IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

PLANNED PARENTHOOD ARKANSAS & EASTERN OKLAHOMA, d/b/a PLANNED PARENTHOOD OF THE HEARTLAND; and STEPHANIE HO, M.D., on behalf of themselves and their patients **PLAINTIFFS**

v. **Case No. 4:15-cv-00784-KGB**

LARRY JEGLEY, Prosecuting Attorney for Pulaski County, in his official capacity, his agents and successors; and MATT DURRETT, Prosecuting Attorney for Washington County, in his official capacity, his agents and successors **DEFENDANTS**

TEMPORARY RESTRAINING ORDER

Before the Court is the motion for temporary restraining order and/or preliminary injunction filed by plaintiffs Planned Parenthood of Arkansas & Eastern Oklahoma, d/b/a Planned Parenthood of the Heartland ("PPH") and Stephanie Ho, M.D. (Dkt. No. 2). Defendants Larry Jegley, who is sued in his official capacity as Prosecuting Attorney for Pulaski County, Arkansas, and Matt Durrett, who is sued in his official capacity as Prosecuting Attorney for Washington County, Arkansas, were personally notified of this motion and served on or about December 28, 2015.

Plaintiffs bring this action seeking declaratory and injunctive relief on behalf of themselves and their patients under the United States Constitution and 42 U.S.C. § 1983 to challenge Sections 1504(a) and 1504(d) of Arkansas Act 577, Reg. Sess. (2015) ("Act 577" or "the Act"), codified at Arkansas Code Annotated § 20-16-1501 *et seq.* This Court has jurisdiction under 28 U.S.C. §§ 1331 and 1343(a)(3).

Based on PPH and Dr. Ho's filings, the Court determined that Federal Rule of Civil Procedure 65(b)(1) was not satisfied so as to permit the Court to consider whether to issue a temporary restraining order without notice. Instead, the Court contacted counsel for the parties on December 28, 2015, and set a hearing on the motion for December 30, 2015 (Dkt. No. 14). Mr. Jegley and Mr. Durrett filed no written response to the motion prior to the December 30, 2015, hearing and have filed no written response to date.

The Court held the hearing on December 30, 2015. The Court concludes that, although it held an adversarial rather than an *ex parte* hearing on the motion, it was not the sort of adversarial hearing that included an opportunity to present evidence beyond the affidavits and exhibits filed with PPH and Dr. Ho's motion so as to allow the basis of the relief requested to be strongly challenged. Therefore, the Court only considers the motion for temporary restraining order at this time. *See, e.g., Piraino v. JL Hein Serv. Inc.*, No. 4:14-CV-00267-KGB (E.D. Ark. May 16, 2014) (citing *McLeodUSA Telecomms. Servs. v. Qwest Corp.*, 361 F. Supp. 2d 912, 918 n.1 (N.D. Iowa 2005)).

I. Background

Based on the filings before the Court and counsels' arguments at the hearing, the Court understands the following to be the factual background of this dispute. PPH operates health centers in Little Rock, Arkansas, and Fayetteville, Arkansas, and has done so for over 30 years. Dr. Ho is a physician licensed by the state of Arkansas who, along with another physician, provides medication abortion services at PPH's health centers. PPH's health centers provide family planning services to men and women, including contraception and contraceptive counseling, screening for breast and cervical cancer, pregnancy testing and counseling, and early medication abortion. PPH currently does not provide surgical abortion in Arkansas (Dkt. No. 2,

Decl. of Suzanna de Baca in Supp. of Pls.' Mot. For TRO and/or Prelim. Inj. ¶ 4 ("de Baca Decl.")).

Arkansas women are currently able to access abortion at three health centers in the state: two in Little Rock and one in Fayetteville. PPH operates two of the three abortion-providing health centers in the state (*Id.*, ¶ 3). PPH operates one center in Little Rock and one in Fayetteville. As long as patients are no more than nine weeks pregnant, patients currently have the option of choosing between a surgical procedure in Little Rock at a center operated by an entity other than PPH and a procedure using medications alone offered in both Little Rock and Fayetteville (Dkt. No. 3, at 2).

There are two methods of performing abortions: medically, by administering drugs, and surgically, using various instruments (Dkt. No. 2, Decl. of Paul M. Fine, M.D., in Supp. of Pls.' Mot. For TRO and/or Prelim. Inj. ¶ 6 ("Fine Decl.")). Medication abortion involves a combination of two prescription pills: mifepristone, also known as RU-486 or by its commercial name Mifeprex, which blocks the hormone progesterone, which is necessary to maintain pregnancy. Mifepristone increases the efficacy of the second medication, misoprostol, also known by its brand name Cytotec, which causes the uterus to contract and expel its contents (*Id.*, ¶ 7). Between PPH's two health centers, it performed 500 medication abortions in 2015—300 of which were at the Fayetteville center (Dkt. No. 2, de Baca Decl., ¶ 6).

