No. 17-51060

In the United States Court of Appeals for the Fifth Circuit

WHOLE WOMAN'S HEALTH, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS AND PATIENTS; PLANNED PARENTHOOD CENTER FOR CHOICE, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS, AND PATIENTS; PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS, AND PATIENTS; PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS AND PATIENTS; ALAMO CITY SURGERY CENTER, P.L.L.C., ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS, AND PATIENTS, DOING BUSINESS AS ALAMO WOMEN'S REPRODUCTIVE SERVICES; SOUTHWESTERN WOMEN'S SURGERY CENTER, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS, AND PATIENTS; NOVA HEALTH SYSTEMS, INCORPORATED, ON BEHALF OF ITSELF, ITS STAFF, PHYSICIANS, AND PATIENTS, DOING BUSINESS AS REPRODUCTIVE SERVICES; CURTIS BOYD, M.D., ON HIS OWN BEHALF AND ON BEHALF OF HIS PATIENTS; JANE DOE, M.D., M.A.S., ON HER OWN BEHALF AND ON BEHALF OF HER PATIENTS; BHAVIK KUMAR, M.D., M.P.H., ON HIS OWN BEHALF AND ON BEHALF OF HIS PATIENTS; ALAN BRAID, M.D., ON HIS OWN BEHALF AND ON BEHALF OF HIS PATIENTS; ROBIN WALLACE, M.D., M.A.S., ON HER OWN BEHALF AND ON BEHALF OF HER PATIENTS,

Plaintiffs-Appellees,

v.

KEN PAXTON, ATTORNEY GENERAL OF TEXAS, IN HIS OFFICIAL CAPACITY; FAITH JOHNSON, DISTRICT ATTORNEY FOR DALLAS COUNTY, IN HER OFFICIAL CAPACITY; SHAREN WILSON, CRIMINAL DISTRICT ATTORNEY FOR TARRANT COUNTY, IN HER OFFICIAL CAPACITY; ABELINO REYNA, CRIMINAL DISTRICT ATTORNEY FOR MCLENNAN COUNTY, IN HIS OFFICIAL CAPACITY,

Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division
No. 1:17-cv-00690

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Certificate of Interested Persons

No. 17-51060
WHOLE WOMAN'S HEALTH, ET AL.,
Plaintiffs-Appellees,

v.

KEN PAXTON, ET AL.,
Defendants-Appellants.

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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• Whole Woman's Health • Planned Parenthood Center for Choice • Planned Parenthood of Greater Texas Surgical Health Services • Planned Parenthood South Texas Surgical Center • Alamo City Surgery Center, P.L.L.C. d/b/a Alamo Women's Reproductive Services • Southwestern Women's Surgery Center • Nova Health Systems, Inc., d/b/a Reproductive Services • Curtis Boyd, M.D. • Robin Wallace, M.D., M.A.S. (formerly as Jane Doe) • Bhavik Kumar, M.D., M.P.H. • Alan Braid, M.D.	• Patrick J. O'Connell Law Offices of Patrick J. O'Connell PLLC • Janet Crepps • Molly Duane • David P. Brown • Madeline Gomez • Autumn Katz • Zoe Levine • Jenny Ma • Rabia Muqaddam • Christine Parker • Julie Rikelman • Caroline Sacerdote • Hillary Schneller • Genevieve Scott • Jessica Sklarsky Center for Reproductive Rights • Melissa Cohen • Jennifer Keighley Planned Parenthood Federation of America

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[1] Several of the District Attorney defendants agreed not to enforce the challenged law until final resolution of the case and also agreed not to participate in the litigation of this case. ROA.395-99.

Statement Regarding Oral Argument

This case warrants oral argument. At issue is the constitutionality of a Texas law prohibiting dismemberment abortions on live fetuses. Oral argument would permit a thorough discussion of the Supreme Court's abortion precedent, as well as the extensive evidence presented at trial in this case.

Table of Contents

Page

Certificate of Interested Persons i
Statement Regarding Oral Argument iv
Table of Authorities vii
Introduction 1
Statement of Jurisdiction 2
Issues Presented 2
Statement of the Case 3
I. Texas Senate Bill 8 3
II. Second-Trimester-Abortion Procedures 4
III. The District Court Litigation 8
Summary of the Argument 11
Standard of Review 15
Argument 16
I. *Gonzales v. Carhart* held that a State's valid interests are furthered by prohibiting a brutal, gruesome abortion procedure, such as live dismemberment. 17
A. The State's interests—most importantly, in protecting unborn life from a brutal, inhumane procedure—are substantial. 17
B. The State's substantial interests are entitled to more than the "marginal consideration" given by the district court. 26
II. SB8 regulates one type of second-trimester abortion—live-dismemberment—while permitting safe, effective, widely used alternative methods of fetal demise like suction and intrauterine injection, which some plaintiffs already use. 28
A. Live-dismemberment abortions are no longer the sole "standard D&E" because alternative methods to cause fetal demise during second-trimester abortions have become frequently used in the past decade. 29

B. Several alternative, safe, and effective means are available to cause fetal demise before performing a live-dismemberment abortion. 32

III. SB8 does not impose a substantial obstacle on abortion access—and certainly not for a large fraction of women seeking abortions in Texas, which would be necessary for a facial injunction. 39

A. SB8's live-dismemberment ban does not "strike at the right itself," and the district court's definition of "substantial" is erroneous. 40

B. A health-related balancing test does not apply in a case like this that does not involve a regulation aimed at protecting patient health, but SB8 satisfies whatever balancing test could apply given the State's significant interest in protecting unborn life. 41

C. Plaintiffs cannot show SB8 results in a substantial burden on abortion access in a large fraction of cases. 43

IV. Alternatively, the Court should apply Texas's severability statute. 48

Conclusion 50

Certificate of Service 51

Certificate of Compliance 51

TABLE OF AUTHORITIES

Page(s)

Cases:

Ayotte v. Planned Parenthood of N. New England,
546 U.S. 320 (2006) 49

Becker v. Tidewater, Inc.,
586 F.3d 358 (5th Cir. 2009) 15

Env't Tex. Citizen Lobby, Inc. v. ExxonMobil Corp.,
824 F.3d 507 (5th Cir. 2016) 15

Glass v. Louisiana,
471 U.S. 1080 (1985) 22

Gonzales v. Carhart,
550 U.S. 124 (2007) .... *passim*

Hopkins v. Jegley,
267 F. Supp. 3d 1024 (E.D. Ark. 2017) 9, 38

Jauch v. Nautical Servs., Inc.,
470 F.3d 207 (5th Cir. 2006) (per curiam) 15

In re Kemmler,
136 U.S. 436 (1890) 22

Planned Parenthood of Cent. Mo. v. Danforth,
428 U.S. 52 (1976) 29

Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott,
748 F.3d 583 (5th Cir. 2014) 15, 33, 43

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

Stenberg v. Carhart,
530 U.S. 914 (2000) 1, 20

Toyota Motor Mfg., Ky., Inc. v. Williams,
534 U.S. 184 (2002) 40

United States v. Raines,
362 U.S. 17 (1960) 48

Voting for Am., Inc. v. Steen,
732 F.3d 382 (5th Cir. 2013) 49

W. Ala. Women's Ctr. v. Miller,
217 F. Supp. 3d 1313 (M.D. Ala. 2016) 9, 10, 36, 38

Washington v. Glucksberg,
521 U.S. 702 (1997) 17

Whole Woman's Health v. Hellerstedt,
136 S. Ct. 2292 (2016) 39, 41, 43

Whole Woman's Health v. Lakey,
769 F.3d 285 (5th Cir. 2014),
vacated in part, 135 S. Ct. 399 (2014) 31

Statutes and Rules

28 U.S.C.
§ 1291 2
§ 1331 2

Tex. Gov't Code § 311.032(c) 49

Tex. Health & Safety Code
§ 171.002(3) 4
§ 171.044 4
§ 171.046 4
§ 171.151 .... 3, 4, 6, 33
§§ 171.151-.153 3
§§ 171.151-.154 3
§ 171.152 44
§ 171.152(a) 4
§ 171.153 3

Tex. Penal Code § 42.092 22

Fed. R. App. P. 11(b)(2) 18

Other Authorities

Act of May 26, 2017, 85th Leg., R.S., ch. 441, § 6, 2017 Tex. Gen. Laws 1164 (eff. Sept. 1, 2017) 3

National Abortion Federation, *2018 Clinical Policy Guidelines for Abortion Care* (2018) 30

New Oxford Am. Dictionary 1736 (3d ed. 2010) 40

Planned Parenthood Federation of America, *2014-2015 Annual Report* (2015) 31

Tara C. Jatlaoui, M.D., et al., *Abortion Surveillance–United States, 2014*, *Surveillance Summaries*, 66 Morbidity & Mortality Weekly Report 1 (Nov. 24, 2017) 31

INTRODUCTION

Second-trimester abortions make up a small percentage of the overall number of abortions in Texas and the United States. The procedure used in some of these second-trimester abortions involves live dismemberment. In the words of a doctor who has performed more than 1,000 abortions, live-dismemberment abortion is "an absolutely brutal procedure in which a living human being is torn to pieces." ROA.2392. Stated differently, "D & E by dismemberment" is "'brutal,' involving as it does 'tearing a fetus apart' and 'ripping off' its limbs." *Gonzales v. Carhart*, 550 U.S. 124, 182 (2007) (Ginsburg, J., dissenting) (alteration marks and citation omitted); *accord id.* at 136 (majority opinion); *Stenberg v. Carhart*, 530 U.S. 914, 958-59 (2000) (Kennedy, J., dissenting). To address the brutality of this live-dismemberment procedure, Texas enacted a law—Senate Bill 8 ("SB8")—that includes a live-dismemberment ban, which regulates only the moment of fetal termination. SB8 merely requires abortion doctors to kill fetuses in a more humane way before dismembering them in the womb. It does not institute a ban of, or create an undue burden upon, second-trimester abortions.

