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CLERK OF THE SHAWNEE COUNTY DISTRICT COURT
CASE NUMBER: 2011-CV-001298

Court: Shawnee County District Court

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Case Title: Hodes & Nauser MDs PA, et al. vs. Lee A Norman MD - Acting Secretary, et al.

Type: MEMORANDUM DECISION AND ORDER

SO ORDERED.

/s/ Honorable Mary E Christopher, District Judge

IN THE DISTRICT COURT OF SHAWNEE COUNTY, KANSAS
DIVISION EIGHT

HODES & NAUSER, M.D.s, P.A. and TRACI LYNN NAUSER, M.D.,	)	
Plaintiffs,	)	Case No. 2011-CV-1298
v.	)	
LEE NORMAN, M.D., in his official capacity as Secretary of the Kansas Department of Health and Environment; STEPHEN HOWE, in his official capacity as District Attorney for Johnson County, Kansas; and DEREK SCHMIDT, in his official capacity as Attorney General for the State of Kansas,	)	
Defendants.	)	

MEMORANDUM DECISION AND ORDER

This matter comes before the Court on *Plaintiffs' Motion for Summary Judgment* (4-23-21), and on *Defendants' Combined Motion for Summary Judgment and Memorandum in Support Thereof* (4-23-21). Plaintiffs Hodes & Nauser MDs, P.A. and Traci Nauser, M.D. appear through their attorneys, Teresa Woody, Hillary Schneller, and Kirby Tyrell. Defendants Lee Norman, M.D., Stephen Howe, and Derek Schmidt appear through their attorneys, Shon Qualseth, Jeffrey Chanay, and Brant Laue.

The Court received oral argument from the parties on their cross-motions for summary judgment on September 8, 2021. Ms. Tyrrell presented oral argument in support of *Plaintiffs' Motion for Summary Judgment*; and in opposition to *Defendants' Combined Motion for Summary Judgment*. Mr. Qualseth presented oral argument in opposition to *Plaintiffs' Motion for Summary Judgment* and in favor of *Defendants' Combined Motion for Summary Judgment*. The

Court has considered parties' motions, arguments, and all supporting and opposing briefing presented by the parties, and is ready to rule.

I. INTRODUCTION AND BACKGROUND OF THE CASE

Plaintiffs filed this action to dispute laws and regulations enacted in 2011[1] for the licensure and regulation of clinicians and facilities providing abortions in Kansas. Plaintiffs' Second Amended Petition asks the Court to issue a declaratory judgment that the statutory Act, K.S.A. 2011 Supp. 65-4a01, *et seq*., and the permanent regulations, K.A.R. 28-34-126 through K.A.R. 28-34-144,[2] violate the constitutional rights of plaintiffs and their patients. Plaintiffs also requested the Court grant them a temporary and then a permanent injunction restraining defendants from enforcing the Act and regulations.[3] Plaintiffs allege the 2011 Act and regulations ("Challenged Laws") violate the constitutional rights of plaintiffs and their patients under the 14th Amendment and Section 1 of the Kansas Constitution Bill of Rights, citing *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 440 P.3d 461 (2019).

The Hon. Franklin R. Theis issued a temporary order enjoining enforcement of the Challenged Laws pending a final ruling in this case. Because of the temporary injunction entered by the Court, the Permanent Regulations did not take effect as scheduled on November 14, 2011.[4] The hearing on the application for a temporary injunction was cancelled because the

[1] See 2011 Kansas House Substitute for Senate Bill 36, codified at K.S.A. 65-4a01-4a12 (2011), and the accompanying regulations promulgated by the Kansas Department of Health and Environment (KDHE) and published on October 27, 2011. The Kansas legislature enacted K.S.A. 65-4a01 through 65-4a12 in 2011; the Act directed the Secretary of the Kansas Department of Health and Environment (KDHE) to "adopt rules and regulations for the licensure of facilities for the performance of abortions."

[2] The effective date of the Permanent Regulations was November 14, 2011.

[3] See 2011 Kansas House Substitute for Senate Bill 36, codified at K.S.A. 65-4a01-4a12 (2011), and the accompanying regulations promulgated by the Kansas Department of Health and Environment (KDHE) and published on October 27, 2011. The Kansas legislature enacted K.S.A. 65-4a01 through 65-4a12 in 2011; the Act directed the Secretary of the Kansas Department of Health and Environment (KDHE) to "adopt rules and regulations for the licensure of facilities for the performance of abortions."

[4] See Court file, *Order Granting Temporary Restraining Order Pending Hearing on Application for Temporary Injunction* (Nov. 10, 2011); *Agreed Order* (Dec. 2, 2011) (agreeing and jointly stipulating that temporary restraining order shall remain in effect pending the Court's issuance of a final judgment in this matter).

parties agreed to extend the temporary restraining order. The Court filed an Agreed Order on December 2, 2011, that states "the Temporary Restraining Order entered on November 10, 2011, shall remain in effect pending the Court's issuance of a final judgment in this matter. During the pendency of these proceedings, defendants shall not seek to enforce either the statutory Act or the Permanent Regulations." (See Court file, Agreed Order, 12-2-11.)

During its 2015 session, the Kansas Legislature repealed K.S.A. 2014 Supp. 65-4a10 and enacted an amended version of the "medication in person" statutory provision effective June 11, 2015. The plaintiffs filed a second amended petition alleging that K.S.A. 65-4a10(b)(1) "as amended by 2015 Kan. Sess. Laws Ch. 84 (H.B. 2228), §1(b)(1)" violated their patients' constitutional rights. Defendants moved to clarify or dissolve the temporary injunction as to that provision, K.S.A. 65-4a10, arguing the 2015 statute was not part of the temporary injunction entered in 2011 and the plaintiffs lacked standing to challenge it. Defendants filed an interlocutory appeal of the district court's ruling, but the appeal was dismissed by the Court of Appeals on jurisdictional grounds. See *Hodes & Nauser, MDs, P.A., and Nauser v. Norman*, No.19-121046, Slip. Op. 5-6, (Kan. Ct. App., Feb. 12, 2021) (unpublished).

The case did not stagnate during interlocutory appeal. This Court found the appeal concerning the medication in person provision would not affect the parties' ability to conduct discovery as to the remaining issues presented in this case. See *Harsch v. Miller*, 288 Kan. 280, 286, 200 P.3d 467 (2009) ("appeal under the civil code does not automatically stay further proceedings in the court below."). As a result, the Court issued an Agreed Amended Case Management Order on December 9, 2020, ordering all discovery to be completed on or before March 5, 2021. All dispositive motions were to be filed by April 23, 2021, and the final pretrial conference was scheduled for June 9, 2021.

Before the final pretrial conference could occur, the Kansas Court of Appeals issued its opinion finding it did not have jurisdiction to consider the defendants' appeal.[5] After dismissal of defendants' appeal on jurisdictional grounds, the parties filed cross-motions for summary judgment and asked that a hearing be scheduled for presentation of oral argument on their dispositive motions in lieu of the final pretrial conference. In addition, defendants moved for a stay of proceedings until the August 2, 2022, election on an Amendment to the Kansas Constitution, arguing the legal basis underlying this litigation would be eliminated if Kansas voters approved the proposed Amendment.[6] Noting the case had been pending for eleven years, this Court denied defendants' motion to stay.

Around April 2019, the Kansas Supreme Court issued its opinion in a separate case, *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 440 P.3d 461 (2019), significant to the analysis of the constitutional issues presented in this case. In *Hodes & Nauser, MDs, P.A. v. Schmidt*, the Kansas Supreme Court majority found plaintiffs established they were substantially likely to prevail on their claim that the Kansas Unborn Child Protection from Dismemberment Abortion Act violated Section One of the Kansas Constitution Bill of Rights or the Fourteenth Amendment, as necessary for issuance of a temporary injunction to enjoin enforcement of the Act.

In this case, the parties' cross-motions for summary judgment raise opposite sides of the same legal arguments. The Court has carefully reviewed parties' respective motions for summary judgment, the parties' arguments, all supporting and opposing briefs, and the record. The

[5] *Hodes & Nauser, MDs, P.A. v. Norman*, No. 121,046, 2021 WL 520661 (Kan. Ct. App. February 2021) (unpublished opinion).

[6] During the 2021 Legislative Session, the Kansas Legislature approved the Value Them Both Amendment ("Amendment"), which will offer Kansas voters an opportunity to add an amendment to the Kansas Constitution clarifying there is no constitutional right to an abortion.

uncontroverted material facts necessary to deciding both summary judgment motions are combined and set forth below.

II. FACTS

1. The statutory Act at issue in this case, K.S.A. 65-4a01 to 65-4a12, was enacted by the Kansas legislature during the 2011 legislative session, and signed by the governor on May 16, 2011. See Ct. file, Agreed CMO 11-9-20, ¶ 4(f).

2. The Act provides for licensure and regulation of "facilities for the performance of abortions" by Kansas Department of Health and Environment (KDHE).[7] See K.S.A. 65-4a01 to 65-4a12.

3. Plaintiff Dr. Nauser is a Board-certified Ob-Gyn licensed to practice medicine in Kansas. Nauser Decl. ¶ 1.

4. Plaintiff Dr. Nauser owns and operates a medical practice, Hodes & Nauser, M.D.s, P.A., which is located in Overland Park, Kansas, and advertises under the name Center for Women's Health ("CWH"). Nauser Decl. ¶ 4. Dr. Nauser is one of only a few providers of abortion in Kansas. Id.

5. Plaintiff Hodes & Nauser, M.D.s, P.A. is a private office-based obstetrics and gynecology practice.

6. CWH was founded in 1978 by Dr. Nauser's father, Dr. Herbert Hodes. Dr. Hodes practiced at CWH until he retired in 2017, after over 40 years practicing medicine. Nauser Decl. ¶ 4.

7. For decades, CWH has provided a full range of obstetrical and gynecological services to its patients: obstetrical care; family planning; gynecological care, including abortion care;

[7] Historically, the KDHE has governed licensure and regulation of hospitals and ambulatory surgical centers, while physicians and medical offices are licensed and regulated by the Kansas State Board of Healing Arts.

screening for cancer and sexually transmitted infections; treatment of menopausal symptoms; and treatment of infertility. Nauser Decl. ¶ 5.

8. CWH offers medication and procedural abortion care. At CWH, Dr. Nauser provides abortion care up to 21.6 weeks LMP.[8] Nauser Decl. ¶ 5.

9. CWH is one of only three abortion providers in the state. The other facilities at which abortion is regularly available are South Wind Women's Center, in Wichita, and Comprehensive Health of Planned Parenthood Great Plains, which operates facilities in Overland Park and Wichita. Nauser Decl. ¶ 4. CWH has provided abortion care in the same physical facility for over 30 years. Nauser Decl. ¶ 4.

10. CWH meets the applicable standards of care and its providers comply with the existing regulations for providers of office-based surgery, K.A.R. 100-25-1 et seq.; Nauser Decl. ¶ 8.

11. CWH also follows the clinical standards set out by American College of Obstetricians and Gynecologists ("ACOG"), the leading medical professional organization for Ob-Gyn's in the United States, and the National Abortion Federation ("NAF"), the leading medical, professional association for clinicians providing abortion care in North America. Nauser Decl. ¶¶ 1, 8.

12. In addition to her practice at CWH, Dr. Nauser provides hospital-based care to patients who need services in that setting. Nauser Decl. ¶ 16. The services in a hospital setting may include but are not limited to antepartum care; vaginal and cesarean deliveries; postpartum care; obstetrical and gynecological surgeries; and labor inductions. Nauser Decl. ¶¶ 6, 15. In some circumstances, Dr. Nauser provides abortion care in situations where patients have been diagnosed with serious medical conditions that complicate their pregnancy and necessitate a hospital setting for their care. Nauser Decl. ¶¶ 6, 20.

[8] Pregnancy is typically dated from the first day of the patient's last menstrual period. The number of weeks appears before the decimal point and the number of days appear after the decimal point, so, for example, 10.6 weeks LMP means 10 weeks and six days since the patient's last menstrual period. Nauser Decl. ¶ 5 n.1.

13. A significant number of pregnancy terminations are performed for patients who seek to end the pregnancy because the fetus has been diagnosed with a severe or lethal condition. Nauser Decl. ¶ 20. Dr. Nauser has provided abortions in cases where the patient's fetus is diagnosed with anencephaly, a condition in which a large part of the fetal brain and skull are missing. Nauser Decl. ¶ 20.

14. Perinatologists and other Ob-Gyns, including other outpatient abortion providers, in the region regularly refer patients to Dr. Nauser for abortion care. Nauser Decl. ¶ 20; Mirabile Decl. ¶ 24.

