPE (masks, gowns, gloves, etc.) that prevents safe practice of surgical cases

Clearly, this is an evolving situation and the coming days and weeks will present different challenges for healthcare facilities, such as ASCs, to grapple with as the COVID-19 pandemic runs its course. As they occur, the ambulatory surgery community will continue to work with federal, state and local health policy leaders to protect and preserve the health of the public during this crisis.

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES et al., Plaintiffs, v. LESLIE RUTLEDGE, et al., Defendants.	Case No. 4:19-cv-00449-KGB

DECLARATION OF JANET CATHEY, M.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

I, Janet Cathey, M.D., declare the following:

1. I am a board-certified obstetrician-gynecologist licensed to practice medicine in Arkansas and Oklahoma. I currently provide medical services at Planned Parenthood of Arkansas & Eastern Oklahoma, doing business as Planned Parenthood Great Plains' ("PPAEO") health center in Little Rock, Arkansas. A copy of my curriculum vitae is attached as Exhibit A.

2. I submit this Declaration in support of Plaintiffs' Motion for a Temporary Restraining Order and/or Preliminary Injunction against the Arkansas Department of Health's order that surgical abortions in the state end during the COVID-19 emergency, as further described below.

3. I received my Bachelor of Science degree and my Medical Doctor degree from the University of Arkansas. I completed my residency in obstetrics and gynecology ("OBGYN")

and was Chief Resident at the University of Arkansas for Medical Sciences ("UAMS"). My residency included training in abortion care to 23.0 weeks.

4. After my residency, I provided care at my private OBGYN practice in Little Rock. My obstetrics practice included the full range of care for pregnant patients, including prenatal visits and monitoring, as well as delivery. My practice also included miscarriage and abortion care. While in private practice, I maintained full OBGYN surgical privileges. In 2013, I became an assistant professor of obstetrics and gynecology at UAMS. At UAMS, I taught residents in the OBGYN department, including in surgical cases, and maintained my own operative privileges.

5. In early 2018, I was approached by Brandon Hill, the CEO of PPAEO, to provide reproductive health care services at PPAEO's Little Rock health center. I began working at the health center in May 2018.

6. At PPAEO's Little Rock health center, I provide a range of family planning services, transgender care, and medication abortion. I also have extensive administrative responsibilities, including overseeing clinical staff and teaching medical students.

7. I am a Fellow in the American College of Obstetrics and Gynecology ("ACOG") and have a Diplomat certification from the American Board of Obstetrics and Gynecology. I am a member of the Arkansas Medical Society, the Little Rock Gynecology Society, and other professional organizations.

8. The facts and opinions included here are based on my education, training, practical experience, information, and personal knowledge I have obtained as an OBGYN and abortion provider; attendance at medical conferences; continuing medical education; review of

relevant medical literature; and conversations with other medical professionals and my patients. If called and sworn as a witness, I could and would testify competently thereto.

The COVID-19 Abortion Ban

9. My understanding of the events giving rise to this challenge is as follows:

a. On April 3, 2020, the Arkansas Department of Health issued a Directive relating to elective surgery during the COVID-19 pandemic (the "April 3 Directive"). The April 3 Directive states that elective-surgery "[p]rocedures … *that can be safely postponed* shall be rescheduled to an appropriate future date." (Emphasis added.)

b. The next day, by Executive Order 20-13, Governor Asa Hutchinson declared that a violation of a directive from the Secretary of Health "is a misdemeanor offense, and upon conviction thereof is punishable by a fine of not less than one hundred ($100) nor more than five hundred dollars ($500) or by imprisonment not exceeding one (1) month, or both."

c. On April 10, 2020, the Arkansas Department of Health served a cease and desist order on Little Rock Family Planning Services ("LRFP"), the only provider of surgical abortions in Arkansas, requiring LRFP to stop performing surgical abortions, except "where immediately necessary to protect the life or health of the patient" (the "COVID-19 Abortion Ban"). The order specified that LRFP could not resume surgical abortions "until after the COVID-19 emergency has ended and the April 3 Directive is withdrawn." Thus, the state has indefinitely barred surgical abortion care in Arkansas, except "where immediately necessary to protect the life or health of the patient."

10. The April 3 Directive did not include any such categorical treatment of surgical abortions. The April 3 "ADH Directive on Elective Surgeries" allowed "urgent" care to continue, and directed that only procedures "that can be safety postponed shall be rescheduled."

It further explained that where there was a risk of progression of the staging of a condition, surgery could be performed.

11. I have reviewed the COVID-19 Abortion Ban and the April 3 Directive. I have reviewed the Declaration of Lori Williams, M.S.N., A.P.R.N., executed on April 12, 2020. I also continue to stay current with the latest recommendations for health professionals in light of COVID-19 from the Centers for Disease Control, ACOG, and other relevant professional bodies.

12. As I detail below, the COVID-19 Abortion Ban deprives patients of necessary health care that cannot safely be postponed and conflicts with leading medical authorities' statements on appropriate means of combatting COVID-19. The COVID-19 Abortion Ban inflicts serious harms on patients who have nowhere else to turn for this urgent, time-sensitive care. If allowed to remain in effect, the ban will have a severe negative impact on many patients' health and lives, without any countervailing public health benefit.

Overview of Abortion and Pregnancy Facts

13. Legal abortion is one of the safest medical procedures in the United States and is substantially safer than continuing a pregnancy through to childbirth.[1]

14. Complications from abortion are rare, and when they occur they can usually be managed in an outpatient clinic setting, either at the time of the abortion or in a follow-up visit. Major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in less than one-quarter of one percent (0.23%) of all abortion cases: in 0.31% of medication abortion cases, in 0.16% of first-trimester in-clinic abortion cases, and in

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

0.41% of in-clinic cases in the second trimester or later.[2] Abortion-related emergency room visits constitute just 0.01% of all emergency room visits in the United States.[3] The risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion, and every pregnancy-related complication is more common among patients giving birth than among those having abortions.[4]

15. A typical pregnancy is generally 40 weeks in duration. While pregnancy can be a celebratory event for many families, even an uncomplicated pregnancy poses challenges to a woman's entire physiology and stresses most major organs.

16. For example, during pregnancy, a woman's heart rate increases in order to pump 30-50 percent more blood. By the second trimester, the heart is already doing 50 percent more work than usual, and that heightened rate continues throughout the rest of the pregnancy. Because of the increased blood flow, a woman's kidneys become enlarged and the liver must produce more clotting factors to prevent the woman from bleeding to death. However, this latter change increases the risks of blood clots or thrombosis.

17. During pregnancy, a woman's lungs must also work harder to clear both the carbon dioxide produced by her own body and the carbon dioxide produced by the fetus. Yet her very ability to breathe in the first place is hampered by the fetus growing in the woman's abdomen, leaving most pregnant women feeling chronically short of breath. Every organ in the

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[2] Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecol. 175 (2015).

[3] Ushma Upadhyay, et al., *Abortion-related Emergency Room Visits in the United States: An Analysis of a National Emergency Room Sample*, 16:88BMC Med. 1, 1 (2018).

[4] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215 (Feb. 2012).

abdomen—e.g., intestines, liver, spleen—is increasingly compressed throughout pregnancy by her expanding uterus.

18. It is also common for pregnant women to experience gastrointestinal symptoms like nausea and vomiting. In the most severe cases, women can experience hyperemesis gravidarum, which occurs when a woman's nausea and vomiting is so significant that she experiences dehydration. This can require IV rehydration to replace electrolytes and IV administration of nausea medication because the patient cannot keep anything down by mouth.

19. In addition to these physiological symptoms associated with pregnancy, a pregnant woman may also experience complications associated with continuing a pregnancy. Pre-existing conditions, including high blood pressure or hypertension, diabetes or other renal abnormalities, and autoimmune disorders can worsen during pregnancy. Other conditions, such as gestational diabetes, gestational hypertension or pregnancy-induced hypertension, and preeclampsia may arise as a consequence of pregnancy.

20. Pregnancy-induced conditions occur in their most severe form prior to 20 weeks, as measured from the patient's last menstrual period ("LMP"). Women who have had a history of pregnancy-induced conditions such as preeclampsia or gestational diabetes with prior pregnancies are also at higher risk for developing those conditions in subsequent pregnancies, requiring earlier and more frequent prenatal surveillance.

21. Even an uncomplicated pregnancy can unexpectedly become life-threatening during the course of labor and delivery. Furthermore, one-third of pregnancies result in a caesarean section (C-section) delivery. Even though C-section deliveries are relatively common, it is still a significant abdominal surgery that carries risks of hemorrhage, infection and injury to

internal organs. It is not uncommon for a vaginal delivery to result in tears or injuries to the pelvic floor that may require extensive repairs.

22. Arkansas has one of the highest rates of maternal mortality in the country.

23. There is a 15 to 20 percent risk of miscarriage present in every pregnancy. Complications from miscarriage include infection, hemorrhage, and even death. In approximately half of all miscarriages, women will seek medical attention.

24. Abortion is extremely common; approximately one in four women in this country will have an abortion by age forty-five.[5]

25. There are two primary methods of abortion: medication abortion and surgical abortion. Both methods are safe, effective means to terminating a pregnancy.[6] Medication abortion involves a combination of two pills: mifepristone and misoprostol.[7] Patients takes the mifepristone in the clinic and then, typically twenty-four to forty-eight hours later, takes the misoprostol at a location of their choosing, most often at their home, after which they expel the contents of the uterus in a manner similar to a miscarriage. In Arkansas, medication abortion is available up to 70 days or 10.0 weeks LMP.

26. "Surgical" abortion involves no incision and no need for general anesthesia. In the first trimester, surgical abortions are generally performed using suction curettage technique (or aspiration), which involves using a curette connected to a suction apparatus to gently empty the contents of the uterus. This procedure typically takes five to ten minutes. Starting around 14

[5] *See* Guttmacher Inst., Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates (Oct. 19, 2017), https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates.

[6] Luu Doan Ireland et al., *Medical Compared With Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 Obstetrics & Gynecol. 22, 22 (2015).

[7] Nat'l Acads., *supra* note 1, at 51.

weeks LMP, abortions are generally performed using a method called dilation and evacuation ("D&E"), in which clinicians dilate the cervix further and use a combination of suction and instruments to empty the uterus. While still a very safe procedure, D&E is more complex than aspiration abortion, especially as gestation advances, and takes longer than aspiration abortion. In Arkansas, abortions may not be performed at and after 22.0 weeks LMP. A gestational age of 21.6 LMP is the legal limit, except in extremely narrow circumstances.

27. Medication abortion can be contraindicated in patients with certain medical conditions. These conditions include chronic renal failure, liver insufficiency, chronic steroid use, and severe anemia or bleeding disorders that make surgical abortion a more appropriate procedure.

28. In my experience, individuals seek abortion for a multitude of complicated and personal reasons; these reasons are well thought out and patients do not make these decisions lightly.

29. Some patients have abortions because they conclude that it is not the right time to become a parent or have additional children, they desire to pursue their education or career, or they lack the necessary financial resources or a sufficient level of partner or familial support or stability. Other patients seek abortions because of the risks pregnancy poses to their health, especially if their past pregnancies have been high-risk.[8] Other patients seek abortions after

[8] M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the US*, 13:29 BMC Women's Health 1, 7 (2013).

receiving a diagnosis of a serious fetal anomaly, which often occurs near the 21.6 legal limit. Some are in abusive relationships, or are pregnant as a result of rape or sexual assault.

30. While patients generally seek abortion as soon as they are able, many face logistical obstacles that can delay access to abortion care. Some patients may not discover they are pregnant until later in their pregnancies; others may experience difficulties finding a provider and scheduling an appointment. Patients need to gather the resources to pay for the abortion and related costs, arrange transportation to a clinic, arrange for time off of work (which is often unpaid, as many patients lack paid time off or sick leave), and, for the vast majority of women seeking abortions who are mothers already,[9] arrange childcare.[10]

31. Under current Arkansas law, and the State-mandated abortion-delay requirement, women who seek a medication or surgical abortion must visit the clinic to receive an ultrasound and State-mandated options counseling at least 72 hours before the procedure. This means that abortion patients must navigate all of the logistical challenges described above at least twice. These requirements are medically unnecessary. If the State were truly concerned about reducing trips to the clinic during the COVID-19 emergency, it would waive the requirement of a separate trip to the health facility 72 hours before an abortion or allow telemedicine counseling, as providers in other fields do.

32. Arkansas law also requires that an unemancipated minor patient obtain either parental consent or a judicial order excusing them of that requirement before they can receive

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[9] Guttmacher Inst., Induced Abortions in the United States 1 (Sept. 2018), https://www.guttmacher.org/sites/default/files/factsheet/fb_induced_abortion.pdf; *see also* Jenna Jerman et al. , *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. 6, 7 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[10] Jerman et al., *supra* note 8 at 8–10; Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLoS One 1, 7–8, 11 (2016); Lawrence B. Finer et al. , *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 335 (2006).

abortion care. For those that choose to involve a parent, negotiating a time when a parent (who may have work and other obligations) can accompany them to the clinic may delay them from accessing care. And for those who cannot involve a parent, navigating the judicial system in order to obtain the required order waiving Arkansas's consent requirement likewise causes them to delay their abortion.

33. Although abortion is always a very safe medical procedure, the health risks associated with the procedure increase with gestational age.[11] Indeed, the strongest factor associated with abortion-related mortality in the United States is gestational age, with the risk of mortality increasing exponentially with weeks' gestation.

34. While the risk of abortion-related mortality and morbidity is very low, there is no way for a medical provider to predict in advance in which patients those risks will materialize and cause harm. Because, statistically, the risks associated with abortion increase with each week of pregnancy, if a provider were forced to select certain patients to delay, the provider would be needlessly increasing the risks to patients' physical safety. Surgical abortion is a procedure that cannot be safely postponed.

35. Not only does delay increase the medical risks of an abortion and of pregnancy, but it can push patients past the point when a particular abortion method or any legal abortion is available. Delay causes patients to require more complex and more expensive forms of care. Aspiration abortion, for example, is available only to approximately 14 weeks LMP. After that, the only procedure available is D&E. D&E, similarly, extends from a one-day to a two-day procedure as gestational age increases. After 21.6 LMP, abortion is no longer available in

[11] Nat'l Acads., *supra* note 1, at 77–78, 162–63.

Arkansas, except if necessary to avert the patient's death or substantial and irreversible physical impairment of a major bodily function.

36. If surgical abortion is not available to patients in Arkansas, they have only three possible options: (1) travel hundreds of miles to try to obtain one in another state, (2) resort to unsafe methods outside the medical system, which increases the risk they will need emergency room or operating room care, or (3) carry the pregnancy to term against their wishes. As I discuss in more detail below, for many patients—and particularly during the COVID-19 pandemic—the only real-world option will be continuing the pregnancy and bearing a child.

Abortion During the COVID-19 Pandemic

37. ACOG, the leading authority in the United States for OBGYN medical practice, along with other well-respected medical professional organizations, has recently emphasized that abortion is urgent care.[12] The conclusion of these leading health care authorities is that abortion cannot be classified as non-urgent or non-essential care and suspended during the COVID-19 outbreak. These authorities have made clear that:

> To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, *abortion should not be categorized as such a procedure*. Abortion is an essential component of comprehensive health care. It is also a *time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible*. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.[13]

38. On April 4, 2020, the World Health Organization ("WHO") issued a similar statement concluding that "[a]bortion is considered an essential service during the coronavirus

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

[13] *Id*. (emphasis added).

pandemic" and that "services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak."[14]

39. The American Medical Association ("AMA")—the country's largest medical organization and one of its foremost authorities on medical and public health matters—concurs with this conclusion. The AMA's March 30, 2020 *Statement on Government Interference in Reproductive Health Care* disapproves of efforts "to ban or dramatically limit women's reproductive health care" during the COVID-19 outbreak by "labeling procedures as 'non-urgent.'"[15]

40. Prior to imposing the COVID-19 Abortion Ban, Defendant Dr. Nathaniel Smith, in press conference statements, and the Arkansas Department of Health recognized that it should be medical providers who exercised their professional judgment and determined whether a procedure was "urgent" and not "safely postponed" during the COVID-19 pandemic. But the COVID-19 Abortion Ban harmfully takes away providers' ability to exercise that professional judgment for the benefit of Arkansas patients, and instead imposes a blanket rule that directly contravenes the uniform position of authoritative medical experts.

41. Denying patients surgical abortions here during the COVID-19 emergency not only conflicts with the leading medical authorities' directives and bans essential, time-sensitive patient care. It also disserves Arkansas' professed interests in conserving Personal Protective Equipment ("PPE"), reducing demands on the medical system, and diminishing in-person contact and travel.

[14] A summary of the WHO's statement is accessible at https://dailycaller.com/2020/04/04/who-abortion-essential-coronavirus-covid-19/.
[15] *Available at* https://www.ama-assn.org/press-center/ama-statements/ama-statement-government-interference-reproductive-health-care.

42. In fact, the next-nearest options for Arkansas woman to currently obtain surgical abortion care are in Shreveport, Louisiana (only up to 16.6 weeks LMP), Granite City, Illinois, and Santa Fe, New Mexico. These clinics are hundreds of miles away, and involve travel to and through states that have reported substantially higher rates of COVID-19 infection than Arkansas.

43. Abortion requires far less PPE and medical attention than continuing a pregnancy.

Pregnancy Care During the COVID-19 Pandemic

44. An uncomplicated pregnancy typically requires a minimum of one prenatal appointment per month, along with additional appointments to complete laboratory tests and ultrasounds. For a complicated or high-risk pregnancy, the number of visits frequently doubles. Each separate encounter with a health care provider, especially during the COVID-19 pandemic, requires the use of gloves, a face mask, and often other forms of PPE.

45. In addition, ACOG and the Society for Maternal Fetal Medicine have developed an algorithm for clinicians' assessment and management of pregnant women who may have or are confirmed to have COVID-19. Appropriate care of these pregnant patients will further increase the number of interactions the patient has with the health care system, as well as increase the use of PPE.

46. The algorithm identifies common symptoms of COVID-19 as a fever of over 100.4°F and a cough, difficulty breathing, or shortness of breath and gastrointestinal symptoms. *Id.* If a pregnant patient presents with *any one* of the symptoms, such as difficulty breathing, then the algorithm instructs the provider to conduct an illness-severity assessment. The severity assessment requires the provider to answer a number of questions, including (1) "does [the patient] have difficulty breathing or shortness of breath?" and (2) "is she unable to keep fluids

down?" While potential COVID-19 symptoms include difficulty breathing, shortness of breath, inability to keep fluids down, and dehydration, they are also common symptoms among all pregnant women.

47. If the provider answers yes to any of the questions, the algorithm considers the patient to be at "elevated risk" and recommends that the patient immediately seek care in the emergency department or an equivalent unit that treats pregnant women, with attendant use of PPE. It recommends that, when possible, the patient be sent to a location where she can be isolated and adhere to local infection control practices, again involving PPE.

48. Comorbidities such as asthma, HIV, diabetes, hypertension, heart disease, and kidney disease are common in Arkansas, and if the pregnant patient has these conditions they are considered to have moderate COVID-19 risk and should also be isolated, with further medical testing as indicated, which may result in hospital admission.

49. Furthermore, virtually all births in Arkansas occur in hospitals. A pregnant patient may present at a hospital multiple times prior to labor for evaluation. Each time a pregnant patient presents at the hospital for evaluation prior to labor, the patient will be interacting in person with hospital staff. Each time a pregnant patient presents at the hospital for evaluation prior to labor, PPE will be used to provide her with care.

50. An uncomplicated birth is attended by at least 4 medical care providers, including but not limited to nursery nurse, a labor and delivery nurse, an OB tech, and a physician. Each of these medical providers uses PPE. The physician utilizes gloves every time she comes into the room to examine the patient, and she usually examines the patient every few hours as the course of her labor progresses. This means a physician could use a significant amount of PPE simply preparing for delivery. During delivery, the physician would have on a gown, shoe

covers, gloves, face mask, and eye wear. The OB tech and labor and delivery nurse will both have on a mask, eyewear and gloves. And the nursery nurse usually has one a gown, eyewear, gloves and a mask, because she is going to receive the baby.

51. A complicated birth is attended by 6-7 medical care providers, including at least two additional people from the ICU or NICU, who are available at the time of delivery to resuscitate the baby if needed, and the anesthesia personnel if the patient requires anything for pain control (*i.e.*, an epidural) during her labor course, which approximately 85% of patients receive. A complicated birth will involve the use of more PPE than an uncomplicated birth, because there will be additional personnel in the room.

52. For an uncomplicated vaginal birth, a patient is admitted to the hospital for at least 24-48 hours in Arkansas. For the one-third of deliveries involving a C-section delivery, the patient remains in the hospital for 48-72 hours. A C-section delivery, a significant abdominal surgery, requires extensive PPE.

53. If complications arise during birth, a patient may be required to stay in the hospital for longer than 72 hours.

54. A pregnant patient's stay in a hospital requires the use of a hospital bed or room, the time and attention of hospital staff, and PPE throughout the stay.