In fact, alternative, more humane, methods of inducing fetal demise are already in widespread use and are shown to be effective and safe to the mother. Two particular ways noted in *Gonzales* are intrauterine injections of the drugs "digoxin or potassium chloride." 550 U.S. at 136. Many abortion doctors—including many in Texas, and even some of the plaintiffs—already induce fetal demise before beginning the surgical portion of the abortion, to avoid violating the federal Partial Birth Abortion Ban Act upheld in *Gonzales*. That these alternate methods are currently used

demonstrates that they do not impose a substantial obstacle to abortion access. Indeed, the past five years have seen *zero* reports in Texas of any complication from these alternate fetal-demise techniques.

The district court nevertheless found SB8's ban on live-dismemberment abortions to be an unconstitutional undue burden on abortion access. That holding is contrary to the evidence in the case and Supreme Court precedent. *Gonzales* already recognized that States may ban brutal abortion procedures where safe alternatives are available. And both *Gonzales* and the record here show that the live dismemberment of a human fetus is distinctly brutal. The Court should uphold Texas's prohibition on live-dismemberment abortions and reverse the district court's decision.

Statement of Jurisdiction

The district court entered a final judgment on November 22, 2017. ROA.1613, 1615-17. Defendants filed their notice of appeal that day. ROA.1618-21. This Court has jurisdiction under 28 U.S.C. §1291. The district court's subject-matter jurisdiction rests on 28 U.S.C. §1331.

Issues Presented

1. *Gonzales v. Carhart*, 550 U.S. 124 (2007), upheld a prohibition on a brutal abortion method because there were reasonably safe alternative methods available. SB8 bans brutal live-dismemberment abortions, but it also has an exception for medical emergencies. And, at trial, Texas presented significant evidence that alternative procedures are already frequently used and are considered by substantial medical literature and abortion providers themselves to be safe and effective. Did the district

court err in determining that SB8 is facially unconstitutional as causing an undue burden on abortion access in a large fraction of cases?

2. Alternatively, should effect be given to the severability clause in Texas law?

Statement of the Case

I. Texas Senate Bill 8

On May 26, 2017, the Texas Legislature passed Senate Bill 8. Act of May 26, 2017, 85th Leg., R.S., ch. 441, §6, 2017 Tex. Gen. Laws 1164, 1165-67 (eff. Sept. 1, 2017). The challenged provisions of SB8 are codified as Texas Health and Safety Code §§171.151-.154.[1] These provisions prohibit "dismemberment abortion": (1) intentionally (2) causing the death of a fetus (3) by dismembering it (4) with forceps or a similar instrument, (5) unless there is a medical emergency. *Id.* §§171.151-.153. A violation carries a criminal penalty. *Id.* §171.153.

Specifically, a "dismemberment abortion" is defined as "an abortion in which a person, with the purpose of causing the death of an unborn child, dismembers the living unborn child and extracts the unborn child one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or a similar instrument . . . ." *Id.* §171.151. SB8 applies only to procedures where forceps or similar instruments are used to cause the death of the fetus. *Id.* The law specifically excludes

[1] SB8 contained a number of provisions, including regulations related to the disposition of fetal remains and the donation of fetal tissue. In this case, plaintiffs have challenged only the portions of SB8 related to dismemberment abortions. ROA.473.

abortions in which suction causes the death. *Id.* And the law does not apply to any procedure carried out on a fetus that is already dead. *Id.*

Additionally, the prohibition applies only when a dismemberment abortion is performed "intentionally," *id.* §171.152(a)—that is, "with the purpose of causing the death of an unborn child," *id.* §171.151. And the prohibition has an exception allowing the procedure in cases of "medical emergency." *Id.* §171.152(a). A "medical emergency" is defined as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed." *Id.* §171.002(3).

II. Second-Trimester-Abortion Procedures

The second trimester of pregnancy is from 13 weeks through 26 weeks of gestation. ROA.1592. Weeks of gestation measure from the last menstrual period (LMP); a decimal point indicates days of gestation (*e.g.*, 15.6 weeks' gestation is 15 weeks and six days). ROA.1592. Texas law prohibits abortions after 22 weeks' gestation, unless a physician certifies that the abortion is necessary to protect the woman's health or if the fetus has a severe fetal abnormality. Tex. Health & Safety Code §§171.044, .046. That separate prohibition is not challenged here.

In the second trimester, a common method of performing abortions after 15 weeks' gestation is a "dilation and evacuation" or "D&E." ROA.1927. D&E procedures begin with the dilation of the woman's cervix to the extent needed to insert surgical instruments into the uterus and maneuver them while removing the fetus

and placenta piece by piece. ROA.1917. SB8 does not ban D&E abortions. It bans only dismembering a live fetus with forceps.

Understanding SB8's effect on second-trimester abortions requires understanding the D&E abortion procedure, which *Gonzales* explained in detail. 550 U.S. at 135-36. Before beginning the dilation process, the woman is given the option of conscious sedation. ROA.1921, 2040. After the sedative is administered, physicians administer a paracervical block, which is local anesthetic (usually lidocaine), via an injection with a 22-gauge needle directly into the woman's cervix. ROA.1921; ROA.2079-80. After the cervical area has been numbed, the physician will insert osmotic dilators (such as laminaria) into the cervical canal. ROA.1918. Osmotic dilators absorb liquid and expand, opening the cervix to facilitate the removal of the fetus and placenta. ROA.1918. This dilation process can take as long as two days to complete. ROA.1923-24. Sometimes physicians will use a drug called misoprostol to aid in dilation. ROA.1923.

After the cervix is sufficiently dilated, the physician then removes the fetus and placenta. ROA.2089. The physician will first use an appropriately sized suction tube (cannula) to remove the amniotic fluid and as much of the fetus as possible. ROA.2012, 2769, 2808. The physician might then use forceps to remove any pieces of the fetus or other pregnancy tissue that the suction did not remove, often including the fetal calvarium (head) and spine. ROA.2590.

Whether suction alone causes the death of the fetus largely turns on whether the abortion is before or after 17 weeks of pregnancy. Before 17 weeks, suction will remove most of the fetus, and therefore suction will cause the death of the fetus.

ROA.2588-90. Suction procedures causing fetal death are not prohibited by SB8—even if forceps are subsequently used to remove any remaining fetal or pregnancy tissue. Tex. Health & Safety Code §171.151. Because removing the fetus through suction does not require as much dilation, this procedure can sometimes be completed in one day without overnight dilation. During one-day procedures, the drug misoprostol is used for dilation. ROA.1923-24. If misoprostol alone fails to achieve sufficient dilation, the patient may be required to have laminaria inserted and return the following day. ROA.4337.

At or after 17 weeks' gestation, suction may not be sufficient to cause fetal demise and complete most of the abortion, because the fetus is larger and more developed. ROA.2590. So, at or after 17 weeks, the physician will often be required to choose between dismembering a live fetus or inducing fetal demise before performing the surgical procedure. ROA.2588-90. SB8 requires the latter choice. For example, physicians "may kill the fetus a day or two before performing the surgical evacuation" by "inject[ing] digoxin or potassium chloride into the fetus, the umbilical cord, or the amniotic fluid." *Gonzales*, 550 U.S. at 136. Injections to cause fetal demise are not banned by SB8 even if forceps are subsequently used to remove the fetus or placenta.

What is banned by SB8 is the use of forceps to intentionally dismember a live fetus in the womb. This brutal procedure was explained in *Gonzales*:

> The doctor, often guided by ultrasound, inserts grasping forceps through the woman's cervix and into the uterus to grab the fetus. The doctor grips a fetal part with the forceps and pulls it back through the cervix and vagina,

> continuing to pull even after meeting resistance from the cervix. The friction causes the fetus to tear apart. For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman. The process of evacuating the fetus piece by piece continues until it has been completely removed. A doctor may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes.

Id. at 135-36; *see also* ROA.2126-29. The pieces of the fetus are collected into a pan. ROA.3943-45. Once the entire fetus has been removed piece by piece, the placenta and any remaining fetal material are suctioned or scraped out of the uterus. ROA.1920.

The D&E procedure has serious risks to the mother, including hemorrhage, uterine perforation or laceration, infection, failed abortion, amniotic fluid embolism, cervical incompetence, Asherman Syndrome, hysterectomy, cardiac arrest, and death. ROA.2073-77, 4300-02, 4317-19, 4331. Doctors will often not perform D&Es on women with cardiac issues, placenta accreta, hypertension, uncontrolled diabetes, extreme obesity, or severe anemia. ROA.2778-79, 4314, 4741-43; *see also* ROA.6329-31, 6350-53 (under seal).

Under SB8, physicians are not prohibited from performing the D&E procedure with forceps on a fetus that is already dead. Thus, SB8 does not prohibit D&E abortions when one of several alternative techniques is used to cause fetal demise before beginning the surgical abortion procedure. This can be done in various ways; the methods most commonly used in Texas are intrauterine injections of "digoxin or potassium chloride"—as suggested by *Gonzales*, 550 U.S. at 136. *See infra* pp.34-38.

Fetal death may also be induced by transecting (cutting) the umbilical cord. *See infra* pp.38-39.

As the trial testimony shows, at the time when a D&E may be performed, the fetus looks like a fully formed baby, with arms, legs, fingers, toes, and facial features. ROA.4265-86. Between 17 and 22 weeks, the fetus ranges from 5 to 7.5 inches long. ROA.4265-86. Babies born as early as 22 weeks can survive. ROA.2819.

III. The District Court Litigation

Plaintiffs, a group of abortion clinics and doctors, filed suit on July 20, 2017, alleging that SB8 banned D&E abortions and constituted an undue burden on a woman's right to abortion. ROA.43-89. The district court issued a temporary restraining order against the law on August 31, 2017, the day before it was to go into effect. ROA.786-802. The parties agreed to extend the temporary restraining order until November 22, 2017 to allow for a trial on the merits. ROA.1055-58.