15. These referrals are based on the referring providers' confidence in Dr. Nauser's expertise and ability to provide high quality abortion care to patients. Nauser Decl. ¶ 20; Mirabile Decl. ¶¶ 24-25.

16. Abortion may be provided in two ways: by medication or by procedure. Raymond Decl. ¶ 8; Nauser Decl. ¶¶ 14-15.

17. Medication abortion typically involves taking two medications by mouth, mifepristone and misoprostol, a day or two apart, ending the pregnancy in an experience similar to a miscarriage. Raymond Decl. ¶ 37; Nauser Decl. ¶ 15.

18. The same medications, mifepristone and misoprostol, are used to manage a patient's incomplete miscarriage. Raymond Decl. ¶ 40; Nauser Decl. ¶ 15; see also Deposition of Melissa Joyce Hague, M.D.[9] ("Hague Dep.") 48:14-23.

19. Medication abortion is safe; complications occur only in a fraction of a percent of cases. Raymond Decl. ¶ 38. The risk of complication associated with medication abortion is similar in

[9] Dr. Hague is a board-certified ob-gyn practicing in Kansas. Her deposition transcript was initially designated confidential, but the parties subsequently agreed the transcript contains no confidential information and is not confidential under the protective order.

magnitude to the adverse effects of common prescriptions and over-the-counter medications such as NSAIDs, like Tylenol. See Raymond Decl. ¶ 39.

20. Medication abortion involves no anesthesia or sedation. Nauser Decl. ¶ 19.

21. Procedural abortion is also safe; it is comparable in safety to a variety of outpatient procedures. Raymond Decl. ¶ 27. It is also safer than other common outpatient care. Raymond Decl. ¶ 29.

22. Procedural abortion involves the evacuation of the uterus with the assistance of suction or other medical instruments. Raymond Decl. ¶ 30; Nauser Decl. ¶ 17. The procedure typically takes approximately five to fifteen minutes. Nauser Decl. ¶ 17.

23. The same procedure is used to manage a patient's incomplete miscarriage. Raymond Decl. ¶ 30; Nauser Decl. ¶ 24; Hague Dep. 47:15- 21; 113:8-21.

24. A local anesthetic is typically used prior to a procedural abortion. Nauser Decl. ¶ 19. Additionally, patients may have mild to moderate sedation (intravenous medication) if their needs make it appropriate. Nauser Decl. ¶ 19.

25. Dilation and curettage ("D&C") to manage miscarriage, endometrial ablation, and diagnostic hysteroscopy, is medically comparable to procedural abortion. Nauser Decl. ¶¶ 23-24; Declaration of James Mirabile, M.D. ("Mirabile Decl.") ¶ 13; see also Hague Dep. 113:8-21(discussing miscarriage). Experts agree that these procedures can be performed safely in a medical office. Nauser Decl. ¶¶ 23-25; Hague Dep. 88:21-92:25; Mirabile Decl. ¶ 14. Indeed, each is safely performed in medical offices in Kansas. Nauser Decl. ¶¶ 23-25; Mirabile Decl. ¶ 16; Hague Dep. 88:21-92:25.

26. Experts agree that abortion services can be provided safely in medical office-based settings in Kansas. Nauser Decl. ¶ 25; Raymond Decl. ¶¶ 31-35; Hague Dep. 82:21-83:4 ("Q: So

the National Academies says here that most abortions can be provided safely in office based settings. . . Do you agree with the National Academies on this? A: Yes, I don't disagree with that.").[10]

27. Abortion is one of the safest types of medical care provided in the United States. Both abortion-related mortality (death) and abortion-related morbidity (i.e., non-fatal complications) are very rare. Declaration of Elizabeth Gray Raymond, M.D., M.P.H. ("Raymond Decl.") ¶ 9.

28. Abortion is approximately 14 times safer than carrying a pregnancy to term. Raymond Decl. ¶ 22. A 2015 publication by the Centers for Disease Control and Prevention (CDC) reported the legal abortion-related mortality rate was 0.7 deaths per 100,000 procedures. Raymond Decl. ¶11. Mortality from childbirth is 8.8 deaths per 100,000 live births.

29. Abortion-related mortality is also significantly lower than that for other common outpatient medical procedures, such as colonoscopy (5 deaths per 100,000 procedures) and some plastic surgeries (1.7 deaths per 100,000 procedures). Raymond Decl. ¶¶ 28-29.

30. Serious non-fatal complications of abortion as currently performed at outpatient facilities are extremely rare. In a recent study examining approximately 55,000 abortions, the incidence of major complications was 0.23%. Raymond Decl. ¶ 18.

31. Abortion is also common. Nearly one in four women in the United States will obtain an abortion in their lifetimes. Raymond Decl. ¶ 6.

32. The majority of people who obtain abortion care in Kansas obtain it in the first trimester of pregnancy. Nauser Decl. ¶ 13; Raymond Decl. ¶ 7.

[10] The National Academies of Science, Engineering, and Medicine are nongovernmental entities established by Congress and by charter to provide independent, objective analysis and advice to address the nation's complex scientific problems and public policies. In 2018, they released a comprehensive report on the safety and quality of abortion care in the United States. See Raymond Decl. ¶ 35.

33. Patients seek abortions for a variety of medical, family, economic, and personal reasons. Some have abortions because they conclude it is not the right time to become a parent or to add to their family, or because of a need to care for the children they already have. Nauser Decl. ¶ 12.

34. Approximately 60% of people obtaining abortion in Kansas already have children. Nauser Decl. ¶ 12.

35. Increased costs associated with the Challenged Laws will inevitably be passed on to patients. Some patients already struggle financially to cover the cost of an abortion and the logistical arrangements associated with it. Nauser Decl. ¶ 32.

36. Under Kansas law, private insurance policies can cover abortion care only through a separate rider. K.S.A. 40-2,190. Insurance provided in any exchange established pursuant to the Affordable Care Act may not be used to cover the cost of abortion care, except in limited circumstances. K.S.A. 40-2,190. People may not rely on Medicaid to cover the cost of abortion care, except if the pregnancy is life-threatening or is the result of rape or incest. *State ex rel. Kline v. Sebelius*, No. 05-C-1050, 2006 WL 237113, at *6 (Kan. 3d Jud. Dist. Ct. Jan. 24, 2006).

37. Under Kansas law, a person seeking abortion care must delay their care by at least 24 hours after receiving certain state-mandated information. K.S.A. 65-6709(a)-(b), (d). Kansas law also requires that, except in limited circumstances, a patient under age 18 must obtain the written, notarized consent of both parents prior to obtaining an abortion or appear before a judge to obtain a bypass of the consent requirement. K.S.A. 65-6705.

38. Kansas prohibits abortion after 22 weeks LMP, except in very narrow circumstances in which the pregnant person's life or health is at risk, K.S.A. 65-6723(e), 6724(a), and abortions are generally prohibited after viability. K.S.A. 65-6703(a).

39. State agencies and employees are prohibited from providing abortion services under K.S.A. 65-6733(d). Abortions may only be performed on University of Kansas properties in a medical emergency. K.S.A. 76-3308(i).

40. In 2015, Kansas lawmakers enacted a ban on a common and safe method of second trimester abortion, known as dilation and evacuation ("D&E"). On April 26, 2019, the Kansas Supreme Court affirmed the district court's June 2015 temporary injunction of the ban and held, among other things, that the Kansas Constitution guarantees the fundamental right of pregnant people to decide "whether to bear or beget a child." *Hodes & Nauser*, 309 Kan. at 671, 440 P.3d at 497. On remand, following discovery, briefing, and argument, the Shawnee County District Court entered a permanent injunction against the ban. See *Hodes & Nauser v. Schmidt*, No. 2015-CV-490 (Kan. 3d Jud. Dist. Ct. April 7, 2021).

41. If the number of abortion providers in Kansas is reduced, some women may have to wait longer to obtain abortion care. Such delay can increase the risk of the abortion procedure. The risks of both morbidity and mortality from abortion increase with gestational age. Raymond Decl. ¶¶ 46-47.

42. Patients who are delayed in accessing abortion care face higher risks of morbidity and mortality than those who are able to access early abortion care. Delay in access to abortion care forces a patient to remain pregnant longer. Pregnancy puts significant stress on the body, causes a variety of physiological changes, and impacts every organ system. Pregnancy can exacerbate underlying medical conditions, or patients can develop conditions as a result of pregnancy. Each day a person remains pregnant means they continue to experience these symptoms and risks, as well as the potential complications of pregnancy. See Nauser Decl. ¶¶ 28, 30.

43. Delay can mean a patient becomes ineligible for the abortion method that is best for them. For example, delay can mean they are beyond the point at which medication abortion is available to them. Nauser Decl. ¶ 29. Or, it can mean the patient has a procedure later than they otherwise would, which can, for example, involve mild or moderate sedation, rather than only local anesthesia. Id.

44. Plaintiffs maintain the Challenged Laws will cause harm to the medical practice including loss of revenue, loss of future patients, and damage to professional standing among colleagues, current patients and potential patients. Nauser Decl. ¶ 32.

45. In general, Kansas regulates health care provided at three types of facilities relevant here: care at office-based surgery practices or private medical offices, ambulatory surgical centers ["ASCs"], and hospitals. The Kansas State Board of Healing Arts regulates licensed clinicians, including the care they prove at medical offices. See, e.g., K.A.R. 100-25-1(f) (defining "office" as "any place intended for the practice of the healing arts in the state of Kansas," and "not includ[ing] a medical care facility . . . that is licensed by [KDHE]"). KDHE regulates and licenses ASCs and hospitals. See, e.g., K.S.A. 65-425 (defining different facilities); see also K.S.A. 65-425(f) (defining "ambulatory surgical center," and stating that "[n]othing in this section shall be construed to require the office of a physician or physicians to be licensed under this act as an ambulatory surgical center").

46. The Kansas State Board of Healing Arts licenses individual clinicians, including physicians who provide care in medical offices. Rule 30(b)(6) Deposition of Kansas Department of Health and Environment by Angela Jirik ("Jirik Dep.") 30:11-22. So, although Kansas does not require [KDHE] licensure of medical offices, the care provided at those facilities is subject to

regulation both by the Kansas State Board of Healing Arts and by the KDHE. See Nauser Decl. ¶¶ 8-10; Hague Dep. 84:9-15.

47. Medical offices provide what Kansas law defines as "minor surgery" or "office-based surgery." "Surgery" is defined as a "manual or operative method that involves the partial or complete excision or resection, destruction, incision, or other structural alteration of human tissue by any means, including . . . for the purpose of . . . terminating pregnancy." K.A.R. 100-25-1(l). "Minor surgery" is a surgery that can "safely and comfortably be performed . . . on a patient who has received no anesthesia," or "local anesthesia or topical anesthesia" and "hospitalization is not reasonably foreseeable." K.A.R. 100-25-1(e). "Office-based surgery" means surgery other than minor surgery that requires any anesthesia, sedation, or parenteral analgesia (anesthetic administered other than by mouth, such as intravenously) and "that is performed by or upon the order of a physician in an office." K.A.R. 100-25-1(g); see also Nauser Decl. ¶ 8.

48. The Board of Healing Arts' Office-Based Surgery Regulations apply to clinicians' provision of medical care in medical offices. The Board's regulations set standards for maintaining the offices' cleanliness; for infection control and the disposal of biological waste; for maintaining drugs, supplies, and medical equipment; and for maintaining the safety of the physical facility. K.A.R. 100-25-2; see also K.A.R. 100-25-5 (requiring licensed clinicians to "meet the standard of care established by the [Board's] regulations).

49. The Board provides further regulation for care that involves sedation or anesthesia, including local anesthesia. Among other things, the Board requires clinicians to provide care within their scope of practice; that the procedures performed can be safely performed and the patient discharged during normal business hours; that equipment is sterile to the extent necessary

to meet the standard of care; that the office has "appropriate emergency drugs" and "sufficient space" for necessary equipment and personnel; and that the office follows their standards for monitoring patient ventilation and blood circulation. K.A.R. 100-25-3.

50. And even further regulation is set out for medical office procedures for which general anesthesia or a spinal or epidural block is provided. See K.A.R. 100-25-4.

51. Medical offices must notify the Board within 15 days of certain incidents, including when a patient is transferred to the hospital. K.A.R. 100-25-2(b)(5), 3(e)(2).

52. Kansas clinicians perform a variety of procedures at medical offices, including abortion procedures, gynecological procedures, miscarriage management, some plastic surgeries, and some dental surgeries. Jirik Dep. 36:9-37:15; Hague Dep. 38:8-19; Mirabile Decl. ¶¶ 4-8; Nauser Decl. ¶ 5.