PPH and Dr. Ho cite various studies in their contention that medication abortion involves very little risk to women who take the medication. For example, they represent that a recent, large study showed only 0.16% of patients experienced a significant adverse event, and only six out of every 10,000 experienced complications resulting in hospital admission (Dkt. No. 2, Fine Decl., ¶ 14). PPH and Dr. Ho represent to the Court that medication abortion offers important

advantages to surgical abortion and that some women have medical conditions, such as extreme obesity or anomalies of the reproductive and genital tract, that make medication abortion a significantly safer option with a lower risk of complications and failure (*Id.*, ¶ 13). PPH and Dr. Ho also contend that some women may prefer medication abortion because they can complete the procedure at a location and time of their choosing, with the company of loved ones (*Id.*, ¶ 11).

In March 2015, Arkansas enacted Act 577, titled the Arkansas Abortion-Inducing Drugs Safety Act, codified at Ark. Code Ann. § 20-16-1501 *et seq.* PPH and Dr. Ho represent that, without order of this Court, the Act will take effect on January 1, 2016, and it will have the effect of banning medication abortion entirely, thereby eliminating abortion access at two of the three health centers in the state, and leaving surgical abortion as the only procedure available—and available only in Little Rock (Dkt. No. 3, at 2). PPH and Dr. Ho specifically challenge two subsections of the Act. Violations of the Act can result in severe penalties, including civil liability and criminal prosecution of the doctors who allegedly violate the Act. Ark. Code Ann. §§ 20-16-1506, 1507.

The first challenged subsection, Section 1504(d) of the Act, the "contracted physician requirement," requires medication abortion providers to "have a signed contract with a physician who agrees to handle complications." Ark. Code Ann. § 20-16-1504(d). This contracted physician "shall have active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug." *Id.*

The second challenged subsection is Section 1504(a) of the Act, the "FPL mandate," which requires medication abortion providers to "satisf[y] the protocol authorized by the United

States Food and Drug Administration, as outlined in the final printed labeling for the [abortion-inducing] drug or drug regimen" when providing or prescribing abortion-inducing drugs. Ark. Code Ann. § 20-16-1504(a). The "final printed labeling for Mifeprex" is defined to "include[] the United States Food and Drug Administration-approved dosage and administration instructions for both mifepristone and misoprostol." Ark. Code Ann. § 20-16-1504(a)(2). This means that, under the Act, abortion providers must follow the FPL regimen when providing medication abortion. PPH and Dr. Ho claim that the FPL regimen sets a threshold below the current standard of care.

In 2000, the United States Food and Drug Administration ("FDA") approved Mifeprex for marketing as an abortion-inducing drug in the United States (Dkt. No. 2, Fine Decl., ¶ 18). In accordance with FDA protocol, Mifeprex was approved with a final printed labeling ("FPL"), an informational document that provides guidance to physicians about the use for which the drug sponsor requested and received FDA approval. According to PPH and Dr. Ho, the FDA itself did not test Mifeprex—instead, the drug manufacturer submitted clinical trials in support of the application for approval. These trials were completed before 1996 and involved fewer than 3,000 women (*Id.*, ¶ 17). The FPL for Mifeprex thus reflects the regimen used in those pre-1996 trials, which demonstrated that that regimen was safe through 49 days after the first day of a woman's last menstrual period ("LMP") (*Id.*). Under that FPL regimen, a medication abortion patient takes 600 mg of mifepristone orally at a health center, returns to the health center 36 to 48 hours later, and takes 400 micrograms of misoprostol orally. Finally, the patient returns 14 days later for a follow-up visit to ensure that the abortion has completed (*Id*., ¶¶ 17-18, n.12).

PPH and Dr. Ho also represent that, by the time mifepristone was approved in 2000, newer research already showed that regimens different from the FPL regimen, requiring a lower

dosage of mifepristone and a different dosage and route of administration of misoprostol, were safe, effective, less burdensome, less costly, and could be used later in pregnancy (*See id.*, ¶¶ 19-20). PPH and Dr. Ho claim that, based on this research, the overwhelming majority of abortion providers began to offer their patients a regimen different from the FPL regimen from the time medication abortion became available in the United States (*Id.*, ¶ 19). To date, more than two million women in the United States have safely had a mifepristone medication abortion, the overwhelming majority of whom have not followed the FPL regimen (*Id.*, ¶ 20).