The district court ultimately concluded that SB8's live-dismemberment ban created an unconstitutional undue burden on abortion access. ROA.1613. But the district court wholly overlooked the evidence at trial establishing that abortions up to 17 weeks' gestation can be performed with suction as the instrument causing fetal demise and, therefore, are not implicated by SB8. ROA.2221, 2227, 2586, 2588-90. The district court also overlooked the substantial evidence that abortion providers in general—including some plaintiffs—either currently use, or in the past routinely used, techniques such as intrauterine injections to cause fetal demise before performing the surgical abortion procedure at or after 18 weeks' gestation. *See infra* pp.30-32.

The district court also ignored the significant evidence offered by Defendants—including the statements of plaintiffs themselves—showing the efficacy and safety to the mother of the various methods of inducing fetal demise from 15 weeks' gestation on, and showing that there were *zero* reports of a complication from a fetal-demise technique in Texas in the past five years. ROA.2530, 2532, 2534-35; *see also* ROA.5241-5534 (under seal); *see also infra* pp.34-39.

Notably, large portions of the district court's opinion, including factual findings, are taken nearly verbatim from other district courts' opinions invalidating similar laws—but on different, substantially less developed factual records at the preliminary-injunction stage. *Compare* ROA.1587-1613, *with W. Ala. Women's Ctr. v. Miller*, 217 F. Supp. 3d 1313, 1336-47 (M.D. Ala. 2016), *and Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1051-69 (E.D. Ark. 2017). In the Alabama case, for example, the State called only one witness. *See Miller,* 217 F. Supp. 3d at 1339 n.24. And, in Arkansas, the case was submitted without an evidentiary hearing. *Hopkins,* 267 F. Supp. 3d at 1034. In contrast, this case involved discovery and a five-day trial on the merits, in which Texas called 12 witnesses and put 83 exhibits into evidence. ROA.39, 2362, 2385-2561, 2565, 2576-2673, 2680-2730, 2746-81, 2785, 2787-2883, 3910-15.

The copying below extends to facts ungrounded in any testimony in this case. For example, the district court insinuated that the alternative fetal-demise method of umbilical-cord transection is difficult on the basis that, at 15 weeks' gestation, the umbilical cord "is the width of a piece of yarn." ROA.1608. But there was no testimony during trial about the size of the umbilical cord, or whether its size was even

relevant to the feasibility of the transection procedure. The word "yarn" does not appear anywhere in the five volumes of trial transcript. ROA.1898-3012. It does, however, appear in the Alabama opinion, in a sentence almost identical to the district court's sentence here. *Compare Miller*, 217 F. Supp. 3d at 1339 ("[D]epending on the gestational age, the cord may be very thin; at 15 weeks, it is the width of a piece of yarn."), *with* ROA.1608 ("Depending on a woman's week of pregnancy, the cord may be very thin; at 15 weeks, the cord is the width of a piece of yarn.").

Other findings copied by the district court from other courts' opinions and used to support the conclusions reached below are flatly contradicted by the uncontroverted testimony in this case. *See infra* pp.36, 37-38. For example, the district court stated that both digoxin and potassium-chloride injections—ways of inducing fetal demise other than live dismemberment—are administered without anesthesia; the district court used this finding to support the conclusion that using these techniques is an undue burden. ROA.1603, 1605. The Alabama opinion contains virtually the same sentences. *Miller*, 217 F. Supp. 3d at 1342, 1345. But plaintiff Dr. Robin Wallace testified that local anesthetic *is* used to numb the tissue in the path of the injection administering digoxin—the same type of local anesthetic used to numb the cervix before performing the abortion procedure. ROA.2169-70. Dr. David Berry, a defense expert, testified that he uses a similar technique to administer local anesthetic before administering an injection of potassium chloride. ROA.2417.

The district court's legal analysis also contained multiple errors. For example, the court explicitly gave the State's recognized interest in unborn life only "marginal" consideration in comparison to the right to an abortion before fetal viability.

ROA.1612. In determining whether SB8 poses a substantial obstacle to women seeking an abortion, the district court construed the term "substantial" to mean the extremely low standard "of substance." ROA.1594. And the district court interpreted *Gonzales* and *Stenberg* to hold that regulations of the "standard D&E" procedure that fall well short of an outright ban are nonetheless unconstitutional. ROA.1596.

Summary of the Argument

The Supreme Court in *Gonzales* held that States may prohibit brutal abortion procedures where there are safe alternatives available. 550 U.S. at 158, 164-65. That is precisely what SB8's ban on live dismemberment does: SB8 prohibits the brutal abortion procedure of intentionally ripping apart a live fetus in the womb, while not regulating D&E abortions where fetal demise is caused by alternative means, such as suction or injection. *Gonzales* itself noted the alternative methods of "digoxin or potassium chloride." *Id.* at 136. And the record here shows that safe fetal-demise methods are used throughout Texas and even by some of the plaintiffs themselves. The district court made clear errors of fact and law in concluding that SB8 is facially unconstitutional, and its injunction should be reversed.

I. The district court massively discounted the State's legitimate interests in banning the brutal procedure of live-dismemberment abortions. The trial testimony and Supreme Court precedent establish the brutality of live dismemberment. And *Gonzales* held that a State has a substantial interest in banning brutal abortion procedures. The district court, though, held that the State's substantial interest in protecting unborn life was worth only "marginal consideration" previability, and that the woman's right to choose abortion before that is "absolute." ROA.1612. This is

precisely the reading of *Roe v. Wade* that *Casey* emphatically rejected. *See Gonzales*, 550 U.S. at 146 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 875-76, 878, 881-83 (1992)).[2] *Casey* made clear that the State's interest in promoting respect for unborn life and protecting the unborn is substantial "*throughout pregnancy.*" 505 U.S. at 876 (emphasis added). The district court's contrary conclusion stands in direct opposition to binding precedent.

II. The record makes clear that multiple, safe alternatives exist for physicians to perform second-trimester abortions without engaging in live dismemberment—namely, suction and injection. The evidence shows that physicians can comply with SB8 by either using suction to complete the abortion, which is possible up to 17 weeks' gestation, or by choosing one of several available methods for causing fetal demise. These methods are already in widespread use, and their safety and efficacy is supported by medical literature. *See infra* Part II.

In particular, the drug digoxin is commonly used to cause fetal demise, and some of the plaintiffs themselves do or have used it after 18 weeks' gestation and consider it to be safe—despite now, when they are in litigation, arguing that it is unacceptably risky. In fact, these providers are comfortable with using digoxin for non-medical reasons: The primary reason most providers use it is to prevent a live birth, thereby complying with the federal Partial Birth Abortion Ban Act. ROA.1934, 1992, 4307, 4327, 4438-43, 4783. Regardless, the record also shows that some abortion providers

[2] All citations to *Casey* in this brief are to the controlling joint plurality opinion unless otherwise noted.

believe that causing fetal demise before beginning the surgical portion of the abortion procedure does have some health benefit. ROA.4307, 4327, 4438-43.

III. In light of the State's valid interest in banning this brutal procedure and the existence of safe alternatives, SB8's live-dismemberment ban does not create a substantial obstacle on abortion access. But instead of requiring that plaintiffs show that SB8 creates a substantial obstacle to obtaining a second-trimester abortion in a large fraction of cases, the district court merely required plaintiffs to show a burden "no more and no less than 'of substance.'" ROA.1594. This analysis cannot be squared with *Casey* and *Gonzales*, and it would render unconstitutional virtually any previability abortion regulation.

No undue burden is imposed by requiring fetal demise before tearing a fetus apart—and certainly not for a large fraction of Texas women seeking abortions, which is what plaintiffs must show for facial invalidity. Alternative methods for fetal demise can be accomplished quickly and safely, resulting in no more delay or risk to the woman than in any second-trimester abortion procedure. Moreover, the evidence showed that 92% of women would prefer to know the fetus is demised before it is dismembered. ROA.2613, 4427, 4438, 4504, 4507. Plaintiffs therefore failed to meet their burden of showing a substantial obstacle in a large fraction of cases.

The district court's erroneous factual findings are contradicted by substantial evidence. Many of the court's findings were simply copied from other judicial opinions at the preliminary-injunction stage in cases with sparse records without regard for the fulsome trial record here. Had the district court applied the proper legal test

to the evidence in the record here, it would have been required to uphold SB8's live-dismemberment ban under *Gonzales*.

IV. Alternatively, the State's severability law must be applied even if some portion of the law were found to be invalid.

Standard of Review

The decision to enjoin SB8 is reviewed for abuse of discretion. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 589 (5th Cir. 2014). "[F]indings of fact are reviewed for clear error and legal issues are reviewed *de novo*." *Becker v. Tidewater, Inc.*, 586 F.3d 358, 365 (5th Cir. 2009) (citation omitted). But "[t]he clearly erroneous standard of review does not apply to [those] factual findings made under an erroneous view of controlling legal principles." *Env't Tex. Citizen Lobby, Inc. v. ExxonMobil Corp.*, 824 F.3d 507, 515 (5th Cir. 2016) (citation omitted). Reversal is warranted under clear error review if the court is "left with the definite and firm conviction that a mistake has been committed." *Jauch v. Nautical Servs., Inc.*, 470 F.3d 207, 213 (5th Cir. 2006) (per curiam) (citation omitted).

Argument

The State has a "legitimate and substantial interest in preserving and promoting fetal life." *Gonzales*, 550 U.S. at 145. And regulations that "express [the State's] profound respect for the life of the unborn" are constitutional as long as they do not impose a "substantial obstacle to the woman's exercise of the right to choose." *Id.*; *Casey*, 505 U.S. at 877. In *Gonzales*, the Supreme Court upheld the federal Partial Birth Abortion Ban Act, which demonstrated respect for fetal life by prohibiting a "brutal and inhumane [abortion] procedure." 550 U.S. at 132, 157. The Court concluded that no substantial obstacle was imposed in a large fraction of cases because safe alternatives to the banned procedure were available. *Id.* at 164-65. That same rationale compels reversal of the district court's decision in this case.

SB8 expresses profound respect for the unborn by prohibiting a brutal form of abortion—live dismemberment. *Gonzales* itself noted the brutality of the live-dismemberment procedure, and the record here confirms its brutality. *See infra* Part I. And more humane methods of causing fetal demise—such as suction or injection—are available and equally effective and safe for the woman. *See infra* Part II.