53. The Board has the power to investigate clinicians, including in response to a complaint. K.S.A. 65-2838, 2839a; Jirik Dep. 33:20-34:12. The outcomes of these investigations can include loss of license to practice medicine in Kansas. K.S.A. 65-2836; Hague Dep. 131:16- 22.

54. Hospitals and ambulatory surgical centers qualify as "medical care facilities" subject to licensure by the State. K.S.A. 65-425(h); see also K.S.A. 65-427.

55. KDHE has promulgated regulations for the licensure and regulation of hospitals and ASCs. See K.S.A. 65-431(a); K.A.R. 28-34-50 et seq.

56. "Ambulatory surgical centers" are facilities that "primarily engage[] in surgery" and have patient stays less than 24 hrs. Jirik Dep. 14:12-24, 19:20-20:2; see also K.A.R. 28-34-50(b) (defining ASC).

57. Typically, procedures performed in an ASC are greater in "complexity" than procedures performed in medical offices. See Jirik Dep. 38:22-39:9.

58. Kansas regulates abortion care regardless of the facility at which it is provided.

59. Abortion care provided in medical offices is subject to the Board's regulation. See K.A.R. 100-25-1 et seq.; Nauser Decl. ¶ 8.

60. ASCs that provide abortion are licensed, regulated, and inspected by the KDHE. Jirik Dep. 34:14-24.

61. The KDHE also regulates certain aspects of abortion care regardless of the facility at which it is provided. For instance, KDHE regulates and inspects all facilities that generate medical waste, including medical offices at which abortion care is provided. K.A.R. 28-29-27 et seq.; Nauser Decl. ¶ 9. Facilities that provide abortion care must also report to KDHE certain information about each abortion performed. K.S.A. 65-445; Nauser Decl. ¶ 10.

62. Additionally, facilities providing medical care—including abortion care—are generally subject to further oversight and regulation, including generally-applicable CLIA (federal standards for clinical laboratory safety) and OSHA (federal standards for occupational health and safety) regulations. Nauser Decl. ¶ 9; Hague Dep. 20:22-21:25. KDHE administers CLIA and thereby also regulates any entity subject to those federal schemes. Nauser Decl. ¶ 9.[11]

63. In 2011, Kansas enacted K.S.A. 65-4a01 to 65-4a12, providing for the licensure and regulation of medical office-based facilities that provide abortion care by the Kansas Department of Health and Environment. See K.S.A. 65-4a01 to 65-4a12.

64. The Act has no legislative findings. See id.

65. Since the State agreed not to enforce the Challenged Laws nearly 10 years ago, the Challenged Laws have not been enforced. See Agreed Order (Dec. 2, 2011).

[11] See also Kan. Dept. of Health & Environ., CLIA Laboratory Certification, https://www.kdheks.gov/lipo/clia_survey_and_cert.htm (last visited April 22, 2021).

66. During that time, facilities at which abortions are regularly performed have continued to be regulated either as medical offices or as ambulatory surgical centers. See Nauser Decl. ¶ 8; Jirik Dep. 34:14-20.

67. The State has identified no concern about the safety of abortion care provided in Kansas during those 10 years.

68. Leading medical authorities, including the American College of Obstetricians and Gynecologists ("ACOG"), have determined that "requiring facilities performing office-based procedures, including abortion, to meet standards beyond those currently in effect for all general medical offices and clinics is unjustified based on an analysis of available evidence." See Hague Dep. 126:13-129:5; Hague Dep. Ex. 36 at 225 (*Consensus Guidelines for Facilities Performing Outpatient Procedures, Evidence Over Ideology*, Feb. 2019).

69. ACOG opposes targeted regulation of abortion providers through laws that "improperly regulate medical care and do not improve patient safety or quality of care." Hague Dep. Ex. 35 at e109 (ACOG Comm. Op. No. 185, Increasing Access to Abortion, Dec. 2020); see also id. at e107 ("ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient-clinician relationship and the practice of medicine, including, for example . . . requirements that only physicians or obstetrician-gynecologists may provide abortion care, . . . restrictions on medication abortion, . . . facility and staffing requirements known as Targeted Regulation of Abortion Providers (TRAP) laws."); id. at e109 (explaining TRAP laws are "[f]acility and staffing requirements enacted in some states under the guise of promoting patient safety [that] single out abortion from other outpatient procedures and impose medically unnecessary requirements designed to reduce access to abortion); Hague Dep. 123:13-126:11.

70. Dr. Nauser believes enforcement of the Challenged Laws would make it more difficult, if not impossible, for plaintiffs to continue providing abortion care. Nauser Decl. ¶ 27.

71. Dr. Nauser states enforcement of the Challenged Laws would interfere with patients' relationships with their providers, disrupt patient care, and could cause delay. Nauser Decl. ¶¶ 28-30.

72. The Challenged Laws would not provide any medical benefit to Dr. Nauser's patients, but would reinforce the State's disapproval of abortion providers and their patients, and stigmatize them. "This can be particularly challenging for our patients with fetal diagnoses who, in most cases, have made the very difficult decision to terminate a much-wanted pregnancy." Nauser Decl. ¶¶ 34-35.

73. The Act makes it unlawful to operate an abortion "facility" without a valid license from KDHE. K.S.A. 65-4a08(a).

74. The Act makes it unlawful to operate an abortion "facility" in the state without possessing a valid license issued by KDHE pursuant to the Act. See K.S.A. 65-a08(a). There is no *mens rea* requirement for a conviction; any violation of the statute no matter the circumstances can result in a Class A nonperson misdemeanor criminal conviction, punishable by up to one year of imprisonment and up to $2,500 in fines. See K.S.A. 65-4a08(c); K.S.A. 21-6602(a)(1), 21-6611(b)(1). Conviction of a Class A misdemeanor can result in the suspension, limitation, or revocation of a doctor's medical license by the Kansas State Board of Healing Arts. K.S.A. 65-2836(c). Violation of the Act's licensing provision also constitutes "unprofessional conduct," which provides additional grounds for suspension, limitation, or revocation of a doctor's medical license by the Board of Healing Arts. See K.S.A. 65-2837(b); 65-4a08(c); 65-2836(b).

75. The Act authorizes KDHE to adopt regulations, license, inspect, and impose penalties on facilities subject to it. K.S.A. 65-4a02-03, 4a05-06, 4a09.

76. The Act defines a "facility" that must obtain a license as one where "five or more" first-trimester abortions, or any second- or third-trimester abortions are performed. K.S.A. 65-4a01(g). Thus, the licensing requirement does not apply to a clinician who performs fewer than five abortions in a month, and who does not perform any second- or third-trimester abortions.

77. In no other context is facility licensure by KDHE based solely on the type of procedure performed. And, in no other context is licensure by KDHE triggered by the number of procedures performed in a particular time period. Kroll Dep. 45:16-25.

78. The KDHE does not license other medical office-based facilities at which clinicians administer medications or perform procedures to manage a patient's miscarriage [see generally K.A.R. 100-25-1 et seq.], even though that treatment is essentially identical to abortion care. Nauser Decl. ¶¶ 15, 22-24; Raymond Decl. ¶¶ 40, 30; Hague Dep. 48:14-23, 113:8-21.

79. There are two exceptions to the Act's licensing requirement: it does not apply where a patient needs an abortion to "prevent [their] death," K.S.A. 65-4a01(f), or in the case of a "medical emergency."[12] K.S.A. 65-4a01(j).

[12] The 2014 amendment to the Challenged Laws defines "medical emergency" to mean:

> "a condition that, in a reasonable medical judgment, so complicates the medical condition of the pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death, or for which a delay necessary to comply with the applicable statutory requirements will create serious risk of substantial and irreversible physical impairment of a major bodily function. No condition shall be deemed a medical emergency if based on a claim or diagnosis that the woman will engage in conduct which would result in her death or in substantial and irreversible physical impairment of a major bodily function."

K.S.A. 65-4a01(j), as amended by L. 2014, ch. 87, § 1(j). A clinician permitted to provide abortion under Kansas law does not violate the "applicable statutory requirements" referenced in K.S.A. 65-4a01(j) when they conclude, based on reasonable medical judgment, that one or more of the following conditions satisfies K.S.A.'s definition of "medical emergency:" preeclampsia with gestational age under 22 weeks; premature rupture of membranes with chorioamniotisis; ectopic pregnancy; placental abruption (class 2 or 3); or inevitable abortion. Pls.' Second Am. Verified Pet. ¶ 46; Defs.' Answer Pls.' Second Am. Verified Pet. ¶ 46.

80. K.S.A. 65-4a02(g) authorizes KDHE to grant waivers or exceptions from the Challenged Laws to ambulatory surgical centers and hospitals that perform abortions when KDHE determines such waivers "will have no significant adverse impact on the health, safety or welfare of the patients." However, KDHE may not provide waivers to medical offices at which abortions are performed. K.S.A. 65-4a02 (g); Nauser Decl. ¶ 68 ("[W]e have been told that no waiver requests from us will be entertained or granted.").

81. The Challenged Laws require that, when "[]mifepristone[] is used for the purpose of inducing an abortion" it must be administered to the patient by a physician or in the same room and in the physical presence of the physician. When any other drug is used for the purpose of inducing an abortion, "the drug or prescription" for the drug must be given to the patient by or in the same room and in the physical presence of the physician who prescribed it. K.S.A. 65-4a10(b) (the "medication-in-person requirement.").

82. Kansas law requires no other medications be administered to a patient by a physician or in the same room and in the physical presence of a physician. Nauser Decl. ¶ 60; Defs.' Resp. to Pls.' First Set Interrog., No. 18, at 13 (The State is "not aware of other . . . drugs or medications that are listed in statutes enforced by KDHE" that must be administered to a patient by a physician or in the same room and in the physical presence of a physician).

83. Experts agree that there is no reason for a physician or nurse to be physically present for administration of mifepristone to patients when other qualified staff may administer the medication. Nauser Decl. ¶¶ 60-61; Raymond Decl. ¶¶ 43-44; Hague Dep. 114:16-116:2 ("Q: So it is your opinion that a physician does not need to be physically present when mifepristone is administered, correct? A: Correct."). But for the requirement, Dr. Nauser and CWH would have

other qualified staff administer mifepristone, just as they do with other medications. Nauser Decl. ¶ 62.

84. The Challenged Laws require a physician or "health professional," i.e., licensed nurse or physician assistant, to fulfill certain tasks, when it is well within the accepted practice and the standard of care for a medical assistant to undertake those tasks. Nauser Decl. ¶¶ 42-45. See K.S.A. 65-4a09(d)(5) (requiring a "licensed health professional" to "provide postoperative monitoring and care"); K.S.A. 65- 4a09(g)(8) (requiring "licensed health professional" to make good faith effort to contact patient within 24 hours after procedure, with patient's consent, to assess recovery); K.A.R. 28-34-141(a) (requiring "health professional" to make good faith effort to contact patient within 24 hours after procedure, with patient's consent, to assess recovery); K.A.R. 28-34-135(m) (requiring medications be administered to patients "only by a facility physician or a facility health professional"); K.A.R. 28-34-138(c) (requiring both physician and "at least one health professional" be "available to each patient throughout the abortion procedure"); K.A.R. 28-34-138(f) (requiring "health professionals" to monitor patient's vital signs throughout abortion procedure); K.A.R. 28-34-139(a) (requiring "physician or health professional" to monitor patient's vital signs and bleeding in recovery). No comparable provisions apply to medical offices or ASCs where care similar to or more complex than abortion is performed. Nauser Decl. ¶ 45; Mirabile Decl. ¶¶ 12-13, 17-18, 21-23; Hague Dep. 98:12-100:2, 102:15-109:19. See also K.A.R. 28-34-55a(c)(one registered nurse must be on duty at ASC whenever a patient is on the premises); cf. K.A.R. 28-34-138(c) (abortion facility regulation requires physician and at least one health professional be "available to each patient throughout the abortion procedure").

85. Specific KDHE regulations applicable to facilities offering abortion care include K.A.R. 28-34-135(m) and 28-34-139(a)(1)-(2). Under K.A.R. 28-34-135(m), medications must be administered to patients "only by a facility physician or a facility health professional." K.A.R. 28-34-139(a)(1)-(2) requires a "physician or health professional" to monitor patient's vital signs and bleeding in recovery. These provisions would prevent facilities that perform abortion from relying on qualified staff, such as medical assistants under supervision, to perform tasks they are qualified to perform. Nauser Decl. ¶¶ 36-43.