55. There is no medical justification for the assertion that stopping surgical abortions will minimize COVID-19 transmission or preserve medical resources including PPE. The essential fact is that being forced to continue a pregnancy involves a continuing need for medical care. If patients in Arkansas are denied surgical abortions, those additional continuing pregnancies here will involve ongoing interactions with medical providers, offices, laboratories, and hospitals, and an ongoing drain on Arkansas's supplies of PPE. Travel to and from the

pregnant patients' various appointments and visits to hospitals will occur far more frequently than the 2-3 short visits to a single clinic that would be involved in obtaining a surgical abortion, increasing in-person interactions not only with medical staff but also with non-medical health facility staff and others.

The Patient Harms Caused by Arkansas' COVID-19 Abortion Ban

56. The pregnant patients affected by the COVID-19 Abortion Ban will suffer the most direct and devastating harms.

57. The COVID-19 Abortion Ban denies patients access to essential, urgent medical care.

58. It applies without any end date and throughout the COVID-19 emergency. The spread of COVID-19 has not yet peaked in Arkansas or in the United States generally, and thus is expected to continue for months. The Governor of Arkansas, for example, has cancelled school attendance for the remainder of the school year, which ends in June.

59. This indefinite ban means that patients now seeking surgical abortion in Arkansas must assume that it will not be available to them at all prior to Arkansas's 21.6 weeks LMP cutoff. For many Arkansas abortion patients, who disproportionately have limited economic resources, travel to obtain an abortion in another state is beyond their financial and practical reach.

60. The abortion patients we see in Arkansas often do not have access to reliable transportation, ready childcare for their existing children, or the greater financial resources required for out-of-state travel plus a more expensive later abortion. To the extent they are employed, it is often in a situation without an entitlement to time off or paid sick leave.

61. The logistical challenges in attempting to travel out of state to seek a surgical abortion elsewhere have greatly increased with the COVID-19 pandemic. Layoffs and work disruptions have further reduced patients' financial resources; shuttered schools and childcare facilities, along with social distancing imperatives, have made arranging childcare even more difficult; and transportation options are much more limited. Sheltering in place has made it even more difficult to leave the home without the knowledge and approval of family members, especially for minors and patients suffering from domestic violence.

62. To the extent that a few patients can attempt to travel hundreds of miles out of state and obtain abortion care elsewhere, that travel will involve additional in-person contacts and risks of contracting COVID-19 for the patients, those with whom they interact en route, and those back home in Arkansas. As gestational age advances, however, even those who reach another state's abortion provider may have to be turned away, if that state's gestational limit has been reached or there are no appointments available in time.

63. Because of all these realities, the COVID-19 Abortion Ban will leave most surgical abortion patients with no choice but to continue their pregnancies against their will in Arkansas. I have seen the devastating impact on patients who fail to secure the abortion they seek and instead find themselves with an unplanned pregnancy they are forced to continue.

64. Studies have shown that patients who are denied a wanted abortion (in contrast to those able to obtain abortion care) face serious consequences, including greater likelihood of living in poverty, staying in abusive relationships, and experiencing mental health issues.[16] They and their newborns are also at risk of negative health consequences such as lower breastfeeding

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

rates and poor maternal and neonatal outcomes.[17] Additionally, patients who seek abortion care but are unable to access that care, therefore carrying to term and adding a child to their families, face large and persistent negative consequences for their financial well-being, as compared to their counterparts who received wanted abortions.[18]

65. As I have described above, forcing an abortion patient to instead continue the pregnancy exposes that patient to vastly more health risks, including an increased risk of serious morbidity and of death. It requires the patient to experience the advancing pregnancy and child birth, and to adjust to an altered medical and psychologic reality thrust upon them. These serious personal consequences are amplified by the COVID-19 pandemic, which adds other medical risks and anxiety for patients suddenly forced to have ongoing, unplanned contact with health care providers.

66. Forcing a patient to carry an unwanted pregnancy to term will not only increase the risks to their health and well-being, but will also increase the duration and frequency of their interactions with medical clinicians and the amount of PPE expended on their care. That directly contravenes public health officials' objectives of further reducing transmission of COVID-19 and the current strain on the medical system.

67. My experience has shown that a few patients may try to self-induce an abortion or to use untested "solutions" offered outside established medicine, exposing themselves to added, unknown health risks. These attempts at self-induction may lead to patients to then need

[17] A.P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 Obstetrics & Gynecology 678 (2007); Jessica D. Gipson, Michael A. Koenig & Michelle J. Hindin, *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 Stud. Fam. Plan. 18 (2008).
[18] Sarah Miller, Laura R. Wherry & Diana Greene Foster, Nat'l Bureau of Econ. Res. (NBER), NBER Working Paper No. 26662, *The Economic Consequences of Being Denied an Abortion* 26 (Jan. 2020), *available at* https://www.nber.org/papers/w26662.pdf (Finding that the impact of being denied an abortion on unpaid bills being reported to collection agencies is as large as the effect of being evicted, and "the impact on unpaid bills is several times larger than the effect of losing health insurance.").

emergency medical care. Likewise, if pregnant patients denied abortions suffer miscarriage as the pregnancy continues, that too will often lead to the patient seeking medical care as I explained above. Again, it will call on the resources of the medical system, including PPE.

68. Even if the COVID-19 emergency ends sooner than expected, and some surgical abortion patients experience only weeks of delay in obtaining care, rather than final denial, those patients will have suffered greatly increased health risks during the period of forced pregnancy[19] and much added psychological distress from the uncertainty the COVID-19 Abortion Ban visited upon them.

69. These pregnant patients may also suffer heightened emotional distress or anxiety as a result of this public health crisis, which has put extreme pressure on hospitals; they may be concerned that if they face issues with their pregnancy, a hospital may struggle to accommodate them or that (by virtue of repeatedly needing medical care) they may be at added risk of exposure to COVID-19.

70. In addition, patients' delayed, later abortion care will itself carry more risks. Any such delayed abortion care is also likely to come very close to the 21.6 LMP limit, and therefore involve two-day rather than one-day D&E procedures, again using more PPE and involving more health care visits than would have occurred without the COVID-19 Abortion Ban. With all patients being denied surgical abortions throughout the COVID-19 emergency, moreover, to the extent the ban is lifted in time for some denied now to still gain care, there will be a crush of need and capacity issues at LRFP, the lone provider of surgical abortion care in the Arkansas.

71. In sum, the COVID-19 Abortion Ban, if allowed to continue in effect, will impose extreme and irreparable harm on Arkansas's surgical abortion patients. It will single those

[19] Nat'l Acads., *supra* note 1, at 77–78.

patients out for this extreme harm despite the fact that doing so exacerbates the challenges of responding to COVID-19, and does not effectively aid in responding to the pandemic in Arkansas. Using the COVID-19 crisis as a justification for banning surgical abortions is a cruel and counterproductive strategy that does a profound disservice to the patients and public health needs in this state.

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

Executed this 12th day of April, 2020.

s/ Janet Cathey, M.D.
Janet Cathey, M.D.

EXHIBIT A

CURRICULUM VITAE
JANET RILEY CATHEY, M.D. ABOG, FACOG

[redacted]

EDUCATION

University of Arkansas- Fayetteville 1975-1978
Bachelor of Science in Zoology - 1978
PHI-BETA-KAPPA
University of Arkansas for Medical Sciences 1978-1982
Medical Doctor - 1982
University of Arkansas Medical Sciences Resident in Obstetrics/Gynecology - 1982-1986
UPJOHN Award for Outstanding Chief Resident

BOARD CERTIFICATION

Diplomat American Board of Obstetrics and Gynecology
Written Boards 1986
Oral Boards 1988
Recertification 1998 & 2008
Maintenance of Board Certification- 2009-2019
Multiple CME courses and hours
(Over 80/ year, available upon request)

PROFESSIONAL MEMBERSHIPS:

Fellow American College of Obstetrics and Gynecology
Diplomat American Board of Obstetrics and Gynecology
American Medical Association
Arkansas State Medical Society
Pulaski County Medical Society
Little Rock Gynecology Society

LICENSURE:

FLEX Exam 1978 (passed on first sitting)
Arkansas C-6132. (active, unrestricted)
Issued February 14, 1982 - Expiration Nov 2019

DEA:

BC0401947, Expiration August 2020, Unrestricted.

WORK EXPERIENCE

Private Practice Obstetrics and Gynecology 1986-1993
2001 Pershing, North Little Rock, Arkansas
Affiliated with Stephen Marks, M.D. and Phillip Alston, M.D.
Maintained privileges at Memorial Hospital (Baptist Springhill) -North Little Rock
Full obstetrics and gynecology surgical privileges

Private Practice Obstetrics and Gyncology – Little Rock Gynecology 1993-2009
9501 Baptist Health Drive, Little Rock, Arkansas
Affiliated with Karen Kozlowski, M.D.
Maintained privileges at Baptist Health Medical Center – Little Rock, Arkansas
Maintained privileges at St. Vincent's Infirmary Medical Center, LR, AR
Maintained privileges at Little Rock Surgical Center- Little Rock, Arkansas
Full obstetrics and gynecology surgical privileges at all named hospitals

Employment Gap 2009-2012
In August 2009 I sustained a spinal cord injury in a motor vehicle accident. Initially, with an incomplete paraplegia I retired from private practice and was granted full disability benefits. I had intensive physical therapy over the next 2 years regained the ability to walk. I now walk with bilateral AFOs. My disability does not limit me in my current scope of practice.

Arkansas Department of Social Security – Department of Disability Services. 2012-2018
701 Pulaski Street, Little Rock AR, 72201
Currently - Medical Consultant (Contract Labor -Disability Reviews)

University of Arkansas Medical Sciences Dept Obstetrics and Gynecology 2013-2018
4301 W. Markham, Slot 518, Little Rock, AR. 72201
Asst Professor of Ob-Gyn, August 1, 2013 – March 31, 2018
Full core gynecology operative privileges – University Hospital

- Teaching Faculty - Resident Gynecology Clinic / Surgical Cases
- Gender Clinic Founder & Director 2014 to 2018
- Teaching/Mentoring – M2/M3/M4 Medical Students

Teaching Awards

- 2013 – Red Sash Award
- 2014 – Golden Apple Award
- 2015 – Red Sash Award
- 2016 – Red Sash Award
  Department Resident Teaching Award and Medical Student Teaching Award
- 2017 - Red Sash Award
  Department Medical Student Teaching Award
- 2018 - Red Sash Award
- **2**016 – Diversity Inclusion Award nomination

Planned Parenthood Great Plains – Little Rock 2018 (Current)
5921 W. 12th Suite C, Little Rock, AR 72204
Director of Gender Health and Education
General family planning and reproductive health clinic

EXHIBIT 4

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

March 21, 2020

In view of the uncertainty and increase in cases of COVID -19 there are increasing concerns of hospital beds availability as well as staff capabilities in hospitals statewide. For this reason, the Arkansas Department of Health is recommending that elective surgery be postponed statewide. The Centers for Disease Control and Prevention (CDC) recommends that healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment (PPE), and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic.

- Procedures, testing, and office visits that can be safely postponed should be rescheduled to an appropriate future date.
- Routine dental and eyecare visits should be postponed.
- Emergent, urgent and time-sensitive care will continue.

Small rural hospitals under 60 beds and critical access hospitals, though strongly advised to follow this guidance to maximize resources, are excluded from this guidance.

Exceptions to this guidance should be made in the following circumstances:

- If there is a threat to the patient's life if the procedure is not performed.
- If there is a threat of permanent dysfunction of an extremity or organ system if the surgery is not done.
- If there is a risk of metastasis or progression of staging of a disease or condition if surgery is not performed.
- If there is a risk that the patient's condition will rapidly deteriorate if surgery is not done, and there is a threat to life, or to an extremity or organ system, or of permanent dysfunction or disability.

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

EXHIBIT 5

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

March 30, 2020

Greetings and thank you for helping the Arkansas Department of Health in our efforts to flatten the COVID-19 curve. In just 19 days, Arkansas has identified 449 positive patients, with 43 currently hospitalized, 16 on ventilators, and 384 health care staff furloughed due to COVID exposure.

We help preserve the health of citizens and our healthcare infrastructure by working in unison to minimize the opportunity for spread.

The Centers for Disease Control and Prevention (CDC) and the Arkansas Department of Health recommends that healthcare facilities and clinicians prioritize urgent and emergency visits and procedures now and for the coming several weeks

Below is the agency guidance intended to provide you with the answers on how your organization should adjust. This may also be found on the agency website at this link https://www.healthy.arkansas.gov/images/uploads/pdf/Elective_Surgery_Guidance_3.21.20final.pdf

March 21, 2020

In view of the uncertainty and increase in cases of COVID-19 there are increasing concerns of hospital bed availability as well as staff capabilities in hospitals statewide. For this reason, the Arkansas Department of Health is recommending that elective surgery be postponed statewide. The Centers for Disease Control and Prevention (CDC) recommends that healthcare facilities and clinicians prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment (PPE), and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic.

- Procedures, testing, and office visits that can be safely postponed should be rescheduled to an appropriate future date.
- Routine dental and eyecare visits should be postponed.
- Emergent, urgent and time-sensitive care will continue.
- Small rural hospitals under 60 beds and critical access hospitals, though strongly advised to follow this guidance to maximize resources, are excluded from this guidance.

Exceptions to this guidance should be made in the following circumstances:

- If there is a threat to the patient's life if the procedure is not performed.
- If there is a threat of permanent dysfunction of an extremity or organ system if the surgery is not done.
- If there is a risk of metastasis or progression of staging of a disease or condition if surgery is not performed.
- If there is a risk that the patient's condition will rapidly deteriorate if surgery is not done, and there is a threat to life or an extremity or organ system or a threat of permanent dysfunction or disability.

https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

EXHIBIT 6

LRFP's Precautions and Protocols in Response to COVID-19 Pandemic[1]

LRFP's patients, visitors, and staff are our highest priority. We are working hard to reduce and prevent the spread of COVID-19 and protect the health and safety of our patients and staff by implementing the following protective measures consistent with the recommendations set forth by the CDC, Arkansas Department of Health and other professional medical organizations and public health authorities:

Patient and Staff Screening:

Prior to scheduling an appointment and upon arrival at LRFP, all individuals are asked the following screening questions:

- Do you have a fever (99.5 degrees or greater), cough, shortness of breath, sore throat, nausea, diarrhea, or fatigue not associated with pregnancy?
- Have you been in contact with someone who has these symptoms or has tested positive for COVID-19?
- Have you traveled outside the United States in the last 21 days?

Patients who answer YES to any of the above questions are instructed to return to their car and call the front desk. A member of the LRFP staff will then provide each such patient with individualized instructions based on their needs and circumstances.

Staff are also required to report any contact with an individual known or suspected to have COVID-19, and must immediately report to the MD or APRN if they experience a cough or any combination of symptoms listed above. Any staff member with suspected symptoms will be referred to the University of Akansas for Medical Sciences (UAMS) for screening. If tested, they will not be permitted to work until a negative test is confirmed. If the staff member tests positive, they will not be permitted to return to LRFP until 2 negative tests are confirmed, or at least 72 hours after resolution of symptoms.

[1] The precautions and protocols described herein are not intended to be exhaustive and are consistently changing in order to best respond to the evolving COVID-19 pandemic.

Temperature Check:

Every individual (including staff) entering LRFP must undergo a temperature check upon arrival. If an individual's temperature is confirmed to be greater than 99.5, an MD or APRN will be immediately notified.

Postponement of Services:

We have evaluated the services and procedures offered by LRFP and have postponed any that are not time-sensitive and for which delay would not risk harm to the patient.

Social Distancing:

The CDC recommends that individuals "socially distance" themselves, which is defined as 6 feet distance from other individuals. As a result, patient appointments will be staggered to decrease the number of persons in the clinic and waiting area at any given time. Patients will also be spaced at least 6 feet from one another while seated in the waiting area. In addition, all LRFP staff and healthcare professionals will work efficiently to discharge patients as soon as medically appropriate to shorten the overall time patients spend in our clinic.

Visitor Policy:

LRFP is limiting the visitors/support people that may accompany patients. Only patients will be admitted into the building at this time. Support people may wait outside, sit in their cars, or return home until patients are ready for pickup. Essential support people (e.g., parents of minors) are permitted but must follow "social distancing" practices in the waiting area. Should it become necessary, LRFP may ask patients to wait in their cars until they can be seen by a healthcare professional.

Cleaning and Infection Control:

- Consultation rooms are thoroughly cleaned and disinfected between each patient.
- Bathrooms, waiting areas, and "high-touch" surfaces (door handles, counseling pages, pens, chairs, tables, etc.) are thoroughly cleaned and sanitized frequently.
- Chairs are spread out to ensure patients can appropriately socially distance themselves in the waiting area.

- All books, magazines, toys, and other items regularly displayed in the waiting areas have been removed.
- All persons entering the building are required to hand sanitize.
- Hand sanitizer is accessible to all patients for use while at the clinic and upon departure.
- Patients are encouraged to practice appropriate cough and tissue disposal etiquette.

Preservation of Personal Protective Equipment (PPE):

LRFP is aware of the PPE shortage our healthcare system is currently facing. In order to aid in combatting this shortage, LRFP is committed to using only the PPE that is necessary to protect our patients and staff. LRFP does not utilize the N-95 respirators (masks) that are critical for first responders fighting COVID-19.

We are all in this together. LRFP is in close communication with various agencies and organizations to stay on top of the evolving COVID-19 situation. For more information on how to protect yourself, please visit the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html

EXHIBIT 7

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

April 3, 2020
ADH Directive on Elective Surgeries

The Secretary of Health, in consultation with the Governor, has sole authority over all instances of quarantine, isolation, and restrictions on commerce and travel throughout Arkansas, as necessary and appropriate to control disease in the state of Arkansas as authorized by Ark. Code Ann. §20-7-109--110. Based on available scientific evidence, it is necessary and appropriate to take further action to ensure that COVID-19 remains controlled and that residents and visitors in Arkansas remain safe.

Throughout February and March of 2020, the Centers for Disease Control and Prevention (CDC) and the Arkansas Department of Health (ADH) recommended that healthcare facilities and clinicians prioritize urgent and emergency visits and procedures for the coming several weeks. Please see CDC Health Care Facilities Guidance and ADH Health Facilities Guidance.

On March 30, 2020, a guidance letter was sent to all health facilities, including ambulatory surgery centers and abortion facilities. Please see ADH Guidance Letter. In view of the continued uncertainty and increase in cases of COVID-19, there are increasing concerns of staff and medical supplies capabilities in hospitals statewide. The following mandatory actions can preserve staff, personal protective equipment (PPE), and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic.

- Procedures, testing, and office visits that can be safely postponed shall be rescheduled to an appropriate future date.
- Routine dental and eye care visits shall be postponed.
- Emergent, urgent and care designated as an exception below will continue.
- Small rural hospitals under 60 beds and critical access hospitals, though strongly advised to follow this directive to maximize resources, are excluded from this directive.

Exceptions to this directive should be made in the following circumstances:

- If there is a threat to the patient's life if the procedure is not performed.
- If there is a threat of permanent dysfunction of an extremity or organ system if the surgery is not done.
- If there is a risk of metastasis or progression of staging of a disease or condition if surgery is not performed.
- If there is a risk that the patient's condition will rapidly deteriorate if surgery is not done, and there is a threat to life or an extremity or organ system or a threat of permanent dysfunction or disability.

EXHIBIT 8

Trent Garner For Senate
@Garner4Senate

I asked the Governor to do this in Arkansas last week. We shouldn't expose women to the risk of the Wuhan COVID-19 virus for an unnecessary elective procedure, and we could save the unborn babies lives. #arpx #arleg #ARNews lifenews.com/2020/03/27/okl…

Oklahoma Gov Orders Abortion Businesses…
Add Oklahoma to the list of states where the governor has made it clear that abortion businesses must stop kiling babies in abortions
lifenews.com

♡ 8 9:28 AM - Mar 29, 2020

See Trent Garner For Senate's other Tweets

EXHIBIT 9

Arkansas schools closed for rest of year due to coronavirus

Andrew Demillo, Associated Press Updated 5:38 pm PDT, Monday, April 6, 2020

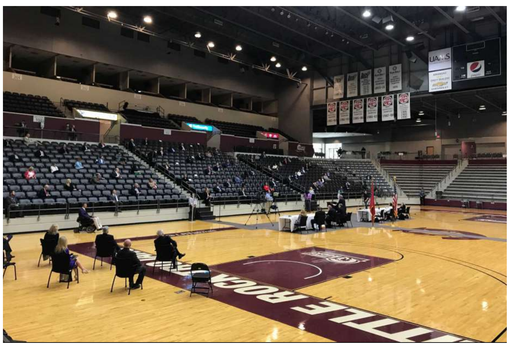


Photo: Andrew Demillo, AP

FILE - In this Thursday, March 26, 2020 file photo, Members of the Arkansas House convene at the Jack Stephens Center in Little Rock, Ark., for a special session focused on a state budget shortfall. Arkansas lawmakers will meet as planned for this year's legislative session amid the coronavirus outbreak, legislative leaders said Friday, April 3, 2020 following two members testing positive for the virus.

LITTLE ROCK, Ark. (AP) — Arkansas' public schools will remain closed for the rest of the academic year due to the coronavirus pandemic, Gov. Asa Hutchinson announced Monday, as a third lawmaker tested positive for the virus.