Accordingly, women in Texas will not face a substantial obstacle when seeking an abortion. The district court erroneously obscured that conclusion by misconstruing "substantial" so that it would be met by any abortion regulation. *See infra* Part III.A. The district court also erroneously applied a balancing test that looked only to the health benefits of SB8, rather than the State's interest in fetal life. *See infra* Part III.B. In any event, any balancing test would be met here: The benefits of preventing live dismemberments overwhelmingly outweigh any minor burdens created by using

available fetal-demise techniques, such as suction or injection. *Id.* And the district court's finding of facial invalidity is entirely unsupported. *See infra* Part III.C.

I. *Gonzales v. Carhart* held that a State's valid interests are furthered by prohibiting a brutal, gruesome abortion procedure, such as live dismemberment.

The State has a substantial and legitimate basis for protecting unborn life from the brutal abortion procedure at issue here, *see infra* Part I.A, and the district court erred legally in assigning that interest only marginal consideration, *see infra* Part I.B.

A. The State's interests—most importantly, in protecting unborn life from a brutal, inhumane procedure—are substantial.

As in *Gonzales*, Texas's prohibition on live-dismemberment abortions advances legitimate state interests. "There can be no doubt the government 'has an interest in protecting the integrity and ethics of the medical profession.'" *Gonzales*, 550 U.S. at 157 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)). Additionally, "[t]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman." *Id.* Both of these interests are significantly advanced by SB8's prohibition of live-dismemberment abortions.

1. "D & E by dismemberment" is '"brutal,' involving as it does 'tearing a fetus apart' and 'ripping off' its limbs." *Gonzales*, 550 U.S. at 182 (Ginsburg, J., dissenting) (alteration marks and citation omitted); *accord id.* at 136 (majority opinion). SB8 prohibits dismemberment of the fetus while alive. As explained below, the record evidence in this case confirms the Supreme Court's recognition of the brutality of the live-dismemberment procedure.

To adequately assess the State's interest in prohibiting these abortions, it is imperative to understand the details of the live-dismemberment abortion procedure. The instruments commonly used to perform a dismemberment abortion are two different types of forceps known as Sopher and Bierer clamps. ROA.2081, 2121, 2125. These instruments are approximately 12 to 13 inches long. ROA.4287.[3] Each instrument has a gripping surface, or teeth, that is used to grasp the fetal part and hold it while the doctor closes the clamps tightly and pulls the part of the fetus out of the woman. ROA.2127-28. The Bierer clamps have bigger, sharper teeth and are often used at higher gestational ages during the second trimester. ROA.2124-25, 4287.

Dr. David Berry, a maternal-fetal medicine specialist, described a live-dismemberment abortion he participated in as a resident:

> One of the faculty members was performing a D&E. I believe it was for a baby that had Spina Bifida. And I was—I was charged with the responsibility of reassembling the baby on the back table after it comes out in parts. So you have an arm and a leg come out . . . . And he pulled out an intact spine, half of the left rib cage with several fractured ribs, the left lung, and the heart, [and] the heart was still beating.

ROA.2433-34.

Dr. Anthony Levatino, a physician who performed approximately 1,200 abortions in his career, described the last second-trimester abortion he performed:

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[3] This record citation is to a photograph of Defendants' Exhibits 23 and 24 which are the actual forceps. The district court clerk refused to take custody of this and other physical evidence in the record. ROA.4267, 4272, 4277, 4282, 4853. Defendants can provide the forceps and any other physical evidence at this Court's request. *See* Fed. R. App. P. 11(b)(2).

> And I reached in with that Sopher clamp and ripped out an arm or a leg and just stared at it in the clamp. I got sick. But, once you start an abortion, you can't stop. You know, I talked earlier about stacking up body parts on the side of the table. We don't do that just to give a gri[s]ly description. When you do an abortion, you have to keep inventory. You have to make sure that you get two arms, two legs, and all the pieces because, if you don't, your patient is going to come back infected, bleeding, and maybe even dead. So I finished that abortion. And I know it seems strange to people. But, for the first time in my life, I really truly looked at that pile of body parts on the side of the table. . . . All I could see was somebody's son or daughter.

ROA.2394-95. Dr. Levatino described the procedure as "an absolutely brutal procedure in which a living human being is torn to pieces." ROA.2392.

This record evidence corroborates the *Stenberg* dissent's summary of the testimony of Dr. Leroy Carhart, a plaintiff in *Stenberg* and *Gonzales*, about the dismemberment procedure:

> As described by Dr. Carhart, the D & E procedure requires the abortionist to use instruments to grasp a portion (such as a foot or hand) of a developed and living fetus and drag the grasped portion out of the uterus into the vagina. Dr. Carhart uses the traction created by the opening between the uterus and vagina to dismember the fetus, tearing the grasped portion away from the remainder of the body. . . . The fetus, in many cases, dies just as a human adult or child would: It bleeds to death as it is torn limb from limb. The fetus can be alive at the beginning of the dismemberment process and can survive for a time while its limbs are being torn off. Dr. Carhart agreed that "[w]hen you pull out a piece of the fetus, let's say, an arm or a leg and remove that, at the time just prior to removal of the portion of the fetus, . . . the fetus [is] alive." Dr. Carhart has observed fetal heartbeat via ultrasound with "extensive parts of the fetus removed," and testified that mere dismemberment of a limb does not always cause death because he knows of a physician who removed the arm of a fetus only to have the fetus go on to be born "as a living child with one arm." At the conclusion of a D & E abortion no intact fetus remains. In Dr. Carhart's words, the abortionist is left with "a tray full of pieces."

Stenberg, 530 U.S. at 958-59 (Kennedy, J., dissenting) (citations omitted).

The aftermath of a D&E abortion performed at Plaintiff Planned Parenthood Center for Choice's clinic is depicted in the record. ROA.3943-45. In the glass dish full of bloody debris, a leg with foot attached and an arm with an intact human hand are clearly visible—after they were torn off a living, nearly viable 20-week fetus. ROA.3943-45. In sum, "[n]o one would dispute that, for many, D & E is a procedure itself laden with the power to devalue human life." *Gonzales*, 550 U.S. at 158.

Gonzales confirms that regulating brutal abortion procedures advances the State's interest in protecting unborn life by increasing general knowledge about abortion and encouraging physicians to "find different and less shocking methods to abort the fetus in the second trimester, thereby accommodating legislative demand." *Id.* at 160. "The State's interest in respect for life is advanced by the dialogue that better informs the political and legal systems, the medical profession, expectant mothers, and society as a whole of the consequences that follow from a decision to elect a late-term abortion." *Id.*

2. *Gonzales* further recognized that a benefit of the federal Partial Birth Abortion Ban Act was to clarify that a particularly brutal abortion procedure could not be used—especially where abortion doctors "acknowledged that they do not describe to their patients what [the D & E and intact D & E] procedures entail in clear and precise terms." *Id.* at 159 (citation omitted). "It is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State." *Id.*

This is still true, as shown by the record here. Plaintiffs' consent forms fail to adequately explain to women that their fetuses may be ripped apart while alive, limb by limb. ROA.4300-02, 4317-19, 4328-32. For example, plaintiff Southwestern's form merely tells women that "the pregnancy tissue will be removed during the procedure." ROA.4300. Plaintiff Alamo's form tells women only that the abortion procedure will "empt[y] the uterus either by vacuum aspiration or evacuation (manual removal of the fetus by forceps)." ROA.4319. Plaintiff Whole Woman's Health's information form states that "[t]he physician will use a suction cannula and/or other specialized instruments such as forceps to remove the pregnancy from the uterus. The physician will use the standard Dilation and Evacuation technique, which calls for the fetus to be removed from the uterus in multiple fragments." ROA.4331. That is the closest any of the plaintiffs' consent forms gets to describing what a dismemberment abortion entails.

As *Gonzales* found, "[t]he State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event," the details of the procedure performed on "her unborn child, a child assuming the human form." 550 U.S. at 159-60. Though they do not inform women of the details of the live-dismemberment procedure, some of these same abortion consent forms also acknowledge possible psychological harm resulting from the abortion—to disclaim liability for it. ROA.4318; *see* ROA.4301 ("I release the physicians and staff of SWSC from any liability or responsibility for any short or long-

term psychological conditions thought to be related to my decision to have an abortion.").

3. The State's interest in prohibiting the live dismemberment of a fetus is also supported by societal and medical ethics. Our society has long recognized dismemberment of living beings as particularly cruel. For example, the Eighth Amendment prohibits execution of prisoners by methods such as dismemberment, which are "inhuman and barbarous" means of inflicting death. *Glass v. Louisiana*, 471 U.S. 1080, 1084 (1985) (Brennan, J., dissenting from denial of cert.) (quoting *In re Kemmler*, 136 U.S. 436, 447 (1890)). Contemporary ethics regards the dismemberment of a human as deeply wrong, even if that individual is condemned to die and anesthetized so they cannot feel pain. ROA.2484-85. In the words of Duke University bioethicist Dr. Farr Curlin, it is "self-evident that it's brutal and inhumane to tear a living organism limb from limb alive." ROA.2473. In fact, it would be a crime under Texas law to intentionally kill an animal by tearing it into pieces. *See* Tex. Penal Code §42.092. SB8 seeks to extend these ethical protections to the unborn.

Extending such minimal respect to the fetus is supported by medical ethics and does not mean that the fetus is being given more importance than the pregnant woman. As the bioethicist Dr. Curlin testified, "SB8 does not require displacing the woman as the primary object of attention of the physician. It merely requires that the fetus not be wholly disregarded. It requires the fetus be given the minimal level of respect[] entailed in not dismembering it alive." ROA.2471. When evaluating any procedure to be performed on a pregnant woman, principles of medical ethics require accounting for harms to both the mother and fetus. ROA.2469-70.

And, as *Casey* stated, "most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision." 505 U.S. at 882. The record evidence here confirms that: 92% of women would prefer to know the fetus is demised before it is dismembered. ROA.2613, 4427, 4438, 4504, 4507.