86. The experts agree that none of these restrictions are necessary for safe abortion care. Nauser Decl. ¶¶ 36-43; Mirabile Decl. ¶¶ 21-23; Hague Dep. 98:12-100:2, 102:15-109:19, 113:8-21, 121:11-122:12. They also agree that there is no justification for applying these provisions solely to facilities at which abortions care is provided. Nauser Decl. ¶¶ 39-43, 45; Hague Dep. 113:8-21, 121:11-122:12,128:16-129:5.

87. Kansas clinicians routinely rely on qualified medical assistants under their supervision to administer medications to patients, which is consistent with the standard of care. Nauser Decl. ¶ 40; Hague Dep. 98:12-100:2. Requiring physicians, licensed nurses, or physician assistants to administer medications takes those clinicians away from tasks their skill level requires they perform. Nauser Decl. ¶ 40.

88. Medical assistants are trained to take a patient's vital signs and monitor patients after minor procedures. Nauser Decl. ¶ 43; Hague Dep. 109:3-19.

89. Plaintiffs already face challenges recruiting and hiring qualified staff because of the hostility toward abortion in the State and in the country, and the threats, harassment, and violence to which staff are subject if they are affiliated with a practice that performs abortions. Nauser Decl. ¶ 38.

90. It is not economically feasible for plaintiffs to hire licensed nurses and physician assistants—who command higher salaries than medical assistants— to perform lower-level duties that do not utilize their skills and training. Nauser Decl. ¶¶ 36-37.

91. The Challenged Laws require that, when any physician is conducting a pelvic exam or performing an abortion procedure, another individual be present in the room, and that, if the physician is a male, the other individual must be female. See K.A.R. 28-34-137(c). The same is not required in medical offices where comparable procedures are performed. Nauser Decl. ¶ 44.

92. Under K.A.R. 100-25-5, the standard of care plaintiffs follow as clinicians practicing in a medical office, is for a male physician to have a second person in the room who is female when examining a female patient. Nauser Decl. ¶ 44.

93. Experts agree that Kansas clinicians do not routinely have a second person in the room when a female clinician examines a female patient. Nauser Decl. ¶ 44; Hague Dep. 100:18-101:13.

94. K.A.R. 28-34-139(a)(3) would impose minimum recovery times following an abortion procedure based on the gestational age of the pregnancy. For example, it mandates that first trimester abortion patients be kept in recovery for a minimum of 30 minutes.

95. The standard of care is to discharge patients based on their individual circumstances, including sedation or anesthesia used, if any; length and course of the procedure; and the patient's overall health. Nauser Decl. ¶¶ 46-47; Mirabile Decl. ¶ 22; Hague Dep. 111:20- 112:23 (discussing facility—not legal—requirement that patient be discharged when they are "awake, aware, able to ambulate," "not a time requirement"). Plaintiffs ordinarily perform first-trimester procedural abortions with only local anesthesia, and the patient is typically fully recovered in under 30 minutes. Nauser Decl. ¶ 47.

96. State law imposes no minimum recovery times for any other patients who obtain any other care in Kansas. There is no minimum recovery time for a patient who has had a first-trimester D&C procedure to complete a miscarriage, regardless of the facility in which it is performed. Nauser Decl. ¶ 46; Hague Dep. 111:20-112:23 (stating that for miscarriage management procedures she performs under moderate sedation at an ASC, state law mandates no minimum recovery times); see also Hague Dep. 130:25-131:15 (explaining that by "general anesthesia," she means conscious, or moderate sedation).

97. There is no medical reason for imposing minimum recovery times on patients who have had abortions, but not patients who have obtained other care—including patients who have had essentially the same procedure to complete a miscarriage. Nauser Decl. ¶ 46; Hague Dep. 111:6-112:4 (agreeing it is not "reasonable to have this requirement apply to abortion patients but not patients who have a D&C for incomplete miscarriage").

98. Patients are discharged when we have assessed that they meet our discharge criteria and are ready to go home. Nauser Decl. ¶ 47.

99. K.A.R. 28-34-127(c) requires that abortion facilities additionally submit to KDHE "documentation of the specific arrangements that have been made for the removal of biomedical waste and human tissue," thus mandating disclosure of the biomedical waste company with which Plaintiffs contract.

100. Other than this requirement for abortion facilities, state law does not require medical offices to disclose their arrangements with biomedical waste companies. See K.A.R. 28-29-27, et seq.; Nauser Decl. ¶ 64.

101. Anti-abortion hostility already makes it extremely difficult to find a biomedical waste company willing to make arrangements with facilities where abortions are performed. Disclosing

the names of companies that work with abortion providers makes that company vulnerable to threats and other pressure by anti-abortion activists, deterring it from contracting with abortion providers. Nauser Decl. ¶ 64. Should the company sever its contract with plaintiffs as a result of concerns for its privacy or threats against it, plaintiffs could be forced to end their abortion practice. Nauser Decl. ¶ 64.

102. Several provisions of the Challenged Laws require abortion facilities to purchase unnecessary equipment and supplies that will go unused, expire, and need to be purchased again. See, e.g., K.A.R. 28-34- 135(c)(2) (requiring child size face masks); K.A.R 28-34-135(c)(5) (requiring catheters in various sizes); K.A.R 28-34-135(c)(6) (requiring child size oral airways); K.A.R 28-34-135(c)(7) (requiring child size nasal cannulas); K.A.R. 28-34-135(e)(2) (requiring nasogastric tubes); K.A.R. 28-34-135(d)(1) (requiring "intraosseous needles").

103. None of these provisions apply to health care facilities providing similar or more complex care than abortion. See, e.g., K.A.R. 28-34-50, et seq. (ASC regulations); see Nauser Decl. ¶ 67.

104. Additionally, K.A.R. 28-34-133(b)(7) requires a recovery area that has a "nurse station with visual observation of each patient," even though no separate recovery room, nursing station, or monitoring by a nurse is needed or part of the standard of care for abortion care. Nauser Decl. ¶¶ 49-50.

105. Patients at CWH recover in their private procedure rooms. There is no medical justification for mandating that CWH patients recover at a nurse station when it is far more private for the patient to recover in the same room in which her procedure was performed. Nauser Decl. ¶¶ 49-50.

106. K.A.R. 28-34-144(c) gives KDHE broad access to patient medical records, including patient identifying information. No other medical offices are routinely compelled to provide regulatory authorities access to patient medical records. See Nauser Decl. ¶ 56; see, e.g., K.A.R. 100-25-1, et seq.

107. Kansans seeking abortion have a strong interest in maintaining the confidentiality of their medical records. Nauser Decl. ¶¶ 57-58. Many CWH patients, particularly those obtaining abortions, would experience substantial stress and anxiety if they learned that their identities and medical records would be open to extensive review by KDHE employees. The risk of exposure of patients' medical records could deter them from accessing abortion at CWH or in the State. Nauser Decl. ¶ 58.

108. K.A.R. 28-34-135(n) requires that, if a stock of controlled drugs is maintained at the abortion clinic, that the clinic "ensure that [it] is registered by the Kansas Board of Pharmacy."

109. The Board of Pharmacy had no mechanism by which to register a medical office like CWH. Nauser Decl. ¶ 52.

110. Kansas-licensed clinicians who practice in medical offices are permitted to maintain and administer controlled drugs, without registering with the Board of Pharmacy or having a pharmacist, so long as they are registered with the U.S. Drug and Enforcement Administration ("DEA"). See K.S.A. 65-1635; Nauser Decl. ¶ 54.

111. The controlled drugs used in connection with abortion care are the same as those used in other gynecological procedures performed at CWH and other medical offices in the state. See Nauser Decl. ¶ 55; Mirabile Decl. ¶ 11.

112. Requiring CWH to hire or contract with a pharmacist would present another unnecessary challenge and unnecessary expense. Nauser Decl. ¶ 54.

113. K.S.A. 65-4a05(a) requires KDHE to make "[a]t least one inspection" of an abortion facility "each calendar year without providing prior notice to the facility," "during regular business hours."

114. As a licensed physician, Dr. Nauser and her practice are currently subject to oversight by the Kansas State Board of Healing Arts, and state law does not require the Board's inspections of medical offices to be unannounced or during business hours. See K.S.A. 65-2864.

115. State law also does not require inspections of other KDHE-licensed facilities to be unannounced or during business hours. K.S.A. 65-433 (stating that KDHE "shall make or cause to be made inspections and investigations as deemed necessary").

116. The Challenged Laws subject plaintiffs to severe criminal and licensure penalties. See K.S.A. 65-4a06(d), (f), and 65-4a08(c). These severe penalties do not apply to the provision of care in medical offices where comparable Ob-Gyn care is provided. Nauser Decl. ¶ 21; see also K.S.A. 65-2836-65-2837 (stating grounds for clinician license revocation).

117. In addition, regulations for ambulatory surgical centers and hospitals do not include criminal penalties, civil liability, or fines for non-compliance, and KDHE testified that its current enforcement mechanisms are sufficient. Jirik Dep. 26:14-30:9 (ASCs), 41:22-42:18 (hospitals).

118. The Court filed an Agreed Order on December 2, 2011, that states:

> "The parties have agreed and jointly stipulated that the Temporary Restraining Order entered on November 10, 2011, shall remain in effect pending the Court's issuance of a final judgment in this matter. During the pendency of these proceedings, defendants shall not seek to enforce either the statutory Act or the Permanent Regulations promulgated by the [KDHE]."

(Court file, Agreed Order, 12-2-11.)

119. "In 2014, the Kansas Legislature amended two sections of the Act (K.S.A. 65-4a01 and K.S.A. 65-4a07); those amendments became effective on April 24, 2014." (Agreed Case

Management Order, Nov. 9, 2020, ¶ 4v.)

120. During its 2015 session, the Kansas Legislature repealed K.S.A. 2014 Supp. 65-4a10 and enacted an amended version of the statute effective June 11, 2015. However, the parties to this action entered a stipulation that: "In 2015, the Kansas Legislature amended K.S.A. 65-4a10; those amendments became effective on June 11, 2015." (Agreed Case Management Order, Nov. 9, 2020, ¶ 4w.)

121. Plaintiffs' second amended petition alleges that K.S.A. 65-4a10(b)(1) "as amended by 2015 Kan. Sess. Laws Ch. 84 (H.B. 2228), § 1(b)(1)" violates their patients' constitutional rights. See Ct. file, 2d Am. Pet., see also *Hodes & Nauser, MDs, P.A., and Nauser v. Norman*, No.19-121046, Slip. Op. 5-6, (Kan. Ct. App., Feb. 12, 2021) (unpublished).

122. Defendants filed a motion to clarify or dissolve the temporary injunction as to K.S.A. 65-4a10. The district court filed an order that addressed defendants' motion but did not grant dissolution or final clarification. Defendants then filed an interlocutory appeal under K.S.A. 60-2102(a)(2). See *Hodes & Nauser, MDs, P.A., and Nauser v. Norman*, No.19-121046, Slip. Op. 6, (Kan. Ct. App., Feb. 12, 2021) (unpublished).

123. The Court of Appeals found the amended 2015 version of K.S.A. 65-4a10 was substantially the same as the 2011 statute:[13]

> "The amended statute is substantially the same as the original in that when a drug is used for the purpose of inducing an abortion, the drug must be administered in the same room and in the physical presence of the physician who prescribed it, [which was] one of the provisions of the Act that Hodes & Nauser challenged as unconstitutional in their original petition and were seeking to enjoin enforcement of through the TRO and the Agreed Order."

See *Hodes & Nauser, MDs, P.A., and Nauser v. Norman*, No.19-121046, Slip. Op. 6, (Kan. Ct. App., Feb. 12, 2021) (unpubl.).

[13] The Court of Appeals also noted Hon. Franklin Theis had stated in *Trust Women Foundation, Inc. v. Schmidt*, Shawnee County District Court case no. 2018-CV-844, filed after the 2015 amendment, that all provisions of the Act remain enjoined in a related case, and the 2015 legislative amendment did not moot the Agreed Order.

124. The Court of Appeals dismissed defendants' interlocutory appeal, concluding it did not have jurisdiction for an immediate appeal from an order granting refusing, modifying, dissolving or continuing an injunction under K.S.A. 60-2102(a)(2). See *Hodes & Nauser, MDs, P.A.,* No.19-121046, Slip. Op. 7-8, 21-22, (Kan. Ct. App., Feb. 12, 2021) (unpubl.).

125. "On February 22, 2019, the parties jointly stipulated to the dismissal of Herbert C. Hodes, M.D. as a Plaintiff." (Agreed Case Management Order, Nov. 9, 2020, ¶ 4x.)

126. The parties jointly stipulated that "Plaintiffs Dr. Nauser and Hodes & Nauser, M.D.s, P.A., have standing to challenge the Act and Regulations on behalf of themselves and their patients." (Agreed Case Management Order, Nov. 9, 2020, ¶ 4y.)