Health officials said the number of infections in Arkansas rose to at least 927, up from 853 on Sunday. Sixteen people in the state have died from COVID-19, the illness caused by the virus.

SCHOOLS CLOSED

Hutchinson said there will be no more on-site instruction this year at public schools, which he had ordered closed until April 17 because of the virus.

The governor said schools will continue to provide at-home instruction for students, including online lessons. Arkansas PBS has been broadcasting lessons for students in kindergarten through 8th grade.

"I know this is a hardship, but I think the teachers, parents and everyone is prepared for this," Hutchinson said.

THIRD LAWMAKER TESTS POSITIVE

A third state representative said he tested positive for the coronavirus, days before the Legislature is set to meet for this year's session.

Rep. Les Warren said his physician told him his positive test result on Sunday. He was self-isolating at home.

For most people, the coronavirus causes mild or moderate symptoms, such as fever and cough that clear up in two to three weeks. For some, especially older adults and people with existing health problems, it can cause more severe illness, including pneumonia.

The Legislature is set to convene Wednesday for this year's fiscal session, with the House planning to meet in the same 5,600-seat basketball arena they used for a special session last month. The Senate will meet at the Capitol, but is restricting how many members will be in the chamber.

Warren said he would vote by proxy.

ELECTIVE SURGERIES ORDER

The state's top health official stopped short of saying whether a prohibition on elective procedures would halt abortions.

The Health Department on Friday issued a directive to all health providers, including abortion clinics, to reschedule procedures "that can be safely postponed." Other states have moved to ban abortions using similar orders.

"Anything that can safely be deferred and postponed should be," said Dr. Nathaniel Smith, the state's health secretary. Smith said the order is not intended to replace a physician's judgment.

An attorney for Little Rock Family Planning Services, the only clinic that performs surgical abortions in the state, said in a statement that it was complying with the directive but didn't elaborate on whether it was still offering the procedure.

Planned Parenthood, which administers abortion-inducing medication at its Little Rock facility, said it was following Department of Health guidance.

"Our doors are open, and we are continuing to see patients at our health center for necessary care, with appropriate screening precautions in place," Planned Parenthood Great Plains CEO Brandon Hill said in a statement.

CHINA OFFICE FUNDING TARGETED

An Arkansas lawmaker on Monday proposed ending the state's economic development efforts in China in response to the pandemic, a move the governor called "shortsighted."

The proposed amendment to the state Economic Development Commission's budget would prevent the agency from spending money on a liaison or office in China.

"It shows a clear message our government is going to change our relationship with China," said Garner, who cited China's initial cover-up of the outbreak.

The commission has had an office in China since 2008 and this year has spent about $285,000 on it. But the commission's spokeswoman, Alisha Curtis, said the agency already planned to scale that back by about $160,000 in the coming fiscal year to a liaison that will focus on existing Chinese business in Arkansas.

"Even though we might not have a physical office, we've got to have a presence there and be able to facilitate that relationship from a commerce standpoint in the future," Hutchinson said.

—

Check out more of the AP's coronavirus coverage at https://apnews.com/VirusOutbreak and https://apnews.com/UnderstandingtheOutbreak

EXHIBIT 10

Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Secretary of Health

To: Arkansas Dentists
From: Dr. Nate Smith, Secretary of Health
Date: March 23, 2020
Regarding: Directive to Dentists to suspend non-emergent dental care

The Secretary of Health, in consultation with the Governor, has sole authority over all instances of quarantine, isolation, and restrictions on commerce and travel throughout Arkansas, as necessary and appropriate to control disease in the state of Arkansas as authorized by Ark. Code Ann. §20-7-109—110. Based on available scientific evidence, it is necessary and appropriate to take further action to ensure that COVID-19 remains controlled and that residents and visitors in Arkansas remain safe.

The Secretary of Health, as of March 23, 2020, directs and mandates that all dental practitioners follow the recommendation of the Arkansas State Board of Dental Examiners and the American Dental Association that only urgent and emergent dental care take place, and that **non-emergent dental care be suspended** until further notice. This directive and mandate is subject to change as the COVID-19 pandemic progresses.

Urgent dental care treatments, which should be treated as minimally invasively as possible, include the following:

- Severe dental pain from pulpal inflammation.
- Pericoronitis or third-molar pain.
- Surgical postoperative osteitis or dry socket dressing changes.
- Abscess or localized bacterial infection resulting in localized pain and swelling.
- Tooth fracture resulting in pain or causing soft tissue trauma.
- Dental trauma with avulsion/luxation.
- Dental treatment cementation if the temporary restoration is lost, broken or causing gingival irritation.

Other emergency dental care includes extensive caries or defective restorations causing pain; suture removal; denture adjustments on radiation/oncology patients; denture adjustments or repairs when function impeded; replacing temporary filling on endo access openings in patients experiencing pain; and snipping or adjustments of an orthodontic wire or appliances piercing or ulcerating the oral mucosa.

EXHIBIT 11

STATE OF ARKANSAS
EXECUTIVE DEPARTMENT

PROCLAMATION

TO ALL TO WHOM THESE PRESENTS COME – GREETINGS: EO 20-05

EXECUTIVE ORDER TO AMEND EXECUTIVE ORDER 20-03 REGARDING THE PUBLIC HEALTH EMERGENCY CONCERNING COVID-19 FOR THE PURPOSE OF ENCOURAGING TREATMENT AND COMMUNICATION BY TECHNOLOGY.

WHEREAS: An outbreak of coronavirus disease 2019 (COVID-19) has spread throughout China and to 59 other countries and territories, including the United States; and

WHEREAS: COVID-19 has been detected within the State of Arkansas and adjoining states, threatening the public safety of the citizens of Arkansas; and

WHEREAS: Great hardship has been brought to bear upon the citizens this state as a result of the spread of COVID-19; and

WHEREAS: On March 11, 2020, by Executive Order 20-03, an emergency was declared in the state as a result of COVID-19, and that emergency is on-going; and

WHEREAS: Citizens of the state have been advised to take precautions to prevent the spread of COVID-19, including the advisement to minimize person to person contact, avoid large gatherings, and to stay home if they feel ill; and

WHEREAS: Citizens heeding this advice need access to the care of physicians and other mental health professionals;

NOW, THEREFORE, I, Asa Hutchinson, Governor of the State of Arkansas, acting under the authority vested in me by Ark. Code Ann. §§ 12-75-101, *et seq.*, do hereby amend Executive Order 20-03 declaring an emergency in the State of Arkansas, and order the following for the duration of this emergency:

(1) To fully leverage telehealth in Arkansas and mitigate the spread of COVID-19, I am suspending the provisions the Telemedicine Act at Ark. Code Ann. §17-80-401, et seq., requiring an in-person encounter, or a face to face examination using real time audio and visual means to establish a professional relationship. Physicians licensed in Arkansas who have access to a patient's personal health record maintained by a physician may establish a professional relationship with a patient using any technology deemed appropriate by the provider, including the telephone, with a citizen located in Arkansas to diagnose, treat and if clinically appropriate, prescribe a non-controlled drug to that patient;

(2) I am suspending the Rules and Regulations of the Arkansas Board of Examiners in Counseling regarding the requirement for a Technology-assisted Distance Counseling or Marriage Family Therapy specialization license, so that Licensed Associate Counselors, Licensed Professional Counselors, Licensed Associate Marriage and Family Therapists, and Licensed Marriage and Family Therapists, in good standing with the Arkansas Board of Examiners in Counseling, may provide reasonable mental health

treatment, using any technology deemed appropriate by the provider, including the telephone, to a citizen located in Arkansas.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Arkansas to be affixed this 13th day of March, in the year of our Lord 2020.

Asa Hutchinson, Governor

GREAT SEAL OF THE STATE OF ARKANSAS

Attest: John Thurston

John Thurston, Secretary of State

EXHIBIT 12

Categories

Clinical
Medical Education News
Membership and Fellowship
Patient Education
Practice Management
Advocacy and Health Policy
Events and Meetings

Sources

News Releases
President's Blog

Clinical | Mar 18, 2020

Share

Joint Statement on Abortion Access During the COVID-19 Outbreak

The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, released the following statement:

"As hospital systems, clinics, and communities prepare to meet anticipated increases in demand for the care of people with COVID-19, strategies to mitigate spread of the virus and to maximize health care resources are evolving. Some health systems, at the guidance of the CDC, are implementing plans to cancel elective and non-urgent procedures to expand hospitals' capacity to provide critical care.

"While most abortion care is delivered in outpatient settings, in some cases care may be delivered in hospital-based settings or surgical facilities. To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure. Abortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.

"The American College of Obstetricians and Gynecologists and the American Board of Obstetrics & Gynecology, together with the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine, do not support COVID-19 responses that cancel or delay abortion procedures. Community-based and hospital-based clinicians should consider collaboration to ensure abortion access is not compromised during this time."

Topics Coronavirus COVID-19 Delivery of health care Health services accessibility Induced abortion Medical societies Obstetric surgical procedures Organizations Virus diseases Women's health services

Latest Clinical News

ACOG Releases Updated Guidance on Exercise in Pregnancy and Postpartum, Includes Recommendations for Athletes
Mar 26, 2020

Joint Statement on Elective Surgeries
Mar 16, 2020

ACOG Updates on Novel Coronavirus Disease 2019 (COVID-19)
Mar 6, 2020

ACOG Statement on "Virginity Testing"
Nov 7, 2019

View More

EXHIBIT 13

AMA STATEMENTS

AMA statement on government interference in reproductive health care

MAR 30, 2020

Statement attributed To:
Patrice A. Harris, M.D., M.A.
President, American Medical Association

"While many physicians and health care workers are on the front lines in the COVID-19 pandemic, it is unfortunate that elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive health care, labeling procedures as 'non-urgent.'

"The AMA will always defend shared decision making and open conversations between patients and physicians, and fight government intrusion in medical care. At this critical moment and every moment, physicians – not politicians – should be the ones deciding which procedures are urgent-emergent and need to be performed, and which ones can wait, in partnership with our patients."

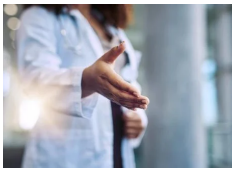
Media Contact:

AMA Media & Editorial
ph: (312) 464-4430
media@ama-assn.org

About the American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises and, driving the future of medicine to tackle the biggest challenges in health care.

AMA Press Center | Coronavirus (COVID-19) | Female Population Care



PHYSICIAN HEALTH

COVID-19 front line: Mount Sinai keeps physician well-being in focus

PUBLIC HEALTH

COVID-19: Rebalancing your staff workload to meet care needs

PHYSICIAN RETIREMENT

Retired doctors hear COVID-19 battle call, look for ways to help

EXHIBIT 14

POLITICS

World Health Organization: Abortion Is 'Essential' During Coronavirus Pandemic

(Photo by FABRICE COFFRINI/AFP via Getty Images)

DAILY CALLER NEWS FOUNDATION

MARY MARGARET OLOHAN
SOCIAL ISSUES REPORTER

April 04, 2020
2:02 PM ET

FONT SIZE:

Abortion is considered an essential service during the coronavirus pandemic, the World Health Organization said in a statement Saturday.

The WHO said in its statement to the Daily Caller News Foundation that "services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak."

"Women's choices and rights to sexual and reproductive health care should be respected, irrespective of whether or not she has a suspected or confirmed COVID-19 infection," WHO said in the statement. (**RELATED: Top WHO Official Tedros Adhanom Ghebreyesus Won Election With China's Help. Now He's Running Interference For China On Coronavirus**)

The statement also said that "sexual and reproductive health care is integral to universal health coverage and achieving the right to health."

World Health Organization (WHO) Director-General Tedros Adhanom Ghebreyesus on March 6, 2020, in Geneva. (FABRICE COFFRINI/AFP via Getty Images)

"This includes contraception, quality health care during and after pregnancy and childbirth, and safe abortion to the full extent of the law," the organization added, noting that the WHO provides both global technology and policy guidance to WHO members "on the use of contraception to prevent unintended pregnancy, safe abortion, and treatment of complications from unsafe abortion."

Governors and health departments across the United States have issued decisions on whether or not abortions are considered essential services. Texas, Ohio, Oklahoma, Indiana and Iowa as well as the governor of Mississippi declared abortions non-essential and banned these procedures to preserve PPE for fighting coronavirus. (**RELATED: WHO Official Defends China, Says Everyone Is 'Over-Focused' On Regime's Coronavirus Numbers**)

Meanwhile, Massachusetts, Michigan, Minnesota, Indiana, New Jersey, Illinois, Oregon, Hawaii and Virginia — all states that have banned elective medical procedures — deemed abortions essential during the outbreak.

There have been 1,172,692 cases of the coronavirus worldwide as of Saturday afternoon, and 62,823 people have died from the virus.

Tags : coronavirus roe v wade who

MARY MARGARET OLOHAN

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Our Community

TRENDING

EXHIBIT 15

COVID-19: Guidance for ASCs on Necessary Surgeries

Updated March 19, 2020

In response to government guidance that hospitals and ambulatory surgery centers postpone elective surgeries during the COVID-19 pandemic, the Ambulatory Surgery Center Association (ASCA) has consulted with clinical leaders to solicit recommendations on how and when facilities should proceed with cases that, for clinical reasons, should not be postponed. A surgery may be deemed urgent and necessary if the treating physician decides that a months-long delay would increase the likelihood of significantly worse morbidity or prognosis for the patient.

First and foremost, if a procedure can be safely postponed without additional significant risk to the patient, it should be delayed until after the pandemic. The current and ongoing efforts to isolate our population and create social distancing are essential steps in saving lives by shortening and ultimately ending the COVID-19 pandemic. The health and safety of patients, along with preventing the spread of COVID-19, must be our highest priority. We concur with the American College of Surgeons that “the risk to the patient should include an aggregate assessment of the real risk of proceeding and the real risk of delay, including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent.”

Physicians should engage with patients and families to make care decisions that minimize potential risks to patients while ensuring they receive necessary care that cannot be safely delayed. Physicians should consider the potential of post-surgical complications that could place stress on the local hospital that may lack capacity for transfers. To that end, facilities should reach out to local hospitals to establish a line of communication that ensures coordination in managing care during the pandemic.

In addition, ASCs should develop explicit controls on how to manage the infection risks of all non-patient visitors (patient caregivers, vendors, contractors, etc.) who present themselves inside the facility and should strictly prohibit all non-essential visitors. Additional social distancing policies should be employed.

Examples of cases that might still need to proceed with surgery at this time include:

- Acute infection
- Acute trauma that would significantly worsen without surgery
- Potential malignancy
- Uncontrollable pain that would otherwise require a hospital admission
- A condition where prognosis would significantly worsen with a delay in treatment

Also, ambulatory surgery centers need to be prepared for the possibility that the pandemic may proceed to a point that strains the system such that hospitals will need to shift necessary surgeries to ASCs and/or ASCs and their resources will be required to serve the communities and the healthcare system in a different capacity. Additional guidance from regulatory agencies would govern those situations.

Finally, facilities need to recognize that the pandemic and its impact could create situations when ASCs may need to temporarily suspend services, such as:

- When a patient, staff or physician who has been in the ASC is suspected or subsequently diagnosed with COVID-19
- When there is a significant shortage of PPE (masks, gowns, gloves, etc.) that prevents safe practice of surgical cases

Clearly, this is an evolving situation and the coming days and weeks will present different challenges for healthcare facilities, such as ASCs, to grapple with as the COVID-19 pandemic runs its course. As they occur, the ambulatory surgery community will continue to work with federal, state and local health policy leaders to protect and preserve the health of the public during this crisis.

EXHIBIT 16

JOINT INFORMATION CENTER

MEDIA RELEASE

Governor Phil Murphy • Lt. Governor Sheila Oliver
Colonel Patrick J. Callahan, Director, State Office of Emergency Management

COVID-19 Press Information

FOR IMMEDIATE RELEASE

March 23, 2020

CONTACT: Jerrel.Harvey@nj.gov

Press Office: Governor's Office

Email: Jerrel.Harvey@nj.gov

Governor Murphy Suspends All Elective Surgeries, Invasive Procedures to Preserve Essential Equipment and Hospital Capacity

TRENTON -- As part of the state's effort to preserve the capacity of the health care system to respond to COVID-19, Governor Phil Murphy today signed Executive Order No. 109, directing the suspension of all elective surgeries and invasive procedures performed on adults that are scheduled to take place after 5:00 p.m. on Friday, March 27. The Governor's Executive Order applies to all medical and dental operations that can be delayed without undue risk to the current or future health of the patient, as determined by the patient's physician or dentist.

"Our new reality calls for aggressive action to reduce the burden on our health care system and protect our frontline medical responders," **said Governor Murphy.** "Given the dramatic shortfall in personal protective equipment we face, it's imperative that we work with our partners in health care to strategically preserve supplies and equipment for emergency purposes only."

In addition to the suspension outlined above, Governor Murphy's Executive Order also requires the following:

- **Protecting the capacity of hospitals**: Physicians and dentists, who are planning to perform surgery or invasive procedures in their offices, must consider the potential burden of post-surgery complications on local hospitals prior to performing any operation.
- **Explicit exemption for family planning and termination of pregnancies**: The order provides that it shall not be interpreted in any way to limit access to family planning services, including termination of pregnancies.
- **Inventory of personal protective equipment to be taken:** Any business, non-hospital health care facility, or institution of higher learning in possession of PPE, ventilators, respirators, or anesthesia machines not required for the provision of critical health care services shall undertake an inventory of these supplies and send that information to the State by 5:00 pm on Friday, March 27. The Office of Emergency Management shall establish a process for affected entities to submit this information. The Order requires facilities to immediately notify patients whose operations have to be suspended.

For a copy of Executive Order No. 109, please click here.

EXHIBIT 17

News Release

Connect with DOL at
https://blog.dol.gov

TRANSMISSION OF MATERIALS IN THIS RELEASE IS EMBARGOED UNTIL
8:30 A.M. (Eastern) Thursday, April 9, 2020

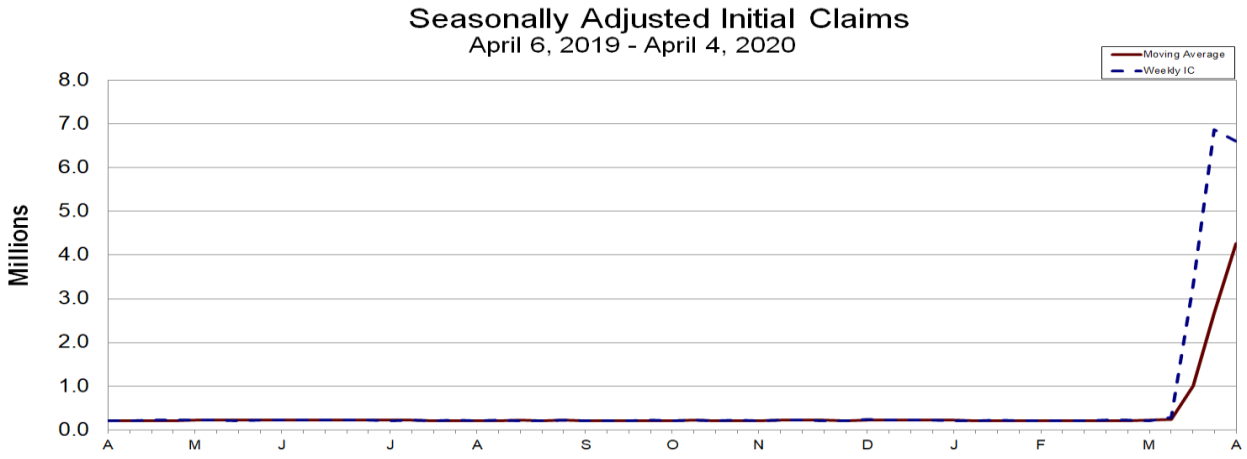
COVID-19 Impact
The COVID-19 virus continues to impact the number of initial claims and its impact is also reflected in the increasing levels of insured unemployment.