SB8 still allows second-trimester abortions to take place. SB8 simply serves the State's interest in requiring the fetus to be killed in a more humane manner than live dismemberment—an interest supported by principles of medical ethics.

4. The State's interest in prohibiting live-dismemberment abortions is also reinforced by considering the context of the State's abortion laws among the international community. To start, 92% of the world's countries—the overwhelming international consensus—ban abortions outright after the first trimester (12 weeks), with some exceptions. ROA.2496. Professor Carter Snead testified that he performed a comparative analysis of abortion laws in 194 countries around the world. ROA.2492. He found that Texas's law permitting abortions up to 22 weeks was more permissive than 95% of other countries in terms of gestational limits. ROA.2498. Only three other countries were roughly as permissive, allowing abortions up to 24 weeks: Singapore, the Netherlands, and the United Kingdom. ROA.2497. Only six countries in the world were more permissive, with no limits on abortion: Bahrain, Canada, China, Cuba, North Korea, and Vietnam. ROA.2497. Even if SB8's ban on live-dismemberment abortions goes into effect, Texas's abortion laws would still be more permissive than a supermajority of other nations, including developed European countries. In

other words, whereas SB8 merely regulates and does not ban second-trimester-abortion procedures, 92% of the countries in the world already outright ban second-trimester abortions.

5. The State's interest in protecting fetal life is also served by prohibiting a procedure that has the potential to cause excruciating pain to a developing fetus. Dr. Colleen Malloy, a neonatologist at Northwestern University, testified that there is no definitive way to say that second- and third-trimester fetuses do not feel pain. ROA.2881. In fact, some medical evidence indicates that a fetus can feel pain at 22 weeks' gestation, even down to 15 weeks' gestation. ROA.2824-29.

Evidence of fetal-pain perception comes from three sources: anatomical structures, physiological responses, and behavioral responses. ROA.2824. Generally, pain is perceived after receptors transmit the pain message to the spinal cord, which carries the message into the deeper parts of the brain—the thalamus and cortical structures—for processing. ROA.2824. From 15 to 22 weeks' gestation, these anatomical structures are in development. ROA.2824-25. Pain receptors begin developing before 15 weeks' gestation. ROA.2880. Between 13 and 16 weeks, the cortical subplate, a part of the fetal brain which likely serves as an interim processing center before it is eventually replaced by the full cortex, is present. ROA.2825. The medical literature contains evidence that pain perception is possible in fetuses with brain systems still in development. ROA.2822-23. Dr. Malloy also testified that she has personally observed brain activity in fetuses as young as 18 weeks' gestation. ROA.2826.

Changes in vital signs and hormonal responses are physiological markers that provide evidence of pain perception. ROA.2827. Researchers have observed vital-

sign changes in fetuses, as well as increases in stress hormones such as adrenaline and cortisol, in response to painful stimuli. ROA.2827-28. For instance, one study showed a marked increase in adrenaline and cortisol levels, independent of a maternal response, in fetuses that had a needle inserted into their abdomen compared with fetuses that had a needle inserted into the umbilical cord, which is not innervated. ROA.2828.

Evidence of pain perception can also be indicated by behavioral markers. Ultrasound imaging studies performed on fetuses between 15 and 22 weeks' gestation showed grimacing, crying in utero, kicking, and moving away from noxious stimuli. ROA.2829. In addition to reviewing hundreds of articles, Dr. Malloy's opinion is also influenced by her own experience as a neonatologist, in treating and observing babies born from 18 to 22 weeks' gestation. ROA.2829, 2880. Doctors will resuscitate babies starting at 22 weeks' gestation, ROA.2819, and Dr. Malloy has observed the pain responses of 22-week babies as a result of treatment. ROA.2829. Since Dr. Malloy began practicing 15 years ago, the age of viability and survival rates have improved significantly. ROA.2819-20. At the beginning of her fellowship in neonatology, a baby born at 25 weeks had about a 50% chance of survival, compared to 85% today. ROA.2820.

Physicians err on the side of caution by attempting to avoid suffering even in previable fetuses born prematurely or undergoing medical procedures in utero. For example, the standard of care for babies born alive that are too young to be resuscitated still includes pain medication and swaddling for comfort. ROA.2830-31. And medical literature indicates that if anesthesia is used on the fetus during fetal surgery, the

surgery is more successful. ROA.2834. Given that there is a possibility that a fetus feels pain in the second trimester, even if there is medical debate on the topic, *see, e.g.*, ROA.2923-24, the State can reasonably require that physicians exercise caution by avoiding any potential suffering through live dismemberment. *See Gonzales*, 550 U.S. at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.").

B. The State's substantial interests are entitled to more than the "marginal consideration" given by the district court.

The district court acknowledged Texas had an interest in fetal life, but ultimately gave it no weight. In doing so, the court erroneously turned back the clock to the pre-*Casey* era when the Supreme Court failed to give sufficient weight to the State's "substantial interest in potential life." 505 U.S. at 876.

In holding SB8 facially unconstitutional, the district court concluded that "[t]he State's legitimate concern with the preservation of the life of the fetus is an interest having its primary application *once the fetus is capable of living outside the womb*. The court must weigh the right [to choose an abortion before viability] against the interest . . . . That the right is dominant over the interest is self-evident. The *right is absolute* and the interest is given only marginal consideration *before fetal viability*." ROA.1612 (emphases added).

The district court's conclusion directly contradicts *Casey* and *Gonzales*—both of which upheld regulations of previability abortions. *Gonzales*, 550 U.S. at 168 (upholding ban on partial-birth abortions with no health exception); *Casey*, 505 U.S. at

883, 887, 899, 901 (upholding informed-consent, 24-hour-waiting-period, parental-notification, and reporting-requirement regulations).

While maintaining *Roe v. Wade*'s central holding regarding the right to choose an abortion, *Casey* "rejected . . . the interpretation of *Roe* that considered all previability regulations of abortion unwarranted. On this point *Casey* overruled the holdings in two cases because they undervalued the State's interest in potential life." *Gonzales*, 550 U.S. at 146 (citing *Casey*, 505 U.S. at 875-76, 878, 881-83). *Casey* made clear that "there is a substantial state interest in potential life *throughout pregnancy*." 505 U.S. at 876 (emphasis added). As a result of this interest, "[e]ven in the earliest stages of pregnancy, the State may enact rules and regulations designed to encourage [a woman] to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term . . . ." *Id.* at 872. The Supreme Court found that this was not only "consistent with *Roe*'s central premises," but "the inevitable consequence of [the Court's] holding that the State has an interest in protecting the life of the unborn." *Id.* at 873.

The district court's conclusion is also irreconcilable with *Gonzales*, in which the Court agreed with *Casey* that the State may adopt regulations to "express profound respect for the life of the unborn," as long as "they are not a substantial obstacle to the woman's exercise of the right to choose." *Gonzales*, 550 U.S. at 146 (citing *Casey*, 505 U.S. at 877). This balance was "central" to *Casey*'s holding. *Id.*

In direct contravention of *Gonzales* and *Casey*, the district court's puzzling analysis—that it is "self-evident" that the right to an abortion is "dominant over" any

abortion regulation "before fetal viability"—would render unconstitutional *any* previability abortion regulation. That is not the law.

II. SB8 regulates one type of second-trimester abortion—live-dismemberment—while permitting safe, effective, widely used alternative methods of fetal demise like suction and intrauterine injection, which some plaintiffs already use.

Several alternative methods exist for causing fetal demise effectively and safely for the woman. ROA.2413-14, 2586-87. SB8's live-dismemberment ban regulates only one specific type of second-trimester-abortion: intentionally causing the death of a fetus through live dismemberment with forceps. *See supra* p.3. SB8 thus does not prohibit various other ways of causing fetal demise in second-trimester abortion, such as by suction or intrauterine injection. Record evidence shows that these alternative methods cause fetal demise safely and effectively. ROA.2413-14, 2586-87. Indeed, the record shows that some plaintiffs themselves already use or have recently used these alternatives, telling patients (although not the court) that these alternatives are safe. *See infra* Part II.

Plaintiffs argued below that SB8 is unconstitutional because it has the forbidden effect of banning "standard D&E," a ban that was conceded by the federal government in *Gonzales* to be an undue burden. 550 U.S. at 147. That contention is incorrect for at least two reasons. First, the "standard" second-trimester procedure has changed over time. As a direct result of *Gonzales* upholding the Partial Birth Abortion Ban Act, fetal demise with digoxin injections became standard protocol in abortions 18 weeks and over by major abortion providers. ROA.4494. At minimum, then, it is debatable that "standard D&E" does not already include inducing fetal demise *before*

removal of the fetus. And removing an already-dead fetus with forceps is still allowed under SB8. *See infra* Part II.A.

Second, as plaintiffs acknowledged below, SB8 does not ban "D&E," but rather only intentionally causing fetal death through live dismemberment with forceps. A D&E abortion where fetal death is caused by suction or intrauterine injection is not covered by SB8, and these alternatives for causing fetal demise are available and safe. *See infra* Part II.B.

A. Live-dismemberment abortions are no longer the sole "standard D&E" because alternative methods to cause fetal demise during second-trimester abortions have become frequently used in the past decade.

Advances in medical knowledge and technology over time result in changes to standard methods and procedures, including abortion procedures. For example, the most prevalent second-trimester-abortion procedure four decades ago was saline amniocentesis; the Supreme Court held Missouri's ban on that procedure was invalid because there was no evidence that the main alternative to that procedure (prostaglandin installation) was in widespread use in Missouri at that time. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 77-79 (1976). Today, though, neither are in widespread use because surgical abortion has become the prevalent second-trimester-abortion procedure in the United States. ROA.1926-27. Thus, a State could easily ban saline amniocentesis now—even if it could not have in 1976 under the holding of *Danforth*—because *Danforth* was based on the facts at the time and turned on what alternatives were available.