127. Plaintiffs seek a declaratory judgment that the Act, K.S.A. 2011 65-4a01 through 65-4a12, including K.S.A. 65-4a10(b)(1) "as amended by 2015 Kan. Sess. Laws Ch. 84 (H.B. 2228), § 1(b)(1)" and the Regulations adopted by KDHE, K.A.R. 28-34-126 through 28-34-44 (collectively, "Challenged Laws"), are unconstitutional and, therefore, unenforceable statewide. See Ct. file, 2d Am. Pet. Plaintiffs request that the Court issue a permanent injunction restraining defendants and all others from enforcing the Challenged Laws. Id.

III. ANALYSIS

A. Standard of Review

On deciding whether summary judgment is appropriate, the court must resolve all facts and inferences drawn from the evidence in favor of the party against whom summary judgment is sought. *Saliba v. Union Pac. R. Co.,* 264 Kan. 128, 131, 955 P.2d 1189, 1192 (1998). "Summary judgment is appropriate when the pleadings . . . and admissions on file . . . show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." *Troutman v. Curtis,* 286 Kan. 452, 454-55, 185 P.3d 930 (2008). A party

opposing summary judgment must provide evidence to establish a dispute regarding a material fact. *Troutman,* 286 Kan. at 455.

B. Plaintiffs' Standing to Challenge on Behalf of Their Patients

In November 2020, the Court approved the parties' Agreed Case Management Order, which contained a list of agreed stipulations. (See Ct. file, *Agreed CMO*, 11-9-20; see also *Agreed Am. CMO*, 12-9-20.) One of the parties' stipulations clarified the scope of plaintiffs' standing to challenge the Act and regulations on behalf of themselves *and their patients*:

> "Plaintiffs Dr. Nauser and Hodes&Nauser, M.D.s, P.A., have standing to challenge the Act and Regulations on behalf of themselves and their patients."

(Ct. file, *Agreed CMO*, 11-9-20.)

Despite their stipulation, the defendants now argue there is no evidence that any woman in Kansas has had or will have her right to continue her pregnancy infringed by the Challenged Laws.[14] Defendants' infringement argument could be construed as an attack on plaintiffs' ability to assert the constitutional rights of their actual or potential patients in challenges to abortion-related regulations.

In *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103, 207 L. Ed. 2d 566 (2020), the United States Supreme Court found abortion providers had standing to assert the constitutional rights of their patients and held, based on *stare decisis* principles, that Louisiana's Act 620 was unconstitutional. The United States Supreme Court explained:

> We have long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations. See, *e.g., Whole Woman's Health*, 579 U. S., at ——, 136 S.Ct., at 2314; *Gonzales*, 550 U.S. at 133, 127 S.Ct. 1610; *Ayotte v. Planned Parenthood of Northern New Eng.*, 546 U.S. 320, 324, 126 S.Ct. 961, 163 L.Ed.2d 812 (2006); *Stenberg v. Carhart*, 530 U.S. 914, 922, 120 S.Ct. 2597, 147 L.Ed.2d 743

[14] The defendants' combined summary judgment motion does not argue plaintiffs' lack standing due to the 2015 amendment to the 2011 Challenged Laws. See *Defendants' Combined Motion for Summary Judgment and Memorandum in Support Thereof* (4-23-21). The Court finds this issue has been waived by the defendants.

(2000); *Mazurek v. Armstrong*, 520 U.S. 968, 969–970, 117 S.Ct. 1865, 138 L.Ed.2d 162 (1997) (*per curiam*); *Casey*, 505 U.S. at 845, 112 S.Ct. 2791 (majority opinion); *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 440, n. 30, 103 S.Ct. 2481, 76 L.Ed.2d 687 (1983); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 62, 96 S.Ct. 2831, 49 L.Ed.2d 788 (1976); *Doe v. Bolton*, 410 U.S. 179, 188–189, 93 S.Ct. 739, 35 L.Ed.2d 201 (1973).

And we have generally permitted plaintiffs to assert third-party rights in cases where the "'enforcement of the challenged restriction *against the litigant* would result indirectly in the violation of third parties' rights.'" *Kowalski*, 543 U.S. at 130, 125 S.Ct. 564 (quoting *Warth*, 422 U.S. at 510, 95 S.Ct. 2197); see, *e.g.*, *Department of Labor v. Triplett*, 494 U.S. 715, 720, 110 S.Ct. 1428, 108 L.Ed.2d 701 (1990) (Scalia, J., for the Court) (attorney raising rights of clients to challenge restrictions on fee arrangements); *Craig*, 429 U.S. at 192, 97 S.Ct. 451 (convenience store raising rights of young men to challenge sex-based restriction on beer sales); *Doe*, 410 U.S. at 188, 93 S.Ct. 739 (abortion provider raising the rights of pregnant women to access an abortion); *Carey v. Population Services Int'l*, 431 U.S. 678, 97 S.Ct. 2010, 52 L.Ed.2d 675 (1977) (distributors of contraceptives raising rights of prospective purchasers to challenge restrictions on sales of contraceptives); *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972) (similar); *Griswold v. Connecticut*, 381 U.S. 479, 481, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) (similar); *Sullivan v. Little Hunting Park, Inc.*, 396 U. S. 229, 90 S.Ct. 400, 24 L.Ed.2d 386 (1969) (white property owner raising rights of black contractual counterparty to challenge discriminatory restrictions on ability to contract); *Barrows v. Jackson*, 346 U.S. 249, 73 S.Ct. 1031, 97 L.Ed. 1586 (1953) (similar). In such cases, we have explained, "the obvious claimant" and "the least awkward challenger" is the party upon whom the challenged statute imposes "legal duties and disabilities." *Craig*, 429 U.S. at 196–197, 97 S.Ct. 451; see *Akron*, 462 U.S. at 440, n. 30, 103 S.Ct. 2481; *Danforth*, 428 U.S. at 62, 96 S.Ct. 2831; *Doe*, 410 U.S. at 188, 93 S.Ct. 739.

The case before us lies at the intersection of these two lines of precedent. The plaintiffs are abortion providers challenging a law that regulates their conduct. The "threatened imposition of governmental sanctions" for noncompliance eliminates any risk that their claims are abstract or hypothetical. *Craig*, 429 U.S. at 195, 97 S.Ct. 451. That threat also assures us that the plaintiffs have every incentive to "resist efforts at restricting their operations by acting as advocates of the rights of third parties who seek access to their market or function." *Ibid.* And, as the parties who must actually go through the process of applying for and maintaining admitting privileges, they are far better positioned than their patients to address the burdens of compliance. See *Singleton*, 428 U.S. at 117, 96 S.Ct. 2868 (plurality opinion) (observing that "the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against," a woman's decision to have an abortion). They

> are, in other words, "the least awkward" and most "obvious" claimants here. *Craig*, 429 U.S. at 197, 97 S.Ct. 451.

June Med. Servs. L. L. C. v. Russo, 140 S. Ct. 2103, 2118–19, 207 L. Ed. 2d 566 (2020).

Based on the prior stipulation of the parties, this Court reasonably concludes the defendants waived any argument concerning plaintiffs' standing to challenge the Act and Regulations on behalf of not only themselves but also on behalf of their patients. In addition, case law supports a finding that plaintiffs are uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, their patients' constitutionally protected right to decide whether to continue a pregnancy. Adopting the reasoning of the Court in *June Med. Servs. L. L. C. v. Russo*, this Court finds the plaintiffs are uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, a woman's decision to have an abortion and should be allowed to assert the rights of their patients because enforcement of the challenged restriction against plaintiffs could result indirectly in violation of patients' constitutional rights.

C. The Right of Personal Autonomy Under Section 1 of the Kansas Constitution Bill of Rights; *Hodes & Nauser MDs, P.A. v. Schmidt*, 309 Kan. 610 (2019).

The Kansas Supreme Court issued a decision in 2019 that must first be analyzed because it guides this Court's consideration of this matter. In *Hodes & Nauser v. Schmidt*, the plaintiffs challenged laws enacted by the Kansas Legislature that "prohibited physicians from performing a specific abortion method referred to in medical terms as Dilation and Evacuation (D & E) except when 'necessary to preserve the life of the pregnant woman' or to prevent a 'substantial and irreversible physical impairment of a major bodily function of the pregnant woman.'" 309 Kan. at 614. In its framing of the issue before it, the Kansas Supreme Court posited that it was tasked with determining if Section 1 of the Kansas Constitution Bill of Rights is "more than an idealized

aspiration" that protects a "woman's right to make decisions about her body, including the decision whether to continue her pregnancy." *Hodes & Nauser,* 309 Kan. at 613. The Court ruled as follows:

> We answer these questions, "Yes."
>
> We conclude that, through the language in section 1, the state's founders acknowledged that the people had rights that preexisted the formation of the Kansas government. There they listed several of these natural, inalienable rights—deliberately choosing language of the Declaration of Independence by a vote of 42 to 6.
>
> Included in that limited category is the right of personal autonomy, which includes the ability to control one's own body, to assert bodily integrity, and to exercise self-determination. This right allows a woman to make her own decisions regarding her body, health, family formation, and family life—decisions that can include whether to continue a pregnancy. Although not absolute, this right is fundamental. Accordingly, the State is prohibited from restricting this right unless it is doing so to further a compelling government interest and in a way that is narrowly tailored to that interest. And we thus join many other states' supreme courts that recognize a similar right under their particular constitutions.

Hodes & Nauser, 309 Kan. at 614.

The Court emphasized in *Hodes & Nauser, MDs, P.A. v. Schmidt* that the Kansas Constitution demonstrated "the supremacy placed on the rights of individuals, preservation of natural rights is given precedence over the establishment of government." 309 Kan. at 660-61 (citation omitted).

In *Hodes & Nauser, MDs, P.A. v. Schmidt,* 309 Kan. 610, the Kansas Supreme Court reviewed section 1 of the Kansas Constitution Bill of Rights to determine whether its protections extend to include a pregnant woman's right of personal autonomy, or ability to control her own body, including the right to make medical decisions about her own body, health, family formation, family life and whether she will continue a pregnancy. The Court observed that section 1 provided constitutional protection for the right of personal autonomy:

> "…section 1's declaration of natural rights, which specifically includes the rights to liberty and the pursuit of happiness, protects the core right of personal autonomy—which includes the ability to control one's own body, to assert bodily integrity, and to exercise self-determination. This right allows Kansans to make their own decisions regarding their bodies, their health, their family formation, and their family life. Pregnant women, like men, possess these rights."

Hodes & Nauser, MDs, P.A., 309 Kan. at 660.

> "***At issue here is the inalienable natural right of personal autonomy***, ***which*** is the heart of human dignity. It encompasses our ability to control our own bodies, to assert bodily integrity, and to exercise self-determination. It ***allows each of us to make decisions about medical treatment and family formation, including whether to bear or beget a child***. For women, these decisions can include whether to continue a pregnancy."

(Emphasis added.) *Hodes & Nauser, MDs, P.A. v. Schmidt,* 309 Kan. at 671.

The Kansas Supreme Court discussed potential "consequences women would face if [it] did not recognize the founders' intent to protect [the natural right of personal autonomy] from an overreaching government." 309 Kan. at 650. The Court warned the consequence of such a failure to extend constitutional protection would be that, upon a woman becoming pregnant, virtually all rights of personal sovereignty under the Kansas Constitution's Bill of Rights would be relinquished to the government. See *Hodes & Nauser, MDs, P.A.,* 309 Kan. at 650.

Ultimately, the Court held: "Consistent with these and other states, today we hold our Kansas Constitution's drafters' and ratifiers' proclamation of natural rights applies to pregnant women. This proclamation protects the right to decide whether to continue a pregnancy." *Hodes & Nauser, MDs, P.A. v. Schmidt,* 309 Kan. 610, 650, 440 P.3d 461 (2019).

D. Strict Scrutiny Review

The Kansas Supreme Court in *Hodes & Nauser, MDs, P.A.* held courts should apply the strict scrutiny standard when reviewing claims of violation of a fundamental right under section 1 of the Kansas Constitution Bill of Rights:

> "As we have already noted, the natural right of personal autonomy is fundamental and thus requires applying strict scrutiny. As such, to justify S.B. 95, the State must establish a compelling interest—one that is 'not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests.' Fallon, 54 UCLA L. Rev. at 1273."

Hodes & Nauser, MDs, P.A., 309 Kan. at 663.

> Imposing a lower standard than strict scrutiny, especially mere reasonableness, or the dissent's "rational basis with bite"—when the factual circumstances implicate these rights because a woman decides to end her pregnancy—risks allowing the State to then intrude into all decisions about childbearing, our families, and our medical decision-making. It cheapens the rights at stake. The strict scrutiny test better protects these rights. See, e.g., *Farley*, 241 Kan. at 669-70, 740 P.2d 1058."