PPH and Dr. Ho represent that the evidence-based medication abortion regimen most commonly used across the country, including by PPH and Dr. Ho, involves 200 mg of mifepristone taken orally at the health center, followed approximately 24 to 48 hours later by 800 micrograms of misoprostol, which the woman self-administers at home buccally, *i.e.*, by dissolving it between her cheek and gum (*Id.*; Dkt. No. 2, de Baca Decl., ¶ 7). PPH and Dr. Ho claim that the evidence-based regimen has a higher rate of effectiveness, a lower risk of complications, and requires fewer surgical interventions to complete the abortion procedure (Dkt. No. 2, Fine Decl., ¶ 24). Plaintiffs also claim that, because the second medication can be taken away from the health center, the evidence-based regimen gives women greater control over the timing of the procedure and allows them to experience the bleeding and cramping that follow taking misoprostol in a location of their choosing, rather than on the way home from the health center (*Id.*, ¶ 25). PPH and Dr. Ho also represent that the lower dosage lessens the cost of the medication procedure. The American College of Obstetricians and Gynecologists ("ACOG")—which PPH and Dr. Ho represent to be the leading professional group for providers of women's health care—has issued a Practice Bulletin declaring evidence-based regimens to be "superior" to the FPL regimen and stating that an evidence-based regimen "make[s] medical abortion safer,

faster, and less expensive, and result[s] in fewer complications as compared to the protocol approved by the FDA over 13 years ago." (*Id.*).

Post-medication abortion, upon discharge, all of PPH's patients are provided with a phone number for a 24-hour hotline staffed by a registered nurse, which they can call regarding any complications, questions, and concerns (Dkt. No. 2, de Baca Decl., ¶ 8). PPH and Dr. Ho state that a nurse who answers the hotline has access to a PPH physician at all times, in the event consultation is necessary (*Id.*). They further state that, in most cases, the patients' questions and concerns can be addressed over the phone (*Id.*). PPH and Dr. Ho state that, if a return visit is deemed necessary, the patient is then given an appointment. However, if the PPH nurse or physician consulted determines that a patient should be treated or evaluated by a physician immediately, he or she refers the patient to a local emergency room (*Id.*, ¶ 9). All patients referred to the emergency room are contacted by PPH health center staff within 24 hours, and a PPH physician is notified of the follow-up with the patient (*Id.*). PPH and Dr. Ho represent that PPH has never had a medication abortion patient who had to be directly transferred from a health center to a hospital (Dkt. No. 2, de Baca Decl., ¶ 11).

PPH and Dr. Ho bring this action seeking declaratory and injunctive relief on behalf of themselves and their patients under the United States Constitution and 42 U.S.C. § 1983, to challenge Sections 1504(a) and (d) of Arkansas Act 577, Reg. Sess. (2015), codified at Ark. Code Ann. § 20-16-1501 *et seq.* PPH and Dr. Ho claim that, without relief from this Court, as of January 1, 2016, PPH will be forced to stop providing abortions entirely, leaving only one health center in the state, located in Little Rock, which will offer only surgical abortion. They represent that, if the Act goes into effect, women in Fayetteville will be forced to travel three hours each way to Little Rock to have a surgical abortion, and women statewide will lose access to a safe,

early method of abortion using medications alone. PPH and Dr. Ho have sued Pulaski County Prosecuting Attorney Mr. Jegley, in his official capacity, and Washington County Prosecuting Attorney Mr. Durrett, in his official capacity, seeking declaratory and injunctive relief only. In their motion, PPH and Dr. Ho ask this Court to enter a temporary restraining order before January 1, 2016, that prevents defendants from enforcing Sections 1504(a) and 1504(d).

II. Standing

PPH and Dr. Ho have standing. There are many cases recognizing that an abortion provider, such as PPH, may sue to enjoin as violations of the United States Constitution or federal law through 42 U.S.C. § 1983 state laws that restrict abortion. "These cases emphasize not the harm to the abortion clinic of making abortions very difficult to obtain legally, though that might be an alternative ground for recognizing a clinic's standing, but rather 'the confidential nature of the physician-patient relationship and the difficulty for patients of directly vindicating their rights without compromising their privacy,' as a result of which 'the Supreme Court has entertained both broad facial challenges and pre-enforcement as-applied challenges to abortion laws brought by physicians on behalf of their patients.'" *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 910 (7th Cir. 2015) (quoting *Isaacson v. Horne*, 716 F.3d 1213, 1221 (9th Cir. 2013)).

Further, the United States Supreme Court held in *Doe v. Bolton*, 410 U.S. 179, 188 (1973), that abortion doctors have first-party standing to challenge laws limiting abortion when, as in *Doe* and the current case, the doctors are subject to penalties for violation of the laws. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 903-04, 909 (1992) (plurality opinion); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Schimel*, 806 F.3d, at 911.

III. Facial Versus An As-Applied Challenge

PPH and Dr. Ho's complaint does not specify whether this action is brought as a "facial" constitutional challenge to the Act or as an "as-applied" challenge (Dkt. No. 1). In the hearing on the motion for temporary restraining order, PPH and Dr. Ho stated that they bring this action as a facial challenge, but if the Court rejects that argument, they wish the Court to then consider the challenge to the Act as an as-applied challenge.

The majority of courts have adopted a definition of facial challenges as those seeking to have a statute declared unconstitutional in all possible applications. *See, e.g., Sabri v. United States*, 541 U.S. 600, 609 (2004); *United States v. Salerno*, 481 U.S. 739, 745 (1987); *Steffel v. Thompson*, 415 U.S. 452, 474 (1974). As-applied challenges are construed as an argument that the Act is unconstitutional as applied to these precise plaintiffs. The Supreme Court has made clear that as-applied challenges are preferred. *See Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 448-451 (2008) (discussing the preference for as-applied challenges as opposed to facial challenges). In *Salerno*, the Supreme Court stated that a "facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully" and will only succeed if a litigant can "establish that no set of circumstances exists under which the Act would be valid." 481 U.S. at 745.