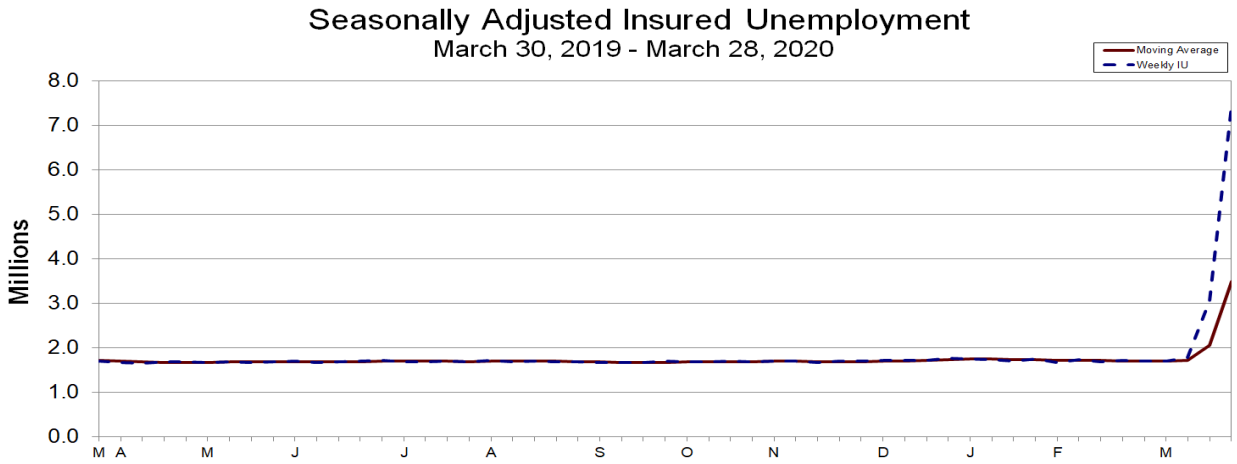
UNEMPLOYMENT INSURANCE WEEKLY CLAIMS

SEASONALLY ADJUSTED DATA

In the week ending April 4, the advance figure for seasonally adjusted **initial claims** was 6,606,000, a decrease of 261,000 from the previous week's revised level. The previous week's level was revised up by 219,000 from 6,648,000 to 6,867,000. The 4-week moving average was 4,265,500, an increase of 1,598,750 from the previous week's revised average. The previous week's average was revised up by 54,750 from 2,612,000 to 2,666,750.

The advance seasonally adjusted **insured unemployment rate** was 5.1 percent for the week ending March 28, an increase of 3.0 percentage points from the previous week's unrevised rate. The advance number for seasonally adjusted **insured unemployment** during the week ending March 28 was 7,455,000, an increase of 4,396,000 from the previous week's revised level. This marks the highest level of seasonally adjusted insured unemployment in the history of the seasonally adjusted series. The previous high was 6,635,000 in May of 2009. The previous week's level was revised up 30,000 from 3,029,000 to 3,059,000. The 4-week moving average was 3,500,000, an increase of 1,439,000 from the previous week's revised average. The previous week's average was revised up by 7,500 from 2,053,500 to 2,061,000.

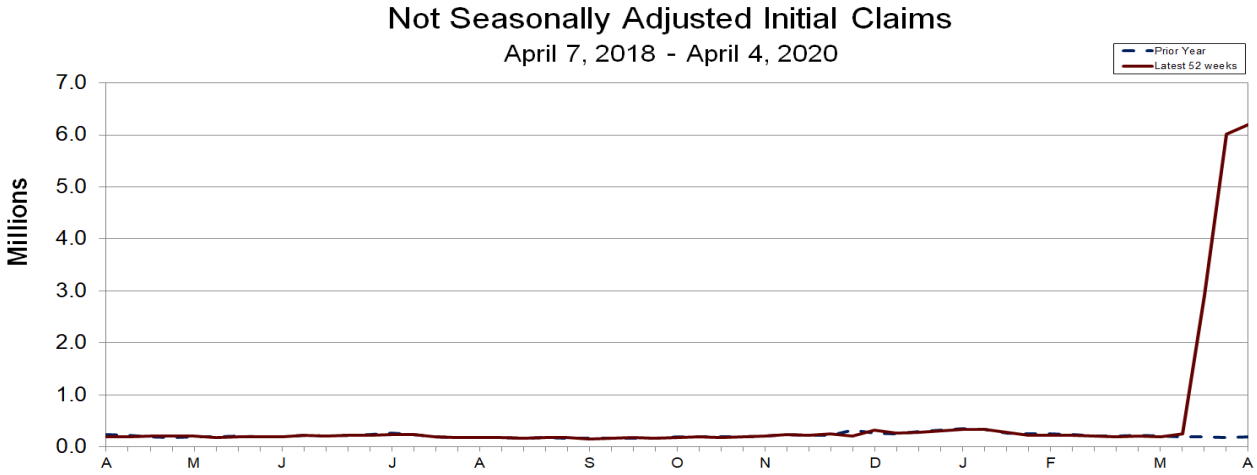


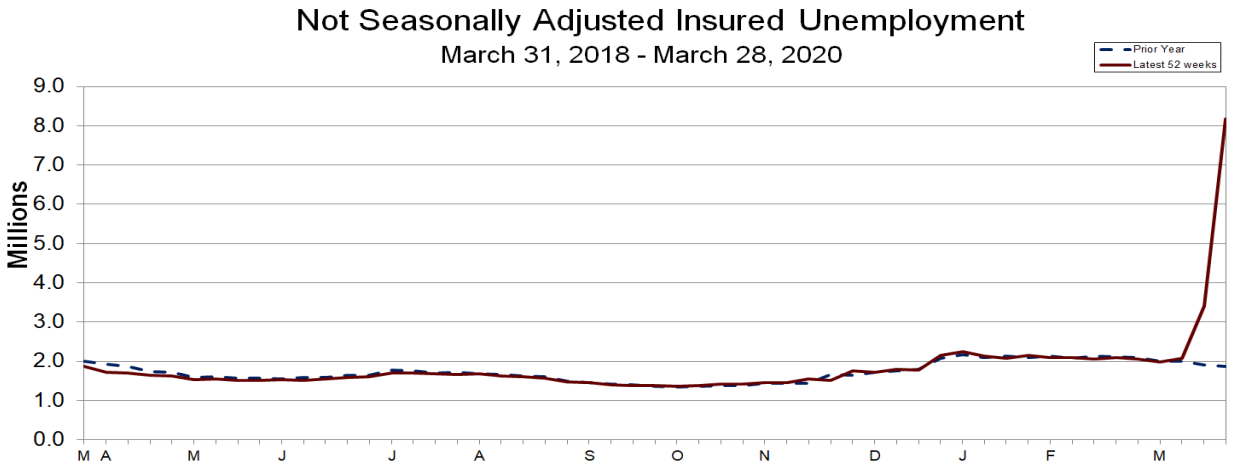


UNADJUSTED DATA

The advance number of actual initial claims under state programs, unadjusted, totaled 6,203,359 in the week ending April 4, an increase of 187,538 (or 3.1 percent) from the previous week. The seasonal factors had expected an increase of 432,645 (or 7.2 percent) from the previous week. There were 196,071 initial claims in the comparable week in 2019.

The advance unadjusted insured unemployment rate was 5.6 percent during the week ending March 28, an increase of 3.2 percentage points from the prior week. The advance unadjusted number for persons claiming UI benefits in state programs totaled 8,177,965, an increase of 4,761,372 (or 139.4 percent) from the preceding week. The seasonal factors had expected a decrease of 61,174 (or -1.8 percent) from the previous week. A year earlier the rate was 1.3 percent and the volume was 1,861,690.





The total number of people claiming benefits in all programs for the week ending March 21 was 3,447,727, an increase of 1,342,462 from the previous week. There were 1,937,342 persons claiming benefits in all programs in the comparable week in 2019.

No state was triggered "on" the Extended Benefits program during the week ending March 21.

Initial claims for UI benefits filed by former Federal civilian employees totaled 2,451 in the week ending March 28, an increase of 1,169 from the prior week. There were 1,752 initial claims filed by newly discharged veterans, an increase of 855 from the preceding week.

There were 9,378 former Federal civilian employees claiming UI benefits for the week ending March 21, a decrease of 414 from the previous week. Newly discharged veterans claiming benefits totaled 5,479, a decrease of 112 from the prior week.

The highest insured unemployment rates in the week ending March 21 were in Rhode Island (6.7), Minnesota (5.6), Massachusetts (5.1), Connecticut (4.9), Washington (4.7), Vermont (4.5), Nevada (4.3), Montana (4.2), New Hampshire (4.2), and Ohio (4.0).

The largest increases in initial claims for the week ending March 28 were in California (+871,992), New York (+286,596), Michigan (+176,329), Florida (+154,171), Georgia (+121,680), Texas (+120,759), and New Jersey (+90,438), while the largest decreases were in Nevada (-20,356), Rhode Island (-8,047), and Minnesota (-6,678).

UNEMPLOYMENT INSURANCE DATA FOR REGULAR STATE PROGRAMS

WEEK ENDING	**April 4**	**March 28**	**Change**	**March 21**	**Prior Year[1]**
Initial Claims (SA)	6,606,000	6,867,000	-261,000	3,307,000	203,000
Initial Claims (NSA)	6,203,359	6,015,821	+187,538	2,920,162	196,071
4-Wk Moving Average (SA)	4,265,500	2,666,750	+1,598,750	1,004,250	212,000
WEEK ENDING	**March 28**	**March 21**	**Change**	**March 14**	**Prior Year[1]**
Insured Unemployment (SA)	7,455,000	3,059,000	+4,396,000	1,784,000	1,705,000
Insured Unemployment (NSA)	8,177,965	3,416,593	+4,761,372	2,074,782	1,861,690
4-Wk Moving Average (SA)	3,500,000	2,061,000	+1,439,000	1,726,250	1,722,500
Insured Unemployment Rate (SA)[2]	5.1%	2.1%	+3.0	1.2%	1.2%
Insured Unemployment Rate (NSA)[2]	5.6%	2.4%	+3.2	1.4%	1.3%

INITIAL CLAIMS FILED IN FEDERAL PROGRAMS (UNADJUSTED)

WEEK ENDING	**March 28**	**March 21**	**Change**	**Prior Year[1]**
Federal Employees (UCFE)	2,451	1,282	+1,169	571
Newly Discharged Veterans (UCX)	1,752	897	+855	447

PERSONS CLAIMING UI BENEFITS IN ALL PROGRAMS (UNADJUSTED)

WEEK ENDING	**March 21**	**March 14**	**Change**	**Prior Year[1]**
Regular State	3,410,969	2,071,116	+1,339,853	1,905,781
Federal Employees	9,378	9,792	-414	10,076
Newly Discharged Veterans	5,479	5,591	-112	6,103
Extended Benefits[3]	0	0	0	1
State Additional Benefits[4]	5,449	5,901	-452	6,019
STC / Workshare [5]	16,452	12,865	+3,587	9,362
TOTAL	3,447,727	2,105,265	+1,342,462	1,937,342

FOOTNOTES

SA - Seasonally Adjusted Data, NSA - Not Seasonally Adjusted Data

1. Prior year is comparable to most recent data.
2. Most recent week used covered employment of 145,230,691 as denominator.
3. Information on the EB program can be found here: EB Program information
4. Some states maintain additional benefit programs for those claimants who exhaust regular benefits, and when applicable, extended benefits. Information on states that participate, and the extent of benefits paid, can be found starting on page 4-4 of this link: Extensions and Special Programs PDF
5. Information on STC/Worksharing can be found starting on page 4-8 of the following link: Extensions and Special Programs PDF

Advance State Claims - Not Seasonally Adjusted

	Initial Claims Filed During Week Ended April 4			Insured Unemployment For Week Ended March 28		
STATE	Advance	Prior Wk	Change	Advance	Prior Wk	Change
Alabama	105,607	80,984	24,623	40,882	18,083	22,799
Alaska	15,370	13,774	1,596	19,644	11,173	8,471
Arizona	132,189	88,940	43,249	59,977	26,387	33,590
Arkansas	60,992	27,756	33,236	34,906	16,148	18,758
California	925,450	1,058,325	-132,875	1,084,955	400,565	684,390
Colorado	45,494	61,838	-16,344	73,586	21,956	51,630
Connecticut	33,418	33,227	191	149,490	80,861	68,629
Delaware	18,863	19,137	-274	23,881	11,506	12,375
District of Columbia	15,393	15,869	-476	29,526	17,661	11,865
Florida	169,885	228,484	-58,599	98,924	35,076	63,848
Georgia	388,175	133,820	254,355	359,105	107,877	251,228
Hawaii	53,082	48,596	4,486	32,459	10,930	21,529
Idaho	30,022	32,941	-2,919	35,211	15,523	19,688
Illinois	200,940	178,421	22,519	263,732	132,114	131,618
Indiana	133,639	139,174	-5,535	75,522	28,987	46,535
Iowa	67,334	55,966	11,368	92,962	53,650	39,312
Kansas	49,756	54,330	-4,574	51,786	17,558	34,228
Kentucky	117,135	113,149	3,986	130,152	24,361	105,791
Louisiana	102,985	97,400	5,585	116,752	58,027	58,725
Maine	30,631	23,770	6,861	40,592	21,967	18,625
Maryland	107,408	85,317	22,091	90,153	47,973	42,180
Massachusetts	139,582	181,423	-41,841	306,580	183,105	123,475
Michigan	384,844	304,335	80,509	363,885	88,183	275,702
Minnesota	111,119	109,095	2,024	256,689	160,873	95,816
Mississippi	46,504	32,015	14,489	27,948	9,581	18,367
Missouri	82,399	104,291	-21,892	118,924	49,470	69,454
Montana	20,011	20,763	-752	37,393	19,099	18,294
Nebraska	26,788	24,725	2,063	37,805	16,641	21,164
Nevada	79,865	71,942	7,923	129,127	58,798	70,329
New Hampshire	36,214	31,378	4836	51,509	27,321	24,188
New Jersey	213,897	206,253	7,644	277,761	156,181	121,580
New Mexico	26,606	27,849	-1,243	46,620	20,087	26,533
New York	345,246	366,595	-21,349	715,750	314,710	401,040
North Carolina	137,573	172,145	-34,572	246,082	75,220	170,862
North Dakota	16,093	11,818	4,275	17,507	8,534	8,973
Ohio	224,182	274,288	-50,106	447,494	214,273	233,221
Oklahoma	51,124	47,744	3,380	54,469	25,268	29,201
Oregon	56,646	47,498	9,148	118,995	63,930	55,065
Pennsylvania *	283,718	404,677	-120,959	571,732	135,708	436,024
Puerto Rico	66,349	45,394	20,955	41,491	19,230	22,261
Rhode Island	28,255	27,800	455	56,668	31,847	24,821
South Carolina	85,018	66,475	18,543	73,653	30,341	43,312
South Dakota	7,916	6,801	1115	7,492	3,538	3,954
Tennessee	116,141	92,500	23,641	116,345	37,541	78,804
Texas	313,832	276,185	37,647	376,955	144,697	232,258
Utah	33,076	28,532	4,544	43,962	24,635	19,327
Vermont	16,176	14,633	1,543	22,175	13,797	8,378
Virgin Islands	11	250	-239	660	512	148
Virginia	149,758	112,497	37,261	133,601	41,827	91,774
Washington	176,827	182,849	-6,022	315,085	158,025	157,060
West Virginia	14,145	14,523	-378	41,404	21,145	20,259
Wisconsin	104,776	110,934	-6,158	209,288	99,574	109,714
Wyoming	4,900	6,396	-1,496	8,719	4,519	4,200
US Total	6,203,359	6,015,821	187,538	8,177,965	3,416,593	4,761,372

Note: Advance claims are not directly comparable to claims reported in prior weeks. Advance claims are reported by the state liable for paying the unemployment compensation, whereas previous weeks reported claims reflect claimants by state of residence. In addition, claims reported as "workshare equivalent" in the previous week are added to the advance claims as a proxy for the current week's "workshare equivalent" activity.

*Denotes state estimate.

Seasonally Adjusted US Weekly UI Claims (in thousands)

Week Ending	Initial Claims	Change from Prior Week	4-Week Average	Insured Unemployment	Change from Prior Week	4-Week Average	IUR
March 30, 2019	211	-4	217.25	1,705	-14	1,722.50	1.2
April 6, 2019	203	-8	212.00	1,667	-38	1,705.75	1.2
April 13, 2019	203	0	208.00	1,659	-8	1,687.50	1.2
April 20, 2019	226	23	210.75	1,682	23	1,678.25	1.2
April 27, 2019	230	4	215.50	1,684	2	1,673.00	1.2
May 4, 2019	225	-5	221.00	1,678	-6	1,675.75	1.2
May 11, 2019	217	-8	224.50	1,683	5	1,681.75	1.2
May 18, 2019	213	-4	221.25	1,675	-8	1,680.00	1.2
May 25, 2019	218	5	218.25	1,695	20	1,682.75	1.2
June 1, 2019	220	2	217.00	1,700	5	1,688.25	1.2
June 8, 2019	220	0	217.75	1,677	-23	1,686.75	1.2
June 15, 2019	219	-1	219.25	1,692	15	1,691.00	1.2
June 22, 2019	224	5	220.75	1,699	7	1,692.00	1.2
June 29, 2019	222	-2	221.25	1,717	18	1,696.25	1.2
July 6, 2019	211	-11	219.00	1,694	-23	1,700.50	1.2
July 13, 2019	217	6	218.50	1,682	-12	1,698.00	1.2
July 20, 2019	211	-6	215.25	1,699	17	1,698.00	1.2
July 27, 2019	216	5	213.75	1,692	-7	1,691.75	1.2
August 3, 2019	214	-2	214.50	1,719	27	1,698.00	1.2
August 10, 2019	218	4	214.75	1,687	-32	1,699.25	1.2
August 17, 2019	215	-3	215.75	1,699	12	1,699.25	1.2
August 24, 2019	215	0	215.50	1,683	-16	1,697.00	1.2
August 31, 2019	219	4	216.75	1,683	0	1,688.00	1.2
September 7, 2019	208	-11	214.25	1,675	-8	1,685.00	1.2
September 14, 2019	211	3	213.25	1,672	-3	1,678.25	1.2
September 21, 2019	215	4	213.25	1,667	-5	1,674.25	1.2
September 28, 2019	218	3	213.00	1,698	31	1,678.00	1.2
October 5, 2019	212	-6	214.00	1,689	-9	1,681.50	1.2
October 12, 2019	218	6	215.75	1,691	2	1,686.25	1.2
October 19, 2019	213	-5	215.25	1,700	9	1,694.50	1.2
October 26, 2019	217	4	215.00	1,695	-5	1,693.75	1.2
November 2, 2019	212	-5	215.00	1,702	7	1,697.00	1.2
November 9, 2019	222	10	216.00	1,697	-5	1,698.50	1.2
November 16, 2019	223	1	218.50	1,665	-32	1,689.75	1.2
November 23, 2019	211	-12	217.00	1,697	32	1,690.25	1.2
November 30, 2019	206	-5	215.50	1,700	3	1,689.75	1.2
December 7, 2019	237	31	219.25	1,725	25	1,696.75	1.2
December 14, 2019	229	-8	220.75	1,716	-9	1,709.50	1.2
December 21, 2019	218	-11	222.50	1,728	12	1,717.25	1.2
December 28, 2019	220	2	226.00	1,775	47	1,736.00	1.2
January 4, 2020	212	-8	219.75	1,759	-16	1,744.50	1.2
January 11, 2020	207	-5	214.25	1,735	-24	1,749.25	1.2
January 18, 2020	220	13	214.75	1,704	-31	1,743.25	1.2
January 25, 2020	212	-8	212.75	1,753	49	1,737.75	1.2
February 1, 2020	201	-11	210.00	1,678	-75	1,717.50	1.2
February 8, 2020	204	3	209.25	1,729	51	1,716.00	1.2
February 15, 2020	215	11	208.00	1,693	-36	1,713.25	1.2
February 22, 2020	220	5	210.00	1,720	27	1,705.00	1.2
February 29, 2020	217	-3	214.00	1,699	-21	1,710.25	1.2
March 7, 2020	211	-6	215.75	1,702	3	1,703.50	1.2
March 14, 2020	282	71	232.50	1,784	82	1,726.25	1.2
March 21, 2020	3,307	3,025	1,004.25	3,059	1,275	2,061.00	2.1
March 28, 2020	6,867	3,560	2,666.75	7,455	4,396	3,500.00	5.1
April 4, 2020	6,606	-261	4,265.50				