In 2007, *Gonzales* described fetal-demise injection as a "safe alternative" to the banned partial-birth procedure, 550 U.S. at 166-67, and those demise techniques were not as widely used as they have now become. After *Gonzales*, major abortion providers began using fetal-demise techniques routinely in all procedures performed after 18 weeks. Notably, they did not do so for medical reasons, but they did so for legal reasons: to comply with the federal Partial Birth Abortion Ban Act, and to avoid the potential liability associated with the delivery of a live baby (18 weeks is the earliest a baby might be born showing signs of life). ROA.1934, 1992, 4307, 4330, 4327, 4438-43, 4783. It follows that providers consider the medical risks of these procedures drastically lower than the risk of legal liability.

In May 2007, one month after the *Gonzales* opinion, Planned Parenthood Federation of America (PPFA) mandated that all affiliates use digoxin—the same drug identified by *Gonzales*, 550 U.S. at 136—to cause fetal demise before most surgical abortions at or above 18 weeks' gestation.[4] ROA.4494; *see also* ROA.5535 (under

[4] Additionally, the National Abortion Federation, an organization that many non-PPFA abortion providers belong to, issues clinical guidelines every year, and those guidelines contemplate the use of digoxin (as well as potassium chloride and lidocaine) to cause fetal demise in second-trimester abortions. *See* National Abortion Federation, *2018 Clinical Policy Guidelines for Abortion Care* at 32, 37 (2018) https://5aa1b2xfmfh2e2mk03kk8rsx-wpengine.netdna-ssl.com/wp-content/uploads/2018_CPGs.pdf [https://perma.cc/25Q4-7LN7]. The district court erroneously excluded the 2015 version of these guidelines as hearsay, even though they were offered only to show that digoxin is in fact being recommended (showing what types of D&E are standard), not that digoxin is safe (a fact shown by other evidence). Moreover, an expert witness authenticated the 2015 guidelines and attested to their reliability in her field. ROA.2151-53, 2177.

seal). If a woman declined digoxin, PPFA affiliates were required to refer them elsewhere for the abortion. ROA.4502, 4730-31. PPFA is by far the country's largest abortion provider: It performed almost 324,000 abortions in 2014,[5] which is about half of all reported abortions in the U.S. for that year.[6] Planned Parenthood is also the largest abortion provider in Texas. *See Whole Woman's Health v. Lakey*, 769 F.3d 285, 288 n.1 (5th Cir. 2014), *vacated in part*, 135 S. Ct. 399 (2014).

Record evidence also shows that fetal-demise techniques besides live dismemberment are commonly used in Texas. For example, plaintiff Alamo requires digoxin to be used in abortions from 18 weeks' gestation and up. ROA.4314. Plaintiff Southwestern requires digoxin to be used from 20 weeks' gestation and up. ROA.4312. And plaintiff Whole Woman's Health has used digoxin to cause fetal demise in the past. ROA.2047. Plaintiff Planned Parenthood of Greater Texas used digoxin from 18 weeks' gestation and up—until 2015, when PPFA attorneys told them to stop using it after a live-dismemberment abortion ban was introduced in the U.S. House of Representatives. ROA.2260-61, 4421, 4431. Every current abortion doctor who testified at trial has used digoxin to cause fetal demise except one, and he works with

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[5] *See* Planned Parenthood Federation of America, *2014-2015 Annual Report* at 30 (2015) https://www.plannedparenthood.org/files/2114/5089/0863/2014-2015_PPFA_Annual_Report_.pdf [https://perma.cc/SA7S-M2GY].

[6] There were 652,639 abortions reported to the Centers for Disease Control and Prevention in 2014. *See* Tara C. Jatlaoui, M.D., et al., *Abortion Surveillance–United States, 2014*, *Surveillance Summaries*, 66 Morbidity & Mortality Weekly Report 1, 1-48 (Nov. 24, 2017) https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm [https://perma.cc/GR3S-8XN4].

other doctors who have used it. ROA.1981, 2046-47, 2060, 2132, 2238-39, 2747, 2772, 2788.

Evidence in the record also shows that potassium chloride is used in Texas to cause fetal demise. ROA.2407-08, 2413-14, 2422-23. And record evidence shows that abortion doctors in Texas have also used umbilical-cord transection to cause fetal demise. ROA.2164, 2251.

B. Several alternative, safe, and effective means are available to cause fetal demise before performing a live-dismemberment abortion.

Gonzales upheld the Partial Birth Abortion Ban Act in part because alternatives were available for the prohibited procedure. 550 U.S. at 164. One of the alternatives mentioned by the Court is "an injection that kills the fetus" and "allows the doctor to perform the procedure." *Id.* Earlier in the opinion, the Court expressly mentioned "digoxin or potassium chloride" injections as two methods used by physicians. *Id.* at 136. Because the Act allowed "a commonly used and generally accepted method," it did not "construct a substantial obstacle to the abortion right." *Id.* at 165. The Court concluded that the Act was not facially invalid "where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health, given the availability of other abortion procedures that are considered to be safe alternatives." *Id.* at 166-67. But contravening this analysis from *Gonzales*, the district court characterized the various methods for achieving fetal demise as "additional medical procedure[s]"—rather than "alternative[s]" like *Gonzales* did when mentioning the same procedures. ROA.1612; *see also* ROA.1602-03.

The trial evidence overwhelmingly shows that suction, digoxin, potassium chloride, and umbilical-cord transection cause fetal demise effectively and safely, and that these methods are feasible alternative options for physicians to comply with SB8 while performing a D&E abortion. Abortion itself carries serious risks. ROA.2073-77, 4300-02, 4317-19, 4331. As one of the plaintiffs conceded in a prior case, at least 210 women each year in Texas are hospitalized after seeking an abortion. *Planned Parenthood of Greater Tex. Surgical Health Servs.*, 748 F.3d at 595. Between 2008 and 2010, Planned Parenthood Greater Texas alone reported three uterine perforations and three additional hospital transfers resulting from abortions. ROA.4793. Yet by contrast, the record in this case shows that there have been *zero* reported complications in Texas related to using digoxin or other methods to cause fetal demise in the past five years. ROA.2530, 2532, 2534-35; *see also* ROA.5241-5534 (under seal).

1. For abortions performed below 17 weeks' gestation, suction will suffice to cause demise, and those abortions are not implicated by SB8. *See* Tex. Health & Safety Code §171.151. This is supported by the testimony of Dr. Amna Dermish, an abortion provider with plaintiff Planned Parenthood of Greater Texas Surgical Health Services, ROA.2198, 2202, and Dr. Monique Chireau, an obstetrician-gynecologist and professor at Duke University, who reviewed the medical literature on the topic. ROA.2576-77, 2584, 4877-79. Dr. Dermish testified that she could comply with SB8 up to 17 weeks' gestation with suction alone. ROA.2221, 2227. Dr. Chireau testified that the medical literature showed that as well. ROA.2586, 2588-90. This fact about suction was overlooked by the district court entirely.

2. Using digoxin to cause fetal demise is unquestionably safe. Plaintiffs argued below that it adds additional risk to the abortion procedure and provides no medical benefit. But its widespread use as described above, *see supra* pp.30-32—including use by plaintiffs themselves—speaks for itself. As Dr. Curlin testified, by using these techniques, plaintiffs' physicians themselves are accepting any side effects and risks that may exist as not disproportionate to the benefits. ROA.2467, 2469. Several of plaintiffs' doctors also testified that digoxin was safe. ROA.2169, 2247, 2248, 2249, 2774. These facts were also ignored by the district court. ROA.1604.

Moreover, plaintiffs tell their patients that using digoxin to cause fetal demise is safe. Planned Parenthood Greater Texas's digoxin consent form states that using digoxin

> helps the clinician comply with a federal abortion law. Some clinicians also believe that using digoxin makes it easier to do the abortion. Studies have shown that it is safe to use digoxin for this purpose. And in one study, more than 90 percent of women who had digoxin preferred knowing that fetal death occurred before the abortion surgery began.

ROA.4438-43.

Alamo's digoxin consent form contains similar statements:

> After a pregnancy has developed to 18 weeks LMP . . . the abortion process is made easier and safer by injecting the fetus with a medication called Digoxin. The purpose of the injection is to cause fetal demise (death) prior to the abortion, to prevent any possibility of a live birth and to help the woman's body prepare for the abortion process.

ROA.4327. Southwestern's consent form contained virtually the same language (only replacing 18 weeks with 20 weeks)—until two weeks before the instant lawsuit

was filed, when plaintiff Dr. Wallace changed the form by removing this language relating to safety and medical benefits. ROA.4307, 4308 (dated July 6, 2017). She did this after discussing with a colleague the likelihood that the consent form would become evidence in this lawsuit. ROA.4775.

Aside from plaintiffs' own statements that digoxin is safe, which were ignored by the district court, Defendants presented the testimony of Dr. Chireau, who performed a review of medical literature related to the safety, efficacy, and use of fetal-demise methods, including digoxin, potassium chloride, and umbilical-cord transection. ROA.2584-87. Based on her review of the medical literature, Dr. Chireau testified that, in her opinion, digoxin is safe and effective to cause fetal demise before the surgical portion of a second-trimester abortion. ROA.2586. Dr. Chireau testified about numerous medical studies supporting the safety of digoxin as a means to cause fetal demise. ROA.2590-2607. The district court also ignored Dr. Chireau's testimony. ROA.1604.

Additionally, Defendants presented testimony that the administration of digoxin is easily learned. Dr. Dermish testified that she learned how to perform trans-abdominal digoxin injections from a physician's assistant after watching it once, and that during her fellowship, physician's assistants and nurse practitioners administered digoxin injections at the Planned Parenthood affiliate where she was working. ROA.2230-33. She also testified that she taught herself how to do transvaginal digoxin injections after reading two articles. ROA.2236-37. Dr. Sherwood Lynn, an abortion doctor at Alamo, testified that he learned so easily he does not even remember the process, and that it is similar to performing amniocentesis and paracervical

blocks. ROA.2752-54. Other witnesses testified to the ease of learning to perform fetal-demise injections. ROA.2774, 2422, 2427-28.