Given the stage of this proceeding, that Mr. Jegley and Mr. Durrett have yet to submit any written response to the motion for temporary restraining order, and given the Supreme Court's preference for as-applied challenges, this Court considers only an as-applied challenge at this stage of the litigation. The Court reserves its analysis of the facial challenge until a more fully developed record is presented to the Court.

IV. Discussion

When determining whether to grant a motion for a temporary restraining order, this Court considers: (1) the movant's likelihood of success on the merits; (2) the threat of irreparable harm to the movant; (3) the balance between the harm to the movant and the injury that granting an injunction would cause other interested parties; and (4) the public interest. *Kroupa v. Nielsen*, 731 F.3d 813, 818 (8th Cir. 2013) (quoting *Dataphase Sys. Inc. v. CL Sys.*, 640 F.2d 109, 114 (8th Cir. 1981)). Preliminary injunctive relief is an extraordinary remedy, and the party seeking such relief bears the burden of establishing the four *Dataphase* factors. *Watkins Inc. v. Lewis*, 346 F.3d 841, 844 (8th Cir. 2003). The focus is on "whether the balance of the equities so favors the movant that justice requires the court to intervene to preserve the *status quo* until the merits are determined." *Id.* "Although no single factor is determinative when balancing the equities," a lack of irreparable harm is sufficient ground for denying a temporary restraining order. *Aswegan v. Henry*, 981 F.2d 313, 314 (8th Cir. 1992).

A. Likelihood Of Success On The Merits

Unless and until *Roe v. Wade*, 410 U.S. 113 (1973), is overruled by the Supreme Court, a state statute is unconstitutional "if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey*, 505 U.S. at 878 (plurality opinion). "Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause." 505 U.S. at 874 (citations omitted).

"'[W]here it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother,' [ ] this Court has made clear that a State may promote but not endanger a woman's health when it regulates the methods of abortion." *Stenberg v. Carhart*, 530 U.S.

914, 931(2000). "Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn." *Gonzales*, 550 U.S. at 158.

"The court retains an independent constitutional duty to review [a legislature's] factual findings where constitutional rights are at stake. . . . Uncritical deference to [the legislature's] factual findings in these cases is inappropriate." *Id.* at 165, 167. An abortion-restricting statute sought to be justified on medical grounds requires not only reason to believe that the medical grounds are valid but also reason to believe that the restrictions do not impose an "undue burden" on women seeking abortions; such restrictions and the medical benefits that the restrictions are believed to confer cannot be disproportionate in their effect on the right to an abortion. *See*, *Gonzales*, 550 U.S. at 146, 157-58; *Stenberg*, 530 U.S. at 938; *Casey*, 505 U.S. at 874, 877.

"An undue burden is an unconstitutional burden." *Casey*, 505 U.S. at 877. In *Casey*, the Court described the "undue burden" test as follows: "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id*. The *Gonzalez* Court then simplified *Casey*'s description, settling on the effects test. 505 U.S. at 158. To show an undue burden, plaintiffs must show that "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Casey*, 505 U.S. at 895. A court limits its inquiry to "the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* at 894.

1. Contracted Physician Requirement

Section 1504(d) of the Act requires medication abortion providers to "have a signed contract with a physician who agrees to handle complications. . . ." Ark. Code Ann. § 20-16-1504(d). This contracted physician "shall have active admitting privileges and gynecological/surgical privileges at a hospital designated to handle any emergencies associated with the use or ingestion of the abortion-inducing drug." *Id.*

At the outset of this analysis, the Court acknowledges precedent from the Eighth Circuit Court of Appeals in *Women's Health Center of West County, Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989), in which the court addressed a Missouri statute requiring abortion providers to have admitting privileges. The Court is mindful that *Webster* was decided before *Casey* and before many other legal, social, and medical changes surrounding abortion. As a result, the Court will examine Section 1504(d) in the light of all controlling current authorities and on the record before it.

Based on the current record before the Court, at this early stage of the proceeding, the Court finds that, in the case of medication abortion, any benefit of admitting privileges in terms of continuity of care is incrementally small. Nothing in the statute requires a contracted physician who has admitting privileges to care for a patient who has complications from a medication abortion or to see the patient before the complications arise, accompany the patient to the hospital, treat her there, visit her, or call her. Further, if the medication abortion patient takes her additional pill or pills to complete the medication abortion procedure and has complications later near her home, not the clinic or the location where the doctor has admitting privileges, the patient is likely to go to the nearest hospital emergency room if she is experiencing complications—a hospital at which the contracted physician under this provision is not likely to

have admitting privileges, especially in this case based on the patient population as described by PPH and Dr. Ho (Dkt. No. 2, de Baca Decl., ¶ 4). Further, based on the record before the Court at this stage of the proceeding, the Court concludes, at least preliminarily, that emergency room physicians are well qualified to evaluate and treat most complications that can arise after a medication abortion and, when necessary, have immediate access to consultation with on-call specialists (Dkt. No. 2, Fine Decl., ¶ 34). PPH's emergency-care protocol also casts doubt as to any relative benefit to the continuity of care gained from a contract physician requirement (Dkt. No. 2, de Baca Decl., ¶¶ 8-11).