Hodes & Nauser, MDs, P.A., 309 Kan. at 671.

Put simply, the Kansas Supreme Court ruled the Kansas Constitution protects a woman's right to decide whether to continue a pregnancy, and the right to access legal abortion services.

E. Do the Challenged Laws Violate Plaintiffs' Fundamental Rights Guaranteed by the Kansas Constitution Bill of Rights Section 1, and the Right to Equal Protection Under the Law?

The plaintiffs argue the Challenged Laws are unconstitutional because they violate plaintiffs' and their patients' protected right to access abortion services as well as their right to equal protection under the law.

1. Fundamental Right of Personal Autonomy Guaranteed Under Section 1 of the Bill of Rights of the Kansas Constitution is Subject to Strict Scrutiny Review

Kansas courts use the three-tiered set of standards utilized by the federal courts to determine the constitutionality of a government restriction on a person's constitutional rights. This tiered system includes the rational basis standard; the heightened or intermediate scrutiny standard; and the strict scrutiny standard. *Hodes & Nauser,* 309 Kan. at 662-63. The use of these standards is dependent upon the nature of the right at stake. *Hodes & Nauser,* 309 Kan. at 663. As the Kansas Supreme Court decided in *Hodes & Nauser,* the "natural right of personal

autonomy is fundamental and thus requires applying strict scrutiny."[15] 309 Kan. at 663. Under this test, "the courts peel away the protective presumption of constitutionality and adopt an attitude of active and critical analysis." *Hodes & Nauser,* 309 Kan. at 673.

The strict scrutiny standard first requires a determination of how the governmental action burdens or infringes on the right at stake. *Hodes & Nauser,* 309 Kan. at 669. Any infringement, i.e., one "regardless of degree," leads to a presumption that the government's action is unconstitutional. *Hodes & Nauser,* 309 Kan. at 669.

The Court explained under the strict scrutiny standard, the government faces a higher burden to prove a challenged law is constitutional. Once an infringement has been identified, the government must justify its intrusion on the right at stake by establishing "a compelling interest—one that is 'not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests.'" *Hodes & Nauser,* 309 Kan. at 663. The government must also meet a second hurdle: it must show it has narrowly tailored the law to serve its compelling interest. *Hodes & Nauser,* 309 Kan. at 669.

2. Have Plaintiffs Provided Evidence That the Challenged Laws Will Infringe on Fundamental Rights Protected by the Bill of Rights § 1 of the Kansas Constitution?

In asserting a constitutional violation, once a plaintiff establishes a protected right, he or she must then show an unconstitutional infringement of that right. See *Hodes & Nauser, MDs, P.A.,* 309 Kan. at 660. Here, plaintiffs have provided evidence establishing that the Challenged Laws will infringe on a woman's fundamental right to access legal abortion services. For example, Dr. Nauser stated the Challenged Laws "will make it more difficult, if not impossible, for CWH to continue offering abortion care." (Nauser Declaration, ¶ 27.) Dr. Nauser indicated

[15] In fact, the Court went to great lengths to explain why it chose not to adopt and apply the federal "undue burden standard" first described in *Planned Parenthood of Southeastern Pa v. Casey,* 505 U.S. 833, 872, 112 S.Ct. 2791 (1992) (plurality opinion).

the Challenged Laws will force CWH to see fewer patients, cause CWH patients to face higher costs, or result in unjustifiably delayed and obstructed services. (Nauser Declaration, ¶ 27.) Dr. Nauser identified other burdens imposed by the Challenged Laws, summarized next:

- Staffing and monitoring restrictions imposed by K.A.R. 28-34-135(m); K.A.R. 28-34-138(c); K.A.R. 28-34-138(f); K.A.R. 28-34-139(a)(2); and K.A.R. 28-34-137(c) increase the costs of services and delay a patient's ability to receive services. (Nauser Declaration, ¶¶ 36-45.) (P. Motion, ¶¶ 96-97.)

- Recovery-related restrictions imposed by K.A.R. 28-34-139(a) burden patients by requiring them to stay at least twice as long as is medically necessary and delays a patient's ability to receive services because less patients can be scheduled in one day. Similarly, the requirements of K.A.R. 28-34-133(b)(7) of a "nurse station with visual observation of each patient in the recovery area" impose staffing and building structure burdens that would also cause delays or prohibit the services offered altogether. (Nauser Declaration, ¶¶ 46-51.) (P. Motion, ¶¶ 108-11, 118-19.)

- Board of Pharmacy registration restrictions imposed by K.A.R. 28-34-135(n) would impose financial burdens on CWH. (Nauser Declaration, ¶¶ 52-55.) (P. Motion, ¶¶ 124-28.)

- Requirements for the administration of mifepristone imposed by K.S.A. 65-4a10(b)(1) restrict a physician's ability to tend to other patients by prohibiting other qualified staff from administering the medication. (Nauser Declaration, ¶¶ 59-62.) (P. Motion, ¶¶ 84-87.)

- Medical waste regulations imposed by K.A.R. 28-34-127(c) threatens CWH's ability to maintain its current medical waste contract, which would result in the closure of CWH. (Nauser Declaration, ¶¶ 63-64.) (P. Motion, ¶¶ 112-15.)

- Equipment and facility requirements imposed by K.A.R. 28-35-135(a)(2); K.A.R. 28-35-135(a)(5); K.A.R. 28-35-135(a)(6); K.A.R. 28-35-135(a)(8); K.A.R. 28-34-135(e)(2); and K.A.R. 28-34-135(d) require abortion clinics to purchase unnecessary supplies. (Nauser Declaration, ¶¶ 65-67.) (P. Motion, ¶¶ 116-17.)

In their motion for summary judgment, the defendants state, "there is no evidence that any part of the Act or any regulation has had or will have any effect on a woman's ability to decide whether to continue her pregnancy." (D. Motion, p. 8.) The defendants go on to say there "is no evidence that any patient will have difficulty contacting another abortion provider in

Kansas regarding her decision whether to continue her pregnancy if plaintiffs do not comply with the Act or the Regulations." (D. Motion, p. 8.)

With respect to the defendants' second point, the plaintiffs have provided evidence that Dr. Nauser is one of the only clinicians in the area who possesses the experience and expertise required to work with women facing certain medical complications or fetal diagnoses. (Nauser Declaration, ¶¶ 20, 31.) (P. Motion, p. 35.) Further, the Supreme Court of Kansas has already determined that a restriction that "threatens the already small number of providers willing to perform" certain abortions also impairs a person's natural rights. *Hodes & Nauser,* 309 Kan. at 672.

Also important, as the plaintiffs illustrate in their responsive brief, "a law infringes the right to abortion not only when it forces a person to seek care elsewhere." (P. Resp. Brief, p. 13.) Instead, restrictions that *merely delay access* to abortion impair a fundamental right. *See Hodes & Nauser,* 309 Kan. at 672 (finding impairment of a natural right due to the implication that S.B. 95 "will delay or completely prevent the exercise" of the fundamental right of abortion).

As a result, it is not difficult for this Court to conclude the Challenged Laws infringe on a woman's right to access legal abortion services. See *Ragsdale v. Turnock,* 841 F.2d 1358, 1370 (7th Cir. 1988) (finding restrictions that caused delay and raised the costs of the services impaired the right at stake).

3. The State's Compelling Interest

The Kansas Supreme Court observed in *Hodes & Nauser, MDs, P.A.,* that the State is free to assert any interests it believes compelling and show how the statute in question is narrowly tailored to those interests. 309 Kan. at 669. Our Court also noted the United States Supreme Court had stated that the " 'State has a legitimate interest in seeing to it that abortion, like any

other medical procedure, is performed under circumstances that insure maximum safety for the patient.'" *Hodes & Nauser, MDs, P.A.,* 309 Kan. at 677, citing *Hellerstedt*, 136 S.Ct. at 2309 (quoting *Roe*, 410 U.S. at 150, 93 S.Ct. 705).

The defendants maintain the State has a valid interest in protecting the health of pregnant women, which is encompassed in its broader interest in promoting the health and safety of all its residents. The defendants further claim the State's interest in protecting the health of pregnant women is linked with its "longstanding interest in regulating the medical profession." (D. Motion, p. 10.)

Finally, the defendants contend states also have "wide discretion to pass laws in areas where there is medical and scientific uncertainty." (D. Motion, p. 11.) The Court will not consider this rationale as the defendants fail to adequately define such "areas where there is medical and scientific uncertainty," or what that phrase means in relation to the medical procedures at issue. Further, defendants fail to identify any evidence that might support an argument of medical and scientific uncertainty.

There is little question the health of pregnant women or non-pregnant women—and of Kansas residents, more generally—is a compelling interest. See *Planned Parenthood of the Heartland v. Reynolds ex rel. State*, 915 N.W.2d 206, 239–40 (Iowa 2018) (finding state has "compelling interest in 'protecting women's health and safety' and ensuring that abortions, like other medical procedures, are performed under safe circumstances for the patient."). Here, the defendants have the burden to establish a compelling State interest in regulating the medical profession in the context of abortion care to protect women's health and safety.

However, not only must the defendants show that the Challenged Laws correspond with a compelling interest; they must also demonstrate that the Challenged Laws "<u>further the identified</u>

state interest that motivated the regulation not merely in theory, but in fact." *Planned Parenthood of the Heartland,* 915 N.W.2d at 239-240; see also *Hodes & Nauser,* 309 Kan. at 680 (emphasis added) (delineating the strict scrutiny standard as requiring the state to prove its restriction *furthers* a compelling interest).

4. Have Plaintiffs Shown the Challenged Laws Further the State Interest of Protecting the Health of Pregnant Women, Not Merely in Theory, But in Fact?

a. Uncontroverted Evidence Establishes the Relative Safety of Abortion Care

The plaintiffs have submitted uncontroverted evidence that abortion care is "one of the safest types of medical care provided in the United States." (P. Motion, ¶ 1.) Both abortion-related mortality (death) and abortion-related morbidity (i.e., non-fatal complications) are very rare. Raymond Decl. ¶ 9. Abortion is approximately 14 times safer than carrying a pregnancy to term. A 2015 publication by the Centers for Disease Control and Prevention (CDC) reported the legal abortion-related mortality rate was 0.7 deaths per 100,000 procedures. Raymond Decl. ¶11, 22. Mortality from childbirth is 8.8 deaths per 100,000 live births.

Abortion-related mortality is also significantly lower than that for other common outpatient medical procedures, such as colonoscopy (5 deaths per 100,000 procedures) and some plastic surgeries (1.7 deaths per 100,000 procedures). Raymond Decl. ¶¶ 28-29. Serious non-fatal complications of abortion as currently performed at outpatient facilities are extremely rare. In a recent study examining approximately 55,000 abortions, the incidence of major complications was 0.23%. Raymond Decl. ¶ 18. Abortion is also common. Nearly one in four women in the United States will obtain an abortion in their lifetimes.

The safety of abortion procedures was considered in *Planned Parenthood of Wisconsin, Inc. v. Van Hollen,* 94 F. Supp. 3d 949 (W.D. Wisc. 2015), *aff'd sub nom. Planned Parenthood*

of Wisconsin, Inc. v. Schimel, 806 F.3d 908 (7th Cir. 2015). Based on the evidence presented, including that from a neutral, court-appointed expert, the court found as follows:

> The types of complications associated with abortions vary somewhat by the type of procedure used. For medication abortions, complications may include adverse reaction to one of the medications, bleeding, infection, failed or incomplete abortions, and very rare risk of death . . . For surgical abortions, complications include an adverse reaction to one of the sedation medications, bleeding, infection, incomplete abortion, and injury to the cervix or uterus, and a very rare risk of death. Planned Parenthood of Wisconsin, 94 F. Supp. 3d at 967.

In considering complication rates, the court found less than 0.65% of 233,805 patients experienced a complication with a medical abortion and only 0.06% required hospitalization as a result of a complication. *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 967. The court also found that 1.27% of 11,487 patients who received a first-trimester surgical abortion experienced a minor complication while only 0.052% experienced a major complication requiring hospitalization. *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 967-68. Complication rates vary based on gestational age, making late second-trimester abortions the most risky. See *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 968 (comparing rate of hospitalizations for first trimester abortions (.071%) and second trimester abortions (1-1.5%)). This data parallels the evidence submitted by the plaintiffs in this case.