	INITIAL CLAIMS FILED DURING WEEK ENDED MARCH 28					INSURED UNEMPLOYMENT FOR WEEK ENDED MARCH 21						
		CHANGE FROM						CHANGE FROM				
STATE NAME	STATE	LAST WEEK	YEAR AGO	UCFE [1]	UCX [1]	STATE	(%) [2]	LAST WEEK	YEAR AGO	UCFE [1]	UCX [1]	ALL PROGRAMS EXCLUDING RAILROAD RETIREMENT
Alabama	80984	70092	78734	48	32	18083	0.9	5596	3952	50	36	18169
Alaska	13774	5927	12887	8	0	11173	3.6	2661	2650	125	13	11311
Arizona	88940	59592	85200	22	19	26387	0.9	8279	7275	171	32	26590
Arkansas	27756	18481	26537	3	3	16148	1.4	5160	5145	65	35	16248
California	1058325	871992	1019797	186	72	400565	2.3	-21347	31907	2222	977	403764
Colorado	61838	42064	60355	24	38	21956	0.8	647	1602	210	122	22288
Connecticut	33227	8127	31265	8	1	80861	4.9	36667	41671	44	57	80962
Delaware	19137	8361	18712	1	9	11506	2.6	6209	5557	9	14	11529
District of Columbia	15869	1407	15490	97	0	17661	3.1	10283	10644	195	7	17863
Florida	228484	154171	223180	95	164	35076	0.4	1348	499	145	93	35314
Georgia	133820	121680	129649	32	28	107877	2.5	80370	83933	187	131	108195
Hawaii	48596	39779	47347	2	41	10930	1.8	4458	4284	55	47	11032
Idaho	32941	19355	31750	23	3	15523	2.1	7654	7512	180	19	15722
Illinois	178421	64307	169191	13	22	132114	2.2	6677	12680	365	132	132611
Indiana	139174	79419	137141	22	20	28987	1.0	8209	10887	19	30	29036
Iowa	55966	15014	54084	19	4	53650	3.5	27154	26681	55	26	53731
Kansas	54330	30767	52840	1	1	17558	1.3	7585	8363	27	30	17615
Kentucky	113149	64126	110981	3	4	24361	1.3	2033	5944	134	97	24592
Louisiana	97400	24962	95734	47	25	58027	3.1	43884	43744	47	14	58088
Maine	23770	2311	23094	2	4	21967	3.6	13264	13614	51	13	22031
Maryland	85317	42336	82921	21	28	47973	1.9	21506	19766	186	81	48240
Massachusetts	181423	32971	177712	64	45	183105	5.1	99978	105775	111	118	183334
Michigan	304335	176329	299598	89	152	88183	2.1	13108	17742	205	93	88481
Minnesota	109095	-6678	106027	31	22	160873	5.6	94086	105386	113	78	161064
Mississippi	32015	26496	31159	6	6	9581	0.9	2914	2385	65	16	9662
Missouri	104291	62045	101325	11	12	49470	1.8	27932	26378	95	29	49594
Montana	20763	5414	20062	40	11	19099	4.2	9281	9120	385	19	19503
Nebraska	24725	9025	24062	17	2	16641	1.7	11782	10578	20	7	16668
Nevada	71942	-20356	69929	7	4	58798	4.3	38976	40019	125	40	58963
New Hampshire	31378	1999	30945	13	10	27321	4.2	23297	23037	11	2	27334
New Jersey	206253	90438	199359	29	7	156181	3.9	50341	56157	227	260	156668
New Mexico	27849	9744	27018	2	2	20087	2.5	10799	10548	147	29	20263
New York	366595	286596	353586	33	21	314710	3.4	147496	166693	307	323	315340
North Carolina	172145	78062	169373	92	97	75220	1.7	54568	55442	120	114	75454
North Dakota	11818	6156	11552	16	6	8534	2.1	2365	3127	15	4	8553
Ohio	274288	77979	268091	44	163	214273	4.0	145950	152496	120	163	214556
Oklahoma	47744	25818	46038	45	22	25268	1.6	8414	11710	58	51	25377
Oregon	47498	17444	43332	26	9	63930	3.4	33407	34844	518	55	64503
Pennsylvania	404677	27226	394157	819	246	135708	2.3	7679	18556	498	190	136396
Puerto Rico	45394	25246	44246	11	1	19230	2.3	3991	3727	161	73	19464
Rhode Island	27800	-8047	27129	3	1	31847	6.7	20990	20821	19	6	31872
South Carolina	66475	34649	64667	18	25	30341	1.5	15230	16236	34	61	30436
South Dakota	6801	5040	6652	13	1	3538	0.8	864	616	40	3	3581
Tennessee	92500	54423	90015	66	36	37541	1.3	19191	19927	80	58	37679
Texas	276185	120759	263858	147	212	144697	1.2	18270	31058	396	939	146032
Utah	28532	8842	27677	41	12	24635	1.7	13809	14982	139	16	24790
Vermont	14633	10849	14236	1	1	13797	4.5	8987	8956	8	4	13809
Virgin Islands	250	127	225	0	0	512	1.5	-72	-84	10	0	522
Virginia	112497	66220	110423	24	24	41827	1.1	20199	21182	169	190	42186
Washington	182849	52940	177379	28	60	158025	4.7	95402	101690	453	454	158932
West Virginia	14523	10987	13876	4	9	21145	3.2	6991	9600	41	40	21226
Wisconsin	110934	59903	105256	20	14	99574	3.5	55967	59491	85	33	99692
Wyoming	6396	2743	6193	14	1	4519	1.7	1322	1733	61	5	4585
Totals	6015821	3095659	5832046	2451	1752	3416593	2.4	1341811	1508238	9378	5479	3431450

Figures appearing in columns showing over-the-week changes reflect all revisions in data for prior week submitted by state agencies.

1. The Unemployment Compensation program for Federal Employees (UCFE) and the Unemployment Compensation for Ex-servicemembers (UCX) exclude claims filed jointly under other programs to avoid duplication.
2. Rate is not seasonally adjusted. The source of U.S. total covered employment is BLS.

UNADJUSTED INITIAL CLAIMS FOR WEEK ENDED MARCH 28, 2020

STATES WITH AN INCREASE OF MORE THAN 1,000

State	Change	State Supplied Comment
CA	+871,992	Layoffs in the services industries.
NY	+286,596	Layoffs in the accommodation and food services, retail trade, and health care and social assistance industries. Increase in initial claims due to COVID-19.
MI	+176,329	Layoffs in the manufacturing, construction, retail trade, administrative, support, waste management, and remediation services, and health care and social assistance industries.
FL	+154,171	Layoffs in the agriculture, forestry, fishing, and hunting, construction, manufacturing, wholesale trade, retail trade, and other services industries.
GA	+121,680	No comment.
TX	+120,759	Layoffs in the accommodation and food services, manufacturing, other services, health care and social assistance, administrative, support, waste management, and remediation services, professional, scientific, and technical services, arts, entertainment, and recreation, information, mining, agriculture, forestry, fishing, and hunting, retail trade, real estate rental and leasing, construction, transportation and warehousing, and management of companies and enterprises industries.
NJ	+90,438	Increase in initial claims due to COVID-19.
IN	+79,419	Layoffs in the manufacturing, arts, entertainment, and recreation, and accommodation and food services industries. Increase in initial claims due to COVID-19.
NC	+78,062	Layoffs in the health care and social assistance, administrative, support, waste management, and remediation services, accommodation and food services, and other services industries.
OH	+77,979	Increase in initial claims due to COVID-19.
AL	+70,092	Layoffs in the accommodation and food services, health care and social assistance, manufacturing, administrative, support, waste management, and remediation services, professional, scientific, and technical services, arts, entertainment, and recreation, educational services, and construction industries. Increase in initial claims due to COVID-19.
VA	+66,220	Layoffs in the manufacturing industry.
IL	+64,307	Layoffs in the other services, accommodation and food services, and retail trade industries.
KY	+64,126	No comment.
MO	+62,045	Layoffs in the manufacturing, retail trade, arts, entertainment, and recreation, and health care and social assistance industries. Increase in initial claims due to COVID-19.
WI	+59,903	Layoffs in the manufacturing and retail trade industries. Increase in initial claims due to COVID-19.
AZ	+59,592	No comment.
TN	+54,423	Layoffs in the accommodation and food services, retail trade, health care and social assistance, transportation and warehousing, and administrative, support, waste management, and remediation services industries.
WA	+52,940	Layoffs in the accommodation and food services industry.
MD	+42,336	No comments.
CO	+42,064	Layoffs in the arts, entertainment, and recreation, accommodation and food services, and other services industries. Increase in initial claims due to COVID-19.
HI	+39,779	Increase in initial claims due to COVID-19.
SC	+34,649	No comment.
MA	+32,971	Increase in initial claims due to COVID-19.
KS	+30,767	No comment.
PA	+27,226	Layoffs in the construction, administrative, support, waste management, and remediation services, and accommodation and food services industries.
MS	+26,496	Increase in initial claims due to COVID-19.
OK	+25,818	No comment.
PR	+25,246	Increase in initial claims due to COVID-19.
LA	+24,962	No comment.
ID	+19,355	Increase in initial claims due to COVID-19.
AR	+18,481	No comment.
OR	+17,444	No comment.

IA	+15,014	Layoffs in the accommodation and food services, health care and social assistance, other services, educational services, administrative, support, waste management, and remediation services, and construction industries. Increase in initial claims due to COVID-19.
WV	+10,987	No comment.
VT	+10,849	Increase in initial claims due to COVID-19.
NM	+9,744	Layoffs in the accommodation and food services, health care and social assistance, retail trade, administrative, support, waste management, and remediation services, other services, arts, entertainment, and recreation, manufacturing, information, and educational services industries. Increase in initial claims due to COVID-19.
NE	+9,025	Increase in initial claims due to COVID-19.
UT	+8,842	No comment.
DE	+8,361	No comment.
CT	+8,127	Layoffs in the educational services and other services industries. Increase in initial claims due to COVID-19.
ND	+6,156	Increase in initial claims due to COVID-19.
AK	+5,927	No comment.
MT	+5,414	Layoffs in the retail trade and accommodation and food services industries. Increase in initial claims due to COVID-19.
SD	+5,040	Increase in initial claims due to COVID-19.
WY	+2,743	Layoffs in the accommodation and food services, health care and social assistance, construction, mining, and retail trade industries. Increase in initial claims due to COVID-19.
ME	+2,311	Layoffs in the accommodation and food services, health care and social assistance, retail trade, manufacturing, arts, entertainment, and recreation, other services, administrative, support, waste management, and remediation services, educational services, construction, and wholesale trade industries. Increase in initial claims due to COVID-19.
NH	+1,999	Increase in initial claims due to COVID-19.
DC	+1,407	Increase in initial claims due to COVID-19.

STATES WITH A DECREASE OF MORE THAN 1,000

State	**Change**	**State Supplied Comment**
NV	-20,356	No comment.
RI	-8,047	No comment.
MN	-6,678	No comment.

TECHNICAL NOTES

This news release presents the weekly unemployment insurance (UI) claims reported by each state's unemployment insurance program offices. These claims may be used for monitoring workload volume, assessing state program operations and for assessing labor market conditions. States initially report claims directly taken by the state liable for the benefit payments, regardless of where the claimant who filed the claim resided. These are the basis for the advance initial claims and continued claims reported each week. These data come from ETA 538, Advance Weekly Initial and Continued Claims Report. The following week initial claims and continued claims are revised based on a second reporting by states that reflect the claimants by state of residence. These data come from the ETA 539, Weekly Claims and Extended Benefits Trigger Data Report.

A. Initial Claims

An initial claim is a claim filed by an unemployed individual after a separation from an employer. The claimant requests a determination of basic eligibility for the UI program. When an initial claim is filed with a state, certain programmatic activities take place and these result in activity counts including the count of initial claims. The count of U.S. initial claims for unemployment insurance is a leading economic indicator because it is an indication of emerging labor market conditions in the country. However, these are weekly administrative data which are difficult to seasonally adjust, making the series subject to some volatility.

B. Continued Weeks Claimed

A person who has already filed an initial claim and who has experienced a week of unemployment then files a continued claim to claim benefits for that week of unemployment. Continued claims are also referred to as insured unemployment. The count of U.S. continued weeks claimed is also a good indicator of labor market conditions. Continued claims reflect the current number of insured unemployed workers filing for UI benefits in the nation. While continued claims are not a leading indicator (they roughly coincide with economic cycles at their peaks and lag at cycle troughs), they provide confirming evidence of the direction of the U.S. economy.

C. Seasonal Adjustments and Annual Revisions

Over the course of a year, the weekly changes in the levels of initial claims and continued claims undergo regularly occurring fluctuations. These fluctuations may result from seasonal changes in weather, major holidays, the opening and closing of schools, or other similar events. Because these seasonal events follow a more or less regular pattern each year, their influence on the level of a series can be tempered by adjusting for regular seasonal variation. These adjustments make trend and cycle developments easier to spot. At the beginning of each calendar year, the Bureau of Labor Statistics provides the Employment and Training Administration (ETA) with a set of seasonal factors to apply to the unadjusted data during that year. Concurrent with the implementation and release of the new seasonal factors, ETA incorporates revisions to the UI claims historical series caused by updates to the unadjusted data.

Weekly Claims Archives
Weekly Claims Data

U.S. Department of Labor news materials are accessible at http://www.dol.gov. The Department's Reasonable Accommodation Resource Center converts Departmental information and documents into alternative formats, which include Braille and large print. For alternative format requests, please contact the Department at (202) 693-7828 (voice) or (800) 877-8339 (federal relay).

U.S. Department of Labor
Employment and Training Administration
Washington, D.C. 20210
Release Number: USDL 20-592-NAT

Program Contacts:
Kevin Stapleton: (202) 693-3009
Media Contact: (202) 693-4676

EXHIBIT 18

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES et al., Plaintiffs, v. LESLIE RUTLEDGE, et al., Defendants.	CIVIL ACTION Case No. 4:19-cv-00449-KGB

DECLARATION OF LEAH GODESKY, ESQ. IN SUPPORT OF PLAINTIFFS' MOTION FOR AN *EX PARTE* TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

I, Leah Godesky, Esq., declare under 28 U.S.C. § 1746 and penalty of perjury that the following is true and correct:

1. I am an attorney at O'Melveny & Myers, LLP, counsel of record for Plaintiffs Little Rock Family Planning ("LRFP") and Dr. Thomas Tvedten (together, "Plaintiffs") in the above-captioned matter. I am a member in good standing of the State Bars of New York and Connecticut, and am admitted *pro hac vice* to represent Plaintiffs in this litigation.

2. I submit this Declaration in support of Plaintiffs' Motion for an *Ex Parte* Temporary Restraining Order and/or Preliminary Injunction relating to the State's enforcement of Executive Order 20-13 and the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries to bar all surgical abortion in Arkansas "except where immediately necessary to protect the life or health of the patient" (the "COVID-19 Abortion Ban").

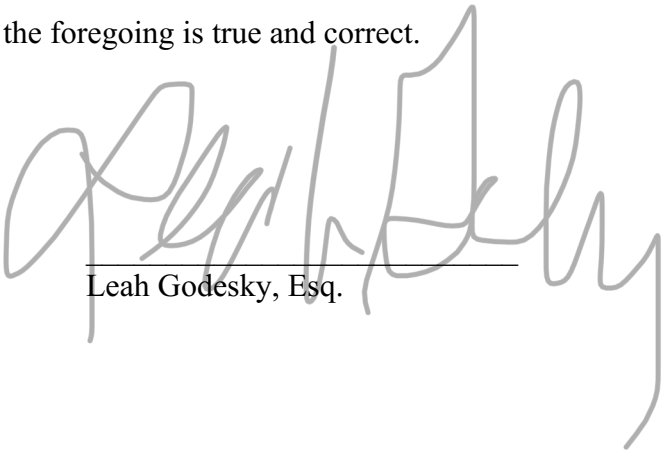
3. Plaintiffs received notice of the COVID-19 Abortion Ban from the Department of Health during the morning of April 10, 2020.

4. At approximately 4:15pm CST on April 12, 2020, I notified counsel for Defendants that Plaintiffs intended to seek an *ex parte* temporary restraining order barring enforcement of the COVID-19 Abortion Ban as unconstitutional, unless Defendants agreed to stop enforcing it. As of 10am CST on April 13, 2020, Plaintiffs have not yet heard from counsel for Defendants.

5. Because of the COVID-19 Abortion Ban, Plaintiffs were forced to turn away numerous women seeking care on April 10, 2020, and would have to do the same tomorrow, April 14, 2020. *Ex parte* relief is therefore warranted for the reasons detailed in Plaintiffs' concurrently filed verified First Supplemental Complaint and memorandum of law in support of their request for an *ex parte* TRO and/or preliminary injunction.

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

Executed this 13th day of April, 2020.



Leah Godesky, Esq.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

LITTLE ROCK FAMILY PLANNING SERVICES, *et al.*, Plaintiffs, v. LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas, *et al.*, Defendant.	Case No.: 4:19-cv-00449-KGB

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

Governor Asa Hutchinson has decided to not order Arkansas citizens to stay home during the COVID-19 pandemic. Many retailers remain open for business. According to the Governor, many hospitals are "empty," and there is no shortage of the medical professionals on whom we all gratefully depend to fight COVID-19 on the frontlines. Manufacturers and places of worship remain open, and medical providers around the State are free to exercise their independent professional judgment to provide patients with all surgical and dental care that they determine cannot be safely postponed. Indeed, orthodontists in Arkansas remain free to schedule visits to adjust wires on patients' braces, and dentists continue to see patients who complain of a cracked tooth.

Nevertheless—and unsurprisingly—the State opportunistically seeks to leverage the instant public-health crisis to continue its unrelenting campaign—which included no fewer than 12 abortion-specific restrictions in 2019 alone, *see* Dkt. No. 1—to prevent women from exercising their constitutionally protected right to access pre-viability abortion care in Arkansas.

See Roe v. Wade, 410 U.S. 113, 163–65 (1973). This time, Arkansas seeks to eliminate patients' right to access surgical-abortion care, i.e., the only type of care available to women who are more than 10 weeks pregnant, as measured from the date of their last menstrual period ("LMP") (the "COVID-19 Abortion Ban" or the "Ban"). On the morning of Friday, April 10, the Arkansas Health Department ("ADH") arrived at the clinic of Plaintiff Little Rock Family Planning Services ("LRFP") to demand that clinicians cease providing surgical-abortion care to numerous women who had already assumed the substantial burdens of making an initial trip to the clinic days earlier to receive the State's mandated (in-person) "informed-consent" information. ADH stated that the provision of surgical abortion "will result in an immediate suspension of [LRFP's] license."[1] Violation of the ADH directive would carry criminal, financial, and licensure penalties, and each day a person or business operates in violation of the guidance would constitute a separate offense.[2]

Contrary to the State's manufactured justifications, the COVID-19 Abortion Ban does nothing to further state interests in public health and safety during the pandemic. LRFP is *wholly self-sustaining* in terms of PPE and has no plans to utilize state PPE resources. If women are forced to continue their pregnancies, the PPE required for the associated prenatal care and delivery would far surpass that used at LRFP in providing abortion care. For much the same reasons, pre-viability abortion care *decreases* rather than exacerbates demand for hospital

[1] Ex. 1. All exhibits identified by "Ex." in this brief are exhibits attached to the concurrently filed motion for an ex parte temporary restraining order and/or preliminary injunction. Unless otherwise indicated, all emphasis is added and all quotation marks, citations, and footnotes are omitted from citations.

[2] *See* Ark. Code § 20-7-101; Executive Order to Amend Executive Order 20-03 Regarding the Public Health Emergency Concerning COVID-19 for the Purpose of Imposing Further Restrictions to Prevent the Spread of COVID-19, EO 20-13, § 2(a) (Apr. 4, 2020), https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-13._.pdf.

capacity; abortion is safer than and does not burden hospitals nearly as much as continued pregnancy, miscarriage management, and childbirth. Nor is the Ban necessitated by social-distancing concerns. LRFP's COVID-19 protocols and procedures strictly limit the number of people in the clinic at any given time and space patients 6 feet apart. Indeed, the hundreds of individuals permitted to gather in Arkansas businesses and churches dwarf the comparatively small number that could be in LRFP at any given time.

At the same time, the harms arising out of the COVID-19 Abortion Ban are severe. Even assuming the COVID-19 Abortion Ban is lifted in weeks rather than months (which even the AHD can't say for certain, and which seems highly unlikely in view of the State's decision to close schools through the end of the school year), the continuously progressing nature of a pregnancy means that countless women's health will be jeopardized, as the risks associated with both abortion care and pregnancy increase over time. In particular, some will be pushed to a more complex and lengthier procedure; others whose pregnancies progress to 18 weeks LMP will be forced to make an additional trip to the clinic for pre-abortion care; and still others will be pushed past the point in pregnancy where abortion is legal in Arkansas (21.6 weeks LMP). Some of the women who are barred from obtaining care under the COVID-19 Abortion Ban may try to travel in the middle of a pandemic to the next-nearest clinic currently providing surgical abortions, which for many women will be in Granite City, Illinois—a *700-mile* roundtrip drive into a State reporting far higher numbers of COVID-19 infections. This travel will not only impose enormous logistical and financial burdens, but also increase patients' risk of exposure to COVID-19 and the risk of infection for other Arkansas residents upon their return. But many of LFRP's patients—a substantial portion of which are poor or low-income—will be unable to make this journey, and will be forced to carry to term and have a child against their will.

The irreparable harm of the COVID-19 Abortion Ban is ongoing. LRFP is scheduled to provide 26 surgical abortions this week, starting tomorrow, April 14, including to at least 12 patients who are not candidates for a medication (i.e., non-surgical) abortion. The State's interest in fighting COVID-19 is valid, and LRFP wholeheartedly shares it. But the COVID-19 Abortion Ban cannot stand. To protect themselves and their patients from this constitutional violation and to avoid further irreparable harm, Plaintiffs seek declaratory and injunctive relief to prevent further enforcement of the Ban.

STATEMENT OF FACTS

A. Abortion Is Critical, Time-Sensitive Health Care.

Patients seek abortion for a wide range of personal and complex reasons.[3] Most people who have abortions already have at least one child, and many have decided they cannot parent another at this stage of their lives.[4] Some patients have abortions because they conclude that it is not the right time to become a parent, they wish to pursue their education or career, or they lack financial resources or partner or familial support or stability.[5] Other patients seek abortions because existing medical conditions put them at greater-than-average risk of medical complications, because they are in abusive relationships, or because they are pregnant as a result of rape or sexual assault.[6]

Abortions are typically provided in Arkansas using one of two methods: medication abortion or surgical abortion.[7] Consistent with Arkansas law, LRFP provides (i) medication

[3] Williams Decl. ¶ 10 (Ex. 2); Cathey Decl. ¶¶ 28–29 (Ex. 3).