The district court incorrectly found that digoxin injections before 18 weeks' gestation would be "arguably experimental." ROA.1604. The district court's findings on this point are nearly verbatim from the Alabama preliminary-injunction opinion which was based on a much more limited record. *Compare Miller*, 217 F. Supp. 3d at 1343, *with* ROA.1604. The district court did not acknowledge that the record evidence here showed that a number of studies supported the safety of digoxin injections before 18 weeks, even as early as 15 weeks. ROA.2597-99, 2604-05. Moreover, study authors from Planned Parenthood Los Angeles indicated in their published article that their protocol was to use digoxin to cause fetal-demise during *all* second-trimester abortions. ROA.2605-07. And Dr. Berry testified that he personally knows doctors in Texas who perform digoxin injections before 18 weeks' gestation because he has referred patients to them. ROA.2415. The district court also never explained why a procedure commonly performed around the country at 18 weeks suddenly becomes dangerous and experimental at 17 weeks.[7] Finally, as explained throughout the rest of this section, the district court's analysis ignores the fact that other fetal-demise alternatives besides digoxin are available: (1) suction may be used before 17 weeks, as discussed above, *see supra* p.33; (2) as discussed below, *see infra* pp.37-38,

[7] The district court also overlooked testimony that even if there are no studies on a particular practice—especially in the case of pregnant women—that does not mean that using that practice is experimental or dangerous. ROA.2475-77. In fact, physicians treating pregnant women do this as a matter of course. ROA.2476-77.

potassium-chloride injections are given as early as 10 weeks' gestation, ROA.2414-15, 2621; and (3) as discussed below, *see infra* pp.38-39, umbilical-cord transection has been found to be safe and feasible as early as 16 weeks' gestation, ROA.2624-25, and could therefore be used before 18 weeks instead of digoxin.

3. The evidence in the record shows that potassium-chloride injections are another safe, effective way physicians can cause fetal demise. Potassium chloride is injected either into the fetal abdomen (thorax), head, or heart to achieve fetal demise. ROA.2419-20. Dr. Chireau testified about numerous studies finding potassium chloride injections to be safe and effective means of causing fetal demise. ROA.2608-09, 2612-18. Dr. Berry, a maternal-fetal medicine specialist who routinely uses potassium chloride to reduce multiple pregnancies, testified that potassium chloride is safe, that he has never had a complication from potassium chloride, and that in his opinion, anyone who can do an intrafetal injection of digoxin can do a potassium chloride injection without additional training. ROA.2407-08, 2413-14, 2422-23. His testimony was virtually unrefuted, as he was the only physician to testify in this case who routinely administers potassium-chloride injections.

Given this testimony, it was clearly erroneous for the district court to say that "[t]he record evidence is, and there is no credible dispute, that the procedure of injecting potassium chloride is very rare, as it carries much more severe risks for a woman," and that physicians who are not subspecialists cannot administer potassium chloride. ROA.1606. This portion of the district court's opinion was copied from the separate district court's decision in the Arkansas preliminary-injunction

opinion, even though that Arkansas opinion obviously refers to a significantly different "record." *See Hopkins*, 267 F. Supp. 3d at 1062.

Additionally, the district court found that "the risk associated with a potassium-chloride injection before the evacuation phase of the standard D&E abortion is not quantifiable because there has been no study on the efficacy or safety of the injection when administered in this manner." ROA.1606. This finding was also largely copied from the Alabama preliminary-injunction opinion—based on a much more limited record. *Miller*, 217 F. Supp. 3d at 1346. But Dr. Chireau testified about several studies that found potassium chloride to be safe and effective. ROA.2608-09, 2612-18.

4. Transecting (cutting) the umbilical cord is another available method of causing fetal demise. Dr. Chireau testified about the medical evidence that umbilical-cord transection is a feasible, safe way to induce fetal demise. ROA.2622-23. Two of the testifying physicians in the case have themselves performed umbilical-cord transections. ROA.2164, 2251. And both Planned Parenthood Federation of America and Planned Parenthood of Greater Texas represent that umbilical-cord transection is an option their physicians can use to comply with the federal Partial Birth Abortion Ban Act. ROA.4414, 4460, 4546, 4564, 4586, 4616, 4625, 4678.

The district court concluded that umbilical-cord transection is "essentially an experimental procedure," ROA.1608, but, once again, the district court's findings are largely copied from a different district court's preliminary-injunction opinion on a much more limited record. *See Hopkins*, 267 F. Supp. 3d at 1063. This clearly erroneous conclusion is not supported by the record here. Some of plaintiffs' own doctors have performed the procedure. ROA.2164, 2251. And the study that Dr. Chireau

testified about involved over 400 patients, in which umbilical-cord transection and therefore fetal demise was achieved safely and "easily" in 100% of the cases. ROA.2622-27. The study authors even specifically stated that abortion providers should consider using umbilical-cord transection as an alternative to digoxin; the context of the study was their own abortion practice, in which they caused fetal demise using umbilical-cord transection—generally without ultrasound guidance or forceps—for *every* patient they had over 16 weeks' gestation. ROA.2624, 2626.

III. SB8 does not impose a substantial obstacle on abortion access—and certainly not for a large fraction of women seeking abortions in Texas, which would be necessary for a facial injunction.

An abortion regulation serving a valid state interest in fetal life is facially constitutional unless it has the purpose of "strik[ing] at the right itself," *Casey*, 505 U.S. at 874-75, or the effect of imposing a "substantial obstacle" to abortion access in a "large fraction" of cases, *Gonzales*, 550 U.S. at 156, 167-68. SB8's live-dismemberment ban passes that test, which the district court obscured by misdefining the term "substantial" to have basically no content. *See infra* Part III.A. The district court also erred by applying a version of the health-benefit-balancing test from *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016), which would be met here in any event. *See infra* Part III.B. And whatever test applies, plaintiffs certainly have not shown a substantial obstacle for a large fraction of women in Texas seeking abortions. *See infra* Part III.C.

A. SB8's live-dismemberment ban does not "strike at the right itself," and the district court's definition of "substantial" is erroneous.

SB8 is not a "substantial" obstacle to abortion access. It has neither the purpose nor effect of "strik[ing] at the right itself," *Casey*, 505 U.S. at 874-75, because it simply prohibits one specific type of brutal second-trimester abortion while allowing alternative, equally effective methods for second-trimester abortions. *See Gonzales*, 550 U.S. at 165; *supra* Part II.

The district court obscured that conclusion, however, by adopting an incorrectly low standard for what qualifies as a "substantial" obstacle. The district court defined "substantial obstacle" as "no more and no less than 'of substance.'" ROA.1594. The district court defined the dispositive question in the case as "does the benefit [of the law] bring with it an obstacle of substance?" ROA.1594. But "of substance" could mean any burden, no matter how minor; by contrast, the common definition of the term "substantial" is "of considerable importance, size, or worth." New Oxford Am. Dictionary 1736 (3d ed. 2010); *see, e.g.*, *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 196 (2002) ("[S]ubstantially" in the phrase "substantially limits" suggests "considerable" or "to a large degree.").

This drastically lax articulation of the substantial-obstacle test directly conflicts with *Casey* and would render virtually all abortion regulations unconstitutional—including the previability regulations upheld in *Casey* and *Gonzales*. *See supra* pp.26-27. As *Casey* recognized, "not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right." 505 U.S. at 873. Abortion is no exception:

> Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or expensive to procure an abortion cannot be enough to invalidate it. 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 liberty protected by the Due Process Clause.

Id. at 874; *see Gonzales,* 550 U.S. at 157-58.

Consequently, the district court's incorrect legal test for what constitutes a "substantial" obstacle alone requires reversal.

B. A health-related balancing test does not apply in a case like this that does not involve a regulation aimed at protecting patient health, but SB8 satisfies whatever balancing test could apply given the State's significant interest in protecting unborn life.

The district court purported to adapt and apply the health-benefit-balancing test of *Whole Woman's Health*, 136 S. Ct. at 2309. ROA.1594, 1609-11. But that test does not apply here because the State has invoked its separate state interest in respecting unborn life. *Whole Woman's Health* was analyzing only health benefits to the patient seeking an abortion—and not benefits to unborn life or society from prohibiting the brutal dismemberment of live fetuses. 136 S. Ct. at 2310. That is because the State in *Whole Woman's Health* asserted its interest only in protecting patient health—not in protecting unborn life. When the State defends its law by asserting only its interest in protecting patient health, the Court applies a balancing test that weighs the asserted health benefits of an abortion regulation against its burdens. *See, e.g.*, *id.* at 2310, 2318. But a health-based cost-benefit analysis cannot control when there are not health interests in both sides of the scale—because the abortion regulation is

based on the State's separate interest in respecting unborn life, not achieving health benefits for the woman. *See, e.g.*, *Gonzales*, 550 U.S. at 158; *Casey*, 505 U.S. at 887.

Even assuming some type of balancing test applies, the district court erred in failing to recognize the benefits provided by SB8. The district court mentioned on several occasions a lack of "medical benefit" as supporting its view that SB8 imposed an undue burden. ROA.1603, 1607, 1608. But "under the undue burden standard a State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest." *Casey*, 505 U.S. at 886. Looking only for medical benefits to the patient instead of giving weight to the State's substantial interest in protecting fetal life is clear error because it inherently overlooks the State's valid interest in protecting unborn life as a "benefit" under the balancing test. As the Supreme Court has stated multiple times, "'[r]egulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose.'" *Gonzales*, 550 U.S. at 146 (quoting *Casey*, 505 U.S. at 877). As in *Gonzales*, "[t]he question is whether the Act, measured by its text in this facial attack, *imposes a substantial obstacle* to late-term, but previability, abortions." *Id.* at 156 (emphasis added).