Despite the increased risk of complication associated with gestational age, the court in *Planned Parenthood of Wisconsin* noted the safety of abortion when compared to pregnancy, finding "women are more likely to experience complications from live births than from having abortions." 94 F. Supp. 3d at 968. In fact, the "risk of death related to abortion overall is less than 0.6 deaths per 100,000 procedures, which equates to a mortality rate of 0.0006%. . . . [while] [t]he comparable risk of death for childbirth is 8.8 out of 100,000 births or a mortality rate of 0.0088%." *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 968. The court also considered

the safety of abortions to other outpatient procedures, finding abortions, in general, "are safer or comparable in safety to other outpatient procedures" like colonoscopies, egg retrieval for in vitro fertilization, hysteroscopies, and vasectomies, as well as in comparison to "other outpatient gynecological procedures like cervical biopsies, endometrial biopsies, IUD insertions, and LEEP procedures." *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 971. See also James Mirabile Declaration ¶¶ 4, 13 (stating many of the gynecological procedures performed in his office "are similar to abortion in terms of technique, duration, complexity, and risk.") This data also parallels the evidence submitted by the plaintiffs here.

The court ultimately determined "abortion is safe, especially in the first trimester when the vast majority of abortions are performed nationwide." *Planned Parenthood of Wisconsin*, 94 F. Supp. 3d at 970. See also *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311, 195 L. Ed. 2d 665 (2016), *as revised* (June 27, 2016) (noting the lower court's determination that "abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring" prior to the passage of a Texas Bill requiring admitting privileges). Here, the plaintiffs have similarly provided uncontroverted evidence that the majority of people who obtain abortion care in Kansas obtain it in the first trimester of pregnancy.

This Court takes note of the defendants' framing of the passage of the Challenged Laws in reference to the news of Kermit Gosnell, a Pennsylvania doctor charged with crimes related to "perhaps the most egregious example of the potential for abuse in an abortion practice." (D. Resp., p. 2-3.) The majority opinion in *Whole Woman's Health* addressed the dissent's concern over "unsafe facilities," including Gosnell's, by finding:

> There is no reason to believe that an extra layer of regulation would have affected that behavior. Determined wrongdoers, already ignoring existing statutes and safety measures, are unlikely to be convinced to adopt safe practices by a new overlay of regulations. Regardless, Gosnell's deplorable crimes could escape

> detection only because his facility went uninspected for more than 15 years. Pre-existing Texas law already contained numerous detailed regulations covering abortion facilities, including a requirement that facilities be inspected at least annually. The record contains nothing to suggest that H.B. 2 would be more effective than pre-existing Texas law at deterring wrongdoers like Gosnell from criminal behavior. 136 S. Ct. 2292, 2313–14 (internal citations omitted).

While the actions of Gosnell were atrocious and utterly beyond comprehension and decency, defendants fail to provide evidence demonstrating that clinics that provide abortion care require advanced levels of regulation to be safe—or that pregnant women seeking an abortion face a specific need for protection.

On the whole, the uncontroverted evidence indicates abortion practices are safe when considered on the spectrum of other gynecological procedures or mandated health screenings.

b. Clinics Kansas Already Regulates the Practice of Medicine at Medical Offices or Clinics

The Board of Healing Arts licenses individual clinicians and regulates outpatient medical clinics or offices.[16] (P. Motion, ¶¶ 42 56.); K.A.R. 100-25-1 et seq. These regulations "set standards for maintaining the offices' cleanliness; for infection control and the disposal of biological waste; for maintaining drugs, supplies, and medical equipment; and for maintaining the safety of the physical facility." (P. Motion, ¶ 44.) In addition to regulating office-based surgeries and special procedures,[17] the Board "provides further regulation for care that involves sedation or anesthesia, including local anesthesia" as well as spinal or epidural blocks.[18] (P. Motion, ¶¶ 45-46.)

Taken together, these regulations cover a variety of procedures performed at medical clinics or offices, which include, as a non-exhaustive example, an assortment of gynecological

[16] As opposed to a hospital or ASC.
[17] See K.A.R. 100-25-3 (delineating requirements for office-based surgeries and special procedures).
[18] K.A.R. 100-25-3; K.A.R. 100-25-4.

procedures, miscarriage management, some plastic and dental surgeries, and abortions. (P. Motion, ¶ 48.)

Specifically, regarding gynecological procedures, the evidence submitted by the plaintiffs indicates "[d]ilation and curettage ("D&C") to manage miscarriage, endometrial ablation, and diagnostic hysteroscopy, is medically comparable to procedural abortion." (P. Motion, ¶ 16.) See also James Mirabile Declaration, ¶¶ 4-7, 13 (describing the services provided at his medical office and comparing them to abortion). Dr. Nauser performs several gynecological procedures in her office: D&Cs, endometrial ablation, colposcopy, diagnostic and operative hysteroscopy, LEEP biopsies, insertion/removal of IUDs, other biopsies, and hymenectomy. (Nauser Decl. ¶ 23.) For these procedures, Dr. Nauser uses "the same forms of sedation" as she does for abortion procedures. (Nauser Decl. ¶ 23.)

The defendants' expert, Dr. Melissa Hague, performs hysteroscopies, LEEP biopsies, endometrial biopsies, and IUD placements in her medical office.[19] (Hague Dep. 38:8-19.) Dr. Hague agreed that the current regulations imposed by the Board "allow [her] to adequately [and] safely provide care in [her] office." (Hague Dep. 95:25-96:17.) Dr. James Mirabile, plaintiffs' expert, performs uterine ablations, biopsies (uterine, endometrial, cervical, vaginal, and LEEP), and diagnostic hysteroscopies in his office. (Mirabile Decl. ¶¶ 4-8.) Dr. Mirabile opined that the Board's regulations of his medical practice, which is not an ASC or hospital, "are reasonable and medically appropriate for patient health and safety." (Mirabile Decl. ¶ 12.)

c. The Challenged Laws do not *Further* a Compelling Interest

The evidence proffered by the defendants to show the Challenged Laws further the stated interests include general statements that the Challenged Laws "attempt to ensure that women

[19] Dr. Hague performs D&Cs, D&Es, ovarian cystectomies, tubal ligations or removals, and other surgical procedures at an ASC or hospital. (Hague Dep. 38:21-39:6.)

who are deciding whether to continue their pregnancies have access to a safe environment in which to exercise such right"[20] and "ensure a minimum level of safety for all women seeking abortions in Kansas. They provide appropriate oversight and standards to ensure patient safety."[21] The defendants also claim the Challenged Laws "provide a baseline of minimum safety standards that any clinic should be able to meet,"[22] while acknowledging clinics are currently subject to regulation by the Kansas State Board of Healing Arts. The defendants also rely on their expert, Dr. Hague, for the following assertions:

- The Challenged Laws "are reasonable regulations designed to enhance patient comfort and safety, particularly in the event of managing unexpected complications." (D. Reply, p. 4.)

- "Having another person in the room to observe the patient and to help facilitate the procedure is standard medical practice and is done in order to ensure the safety of the woman having the procedure."[23] (D. Reply, p. 4.)

- "A patient's physical and mental condition should be monitored during any procedure."[24] (D. Reply, p. 4.)

- "The requirement that another licensed health professional be available within a facility at the time of an abortion procedure is a reasonable[25] requirement for the safety of the patient." (D. Reply, p. 5.)

- Monitoring a patient's vital signs and bleeding "is a reasonable requirement that helps ensure a patient's safety after a procedure that presents risks like those inherent to D&Cs and D&Es."[26] (D. Reply, p. 5.)

- "[T]here may be circumstances where a minimum of 30 minutes recovery time following a first-trimester abortion may not be necessary. However, the 30-minute recovery time

[20] (D. Motion, p. 12.)
[21] (D. Reply, p. 2.)
[22] (D. Reply, p. 7.)
[23] In her deposition, Dr. Hague agreed this specific regulation was unnecessary for patient health and safety. (Hague Dep: 100:18-101:13.)
[24] K.A.R. 100-25-3(b)(5) requires a patient's vital signs to be considered in making a determination of whether the patient is ready to be discharged after an office-based special procedure or surgery. Subsection (d)(4) of the same regulation mandates certain patient monitoring during the application of anesthesia.
[25] Finding a regulation "reasonable" does not equate with it being necessary or required to protect patient's health and safety.
[26] In her deposition, Dr. Hague agreed the regulation requiring a physician, nurse, or physician assistant to monitor vital signs (rather than a medical assistant) was unnecessary for patient health and safety. (Hague Dep: 109:3-19.)

> requirement may be helpful to determine if there are unexpected complications, such as bleeding, that begin later in the 30-minute recovery period."

(D. Reply, p. 6.)[27]

The showing required for strict scrutiny is not whether the laws "attempt to ensure" certain results or are "reasonable;" instead, the defendants must show the Challenged Laws *further a compelling interest*. They have not met their burden. The defendants fail to explain why the Challenged Laws are needed above and beyond the regulations already imposed by the Board of Healing Arts. Specifically, defendants fail to meet their burden to demonstrate that clinics performing abortions need targeted restrictions when other clinics performing comparable or more risky procedures do not require added oversight.

For the sake of comparison, consider hospitals and ASCs, which are both regulated and licensed by KDHE. See K.S.A. 65-425; K.S.A. 65-427; K.S.A. 65-431; K.A.R. 28-34-50 et seq. The parties do not dispute that the procedures performed at those institutions are typically greater in complexity than those performed at medical offices or clinics. (P. Motion, ¶ 54.) The regulations and licensing hurdles facing hospitals and ASCs are also applied broadly to all hospitals and ASCs, defined as follows:

> (a) "General hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have a variety of medical conditions.
>
> (b) "Special hospital" means an establishment with an organized medical staff of physicians; with permanent facilities that include inpatient beds; and with medical services, including physician services, and continuous registered professional nursing services for not less than 24 hours of every day, to provide diagnosis and treatment for patients who have specified medical conditions.

[27] In her deposition, Dr. Hague agreed the regulation requiring patients to remain in recovery for 30 minutes following a first trimester abortion procedure is unnecessary for patient health and safety. (Hague Dep: 110:14-24.)

. . .

(f) "Ambulatory surgical center" means an establishment with an organized medical staff of one or more physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physician services during surgical procedures and until the patient has recovered from the obvious effects of anesthetic and at all other times with physician services available whenever a patient is in the facility; with continuous registered professional nursing services whenever a patient is in the facility; and which does not provide services or other accommodations for patient to stay more than 24 hours. Before discharge from an ambulatory surgical center, each patient shall be evaluated by a physician for proper anesthesia recovery. Nothing in this section shall be construed to require the office of a physician or physicians to be licensed under this act as an ambulatory surgical center.

. . .

(h) "Medical care facility" means a hospital, ambulatory surgical center or recuperation center, but shall not include a hospice which is certified to participate in the medicare program under 42 code of federal regulations, chapter IV, section 418.1 et seq. and amendments thereto and which provides services only to hospice patients.

(i) "Critical access hospital" shall have the meaning ascribed to such term under K.S.A. 65-468 and amendments thereto.

(j) "Hospital" means "general hospital," "critical access hospital," or "special hospital." K.S.A. 65-425.

(f) (1) "Critical access hospital" means a member of a rural health network that: Makes available 24-hour emergency care services; provides not more than 25 acute care inpatient beds or in the case of a facility with an approved swing-bed agreement a combined total of extended care and acute care beds that does not exceed 25 beds; provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient; and provides nursing services under the direction of a licensed professional nurse and continuous licensed professional nursing services for not less than 24 hours of every day when any bed is occupied or the facility is open to provide services for patients unless an exemption is granted by the licensing agency pursuant to rules and regulations. The critical access hospital may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist and radiological technologist on a part-time, off-site basis under written agreements or arrangements with one or more providers or suppliers recognized under medicare. The critical access hospital may provide inpatient services by a physician assistant, advanced

> practice registered nurse or a clinical nurse specialist subject to the oversight of a physician who need not be present in the facility. In addition to the facility's 25 acute beds or swing beds, or both, the critical access hospital may have a psychiatric unit or a rehabilitation unit, or both. Each unit shall not exceed 10 beds and neither unit shall count toward the 25-bed limit or be subject to the average 96-hour length of stay restriction. K.S.A. 65-468.

In contrast, the Challenged Laws do not have broad applicability to all medical offices or clinics. Instead, the Challenged Laws define "clinic" and "facility" specifically as those that provide abortion services:

> (d) "Clinic" means any facility, other than a hospital or ambulatory surgical center, in which any second or third trimester, or five or more first trimester abortions are performed in a month.
> . . .
> (g) "Facility" means any clinic, hospital or ambulatory surgical center, in which any second or third trimester elective abortion, or five or more first trimester elective abortions are performed in a month, excluding any abortion performed due to a medical emergency. K.S.A. 65-4a01; see also K.S.A. 65-4a09 (denoting the regulations as for "facilities for the performance of abortions").