[4] Williams Decl. ¶ 10.

[5] Williams Decl. ¶ 10; Cathey Decl. ¶ 29.

[6] Williams Decl. ¶ 10; Cathey Decl. ¶ 29.

[7] Williams Decl. ¶ 11; Cathey Decl. ¶¶ 25–26.

abortion up to ten weeks (seventy days) LMP, and (ii) surgical abortion up to twenty-one weeks and six days LMP.[8] Both methods are a safe and effective means of terminating a pregnancy, although some patients have medical or other circumstances that make surgical abortion more appropriate for them.[9]

Medication abortion involves taking a combination of two pills, mifepristone and misoprostol, after which the patient expels the contents of the pregnancy in a manner similar to a miscarriage.[10] Not all patients, even those who go to LRFP before 10 weeks LMP, are eligible for medication abortion. For some patients, like those with anemia, medication abortion is contraindicated.[11] In fact, a variety of medical conditions can push women toward surgical abortion rather than medication abortion.[12] And some women who can choose between surgical and medication abortion—that is, women who are less than 10 weeks LMP—often strongly prefer surgical abortion.[13] Although there can be many reasons for this preference, many women prefer surgical care because it allows them to return to work and other responsibilities more quickly.[14]

Despite its name, "surgical" abortion involves no incision or general anesthesia.[15] There are two types of surgical abortion. The first is aspiration abortion, in which gentle suction is

[8] Williams Decl. ¶¶ 12–13.

[9] Williams Decl. ¶¶ 11, 16; Cathey Decl. ¶ 27.

[10] Williams Decl. ¶ 12; Cathey Decl. ¶ 25.

[11] Williams Decl. ¶ 16; Cathey Decl. ¶ 27.

[12] Williams Decl. ¶ 16; Cathey Decl. ¶ 27.

[13] Williams Decl. ¶ 16.

[14] Williams Decl. ¶ 16.

[15] Williams Decl. ¶ 13; Cathey Decl. ¶ 26.

used to safely empty the contents of the uterus.[16] The procedure usually takes approximately 5 to 10 minutes. Beginning at approximately 14 weeks LMP, abortions generally require a still-very-safe but more-complex procedure known as dilation and evacuation, or "D&E" abortion, which requires more procedure and recovery time than the aspiration procedure.[17] A D&E is usually a one-day procedure, but as pregnancy progresses, it becomes a two-day procedure because patients must come into LRFP the day before to begin the process of dilating their cervix.[18] A D&E requires more skill and time, and the cost of abortion care increases with the progression of a pregnancy.[19]

In 2019, LRFP provided approximately 1,950 abortions. Of those, approximately 1,725 were surgical abortions.[20] From January through March 2020, LRFP provided 5 abortions, of which 478 were surgical procedures.[21]

B. Abortion Is Extremely Safe, But Risks Increase When It Is Delayed.

As this Court recently found, abortion in Arkansas (and in the nation as a whole) "is one of the safest medical procedures available." *Little Rock Family Planning v. Rutledge*, 397 F. Supp. 3d 1213, 1279 (E.D. Ark. 2019); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016).[22] In particular, major complications—defined as complications requiring hospital admission, surgery, or blood transfusion—occur in less than one-quarter of one percent

[16] Williams Decl. ¶ 13; Cathey Decl. ¶ 26.

[17] Williams Decl. ¶ 13.

[18] Williams Decl. ¶¶ 13, 22.

[19] Williams Decl. ¶¶ 13, 19, 22.

[20] Williams Decl. ¶ 15.

[21] Williams Decl. ¶ 15.

[22] *See also* Williams Decl. ¶ 9; Cathey Decl. ¶¶ 13–14.

(0.23%) of all abortion cases.[23] Moreover, as this Court found, "legal abortion is significantly safer for a woman than carrying a pregnancy to term and giving birth." *Id.*[24]

In the rare instances when complications from abortion do occur, they can usually be managed in an outpatient-clinic setting, either at the time of the procedure or during a follow-up visit. *Id.* at 1278–79 ("[C]omplications rarely require hospital admission").[25] "Since January 2017, LRFP" has a "rate of 0.07% for complications requiring hospital transfers." *Id.* at 1281.

Surgical abortion requires minimal personal protective equipment ("PPE").[26] For the state-mandated ultrasound before every abortion, LRFP uses only non-sterile gloves.[27] For surgical abortions, the physician uses sterile gloves (one pair per procedure) and a surgical mask (worn throughout the day); the assistant uses only a surgical mask (also worn throughout the day) and gloves.[28] When necessary, LRFP uses reusable gowns and eyewear.[29]

Although abortion is a very safe procedure, the associated health risks increase as pregnancy progresses.[30] Delay may worsen any maternal-health conditions that predate or result from the pregnancy.[31] Delay can likewise push a patient from an aspiration abortion to a more complex and longer D&E or from a one-day procedure to a two-day procedure (beginning at

[23] Cathey Decl. ¶ 23; *see also* Williams Decl. ¶ 9.

[24] *See also* Williams Decl. ¶ 9; Cathey Decl. ¶ 13.

[25] *See also* Williams Decl. ¶ 9; Cathey Decl. ¶ 14.

[26] Williams Decl. ¶¶ 18, 27–28; *see* Cathey Decl. ¶ 43.

[27] Williams Decl. ¶ 18.

[28] Williams Decl. ¶ 18.

[29] Williams Decl. ¶ 18.

[30] Williams Decl. ¶ 22; Cathey Decl. ¶¶ 33–34, 65, 67–68; *see also* Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77–78, 162–63 (2018).

[31] Williams Decl. ¶ 22; Cathey Decl. ¶¶ 33–34.

approximately 18 weeks LMP).[32] And delay can push a patient beyond the point at which abortion is available in the State (i.e., 21.6 weeks LMP), thereby giving rise to a risk that she will attempt to terminate her pregnancy outside the medical system or be forced to carry to term against her will.[33]

C. Even Before the COVID-19 Ban, Women Seeking Abortions in Arkansas Faced Many Hurdles in Obtaining Care.

LRFP's patients generally seek abortion as soon as they are able, but many face logistical obstacles that can delay access to abortion care.[34] Some patients may not discover they are pregnant until later in their pregnancies, while others may experience difficulties navigating the medical system, including finding a provider and scheduling an appointment.[35] Many of LRFP's patients are struggling financially,[36] and patients need to gather the resources to pay for the procedure and related costs. They must also figure out transportation to the clinic, arrange for time off work (which is often unpaid, because many patients lack paid time off or sick leave), and, for many of those patients who are mothers already, arrange childcare.[37] Arkansas's existing legal restrictions increase the challenges facing women who seek care in the State, too. For example, Arkansas law mandates that all patients visit the clinic in-person at least 72 hours before their abortion to receive state-mandated information. *See* Ark. Code § 20-16-1703. Moreover, any woman seeking an abortion must be evaluated via a medical history, a physical examination, counseling, and laboratory tests. *See* Ark. Admin. Code 007.05.2-8(A).

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[32] Williams Decl. ¶ 22; Cathey Decl. ¶ 35.

[33] Williams Decl. ¶¶ 22, 47–48; Cathey Decl. ¶¶ 35–36, 66–67.

[34] *See* Williams Decl. ¶¶ 19–21, 46–47; Cathey Decl. ¶ 30.

[35] Williams Decl. ¶ 19; Cathey Decl. ¶ 30.

[36] Williams Decl. ¶ 19.

[37] Williams Decl. ¶¶ 19–20; Cathey Decl. ¶ 30.

D. LRFP's Initial Response to COVID-19.

On March 11, 2020, Governor Asa Hutchinson issued Executive Order 20-03, declaring a state of emergency in Arkansas due to the outbreak of the COVID-19 virus.[38] Ten days later, on March 21, 2020, ADH issued a public statement (the "March 21 Guidance") recommending that health care facilities and clinicians "prioritize urgent and emergency visits and procedures now and for the coming several weeks."[39] The letter's stated goals were to "preserve staff, personal protective equipment (PPE), and patient care supplies; ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic."[40] The ADH stated that "[p]rocedures … that can be safely postponed shall be rescheduled to an appropriate future date." The ADH's guidance also provided specific exemptions for "small rural hospitals under 60 beds," and clarified that procedures should proceed if there is risk of "progression of staging of a disease or condition if surgery is not performed."[41] The ADH reiterated this guidance in another letter issued on March 30, 2020.[42]

In the meantime, beginning in mid-March, LRFP began to implement measures to protect its patients and staff.[43] LRFP determined that it would cease providing basic gynecological care—i.e., pap smears, STD testing, and contraceptive counseling and services—and that, where

[38] Executive Order to Declare an Emergency, As Authorized by Ark. Code Ann. § 12-75-114, and Order the Arkansas Department of Health to Take Action to Prevent the Spread of COVID-19, as Authorized by Ark. Code. Ann. § 20-7-110, EO 20-03 (March 11, 2020), https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-03.__1.pdf.

[39] Ex. 4.

[40] *Id.*

[41] *Id.*

[42] Ex. 5.

[43] Williams Decl. ¶ 25.

possible and permitted by law, prescriptions would be administered over the phone.[44] LRFP also began performing enhanced telephonic and in-person screening of patients for COVID-19 symptoms, and staggering patient-appointment times to reduce the number of patients at the facility at any given time, minimizing possibilities for exposure.[45]

LRFP expanded on and formalized these precautions in its April 2, 2010 COVID-19 Response Protocol (the "LRFP Protocol"). That protocol sets forth detailed information about (1) postponement of LRFP services for which delay would not risk harm to the patient (i.e., certain gynecological care); (2) screening patients for symptoms of infection, both telephonically and on site; (3) staggering appointment times to minimize in-person contact and shorten the time patients spend in the clinic; (4) spacing individuals at least 6 feet apart in waiting areas to comply with the State's and CDC's "social distancing" guidelines; (5) limiting visitors and support people by requiring that they sit in cars or return home until patients are ready to be picked up; (6) performing temperature checks on all individuals entering the building (including staff); and (7) enhancing infection-control protocols with frequent clinic sanitization and patient-etiquette education.[46] Given these changes, no more than 6 to 8 patients are in LRFP's waiting room at any given time, and once patients are checked in for care, they are in individual treatment rooms except for the time they spend in recovery, during which they are at least 6 feet apart.[47]

The LRFP Protocol also states that "LRFP is aware of the PPE shortage our healthcare system is currently facing," and "is committed to using only the PPE that is necessary to protect

[44] Williams Decl. ¶ 25.

[45] Williams Decl. ¶ 25.

[46] Ex. 6.

[47] Williams Decl. ¶ 26.

[its] patients and staff."[48] LRFP is self-sustaining in terms of PPE for the next several months, and has not availed itself of any PPE offered by the State's medical society.[49] LRFP has no intention of utilizing any state PPE stockpiles or resources, and is prepared to switch to cloth/reusable masks should it become necessary.[50] Care at LRFP does not require the use of N-95 masks, the PPE that appears to be in shortest supply in battling the COVID-19 pandemic.[51] Likewise, because all LRFP's procedures are performed in its own outpatient facility, LRFP is not using any hospital resources that may be needed for COVID-19 response—no hospital staff or supplies, no hospital beds (let alone ICU beds), and no ventilators.[52] LRFP is strictly adhering to its Protocol.[53]

E. Further State Action Against LRFP And Its Patients.

On April 1, 2020, representatives from the ADH called LRFP twice to inquire about what the clinic was doing to reduce non-essential services, preserve PPE, and protect against the spread of COVID-19.[54] On both occasions, LRFP summarized the practices outlined in the LRFP Protocol discussed above.[55] At no point during either conversation did the ADH representatives suggest that LRFP was not complying with the State's elective-surgery guidance.[56]

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[48] Ex. 6.

[49] Williams Decl. ¶ 27.

[50] Williams Decl. ¶ 27.

[51] Williams Decl. ¶ 28.

[52] Williams Decl. ¶ 28.

[53] Williams Decl. ¶ 29.

[54] Williams Decl. ¶ 30.

[55] Williams Decl. ¶ 30.

[56] Williams Decl. ¶ 30.

On April 3, 2020, the ADH issued a Directive reiterating the goals and instructions from the ADH's March 21 Guidance (the "April 3 Directive").[57] The April 3 Directive, like the March 21 Guidance before it, was not intended to stop the provision of medical care in the State; rather, it again stated that "[p]rocedures … that can be safely postponed shall be rescheduled to a future date."[58] It further stated that "urgent" care and "care designated as an exception . . . will continue," including situations in which "there is a risk of . . . progression of staging of a . . . condition if surgery is not performed."[59]

When Governor Hutchinson was asked about the April 3 Directive during an April 6, 2020 press conference, Defendant State Health Director Dr. Nathaniel Smith explained that it is "not intended to replace a physician's judgment," and reiterated that the April 3 Directive encompasses only procedures that can "be safely deferred."[60] At no point during the conference did the Governor or Dr. Smith suggest that surgical abortion was impermissible under the April 3 Directive.[61]

On April 4, 2020, Governor Hutchinson issued Executive Order 20-13, declaring "the entire state an emergency disaster area," and prohibing "gatherings of more than ten (10) people in any confined indoor or outdoor space" "until further notice."[62] The Governor declined,

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[57] Ex. 7.

[58] *Id.*

[59] *Id.*

[60] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 6, 2020), https://www.youtube.com/watch?v=KS2Kb4V8U3I.

[61] Williams Decl. ¶ 31.

[62] Executive Order to Amend Executive Order 20-03 Regarding the Public Health Emergency Concerning COVID-19 for the Purpose of Imposing Further Restrictions to Prevent the Spread of COVID-19, EO 20-13, § 2(a) (Apr. 4, 2020), https://governor.arkansas.gov/images/uploads/executiveOrders/EO_20-13._.pdf.

however, to issue a stay-home order to all Arkansas residents, and continued to permit "gatherings of ten (10) or more people in . . . parks, trails, athletic fields and courts, parking lots, golf courses, and driving ranges where social distancing of at least six (6) feet can be easily maintained."[63] The Order also does "not apply to businesses, manufacturers, construction companies, places of worship, the Arkansas General Assembly, municipal or county governing bodies, or the judiciary," though those entities were also advised to maintain appropriate social-distancing practices.[64] Finally, the Order stated that "pursuant to Ark. Code Ann. § 20-7-101, violation of a directive from the Secretary of Health during this public health emergency is a misdemeanor offense, and upon conviction thereof is punishable by a fine of not less than one hundred dollars ($100) nor more than five hundred dollars ($500) or by imprisonment not exceeding one (1) month, or both."[65]

Protestors appear at LRFP nearly every day that it provides abortion care.[66] Between April 4 and 10, 2020, however, the harassment and intimidation from on-site protestors—who recklessly fail to exercise proper social distancing—significantly increased.[67] They summoned police to the clinic twice.[68] Since the start of COVID-19 concerns, social-media complaints against the clinic have likewise increased, including some specifically requesting action by the Governor and state legislators to stop the provision of abortion care. For example, on March 29, 2020, State Senator Trent Garner announced in a tweet that he had "asked the Governor to [ban

[63] *Id.* § 2(b).

[64] *Id.* § 2(c).

[65] *Id.* § 13.

[66] Williams Decl. ¶ 33.

[67] Williams Decl. ¶ 33.

[68] Williams Decl. ¶ 33.

abortions] in Arkansas …. We shouldn't expose women to the risk of the Wuhan COVID-19 virus for an unnecessary elective procedure, and we could save the unborn babies."[69]

On April 7, ADH inspectors performed an unannounced in-person inspection at LRFP.[70] At no point during the inspection, which occurred on a day during which both surgical and medication abortions were provided, did the ADH representatives suggest that LRFP was not complying with the State's April 3 Directive.[71]

On April 8, 2020, the Governor gave an interview to PBS during which he discussed Arkansas's "targeted" approach to managing risks relating to COVID-19.[72] When asked whether he thinks "that by not requiring or ordering people to stay home, unless they have to be out, is not putting other people at risk," the Governor responded "No."[73] He elaborated that "as long as they do what they're supposed to do, which is social distance, wear a mask when you're out, this accomplishes the purpose."[74] The Governor further said that currently in the State, there are "a lot of hospitals that are empty right now and health care workers that are empty,"[75] presumably meaning that health care workers are available to provide care.

On April 9, the Governor and Dr. Smith were asked at a press conference if "elective

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[69] Ex. 8.

[70] Williams Decl. ¶ 34.

[71] Williams Decl. ¶ 34.

[72] *Arkansas Gov. Asa Hutchinson on why he hasn't issued a stay-at-home order*, PBS (Apr. 8, 2020) https://www.pbs.org/newshour/show/arkansas-gov-asa-hutchinson-on-why-he-hasnt-issued-a-stay-at-home-order; *see also Arkansas governor defends no stay-at-home statewide order as 'successful,'* CNN (Apr. 12, 2020) https://www.cnn.com/2020/04/12/politics/arkansas-governor-no-stay-at-home-order-coronavirus-cnntv/index.html.

[73] *Id.*

[74] *Id.*

[75] *Id.*

surgery" is still permitted in the State, and Dr. Smith responded that judgments at surgical centers would be left primarily to the providers.[76] At no point during the conference did the Governor or Dr. Smith suggest that surgical abortion care is not permissible under the April 3 Directive.[77]

Then, on the morning of April 10, ADH inspectors hand delivered a cease-and-desist order to LRFP (the "C&D Order").[78] It acknowledged that the April 7 inspection "did not reveal any deficiencies with respect to the rules for abortion facilities in Arkansas," but asserted that LRFP was "in violation of the April 3, 2020 Arkansas Department of Health Directive on Elective Surgeries."[79] The C&D Order stated that the April 3 Directive "mandates the postponement of all procedures that are not immediately medically necessary during the COVID-19 emergency," and thus, according to ADH, the "prohibition applies to surgical abortions that are not immediately necessary to protect the life or health of the patient."[80] The C&D Order ordered LRFP to "immediately cease and desist the performance of surgical abortions, except where immediately necessary to protect the life or health of the patient."[81] The C&D Order also stated that "[a]ny further violations of the April 3 Directive will result in an immediate suspension of [LRFP's] license."[82] On April 10, LRFP was scheduled to provide surgical-abortion care to 8 patients whom LRFP had to turn away, including one patient at 17 weeks

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[76] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 9, 2020), https://www.youtube.com/watch?v=Kg-qMqmycAM.

[77] *Id.*

[78] Ex. 1.

[79] *Id.*

[80] *Id.*

[81] *Id.*

[82] *Id.*

LMP.[83]

Later on April 10, the Governor and Dr. Smith held a press conference regarding COVID-19.[84] Consistent with Governor Hutchinson's decision that same week to close Arkansas's public schools for the remainder of the school year,[85] Dr. Smith admitted that he "can't say with certainty" how long the C&D Order against LRFP will be in place.[86] When a reporter pressed a question regarding whether the C&D Order means that "some of [the women who would otherwise visit LRFP] are going to have a baby," the Governor deflected and avoided the critical inquiry by instead asking, "[i]s there a remote [i.e., telephonic] question"?[87]

Meanwhile, a range of medical services continue at facilities around the State. To take just one example, the ADH has expressly permitted orthodontists to continue seeing patients to adjust their orthodontic wires and appliances, and dentists may treat patients whom complain of a cracked tooth.[88] And Arkansas has relaxed telemedicine rules for every medical treatment except abortion—indeed, even the pre-abortion-care, state-mandated informed-consent process must still occur in-person.[89]

F. Medical Experts Have Determined That Abortion Care Remains Critical, Time-Sensitive Health Care That Should Not Be Delayed Even During the Pandemic.

Widely respected national medical organizations have concluded that abortion is a time-

[83] Williams Decl. ¶ 38.

[84] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 10, 2020), https://www.youtube.com/watch?v=X2v1SIesdyc.

[85] Ex. 9.

[86] Channel for Gov. Asa Hutchinson, *Governor Hutchinson Provides COVID-19 Update*, YouTube (Apr. 10, 2020), https://www.youtube.com/watch?v=X2v1SIesdyc.

[87] *Id.*

[88] Ex. 10.

[89] Ex. 11.

sensitive, urgent form of health care that even the COVID-19 pandemic should not delay:

- ACOG, the American Board of Obstetrics & Gynecology, the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine issued a joint statement on "Abortion Access During the COVID-19 Outbreak" providing that "[t]o the extent … hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure."[90] Abortion, these expert medical organizations concluded, "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[91]

- The American Medical Association ("AMA")—the country's largest medical organization and one of its foremost authorities on medical and public-health matters—concurs. The AMA's March 30, 2020 Statement on Government Interference in Reproductive Health Care disapproves of efforts "to ban or dramatically limit women's reproductive health care" during the COVID-19 outbreak by "labeling procedures as 'non-urgent.'"[92]

- On April 4, 2020, the World Health Organization ("WHO") issued a similar statement concluding that "[a]bortion is considered an essential service during the coronavirus pandemic" and that "services related to reproductive health are considered to be part of essential services during the COVID-19 outbreak."[93]

- The Ambulatory Surgery Center Association's and the American College of Surgeons recommend that consideration of whether a surgery should appropriately be delayed during the pandemic must account for risk to the patient, "including the expectation that a delay of 6–8 weeks or more may be required to emerge from an environment in which COVID-19 is less prevalent."[94]

At least 19 States and the District of Columbia have similarly concluded that abortion is an essential aspect of women's healthcare that should continue despite the challenges posed by

[90] Ex. 12.