Regardless of whether this Court examines if the Act furthers the legislature's stated purpose, even if this Court accepts that this portion of the Act meets rational basis review, the Court is persuaded, for now, that PPH and Dr. Ho have a substantial likelihood of success on their argument that this portion of the Act as applied to PPH and Dr. Ho would result in an undue burden and would have the effect of placing a substantial obstacle in the path of a woman's right to choose to have an abortion of a nonviable fetus.

The burden on abortion imposed by this portion of the Act as applied to PPH and Dr. Ho, at least based on the record before the Court at this stage of the proceeding, appears greater than in the cases in which the Fourth and Fifth Circuits have upheld similar admitting privileges requirements because the plaintiffs in those cases failed to satisfy the courts that the challenged statutes would lead to a substantial decline in the availability of abortion. In both *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 734 F.3d 406 (5th Cir. 2013), and *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 162, 170 (4th Cir. 2000), the courts decided that the evidence compelled the conclusion that the clinics forced to close due to the regulation performed only a small proportion of each state's abortions. That is not the case here.

This Court finds on the record before it at this stage of the proceeding that, despite trying for months to find a contracted physician, PPH and Dr. Ho cannot comply with the contracted physician requirement (Dkt. No. 2, de Baca Decl., ¶ 12). According to Ms. de Baca, PPH and Dr. Ho identified and contacted several physicians who meet the requirements of the Act, but only one or two of them even considered contracting with PPH. The others either refused to call back or said that they could not contract with PPH because of fear of stigma and harassment from being associated with an abortion provider or because they do not support a woman's right to choose (*Id.*, ¶¶ 14-15). *See also Schimel*, 806 F.3d at 917 (noting the "vilification, threats, and sometimes violence directed against abortion clinics and their personnel in states. . . in which there is intense opposition to abortion."); *West Ala. Women's Ctr. v. Williamson*, 2015 WL 4873125 at, *8-9 (M.D. Ala. Aug. 13, 2015) (discussing possible violence, harassment, and stigma abortion providers face); *Planned Parenthood Se., Inc. v. Strange*, 33 F.Supp.3d 1330, 1349-53 (M.D. Ala. 2014) (describing the anti-abortion harassment and stigma that prevents physicians from associating with abortion providers, including protestors who "threaten economic destruction for any doctor who enable[s] the provision of abortion"). On the record before it at this stage of the proceedings, the Court credits the representation that, up until last week, PPH and Dr. Ho were attempting to identify qualified physicians who would be willing to contract with PPH but have located none (Dkt. No. 2, de Baca Decl., ¶¶ 14-15).

If the Act goes into effect, PPH and Dr. Ho represent that only one health center in the state—located in Little Rock—will provide abortions. They also represent that these abortions will only be surgical. Removing medication abortion as an option for women will result in serious negative consequences for those women for whom medication abortion is medically

indicated (Dkt. No. 2, Fine Decl., ¶ 13). It is unclear from this record what percentage of the PPH patient population that may be.

Overall, PPH and Dr. Ho claim that the resulting increase in travel distances will have a serious impact on PPH's patients, particularly low-income women and women who have limited access to transportation (*Id.*, ¶ 56). The majority of medication abortions PPH physicians performed were at its Fayetteville health center (Dkt. No. 2, de Baca Decl., ¶ 18). If PPH's Fayetteville health center stops providing abortions, women in the area will have to make a 380-mile round trip to Little Rock to access surgical abortion services (Dkt. No. 2, Fine Decl., ¶ 52; de Baca Decl., ¶ 18).

Because of a different Arkansas abortion restriction that requires women seeking abortions to receive certain state-mandated information in person at least 48 hours prior to the abortion, women will have to make that trip more than once. *See* Ark. Code Ann. § 20-16-1703. These women will have to arrange the necessary funds, transportation, child care, and time off work required to travel to the sole remaining abortion provider in the state twice (*See* Dkt. No. 2, Fine Decl., ¶¶ 53, 56). Some women forced to make the trips will be unable to do so because of these obstacles (Dkt. No. 2, Fine Decl., ¶ 55). Others will be delayed by the increased travel distances and increases in costs, forcing these women into later abortions that are both riskier and more expensive, if they can obtain them at all (*Id.*, ¶¶ 53-54). Inability to travel to the sole remaining clinic in the state will lead some women to take desperate measures, such as attempting to self-abort or seeking care from unsafe providers, which would further put their health at risk (*Id.*, ¶ 55).