This is despite the fact that, as discussed above, many medical clinics perform procedures riskier than or comparable to abortion by procedure on a daily basis. For example, "clinicians, who are not physicians, such as certified nurse midwives, may provide care in connection with an uncomplicated pregnancy at a maternity or birth center . . . even though childbirth carries significantly more risk than abortion." (Raymond Decl., ¶ 22.) Even the State's expert, Dr. Hague, agreed that clinics performing abortions should be required to meet the same safety requirements as any facility performing medical procedures. (Hague Dep. 128:16-129:5.)[28] See *Whole Woman's Health,* 136 S. Ct at 2315 (finding laws at issue did not serve the stated purpose

[28] Dr. Hague also agreed that some of the Challenged Laws were unnecessary for patient health and safety: 1) limiting the administration of medication to nurses, physicians, and physician assistants, required by K.A.R. 28-34-135(m); 2) requiring another person to be in the room when a female physician conducts a pelvic exam, K.A.R. 28-34-137(c); 3) limiting the monitoring of vital signs and bleeding to a physician, nurse, or physician assistant, K.A.R. 28-34-139(a)(2); 4) requiring patients to remain in recovery for 30 minutes following a first trimester abortion procedure, K.A.R. 28-34-139(a)(3)(A); 5) requiring a physician to be in the room when a patient is administered mifepristone, K.S.A. 65-4a10(b)(1). (Hague Dep: 98:12-100:2; 100:18-101:13; 109:3-19; 110:14-24; 114:16-116:2.)

of preserving women's health when the laws were not based on actual differences between abortion and other reasonably related surgical procedures yet imposed unique requirements on abortion care); *Planned Parenthood of Wisconsin,* 806 F.3d at 914-15 (finding the state appeared "to be indifferent to complications of any other outpatient procedures, even when they are far more likely to produce complications than abortions."); *Ragsdale,* 841 F.2d at 1370 ("It is as much a vice to treat abortion similarly to dissimilar procedures as it is to treat it differently from analogous procedures. In either case, imposition of burdensome requirements which are completely unnecessary to the performance of safe abortions is attempted.").

The disparate application of the Challenged Laws is amplified by the fact that not all facilities performing abortions must be in compliance with the Challenged Laws; a clinic or facility performing fewer than five abortions per month (and no second- or third-trimester abortions) is exempt. See K.S.A. 65-4a02(g). Defendants provide no explanation of this difference in treatment.

Further, under K.S.A. 65-4a02(g), hospitals and ASCs that perform abortions can be granted a waiver from the application of the Challenged Laws when KDHE determines "such waivers 'will have no significant adverse impact on the safety or welfare of the patients.'" Medical offices or "clinics" that perform abortions cannot receive a waiver under the Challenged Laws.[29]

Finally, the defendants have provided no evidence of an event impacting the health or safety of a person seeking abortion care services during the 10-year pendency of this action and when the Challenged Laws were not enforced by the State. The lack of evidence supports the inference that abortion care services are comparatively safe and illustrates the success of the

[29] The plaintiffs cite facts supporting the idea that the Challenged Laws impose greater regulation on abortion providers as a class than on ASCs, generally. See Plaintiffs' Motion, ¶ 95 (comparing K.A.R. 28-34-55a(c) and K.A.R. 28-34-138(c).

regulatory oversight of the Board of Healing Arts. See *Whole Woman's Health*, 136 S. Ct. at 2311-12 ("We have found nothing in Texas' record evidence that shows that, compared to prior law . . . the new law advanced Texas' legitimate interest in protecting women's health.").

It is defendants' burden to establish a compelling State interest in regulating the medical profession in this context, and they have failed to carry it. Based on the foregoing, the Court finds the Challenged Laws do not further the State interests of regulating the medical profession or of protecting the health and safety of women.

5. Have Defendants Shown the Challenged Laws Are Narrowly Tailored?

The defendants additionally bear the burden to prove that the Challenged Laws are narrowly tailored to serve the State interests identified. The government is tasked with showing it has narrowly tailored the law to serve its compelling interest. *Hodes & Nauser,* 309 Kan. at 669.

As set forth above, the Court has determined defendants have not provided facts demonstrating that the current licensure and regulatory requirements for physicians and medical practices overseen by the Kansas State Board of Healing Arts is inadequate. Defendants offer no facts and little argument that going beyond the standards currently in effect would result in additional protection or medical benefit for the health of women. Indeed, defendants have not shown why these specific Challenged Laws are necessary to serve a unique health situation facing women seeking abortion care services.

In contrast, the plaintiffs have presented undisputed evidence that abortion care services are safe or comparable to other outpatient care not regulated by the Challenged Laws (in addition to the oversight provided by the Board of Healing Arts).

Further, as previously discussed, the Challenged Laws are only applicable to abortion providers that perform a certain number of abortions per month, meaning there is a possibility

the Laws will not even reach the very women they are intended to protect.[30] On the same note, the Challenged Laws are only meant to apply to clinics or facilities performing abortion care services, which will result in clinics or facilities performing similar or comparable medical procedures being subject only to the regulations imposed by the Board of Healing Arts, when defendants insinuate such regulation is inadequate, at least in the context of abortion care services.[31]

As a result, the Court concludes the Challenged Laws are not narrowly tailored to serve a compelling interest.

6. Violation of Equal Protection Rights

The plaintiffs maintain the Challenged Laws violate the Equal Protection Clause on three distinct grounds. The plaintiffs' first claim is dispositive. "The guiding principle of the Equal Protection Clause is that similarly situated individuals should be treated alike." *State v. Limon*, 280 Kan. 275, 283, 122 P.3d 22 (2005).

As in the Court's previous analysis, equal protection claims are analyzed using one of three levels of scrutiny: strict, intermediate, and the rational basis test, with the level of scrutiny dependent on the nature of the classification and the rights affected by the classification. *Limon*, 280 Kan. at 283. A challenged law "will be subject to the rational basis test unless the legislative classification targets a suspect class or burdens a fundamental right." *Limon,* 280 Kan. at 283-84.

The Kansas Supreme Court has delineated the "stair-step analysis" that is used in equal protection claims as follows:

[30] The representative designated for KDHE was not aware of any "other licensing scheme it is charged with enforcing that is triggered by an arbitrary number of procedures the facility performs." (P. Motion, p. 44); (Kroll Dep: 45:16-20.)

[31] The representative designated for KDHE was not "aware of another facility licensed by KDHE where the licensure is specific to the type of procedure." (P. Motion, ¶ 79); (Kroll Dep: 45:21-25.)

> The first step of an equal protection analysis is to determine the nature of the legislative classifications and whether the classifications result in arguably indistinguishable classes of individuals being treated differently . . . After determining the nature of the legislative classifications, a court examines the rights which are affected by the classifications. The nature of the rights dictates the level of scrutiny to be applied . . . The final step of the analysis requires determining whether the relationship between the classifications and the object desired to be obtained withstands the applicable level of scrutiny. Downtown Bar & Grill, LLC v. State, 294 Kan. 188, 192–93, 273 P.3d 709 (2012).

There is no dispute that the Challenged Laws apply only to hospitals, ASCs, or medical clinics/offices that provide abortion care services. (P. Motion, ¶ 60.) There is also no evidence to support a finding that these types of medical facilities are not similarly situated to other medical facilities that do not provide abortion care services. In fact, prior to the promulgation of the Challenged Laws, all medical clinics were regulated by the Board of Healing Arts and all hospitals and ASCs were regulated and licensed by KDHE under the same rules. As a result, the Court finds that abortion care providers, like CWH, are similarly situated to office-based medical providers that do not offer abortion care services.

The Challenged Laws do not implicate a suspect class; however, they do implicate a fundamental right. Kansans enjoy the fundamental right of personal autonomy which has been interpreted to include the right to access abortion care services. *Hodes & Nauser,* 309 Kan. at 613. When the right in question is fundamental, the law requires a strict scrutiny analysis. The strict scrutiny standard requires a determination of whether the governmental action is narrowly tailored to serve a compelling interest. *Hodes & Nauser,* 309 Kan. at 669.

The Court has already determined the Challenged Laws infringe on the fundamental right to access abortion services.[32] By choosing to regulate abortion care providers separately from providers conducting comparable or more risky procedures, the Challenged Laws jeopardize the

[32] *Supra* discussion on pages 13-16 of this Order.

continuity of abortion care services, which could result in delay in care or higher costs passed onto patients.

The Court has also already found the interest at stake—the health of women, if considered broadly—is a compelling interest.[33] However, the Court further determined the Challenged Laws do not serve or further the stated interest, because the evidence showed abortion procedures are safe when compared to other gynecological care, which was not being similarly regulated.[34] Further, the uncontroverted facts do not support a finding that abortion providers require enhanced regulation above and beyond that already in place as overseen by the Board of Healing Arts. Finally, this Court has held the Challenged Laws were not narrowly tailored to serve the interest of protecting the health of women.[35]

This Court has carefully reviewed plaintiffs' claims of violation of equal protection under the law. The Court agrees the Challenged Laws violate the Equal Protection Clause by targeting abortion providers with unnecessary, burdensome regulations that violate a woman's fundamental right to decide whether to beget and bear children, and the right to access abortion services.

7. Severability

In reliance on *Creecy v. Kansas Dep't. of Revenue*, the defendants urge this Court to consider the constitutionality of each provision of the Challenged Laws and sever only those that are unconstitutional. 310 Kan. 454, 466, 477 P.3d 959 (2019). In *Creecy*, the Kansas Supreme Court noted "the facial unconstitutionality of one provision in a statute does not necessarily make the entire statute null and void." 310 Kan. at 466. The defendants also identify K.S.A. 65-4a12, the severability clause of the Challenged Laws. The "presence of a severability clause is direct

[33] *Supra* discussion on pages 16-17 of this Order.
[34] *Supra* discussion on pages 17-28 of this Order.
[35] *Supra* discussion on pages 28-29 of this Order.

evidence of legislative intent . . . [and] 'is an aid merely; not an inexorable command.'" *Gannon,* 304 Kan. at 520, *quoting Dorchy v. State of Kansas,* 264 U.S. 286, 290, 44 S.Ct 323 (1924).

The Kansas Supreme Court has outlined the "test for severability:" "[1] the act would have been passed without the objectionable portion *and* [2] [] the statute would operate effectively to carry out the intention of the legislature with such portion stricken." *Gannon v. State,* 304 Kan. 490, 519, 372 P.3d 1181 (2016), *quoting Brennan v. Kansas Insurance Guaranty Ass'n,* 293 Kan. 446, 463, 264 P.3d 102 (2011).

The Court has called into question the constitutionality of the Challenged Laws as a whole—specifically, the Court has found problematic the absence of any justification for an added layer of regulation in the Challenged Laws as distinct from other providers who offer comparable or riskier services. Particularly when confronted with the abundant evidence, and similar findings from other courts, that abortion care services are relatively safe and do not demand heightened restrictions.

As a result, the Court declines the invitation to fine-tune the Challenged Laws so that only those parts that are constitutional survive. The Court agrees with the plaintiffs that the Challenged Laws "impose a comprehensive and interdependent scheme . . . riddled with constitutional infirmities," which requires them to be struck in their entirety. (P. Motion, p. 21.) See *Fed. Lank Bank of Wichita v. Bott,* 240 Kan. 624, 637, 732 P.2d 710 (1987) (not applying severability clause when entire statute was permeated with constitutional deficiencies).

IV. CONCLUSION AND ORDERS

For the reasons set forth above, Plaintiffs' Motion for Summary Judgment is granted. Defendants' Combined Motion for Summary Judgment is denied. Under the strict scrutiny standard of review set forth in *Hodes & Nauser, MDs, P.A. v. Schmidt,* 309 Kan. 610 (2019), and

based on the uncontroverted facts, the Court concludes the Challenged Laws are unconstitutional and unenforceable. Therefore, the Court GRANTS plaintiffs' request for a declaratory judgment that the Challenged Laws are unconstitutional and, therefore, unenforceable statewide. The Court GRANTS plaintiffs' request for issuance of a permanent injunction restraining defendants and all persons acting in concert with them from enforcing the Challenged Laws in their entirety, or any provision thereof.

This Memorandum Decision and Order shall constitute the Court's entry of judgment when filed with the Clerk of this Court. No further journal entry is required.

IT IS SO ORDERED.

This Order is effective on the date and time shown on the electronic file stamp.

HON. MARY E. CHRISTOPHER
DISTRICT COURT JUDGE

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above document was filed electronically on the date stamped on the order, providing notice to the following:

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