[91] *Id.*

[92] Ex. 13.

[93] Ex. 14.

[94] Ex. 15.

COVID-19.[95] As one large group of States explained in an amicus brief, their experiences "demonstrate that the present public health crisis can be addressed effectively without denying access to abortion services."[96] Moreover, "because abortions cannot readily be postponed for weeks or months, and also effectuate the constitutional right to choose to terminate a pregnancy prior to fetal viability, abortions are on a different footing from the types of medical services that can be considered 'nonessential.'"[97]

G. Forcing Women To Continue Their Pregnancies During the Pandemic Is Harming Patients and Arkansas's Health Care System.

The COVID-19 pandemic has exacerbated the already-significant obstacles that women seeking abortion care in Arkansas face. During the current crisis, patients must navigate the pre-existing barriers to care against a formidable backdrop of heightened job insecurity, minimal public-transit availability, and limited childcare assistance during school closures.[98] Moreover, as jobless claims continue to soar,[99] fewer people will be able to afford the costs of securing critical abortion care. All these factors can cause delays in obtaining care which, in turn, result in higher physical, financial, psychological, and emotional costs to patients.

For these reasons, and the ones detailed above, many women are unable to seek care at LRFP before 10 weeks LMP and are therefore ineligible to obtain a medication abortion. In

[95] *See* Amicus Br. for 18 States and the District of Columbia in Support of Respondents, *In re Abbott*, No. 20-50264 (5th Cir. Apr. 3, 2020) [hereinafter "States Amicus Br."]; Ex. 16 ("The order provides that it shall not be interpreted in any way to limit access to family planning services, including termination of pregnancies.").

[96] States Amicus Br. 4.

[97] States Amicus Br. 4.

[98] Williams Decl. ¶ 46.

[99] *See* Ex. 17.

addition, there are others for whom medication abortion is not medically appropriate.[100] Unless the Court enjoins the COVID-19 Abortion Ban, all these women will, at best, unnecessarily face the risks of continued pregnancy, and—assuming they are ultimately able to access abortion care—the increased and wholly unnecessary risks associated with delayed abortion care.[101] Some will be pushed to the more complex and lengthier D&E procedure necessary after approximately 13 weeks LMP; others whose pregnancies are pushed past 18 weeks LMP will be required to make additional visit to the clinic to obtain the care they need.[102] All that assumes, however, that these women will be able to obtain care at LRFP when the COVID-19 Abortion Ban is lifted; LRFP has limited staff and capacity, and likely will not be able to treat all the women who would need near-term care after waiting and being delayed for weeks—if not months.[103] And given that the public-health crisis is expected to last weeks if not months, many others will be pushed past the point at which they can obtain an abortion in Arkansas at all.[104]

Women who cannot obtain abortion care in Arkansas will have no good options: The next-nearest clinic providing surgical abortions is in Shreveport, Louisiana (a more than 600-mile roundtrip drive from Fayetteville, Arkansas), but that clinic provides care only up to 16.6 weeks LMP and is subject to continuing threats of closure.[105] Many women will thus be forced to travel to Granite City, Illinois, which is not only a more-than-700-mile roundtrip drive from Little Rock, but it—like Shreveport—is in a State with a far higher incidence of COVID-19.

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[100] Williams Decl. ¶¶ 16, 47; Cathey Decl. ¶ 27.

[101] Williams Decl. ¶¶ 22, 46–49; Cathey Decl. ¶¶ 33–34, 68–70.

[102] Williams Decl. ¶ 22; Cathey Decl. ¶ 35.

[103] Williams Decl. ¶ 48; Cathey Decl. ¶ 70.

[104] Williams Decl. ¶¶ 46–49; Cathey Decl. ¶¶ 36, 63–66.

[105] Williams Decl. ¶ 47.

(Illinois has reported 17,887 cases of COVID-19 and 596 deaths,[106] whereas Arkansas has 1,171 reported cases and 23 deaths[107]). And there is no guarantee that the clinic in Granite City will have the capacity to treat women who would have otherwise obtained care in Arkansas. Thus, even if women obtain treatment outside Arkansas, they do so only at heightened risk of contracting COVID-19 and carrying it back to this State. But many of LFRP's patients will not even be able to make the trip and will instead be forced to carry to term against their will or seek to terminate their pregnancy outside the medical system.[108]

Every day that a woman remains pregnant against her will, she not only experiences the emotional and physical consequences of continuing pregnancy, but also risks contracting the COVID-19 virus, thereby further jeopardizing her ability to visit a clinic and receive time-sensitive care.[109] In addition, the longer a woman remains pregnant—and especially if forced to carry a pregnancy to term—the heavier burden she places on the health care system, the more interactions she must have with a variety of clinicians and staff, and the much greater use of PPE her care requires.[110] An uncomplicated pregnancy typically requires a minimum of one prenatal appointment per month, along with additional appointments to complete laboratory tests and ultrasounds.[111] For a complicated or high-risk pregnancy, the number of visits frequently

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[106] *See* Ill. Dep't of Pub. Health, Coronavirus Disease 2019 (COVID-19), https://www.dph.illinois.gov/covid19 (visited Apr. 10, 2020).

[107] *See* Ark. Dep't of Health, COVID-19, https://www.healthy.arkansas.gov/programs-services/topics/novel-coronavirus (visited Apr. 10, 2020).

[108] Williams Decl. ¶¶ 46–48; Cathey Decl. ¶¶ 63, 67.

[109] Williams Decl. ¶ 49; Cathey Decl. ¶ 69.

[110] Williams Decl. ¶ 49; Cathey Decl. ¶¶ 44–45.

[111] Cathey Decl. ¶ 44.

doubles.[112] Moreover, pregnant women commonly experience shortness of breath, vomiting, and other symptoms that are also common symptoms of COVID-19; appropriate medical care for pregnant patients during the COVID-19 pandemic is therefore even more complicated, and will frequently lead to the isolation and hospitalization—with PPE use—of pregnant patients who could have the infection.[113]

Virtually all births in Arkansas occur in hospitals, and pregnant patients typically present at a hospital one or more times prior to actual delivery.[114] An uncomplicated birth is attended by at least four clinicians, over a considerable labor period, with significant use of PPE.[115] A complicated birth involves 6 to 7 providers with even more PPE.[116] One-third of pregnancies result in caesarean section, a major abdominal surgery.[117] And after giving birth, patients remain in the hospital for multiple days.[118] Throughout labor, delivery, and recovery, patients are having repeated close contact with large numbers of people in the hospital and taking up hospital beds.[119] Even with this extensive health care before and during delivery, Arkansas has one of the highest rates of maternal mortality in the country.[120]

Banning surgical abortion is thus flatly contradictory to Arkansas's stated objectives in issuing ADH's elective-surgery guidance: Banning abortion does not preserve PPE, but rather

[112] Cathey Decl. ¶ 44.

[113] Cathey Decl. ¶¶ 18, 44–47.

[114] Cathey Decl. ¶ 49.

[115] Cathey Decl. ¶ 50.

[116] Cathey Decl. ¶ 51.

[117] Cathey Decl. ¶ 21.

[118] Cathey Decl. ¶ 52.

[119] Cathey Decl. ¶ 54.

[120] Cathey Decl. ¶ 22.

increases the overall need for it. And it does not reduce, but rather exacerbates, the burden on the health care system. That Arkansas has continued to allow a variety of non-essential activities to continue during the pandemic—including significant retail activity, leisure time on golf courses and driving ranges, and small-group fairs and festivals, *see supra* pp.12–13—while banning all surgical abortion under the pretext that abortion is a non-essential service reveals the COVID-19 Abortion Ban for what it is: part of the State's long-running campaign to severely restrict or outright eliminate women's ability to access constitutionally guaranteed health care. *See* Dkt. No. 1 (original complaint).

Beginning tomorrow, April 14, 2020, LRFP has 26 patients scheduled to receive surgical abortion care this week, including:

- 12 who are more than 10 weeks LMP (i.e., patients who are not candidates for a medication abortion);
- 8 who are more than 12 weeks LMP, and will soon require a D&E instead of an aspiration abortion to terminate their pregnancy if their abortion is delayed; and
- 3 who are more than 17 weeks LMP, and will soon require a two-day procedure instead of a one-day procedure, and in short order be past Arkansas's legal limit for abortion care.[121]

ARGUMENT

Plaintiffs seek an *ex parte* TRO, and thereafter a preliminary injunction, to prevent Defendants from enforcing the COVID-19 Abortion Ban, which would inflict imminent and irreparable injury on Plaintiffs' patients by depriving them of the health care to which they have a right under the Constitution and that is necessary to protect themselves from serious harm. As explained in Plaintiffs' motion and verified First Supplemental Complaint, the requirements for an *ex parte* TRO have been met because (1) Plaintiffs and their patients will suffer irreparable

[121] Williams Decl. ¶ 40.

harm if relief is not immediately granted to preserve the status quo before Defendants have an opportunity to be heard, and (2) Plaintiffs have tried to resolve this matter without litigation and have expressly informed Defendants that Plaintiffs would seek emergency relief if the matter could not otherwise be resolved. *See* Fed. R. Civ. Proc. 65(b).[122] And as explained more below, the four facts that this Court considers in deciding whether to grant a TRO and subsequent preliminary injunctive relief all tip heavily in Plaintiffs' favor: the (1) probability that the movant will succeed on the merits; (2) threat of irreparable harm to the movant; (3) balance of equities; and (4) public interest. *See Grasso Enters., LLC v. Express Scripts, Inc.*, 809 F.3d 1033, 1036 n.2 (8th Cir. 2016).

Plaintiffs are likely to succeed on the merits of their claim that the COVID-19 Abortion Ban directly contravenes decades of binding Supreme Court precedent and is unjustified by the current crisis. Additionally, enforcement of the Ban will inflict severe and irreparable harm on Plaintiffs' patients while failing to advance the State's purported interests. Plaintiffs have already been forced to turn away at least one woman approaching the legal limit for abortion in Arkansas.[123] LRFP has at least three other women scheduled to receive abortion care this coming week who are likewise approaching the gestational limit.[124] They will all be forced to carry their pregnancies to term against their will or, in the midst of a pandemic, assume the substantial burdens associated with attempting to travel to another State to exercise their constitutional right to access pre-viability abortion care. This is immediate, irreparable harm under any definition. *See, e.g.*, *Tempur-Pedic Int'l, Inc. v. Waste to Charity, Inc.*, 2007 WL

[122] Godesky Decl. ¶¶ 4–5.

[123] Williams Decl. ¶¶ 38, 47.

[124] Williams Decl. ¶ 40.

535041, at *1 (W.D. Ark. Feb. 16, 2007) (granting ex parte TRO to prevent "incalculable and irreparable injury to [plaintiff's] reputation and good will as well as the harm done to the public" by defendants' misappropriation and resale of plaintiffs' products); Order, *Robinson v. Marshall*, No. 2:19-cv-365 (M.D. Ala. Mar. 30, 2020) (Dkt. No. 83) (granting request for *ex parte* TRO to enjoin enforcement of ban on abortion). Finally, the balance of hardships weighs decisively in Plaintiffs' favor, and the public interest would be served by blocking the enforcement of the unconstitutional and harmful ban. This Court should grant Plaintiffs' request for injunctive relief.

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

A. The COVID-10 Abortion Ban Is Unconstitutional Because It Bans Pre-Viability Abortions.

For nearly five decades, the Supreme Court has been clear that a State may not ban pre-viability abortion. *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 163–65 (1973); *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 846 (1992) (plurality op.) (reaffirming *Roe*'s "central principle" that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion"). The Supreme Court has repeatedly reaffirmed *Roe*'s central holding, most recently in 2016. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). This Court, too, recently said that the law is clear that "prohibitions on abortions pre-viability . . . are *per se* unconstitutional under binding Supreme Court precedent." *Little Rock Family Planning Servs.*, 397 F. Supp. 3d at 1266.

This cardinal principle is not altered in circumstances where—as here—the State permits some abortions to proceed under a ban. Indeed, the Eighth Circuit struck down a law banning abortion after 12 weeks of pregnancy, explaining that "[w]hether or not 'exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision

to terminate her pregnancy before viability.'" *Edwards v. Beck*, 786 F.3d 1113, 1117 (8th Cir. 2015) (quoting *Casey*, 505 U.S. at 879). Courts across the nation have come to the same conclusion. *See also, e.g.*, *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015) (ban on abortions after six weeks); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265, 271-73 (5th Cir. 2019) (ban on abortions starting at fifteen weeks); *Isaacson v. Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013) (ban on abortions starting at twenty weeks); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996) (ban on abortions starting at twenty weeks); *Sojourner T. v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992) (ban on all abortions with exceptions); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69, 1371–72 (9th Cir. 1992) (ban on all abortions); *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630–32 (M.D.N.C. 2019) (ban on abortions starting at twenty weeks).[125] This is because the availability of abortions for *some* women "does not [] alter the nature of the burden" that a ban on pre-viability abortion imposes on women who do not fall within an exception to that ban. *Horne*, 716 F.3d at 1227.

In fact, and directly on point here, a district court in Alabama held yesterday that a ban on certain abortions during the COVID-19 pandemic is unconstitutional under *Roe* and its progeny. *See Robinson v. Marshall*, No. 2:19-cv-365, slip op. at 22 n.6, 31–34 (M.D. Ala. Apr. 12, 2020). That court explained that, notwithstanding the State's interests in "preserving healthcare resources

[125] *See also, e.g.*, *Robinson v. Marshall*, 415 F. Supp. 3d 1053 (M.D. Ala. 2019) (ban on nearly all abortions); *SisterSong Women of Color Reprod. Justice Collective v. Kemp*, 410 F. Supp. 3d 1327 (N.D. Ga. 2019) (ban on abortions after six weeks); *Reprod. Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Parson*, 389 F. Supp. 3d 631 (W.D. Mo. 2019), *modified*, 408 F. Supp. 3d 1049 (W.D. Mo. 2019) (ban on abortions after various weeks); *Preterm-Cleveland*, 394 F. Supp. 3d at 796 (enjoining ban on abortion at six weeks); *Jackson Women's Health Org. v. Dobbs*, 379 F. Supp. 3d 549 (S.D. Miss. 2019), *aff'd*, 951 F.3d 246 (5th Cir. 2020) (ban on abortions after six weeks); Order Granting Stipulated Preliminary Injunction as to State Defendants, *Planned Parenthood Ass'n of Utah v. Miner*, No. 2:19-cv-00238 (D. Utah Apr. 18, 2019), Dkt. No. 34 (ban on abortions after eighteen weeks).

and reducing close social contact, . . . the choice to terminate a pregnancy before viability must belong to the woman, not the State." *Id.* at 33.

The same is true here: Unless enjoined, the COVID-19 Abortion Ban will act as a ban on virtually all pre-viability abortions after 10 weeks LMP, *see supra* p.5, and a complete ban for patients for whom medication abortion is contraindicated. As such, it is flatly unconstitutional under decades of Supreme Court precedent, including *Roe*. This Court should grant an *ex parte* TRO (and then a preliminary injunction) because Plaintiffs are certain to prevail on the merits of their challenge to the Ban.

B. Even If The Undue-Burden Test Applies to the COVID-19 Ban, Plaintiffs Are Likely To Prevail.

Defendants will likely argue that because of the current crisis, the Court should apply the undue-burden test to evaluate the COVID-19 Abortion Ban's constitutionality. *Cf. In re Abbott*, 2020 WL 1685929, at *1 (5th Cir. Apr. 7, 2020) (holding that "*Casey*'s undue-burden analysis" applied to COVID-19 regulation of abortion). Even if the undue-burden standard applies, Plaintiffs are likely to succeed because the burdens of the COVID-19 Abortion Ban far outweigh its purported benefits. Under the undue-burden test, a regulation of abortion that "has the effect of placing a substantial obstacle in the path of a woman's choice" even "while furthering [a] valid state interest," "cannot be considered a permissible means of serving its legitimate ends." *Whole Woman's Health*, 136 S. Ct. at 2309 (alteration in original) (quoting *Casey*, 505 U.S. at 877). This test "requires courts to consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2298.

As detailed below, nothing about the COVID-19 pandemic justifies banning surgical abortion and the burdens of doing so are extreme. Indeed, just yesterday, the above-referenced district court in Alabama reasoned—in granting a preliminary injunction relating to a COVID-

19-related abortion ban—that to the extent the undue-burden standard applied—the ban "pose[d] a substantial obstacle to many women in Alabama." *Robinson*, *supra*, slip op. at 35. As to burdens, the court observed that postponement of abortions during the pandemic "would amplify existing challenges" in accessing abortion care, "pose severe health risks, and render abortions functionally unavailable for at least some women." *Id.* at 37. On the other side of the ledger, the State's purported interests in the ban—"the preservation of healthcare resources (including personal protective equipment) and the prevention of close social contact"—"fall far short." *Id.* at 37–38. "[M]ost abortions and related appointments require a limited amount of [PPE]," the *Robinson* court observed; "a delayed abortion does not erase . . . the patient's short-term need for medical care"; and continued pregnancy requires far more PPE than abortion. *Id.* at 38–42. Because the burdens of Alabama's restriction on abortion during the pandemic far outweighed its benefits, the district court held "that the burden imposed by the [] restriction is undue." *Id.* at 42. This Court should reach the same conclusion here.

1. The burdens arising from enforcement of the COVID-19 Abortion Ban are substantial.

As to its burdens, the Ban is prohibiting surgical abortion entirely (absent a threat to the patient's health or life) during the COVID-19 pandemic—which could last for months. Indeed, Defendant Smith recently acknowledged during a press conference that he cannot say with certainty when the COVID-19 Abortion Ban would end. *See supra* p.16. The potential length of the Ban is underscored by Arkansas's decision last week to cancel school through the end of the year. *See id*. Although abortion is a very safe procedure, the associated health risks increase as pregnancy progresses.[126] Delay in receipt of care leads to myriad harms, and leading medical

[126] Williams Decl. ¶ 22; *see also* Nat'l Acads. of Scis. Eng'g & Med., The Safety & Quality of Abortion Care in the United States 77–78, 162–63 (2018).

organizations around the country unanimously agree that abortion care cannot be safely postponed during the COVID-19 pandemic. *See supra* p. 17.

In addition to delay, many women will be burdened by attempts to travel extreme distances beyond Arkansas to obtain care—indeed, the only option to receive care for many of LRFP's patients is to make logistical and financial arrangements for a 700-mile trip that will simply not be feasible for many women (and assumes that the clinic in Illinois has sufficient capacity to treat them). *See supra* pp. 18–20. Those women will be forced to carry to term against their will or terminate their pregnancies outside the medical system. *See id*. And for the women who *are* able to travel to Illinois to receive care, they will do so at a risk of contracting COVID-19 and spreading it to other Arkansas citizens. *See id.*

These harms are particularly acute for those LRFP patients for whom the COVID-19 Abortion Ban will:

> (i) worsen any maternal-health conditions that predate the pregnancy or result from the pregnancy;
>
> (ii) likely stand in the way of the patient ultimately accessing abortion care, because of patient-specific factors like medical history, the circumstances that led to the patient's decision to seek care in the first place (e.g., domestic violence), and the logistical and financial obstacles faced by the patient;
>
> (iii) bar access to abortion because medication abortion is contraindicated;
>
> (iv) push from a less time-intensive and less expensive aspiration abortion to a D&E, which is required after approximately 14 weeks LMP (assuming that LRFP has the capacity to treat these patients);
>
> (v) require the patient to visit the clinic an additional time for a two-day procedure, instead of a one-day procedure, which begins at approximately 18 weeks LMP (again, making an adequate-capacity assumption); or
>
> (vi) push beyond the point at which abortion is available in the State (i.e., 21.6 weeks LMP, *see* Ark. Code Ann. § 20-16-1405).

2. The COVID-19 Abortion Ban has few, if any, benefits.

On the other side of the ledger, the Ban has few, if any, benefits. Because Defendants' actions do not serve these interests, they necessarily cannot outweigh the burdens on patients' constitutional rights. *Cf. Chandler v. Miller*, 520 U.S. 305, 319, 323 (1997) (holding unconstitutional Georgia law requiring candidates for political office to take a urinalysis drug test because, while it was "relatively noninvasive," it did not advance any state interests); *Harper v. Va. State Bd. of Elections*, 383 U.S. 663, 670 (1966) (invalidating de minimis poll tax, notwithstanding States' wide latitude to regulate the electoral process, because it conferred no legitimate benefit); *SpeechNow.org v. Fed. Election Comm'n*, 599 F.3d 686, 695 (D.C. Cir. 2010) (en banc) (holding law unconstitutional because "the First Amendment cannot be encroached upon for naught" and "something . . . outweighs nothing every time" (alteration in original).