Although there may be cases in which additional travel time does not in itself rise to the level of an undue burden, this factor must be evaluated on a case-by-case basis and balanced

against the strength of the state's interest. *Casey*, 505 U.S. at 885-86. The Court concludes that, on this record and for now, PPH and Dr. Ho are likely to succeed in demonstrating that the increased travel time rises to the level of an undue burden. Even when compared to other courts that have upheld such requirements, the increased travel time here surpasses those at issue in many of the other cases. *See, e.g., Planned Parenthood of Greater Texas Surgical Health Servs. V. Abbott*, 748 F.3d 583, 598 (5th. Cir. 2014) (determining that a clinic closure was not an undue burden when another clinic was accessible within 150 miles); *Women's Med. Prof. Corp. v. Baird*, 438 F.3d 595, 605 (6th Cir. 2006) (same within 45 to 44 miles); *Greenville Women's Clinic*, 222 F.3d at 165 (same within 70 miles).

At this stage of the proceeding, this Court adopts the view that it may not factor into its analysis that the states of Oklahoma and Tennessee provide opportunities across state lines for Arkansas residents to obtain an abortion, despite Mr. Jegley and Mr. Durrett's urging this Court to do so. As the Supreme Court explained in *Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350 (1938):

> the obligation of the State to give the protection of equal laws can be performed only where its laws operate, that is, within its own jurisdiction. It is there that the equality of legal right must be maintained. That obligation is imposed by the Constitution upon the States severally as governmental entities−each responsible for its own laws establishing the rights and duties of persons within its borders. It is an obligation the burden of which cannot be cast by one State upon another, and no State can be excused from performance by what another State may do or fail to do.

See also Schimel, 806 F.3d at 918-19; *Jackson Women's Health Organization v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014) (holding that "the proper formulation of the undue burden analysis focuses solely on the effects within the regulating state."). The Court, at least at this stage, finds this reasoning persuasive.

Further, this Court acknowledges the Fifth Circuit's decision in *Whole Woman's Health v. Cole*, 790 F.3d 563, 578 (5th Cir. 2015), *cert. granted*, -- U.S. --, -- S.Ct. --, -- L.Ed.3d --, 2015 WL 5176368 (Nov. 13, 2015). That decision has been stayed pending review by the Supreme Court.

2. FPL Mandate

PPH and Dr. Ho also challenge the FPL mandate. Section 1504(a) of the Act requires medication abortion providers to "satisf[y] the protocol authorized by the United States Food and Drug Administration, as outlined in the final printed labeling for the [abortion-inducing] drug or drug regimen" when providing or prescribing abortion-inducing drugs. Ark. Code Ann. § 20-16-1504(a). According to PPH and Dr. Ho, because mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug, it is the only medication with an FPL describing an abortion regimen (Dkt. No. 2, Fine Decl., ¶ 18). The "final printed labeling for Mifeprex" is defined to "include[] the United States Food and Drug Administration-approved dosage and administration instructions for both mifepristone and misoprostol." Ark. Code Ann. § 20-16-1504(a)(2). According to PPH and Dr. Ho, this means that, under the Act, abortion providers must follow the FPL regimen when providing medication abortion. Violations of the Act can result in severe penalties, including civil liability and criminal prosecution. Ark. Code Ann. §§ 20-16-1506, 1507.

This Court determines that, based on the record before the Court at this stage of the proceeding and at least for now, the FPL regimen does not appear to be the current standard of care and that it appears to be inferior to the evidence-based regimen used currently by PPH and Dr. Ho and by abortion providers around the country today. In determining whether regulations actually further women's health, the Supreme Court has repeatedly looked at the generally

accepted standards for medicine set by the nation's major health organizations. *See, e.g.*, *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (considering American College of Obstetricians and Gynecologists and other standards).

Based on the record before the Court at this stage of the proceeding, the Court understands that the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association, the World Health Organization, and the Royal College of Obstetricians and Gynecologists have all endorsed the use of an alternative regimen through 63 days LMP (Dkt. No. 2, Fine Decl., ¶ 25). The ACOG has declared that "[b]ased on the efficacy and the adverse effect profile, evidence-based protocols for medication abortion are superior to the FDA-approved regimen." Am. Coll. of Obstetricians & Gynecologists, Practice Bulletin No. 143: Medical Management of First Trimester Abortion 2 (Mar. 2014) (*See also* Dkt. No. 2, Fine Decl., ¶ 25).

Under Arkansas law, medical negligence or malpractice actions arise when a provider renders care that falls below the acceptable standard of care, which in most litigated cases must be established by expert testimony provided by a medical care provider of the degree of skill and learning ordinarily possessed and used by members of the profession of the medical care provider in good standing, engaged in the same type of practice in the locality in which he or she practices or in a similar locality. *See* Ark. Code Ann. § 16-114-206. *But see Broussard v. St. Edward Mercy Health Sys., Inc.*, 2012 Ark. 14 (determining that the portion of Ark. Code Ann. § 16-114-206 that required expert testimony in malpractice actions to be given by medical care providers of the same specialty as the defendant violated the separation of powers and was unconstitutional). Based on the record before the Court at this stage of the proceeding, the Court is persuaded that the standard of care under Arkansas law likely equates to what PPH and Dr.