Thus, even if a balancing test of some sort applies, SB8's live-dismemberment ban readily satisfies it. As explained in Part I, the State has a substantial interest in respecting unborn life and in protecting the unborn from the brutality of being dismembered alive. And, as explained in Part II, there are safe, widely-used alternative

methods to induce fetal demise during second-trimester abortions. So even assuming that plaintiffs had adequately established the burdens they allege, they are minor compared to the violent and potentially agonizing death the fetus must suffer during a live-dismemberment abortion. Testimony in this case confirms this: Bioethicist Dr. Curlin testified that even assuming the burdens plaintiffs allege to be true, they are not disproportionate—and are indeed minor—compared to the objective good of preventing the fetus from being dismembered alive. ROA.2467-69, 2477.

C. Plaintiffs cannot show SB8 results in a substantial burden on abortion access in a large fraction of cases.

1. Plaintiffs have challenged SB8 only on its face. In a "[b]road challenge[] of this type," there is a "'heavy burden' [imposed] upon the parties maintaining the suit." *Gonzales*, 550 U.S. at 167. Assuming the "large fraction" test applies, in order to prevail, plaintiffs must show that "the Act would be unconstitutional in a large fraction of relevant cases." *Id.* at 167-68 (citing *Casey*, 505 U.S. at 895).[8] As in *Gonzales*, "the statute here applies to all instances in which the doctor proposes to use the prohibited procedure, not merely those in which the woman suffers from medi-

[8] *Gonzales* recognized that the Court had not decided whether *Casey*'s "large fraction" test or the typical "no set of circumstances" test was the appropriate test for facial invalidity in the abortion context, but did not resolve the question. 550 U.S. at 167. This Court has acknowledged the ambiguity. *Planned Parenthood of Greater Tex. Surgical Health Servs.,* 748 F.3d at 588. In *Whole Woman's Health*, the Court appeared to rely on the large-fraction test but did not directly address the issue. 136 S. Ct. at 2320.

cal complications." *Id.* at 168. The Court must determine whether the law is unconstitutional in a large fraction of cases, not speculative exceptional circumstances where demise is not possible or fails to happen.

In 2015, there were 53,940 abortions in Texas. ROA.4256, 4259. There were approximately 3,150 abortions between 15 and 22 weeks' gestation (the period during which D&Es are performed), approximately 5.8% of all abortions in Texas: 965 abortions at 15 weeks' gestation; 555 abortions at 16 weeks' gestation; 568 at 17 weeks; 319 at 18 weeks; 300 at 19 weeks; 236 at 20 weeks; and 207 at 21 weeks. ROA.4256, 4259. So assuming SB8 would not be implicated by abortions under 17 weeks because suction will cause the death of the fetus, *see supra* p.33, SB8 would only potentially affect about 3% of abortions in Texas.

In the vast majority of those cases, physicians can induce fetal demise successfully without significant risk to the patient. And in rare cases where a patient faces a medical emergency, SB8 contains an exception for these situations. Texas Health & Safety Code §171.152.

2. The evidence in this case shows that failures in causing fetal demise are rare. The district court found that the failure rate for digoxin ranges between 5 and 10%, but this clearly erroneous finding was contradicted by the record. ROA.1603. Plaintiffs Southwestern and Alamo describe digoxin failures as "unusual." ROA.4307, 4317. Plaintiff and expert Dr. Wallace testified that in her experience, digoxin only has a failure rate of 2%. ROA.2150. Dr. Dermish testified that she had no digoxin failures in 2015. ROA.2244. Dr. Chireau testified that medical literature indicates that the failure rate for digoxin is very low. She discussed several studies with a 0%

failure rate, and one such study had 1,677 participants. ROA.2595. Another study with 1,600 patients had over 99% effectiveness. ROA.2601-02.

An important fact established by the evidence and disregarded by the district court is that, if digoxin fails the first time, it can be given again. ROA.4300, 4307, 4428, 4438. If the failure rate for a first dose of digoxin is generously estimated at 2% (plaintiff Dr. Wallace's estimate), and assuming a second dose would have the same effectiveness rate, that means for approximately 3,150 women seeking a D&E abortion annually in Texas, there would only be approximately 1.26 failures. Plus, the failure amount would probably be even less than that: Because suction can accomplish the abortion during the 15th and 16th weeks of pregnancy, digoxin would only be needed for approximately 1,630 women annually seeking abortions after 16 weeks in Texas. Assuming the same 2% failure rates, there would reasonably be less than one digoxin failure per year (0.652).

Importantly, this figure assumes that every woman undergoing abortion between 17 and 22 weeks' gestation would receive digoxin to cause fetal demise. As was discussed above, there are other methods to accomplish fetal demise. Potassium chloride also has close to a 100% effectiveness rate. ROA.2608, 2614-15, 2618. Dr. Berry testified that he has never had a failure, and has never been unable to give an injection due to medical contraindication or anatomy. ROA.2408. Potassium chloride is effective when administered intrafetally and requires no special training, as it is the same technical procedure as an intrafetal digoxin injection, which most plaintiffs already perform. ROA.1976-77, 2158, 2238, 2419-21, 2422-23, 2616-17, 2773.

Dr. Chireau testified that umbilical-cord transection also has a high rate of success—100% in the study she specifically testified about. ROA.2625. Plaintiff Dr. Wallace transected the umbilical cord to cause fetal demise in a rare instance where digoxin failed to work. ROA.2164.

3. The evidence in this case also shows that the requirement of inducing fetal demise before dismemberment abortion will not significantly increase the cost or time to obtain abortions for a large fraction of women. The district court clearly erred in finding that requiring demise would result in an additional 24-hour delay, based on evidence that most doctors wait 24 hours before checking a patient to see if demise occurred. ROA.1610-11.

This reasoning is inconsistent with the reality that patients must already wait for dilation to occur in a second-trimester abortion—and fetal demise can be induced during that period, thus resulting in no additional delay. The record shows that in a one-day procedure, women must already wait a few hours to allow for sufficient dilation, and in two-day procedures, they must wait overnight. ROA.1923-24, 2059. And the record contains testimony that intrafetal digoxin is 98% effective at causing fetal demise after five hours, and potassium chloride causes demise within seconds when administered into the fetal heart (and within a few minutes if administered intrathoracically). ROA.2419-20, 2608-09, 2620. Planned Parenthood states that intrafetal digoxin results in fetal demise in 1 to 2 hours, and that administration of digoxin can take place anywhere from 24 hours to 30 minutes before the procedure. ROA.4433, 4582-83, 4653. Thus, administering digoxin or potassium chloride at the

same time dilation procedures begin would not cause any additional delay, and certainly not a 24-hour delay.

Additionally, the district court failed to take into account the fact that any delay in the procedure attributable to causing fetal demise could only possibly apply to women with pregnancies between 17 and 18 weeks' gestation. As discussed above, suction causes demise in procedures up to 17 weeks' gestation. *See supra* p.33. And for procedures above 18 weeks, the procedure already takes longer than one day to allow for sufficient dilation to be achieved. ROA.4312, 4314. Even then, plaintiff Dr. Wallace already uses a two-day procedure for approximately 50% of her patients between 15 and 17.6 weeks' gestation. ROA.2170-71. Patients already receiving a two-day procedure would not face any delay from SB8's live-dismemberment ban, even if it were true that demise could not be achieved sooner than 24 hours.

The district court speculated that "perhaps" costs would be increased for women whose procedures would be lengthened by up to a day, which would be burdensome for low-income women. ROA.1610. As just explained, there would be no delay—and not for a large fraction of women in Texas seeking abortions. Regardless, there was no evidence presented as to how many women seeking abortions in Texas between 17 and 18 weeks' gestation are low-income and the degree of burden imposed by any possible delay such that it would become a substantial obstacle to receiving an abortion—and certainly not for a large fraction of women in Texas seeking abortions.

The district court also concluded that "[i]f the Act alone does not create an undue burden, its interaction with other Texas law [the 24-hour waiting period] pushes

the previability-abortion burden on a woman seeking a second-trimester abortion above the undue threshold." ROA.1610. As explained, there would not be additional delay given that the dilation portion of a second-trimester abortion already involves delay, during which one of the fetal-demise techniques could be performed. In all events, the district court provided no basis to explain how a mere 48-hour delay in obtaining an abortion is facially invalid, while a 24-hour waiting period is not. *Casey*, 505 U.S. at 886-87.

4. Even assuming arguendo that there are discrete cases where SB8 would present a substantial obstacle to abortion access, they are exceedingly rare and would be more properly addressed through an as-applied challenge. The possibility of exceptional situations does not result in facial unconstitutionality. As the Supreme Court stated in *Gonzales*, "it is neither [the Court's] obligation nor within our traditional institutional role to resolve questions of constitutionality with respect to each potential situation that might develop." 550 U.S. at 168. "[I]t would indeed be undesirable for this Court to consider every conceivable situation which might possibly arise in the application of complex and comprehensive legislation." *Id.* (quoting *United States v. Raines*, 362 U.S. 17, 21 (1960)). For this reason, "[a]s-applied challenges are the basic building blocks of constitutional adjudication." *Id.* (citation omitted).

IV. Alternatively, the Court should apply Texas's severability statute.

If the Court were to agree that SB8 imposes an impermissible substantial obstacle in some contexts (for instance, as applied to women with pregnancies at certain gestational ages), the Court should only affirm an injunction of the relevant portion or application of SB8, leaving the rest of the law intact. "Generally speaking, [w]e

prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force, or to sever its problematic portions while leaving the remainder intact." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328-29 (2006) (citation omitted). "Texas's strong severability statute, which preserves statutes even if in some 'applications' they are unconstitutional, clearly applies to the hypothetical situations Appellees invoked. Tex. Gov't Code §311.032(c). Severability is a state law issue that binds federal courts." *Voting for Am., Inc. v. Steen*, 732 F.3d 382, 398 (5th Cir. 2013).

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted.

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Certificate of Service

On February 26, 2018, this brief was served via CM/ECF on all registered counsel and transmitted to the Clerk of the Court. Counsel further certifies that: (1) any required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (2) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1; and (3) the document has been scanned with the most recent version of Symantec Endpoint Protection and is free of viruses.

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This brief complies with: (1) the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 12,981 words, excluding the parts of the brief exempted by Rule 32(f); and (2) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Equity) using Microsoft Word (the same program used to calculate the word count).

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