With regard to PPE, LRFP is wholly self-sustaining and has no plans to utilize the State's PPE stockpile. *See supra* pp. 10–11. Nor is the COVID-19 Abortion Ban necessary to address social-distancing concerns: LRFP has already implemented a strict protocol that keeps patients at least 6 feet apart from one another during the entirety of their clinic visit. *See supra* p. 10. As to hospital capacity, legal abortion is exceptionally safe and almost never requires hospitalization. *See Whole Woman's Health*, 136 S. Ct. at 2311–12, 2315; *see also supra* pp. 4–6. And because all LRFP's procedures are performed in its own outpatient facility, it is not using any hospital resources that may be needed for COVID-19 response—no hospital staff or supplies, no hospital beds (let alone ICU beds), and no ventilators. *See supra* p. 11.

Indeed, abortions *reduce* rather than exacerbate burdens on Arkansas's health care system. Every day that a woman remains pregnant against her will, she not only experiences the

emotional and physical consequences detailed above, but also risks contracting the COVID-19 virus, thereby jeopardizing her ability to visit a clinic and receive time-sensitive care. *See supra* pp. 20–21. In addition, the longer a woman remains pregnant—and especially if forced to carry a pregnancy to term—the heavier of a burden she places on an already-strained healthcare system and the State's PPE resources. *See supra* pp. 20–21.

* * * * * *

Plaintiffs have thus established that they are likely to succeed on the merits of their claim that the COVID-19 Abortion Ban violates the substantive due process rights of their patients. *See Casey*, 505 U.S. at 878 ("Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right."); *see also Whole Woman's Health*, 136 S. Ct. at 2309.

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

The State may argue that language cherry-picked from a 1905 case, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), rather than the standard that the Supreme Court has specifically identified and applied in abortion cases like *Roe, Casey,* and *Whole Woman's Health*, governs the Ban's constitutionality. Any such suggestion is wrong.

Jacobson is not a case about the State's powers during an emergency. Rather, that case—which was decided the same year as *Lochner v. New York*, 198 U.S. 45 (1905), i.e., at a time when the power of the State to enact measures for the health and safety of its citizens was far less established—stands for the now-unremarkable proposition that States may pass measures "to safeguard the public health and the public safety." 197 U.S. at 25.

Moreover, in recognizing States' police powers, the Court explicitly recognized that those powers could not be used to "contravene the Constitution of the United States or infringe any right granted or secured by that instrument." *Id*. It explained that to pass constitutional

muster, an exercise of the police power—there a compulsory vaccination law—must have a "real or substantial relation to the protection of the public health and the public safety" and be "justified by the necessities of the case." *Id*. at 28, 31. That test was the generally applicable test at the time, *see Women's Kansas City St. Andrew Soc. v. Kansas City*, 58 F.2d 593, 598 (8th Cir. 1932) (applying *Jacobson* test to challenge to zoning ordinance that forbid plaintiff from using property to operate nursing home), which long predated the Supreme Court's development of heightened standards of scrutiny, not to mention today's substantive due process jurisprudence, including in *Roe*, *Casey*, and *Whole Woman's Health*. *See, e.g.*, Richard H. Fallon, Jr., *Strict Judicial Scrutiny*, 54 UCLA L. Rev. 1267 (2007) (tracing evolution of heightened constitutional scrutiny from collapse of *Lochner* era through *Carolene Products* to 1960s).

Thus, far from diluting the protection given liberty interests in emergencies, *Jacobson* recognized a liberty interest in pursuing the medical treatment one believed best for one's self. Indeed, subsequent Supreme Court decisions have expressly understood *Jacobson* in this manner, noting that *Jacobson* "balanced an individual's liberty interest in declining an unwanted smallpox vaccine against State's interest in preventing disease," in much the same way as that the Court evaluates liberty interests today. *Cruzan ex rel. Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); *see also, e.g.*, *Sell v. United States*, 539 U.S. 166 (2003). Lower courts have similarly recognized that *Jacobson* does not supplant the modern substantive constitutional test applied to the right in question. *See, e.g.*, *Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F.3d 396, 419–20 (6th Cir. 2019) (applying strict scrutiny to substantive due process claim, even where the challenged program "may be an example of a state's proper exercise of its *parens-patriae* role" (citing *Jacobson*, 197 U.S. at 38)); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348, 352–54 (4th Cir. 2011) (assuming strict scrutiny

applies to free exercise challenge to vaccination requirement (citing *Jacobson*, 197 U.S. at 12)). Indeed, even the Fifth Circuit, which relied heavily on *Jacobson* in granting a writ of mandamus in a case similar to this one, ultimately did so because the district court failed to apply *Casey's* undue-burden test. *In re Abbott*, No. 20-50296, slip op. at 2–3 (5th Cir. Apr. 10, 2020).[127]

Thus, nothing in *Jacobson* requires this Court to deviate from the well-established jurisprudence that applies to restrictions on the right to abortion and Plaintiffs are likely to succeed on the merits of their claim that the COVID-19 Abortion Ban is unconstitutional.

II. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS OF THEIR EQUAL PROTECTION CLAIM.

The COVID-19 Abortion Ban treats abortion providers differently than other businesses and healthcare providers, and it treats patients seeking abortions differently than other patients. That differential treatment is not justified by any legitimate governmental interest. Plaintiffs are therefore also likely to succeed on the merits of their claim that the Ban violates the Equal Protection Clause. In fact, the Ban's imposition of unnecessary restrictions on abortion providers and patients fails equal protection review under any level of scrutiny.

The Equal Protection Clause is "essentially a direction that all persons similarly situated should be treated alike." *Stevenson v. Blytheville Sch. Dist. #5*, 800 F.3d 955, 970 (8th Cir. 2015). "Generally, a law will survive . . . scrutiny if the distinction it makes rationally furthers a

[127] Even if the Court believed that *Jacobson* had some bearing on this case *and* supplied some lesser standard of scrutiny applicable to infringement of abortion rights, Arkansas's Ban would still fail. *Jacobson* upheld a smallpox-vaccination requirement *only after* "balanc[ing] [the defendant] individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan*, 497 U.S. at 278 (citing *Jacobson*, 197 U.S. at 24–30). The Ban fails such balancing because, as explained above, it goes "beyond the necessity of the case" in restricting abortion access under the guise of Arkansas's police powers; it "has no real or substantial relation to" the State's purported interests in conserving PPE or hospital capacity; and it "is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law." *Jacobson*, 197 at 28, 30; *see supra* Part I.B.

legitimate state purpose." *Zobel v. Williams*, 457 U.S. 55, 60 (1982). "The State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 446 (1985). "Some particularly invidious distinctions are subject to more rigorous scrutiny." *Zobel*, 457 U.S. at 60.

Where government action discriminates on the basis of a fundamental right, such as the right to access pre-viability abortion care, equal-protection analysis requires strict scrutiny. *See Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 312 & n.3 (1976) (noting classifications burdening fundamental rights are reviewed under strict scrutiny); *Craigmiles v. Giles*, 312 F.3d 220, 223 (6th Cir. 2002) ("When a statute regulates certain 'fundamental rights' (*e.g.* voting or abortion) . . . the statute is subject to 'strict scrutiny.'"). As the Supreme Court recently noted in adjudicating the undue-burden claim in *Whole Woman's Health*, it would be "wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue." 136 S. Ct. at 2309–10. Such heightened equal protection review requires close tailoring to extremely weighty state interests. *See, e.g.*, *Grutter v. Bollinger*, 539 U.S. 306, 326 (2003).

The COVID-19 Abortion Ban cannot withstand any heightened equal protection scrutiny. It singles out patients seeking abortion care (and abortion providers) for unique regulation, even though doing so undermines rather than advances the State's interests in combatting the current pandemic. *See, e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 791 (7th Cir. 2013) (noting equal protection problem when State regulates abortion care in manner different than other medical care without medical justification). Arkansas has allowed other patients to obtain medical services under the terms of the earlier ADH guidance, which allows

"healthcare facilities and clinicians" to determine themselves what constitutes "urgent and emergency visits and procedures" and to continue to provide that care. Patients of dentists and orthodontists are free to schedule appointments to address cracked teeth and wiring on braces. *See supra* p. 16. The State has also allowed most businesses to remain open as long as they observe social-distancing practices. *See supra* p. 13. And it has specifically allowed golf course and driving ranges to remain open, parades of ten or fewer people, and fairs and festivals of fewer than ten people. *See supra* pp. 21–22. That Defendants would assert that even some people seeking abortions should be forced to wait indefinitely to exercise their constitutional rights, but golf games and retail therapy can proceed unchecked, only underscores the credible fear that patients seeking abortion care and their doctors are being singled out based on hostility to abortion rather than a need to further a state interest legitimately. *Cf. The Florida Star v. B.J.F.*, 491 U.S. 524, 540 (1989) (such underinclusiveness undercuts legitimacy of asserted governmental interest).

And while LRFP has determined—consistent with the determinations of the AMA, ACOG, and the WHO—that abortion is a time-sensitive, urgent form of health care that cannot be delayed without placing a patient at risk of suffering serious and/or irreparable harm, *see supra* pp. 10–11, 16–18, the Ban precludes Plaintiffs' patients from obtaining surgical abortion care during the pandemic. Patients of other health care providers have not been singled out in the same manner, nor are their health care providers prevented from exercising their best medical judgment to determine whether and what healthcare must proceed during the pandemic. This differential treatment, which affects a fundamental constitutional right, flatly violates the guarantees of the Equal Protection Clause. *See, e.g.*, *Schimel*, 806 F.3d at 914 (reasoning that State's "indifferen[ce] to complications of any other outpatient procedures, even when they are

far more likely to produce complications than abortions" undermines its interest); *Van Hollen*, 738 F.3d at 790 (explaining that "[a]n issue of equal protection of the laws is lurking in this case" because "the state seems indifferent to complications from non-hospital procedures other than surgical abortion (especially other gynecological procedures), even when they are more likely to produce complications," such as colonoscopies).

The Ban cannot even withstand rational basis review. It treats abortion providers and patients "differently . . . than similarly situated persons." *Stevenson*, 800 F.3d at 972. Providers of comparable procedures are not precluded from exercising their best medical judgment about what care is emergent or urgent and thus may be provided during the current pandemic. That differential treatment violates Plaintiffs' and their patients' equal protection rights. *See Romer v. Evans*, 517 U.S. 620, 633 (1996) (holding that law that on its face imposes a "special disability" on one group alone violates equal protection guarantee).

Moreover, as detailed above, the COVID-19 Abortion Ban does not advance any legitimate state interest. *See supra* Part I.B.2. As the Supreme Court has explained, "if the constitutional conception of 'equal protection of the laws' means anything, it must at the very least mean that a bare . . . desire to harm a politically unpopular group cannot constitute a legitimate governmental interest." *Dep't of Agric. v. Moreno*, 413 U.S. 528, 534 (1973); *see also Cleburne*, 473 U.S. at 448 ("Private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect."); *Ranschburg v. Toan*, 709 F.2d 1207, 1211 (8th Cir. 1983) ("An intent to discriminate is not a legitimate state interest."). In fact, the Supreme Court has specifically cautioned against laws that single out abortion facilities for differential treatment. *See Whole Woman's Health*, 136 S. Ct. at 2315 (finding no legitimate safety reason

for singling out abortion facilities because "abortions taking place in an abortion facility are safe—indeed safer than numerous procedures that take place outside hospitals").

Although rational-basis review does not "require a perfect or exact fit between the means used and the ends sought," *Walker v. Hartford Life & Accident Ins. Co.*, 831 F.3d 968, 978–79 (8th Cir. 2016), it is "not toothless," *Kansas City Taxi Cab Drivers Ass'n, LLC v. City of Kansas City*, 742 F.3d 807, 810 (8th Cir. 2013). Instead, equal protection review requires, at a minimum, that a statute's discriminatory line-drawing be rationally related to a legitimate state interest. Here, there is simply no plausible policy reason for singling out abortion providers and patients for more stringent restrictions during the pandemic. Indeed, the Ban does not advance the State's purported interests *at all*; much less does treating abortion providers and patients more strictly than other health care workers and patients. Plaintiffs are accordingly likely to prevail on the merits of their claim that the COVID-19 Abortion Ban violates the Equal Protection Clause. *See, e.g.*, *Planned Parenthood of Greater Ohio v. Hodges*, 188 F. Supp. 3d v684, 693–94 (S.D. Ohio 2016) (granting preliminary injunction and finding plaintiffs likely to succeed on equal protection challenge to state funding law that singled out abortion for different treatment); *Planned Parenthood of Kan. v. Lyskowski*, 2015 WL 9463198 (W.D. Mo. Dec. 28, 2015) (granting preliminary injunction upon finding plaintiff likely to succeed on claim that state agency violated Equal Protection Clause by treating abortion facility more harshly than others in ambulatory-surgical-center licensing process); *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health*, 984 F. Supp. 2d 912, 921–25 (S.D. Ind. 2013) (granting preliminary injunction and finding plaintiffs likely to succeed on equal protection challenge to requirement that abortion clinics, but not physician's offices, meet physical plant requirements).

III. PLAINTIFFS' PATIENTS WILL SUFFER IRREPARABLE HARM IF THE BAN IS ENFORCED.

Plaintiffs' patients are and will continue to suffer serious and irreparable harm in the absence of an *ex parte* TRO and preliminary injunction. *First*, Defendants' actions will prevent Arkansas women from exercising their fundamental constitutional right to access pre-viability abortion care and it will treat abortion providers and patients differently than other healthcare providers and patients. "It is well-settled that the inability to exercise a constitutional right constitutes irreparable harm." *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1068 (E.D. Ark. 2017) ("*Jegley II*"); *see also Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) (Plaintiffs' showing of interference "with the exercise of its constitutional rights and the rights of its patients supports a finding of irreparable injury"); *M.B. v. Corsi*, 2018 WL 5504178, at *5 (W.D. Mo. Oct. 29, 2018) ("A threat to a constitutional right is generally presumed to constitute irreparable harm."); *Hughbanks v. Dooley*, 788 F. Supp. 2d 988, 998 (D.S.D. 2011) ("When an alleged constitutional right is involved, most courts hold that no further showing of irreparable injury is necessary." (quoting 11A Charles Alan Wright et al., Federal Practice & Procedure § 2948.1 (2d ed. 1995))); *Am. Civil Liberties Union of Ky. v. McCreary Cty.*, 354 F.3d 438, 445 (6th Cir. 2003) ("[W]hen reviewing a motion for a preliminary injunction, if it is found that a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." (citing *Elrod v. Burns*, 427 U.S. 347, 373 (1976))).

Second, forcing patients to forgo abortion care and remain pregnant against their will inflicts serious physical, emotional, and psychological consequences that alone constitute irreparable harm.[128] Some women will be forced to give birth; others may attempt to terminate

[128] Williams Decl. ¶¶ 22, 41–45, 49. *See also* Ex. 12 (stating that the "consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being").

their pregnancies outside the medical system. Some may travel across state lines, incurring additional expenses and increasing the likelihood of exposure to the virus. And even those women who are able to obtain abortion care in Arkansas after the crisis passes will suffer significant harm because of their delay in accessing care. *See supra* pp. 7–8, 16–18; *see also, e.g.*, *Planned Parenthood Sw. Ohio Region v. Hodges*, 138 F. Supp. 3d 948, 960 (S.D. Ohio 2015) (finding irreparable harm where "patients could face a delay" in obtaining abortion care). As the Supreme Court has said, "the abortion decision is one that simply cannot be postponed." *Bellotti v. Baird*, 443 U.S. 622, 643 (1979). That the State would inflict these irreparable harms on Arkansas women in the midst of a global pandemic, putting them at greater risk of contracting COVID-19, only underscores the need for injunctive relief. *See Roe*, 410 U.S. at 153 ("The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent."); *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th Cir. 2018) (explaining that the "disruption or denial of . . . patients' health care cannot be undone after a trial on the merits"); *Planned Parenthood of Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013); *Roe v. Crawford*, 396 F. Supp. 2d 1041, 1044 (W.D. Mo. 2005) (holding delay in abortion is irreparable injury due to "medical, financial, and psychological risks" associated with it), *stay of preliminary injunction denied*, 546 U.S. 959 (2005).

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

When considering the balance of harms, "[a]t base," the question is "whether the balance of equities so favors the movant that justice requires the court to intervene to preserve the status quo until the merits are determined." *Dataphase Sys., Inc. v. CL Sys., Inc.*, 640 F.2d 109, 113 (8th Cir. 1981). Plaintiffs' patients will suffer numerous irreparable harms without an injunction,

and Plaintiffs' requested relief will simply preserve the status quo as it exists now. If Plaintiffs' request for injunctive relief is denied, their patients will be "effectively forced against their will to remain pregnant until they give birth." *Planned Parenthood Minn., N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011).

On the other side of the scale, Defendants will realize *no* benefits from enforcing the COVID-19 Abortion Ban. That is particularly true given that Plaintiffs are entirely self-sustaining in terms of PPE resources and have implemented strict social-distancing practices and protocols that diminish the risk of infection at the clinic. *See supra* pp. 10–11. And the provision of abortion care reduces rather than increases the use of hospital resources needed to fight COVID-19. *See supra* pp. 6–7, 11.

In this setting, injunctive relief is supported by the balance of harms and the public interest. "The Eighth Circuit has stated that 'whether the grant of a preliminary injunction furthers the public interest . . . is largely dependent on the likelihood of success on the merits because the protection of constitutional rights is always in the public interest.'" *Little Rock Family Planning Servs. v. Rutledge*, 397 F. Supp. 3d 1213, 1322–23 (E.D. Ark. 2019) (citing *Planned Parenthood Minn., N. Dakota, S. Dakota v. Rounds*, 530 F.3d 724, 752 (8th Cir. 2008), *appeal filed*, No. 19-2690 (8th Cir.)). That is precisely the case here: The public has no interest in the enforcement of an unconstitutional ADH C&D Order. *See Planned Parenthood of Greater Iowa, Inc. v. Miller*, 1 F. Supp. 2d 958, 964 (S.D. Iowa 1998) (public interest is served by enjoining unconstitutional statute because "[t]he protection of constitutional rights clearly outweighs any interest the State may have in promoting the interests of the fetus with a statute that is unconstitutional"); *see also, e.g.*, *Am. Civil Liberties Union Fund of Mich. v. Livingston Cty.*, 796 F.3d 636, 649 (6th Cir. 2015) ("[W]hen a constitutional violation is likely…the public

interest militates in favor of injunctive relief because it is always in the public interest to prevent violation of a party's constitutional rights."). Accordingly, granting Plaintiffs' request for injunctive relief serves the public interest.

V. A BOND IS NOT NECESSARY IN THIS CASE.

This Court should waive the Federal Rule of Civil Procedure 65(c) bond requirement. Where plaintiffs are "serving a public interest in acting to protect [important] constitutional rights related to abortion," and the governmental defendants "will not be harmed by the order to preserve the status quo," courts have exercised their discretion to waive the security requirement. *Jegley II*, 267 F. Supp. 3d at 1111; *see also Evenstadv. City of W. St. Paul*, 306 F. Supp. 3d 1086, 1102 (D. Minn. 2018) (waiving bond requirement where plaintiff was "seek[ing] to vindicate an important constitutional right"). In fact, this Court recently declined to require Plaintiffs to provide security upon grant of a preliminary injunction barring Arkansas from enforcing two bans and one regulation of abortion that would have eliminated the overwhelming majority of abortion care in Arkansas. *See Little Rock Family Planning*, 397 F. Supp. 3d at 1323.

This Court should use its discretion to waive the bond requirement here, where injunctive relief will result in no monetary loss to Defendants. Moreover, Plaintiffs are health care providers dedicated to serving low-income and underserved communities,[129] and a bond would strain their already-limited resources. *See Richland/Wilkin Joint Powers Auth. v. U.S. Army Corps of Eng'rs*, 826 F.3d 1030, 1043 (8th Cir. 2016) (affirming district court's waiver of bond requirement "based on its evaluation of public interest").

[129] *See* Williams Decl. ¶ 19.

CONCLUSION

For these reasons, this Court should grant Plaintiffs' motion for an *ex parte* TRO and/or preliminary injunction to enjoin Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them, from enforcing or requiring compliance with the ADH April 3 Directive as applied in the C&D Order to surgical abortions. Most urgently, Plaintiffs seek relief on behalf of patients who are particularly burdened by the COVID-19 Abortion Ban because of the time-sensitive nature of abortion care, including patients for whom the Ban will, in the good-faith, professional judgment of the treating physician:

> (i) likely worsen any maternal-health conditions that predate the pregnancy or result from the pregnancy;
>
> (ii) likely stand in the way of the patient ultimately accessing abortion care, because of patient-specific factors like medical history, the circumstances that led to the patient's decision to seek care in the first place (e.g., domestic violence), and the logistical and financial obstacles faced by the patient;
>
> (iii) bar access to abortion because medication abortion is contraindicated;
>
> (iv) likely push to a more complex and more time-intensive surgical-abortion procedure (beginning around 14 weeks LMP);
>
> (v) require the patient to visit the clinic an additional time for a two-day procedure, instead of a one-day procedure, which begins at approximately 18 weeks LMP; or
>
> (vi) likely push beyond the point at which abortion is available in the State (i.e., 21.6 weeks LMP).

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Respectfully submitted,

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** Motion for admission pro hac vice granted*
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