Ho, as well as abortion providers around the country, use today as the evidence-based method for medication abortion, not the FPL regimen (Dkt. No. 2, Fine Decl., ¶ 20). As a result, it appears this portion of the Act mandates care below the acceptable standard of care as defined elsewhere under Arkansas law, yet the Act subjects providers to criminal and civil liability for failing to abide by the Act.

Based on the state of the record before the Court at this stage of the proceeding, the Court for now is persuaded that, even under a deferential standard, some of the legislative findings cited in support of this portion of the Act are inaccurate, incomplete, irrelevant, or outdated (Dkt. No. 2, Fine Decl., ¶¶ 40-49). "Although we review [legislative] factfinding under a deferential standard, . . . [t]he Court retains an independent constitutional duty to review factual findings when constitutional rights are at stake." *Gonzales*, 550 U.S. at 165.

At the hearing, counsel for Mr. Jegley and Mr. Durrett suggested that the way in which these drugs were approved by the FDA might dictate this statute's requirements. The Ninth Circuit Court of Appeals in *Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 907 (9th Cir. 2014), appears to have addressed this, or a similar argument, and rejected it:

> When the FDA approved mifepristone for use in abortions, it imposed restrictions on mifepristone's marketing and distribution—but not on its use—under the FDA's "Subpart H" regulations. *See* 21 C.F.R. § 314.520. These restrictions require the manufacturer to distribute mifepristone only to doctors who sign an agreement "stating that he or she possesses the necessary qualifications and will adhere to the other requirements." One Subpart H restriction requires doctors to agree to provide each patient "a copy of the Medication Guide and Patient Agreement" and obtain the patient's signature on the Patient Agreement. In the Patient Agreement, the patient attests that she "understand[s]" the steps involved in the on-label regimen. The patient agrees to "follow my provider's advice about when to take each drug." The Subpart H restrictions, Medication Guide, and Patient Agreement do not require doctors to administer mifepristone according to the on-label regimen. *Cline v. Okla. Coal. for Reprod. Justice*, 313 P.3d 253, 261 n. 17 (Okla. 2013) (per curiam).

See also Planned Parenthood Cincinnati Region v. Taft, 444 F.3d 502, 505 (6th Cir. 2006) (discussing FDA requirements and off-label use). The Supreme Court itself has recognized that off-label use "is an accepted and necessary corollary of the FDA's mission." *Humble*, 753 F.3d at 915 (quoting *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 350 (2001)).

Regardless of whether this Court examines if the Act furthers the legislature's stated purpose, even if this Court accepts that this portion of the Act meets rational basis review, based on the state of the record before the Court at this stage of the proceeding, the Court is persuaded, for now, that PPH and Dr. Ho have a substantial likelihood of success on their argument that this portion of the Act as applied to PPH and Dr. Ho would result in an undue burden and would have the effect of placing a substantial obstacle in the path of a woman's right to choose to have an abortion of a nonviable fetus.

On the record before the Court, the Court determines that, if this portion of the Act goes into effect, women with gestational ages between 50 and 63 days LMP would not be able to access medication abortions, causing all of those women to have to travel to Little Rock to obtain a surgical abortion, and women for whom medication abortion remains an option would have to undergo the inferior, below the standard of care regimen (Dkt. No. 2, Fine Decl., ¶ 25). Even when available, the cost of a medication abortion would increase under the FPL mandate because of the increased dosage of mifepristone and the accompanying increased cost of the drug (Dkt. No. 2, de Baca Decl., ¶ 17). Given the higher cost due to the increased doses of mifepristone and the extra visit to the health center to take the misoprostol, the FPL mandate could result in some women not being able to access abortion at all (Dkt. No. 3, at 9). The additional trip to the clinic for the patient also increases costs for transportation, lodging, child care, and time away from work, if necessary. Further, because many women do not discover they are pregnant until

49 days LMP, which is the last day the on-label regimen is available under the Act, the Act may ban effectively medication abortions for some women. There is evidence in the record that most of PPH and Dr. Ho's medication abortion patients are between 50 and 63 days LMP (Dkt. No. 2, de Baca Decl., ¶ 16). The Court is aware of the language in *Casey* stating that "the incidental effect of making it more difficult or more expensive to procure an abortion" is in and of itself not enough to meet the substantial obstacle requirement. 505 U.S. at 874. However, on the record currently developed before the Court, all of the other factors, in conjunction with the increased cost, effort, time, extra dosage of the medication, and the potential for treatment to fall below the standard of care, are enough for PPH and Dr. Ho to meet their burden at this stage of the proceeding.

B. The Threat Of Irreparable Harm

A plaintiff seeking temporary injunctive relief must establish that the claimant is "likely to suffer irreparable harm in the absence of preliminary relief." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). As a general rule, economic loss does not constitute irreparable harm. *See Sampson v. Murray*, 415 U.S. 61, 90 (1974). A threat of irreparable harm exists when a party alleges a harm that may not be compensated by money damages in an action at law. *See Kroupa*, 731 F.3d at 820. Accordingly, "[l]oss of intangible assets such as reputation and goodwill can constitute irreparable injury." *United Healthcare Ins. Co. v. Advance PCS*, 316 F.3d 737, 741 (8th Cir. 2002). The deprivation of constitutional rights "unquestionably constitutes irreparable injury." *Elrod v. Burns*, 427 U.S. 347, 373 (1976); *Planned Parenthood of Minn., Inc. v. Citizens for Cmty. Action*, 558 F.2d 861, 867 (8th Cir. 1977) (same).

PPH and Dr. Ho allege that the Act threatens irreparable harm because the contract physician requirement eliminates abortions in Fayetteville, making abortions available only in

Little Rock, causing women to travel to Little Rock to obtain an abortion (Dkt. No. 3, at 19) and eliminates entirely the option of medication abortion, even for women for whom a medication abortion is medically indicated (Dkt. No. 3, at 20). Even without the contract physician requirement, PPH and Dr. Ho maintain that the FPL mandate would cause irreparable injury in that medication abortion will be unavailable after 49 days LMP, causing all women between 50 and 63 days LMP to travel to Little Rock for a surgical abortion (*Id.*). They also contend that, even for those women for whom medication abortion would remain an option under the FPL mandate, those women would be required to receive critical medical care through an inferior regimen that likely is inconsistent with the current standard of care (*Id.*). Mr. Jegley and Mr. Durrett contest these representations and claim no irreparable harm has been shown.

For now, because this Court finds, based on the state of the record before the Court at this stage of the proceeding, that those portions of the Act as applied to PPH and Dr. Ho likely would result in an undue burden and would have the effect of placing a substantial obstacle in the path of a woman's right to choose to have an abortion of a nonviable fetus, the Court finds PPH and Dr. Ho have demonstrated the threat of irreparable harm.

C. Balance Equities and the Public Interest

PPH and the Dr. Ho argue that the aforementioned threats of injury to them outweigh any harm caused to Mr. Jegley and Mr. Durrett. In fact, PPH and Dr. Ho contend that defendants will not be harmed because the issuance of a temporary restraining order will merely preserve the *status quo* and that PPH and Dr. Ho have been providing medication abortions to women for years (Dkt. No. 3, at 20-21). PPH and Dr. Ho also argue that the public interest weighs in favor of entering a temporary restraining order because the public interest "is not served by burdening women without any medical benefit" (Dkt. No. 3, at 22).

The Court must examine its case in the context of the relative injuries to the parties and to the public. *Dataphase*, 640 F.2d at 114. After balancing the relative injuries and the equities, while evaluating the limited record before it, the Court finds that because enforcement of the Act would result in the threat of irreparable harm to PPH and Dr. Ho, as well as the patients of PPH and Dr. Ho, the resulting harm to PPH and Dr. Ho is greater than the potential harm to the state. At this stage of the proceedings, the Court finds that the threat of irreparable harm to PPH and Dr. Ho, and the public interest, outweighs the immediate interests and potential injuries to the state.

V. Security

Under Federal Rule of Civil Procedure 65(c), a district court may grant a temporary restraining order "only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." Fed. R. Civ. P. 65(c). In these proceedings, Mr. Jegley and Mr. Durrett have neither requested security in the event this Court grants a temporary restraining order nor presented any evidence that they will be financially harmed if they were wrongfully enjoined. For these reasons, the Court declines to require security from PPH or Dr. Ho.

VI. Conclusion

For the foregoing reasons, the Court determines that PPH and Dr. Ho have met their initial burden for the issuance of a temporary restraining order to maintain the *status quo*. Therefore, the Court grants PPH and Dr. Ho's motion for temporary restraining order. The Court hereby orders that Mr. Jegley and Mr. Durrett, and all those acting in concert with them, are temporarily enjoined from enforcing the requirements of Sections 1504(a) and 1504(d) of Arkansas Act 577, Reg. Sess. (2015), against PPH, Dr. Ho, and all those acting in concert with

them. Further, Mr. Jegley and Mr. Durrett are enjoined from failing to notify immediately all state officials responsible for enforcing the requirements of Sections 1504(a) and 1504(d) of Arkansas Act 577, Reg. Sess. (2015), about the existence and requirements of this temporary restraining order. Pursuant to Federal Rule of Civil Procedure 65(b)(2), this temporary restraining order shall not exceed 14 days from the date of entry of this Order and shall expire by its own terms on Thursday, January 14, 2016, at 4:45 p.m. unless the Court, for good cause shown, extends it.

SO ORDERED this 31st day of December, 2015, at 4:45 p.m.

Kristine G. Baker
United States District Judge