IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

FALLS CHURCH MEDICAL CENTER, LLC, *et al.*, Plaintiffs, v. M. NORMAN OLIVER, *et al.*, Defendants.	CASE NO: 3:18-CV-428-HEH

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT

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INTRODUCTION

For over forty years, the Commonwealth of Virginia has enforced two long-outdated and medically unnecessary abortion restrictions that are now before the Court. One of these laws arbitrarily bars highly qualified clinicians—regardless of the extent of their training and proficiency—from providing abortion care. The other law requires that second-trimester abortions be performed in a hospital, which does nothing to improve patient safety and has left the Commonwealth with only two facilities providing generally-available second-trimester abortion care. Plaintiffs challenge these two laws in Count III and Count IV of their Amended Complaint.

No genuine dispute of material fact exists: these laws burden patients without providing any benefits. Defendants admit that advanced practice clinicians ("APCs")[1] can be trained to provide early abortion in Virginia—as they do in other states—and that there is no medical reason to prevent them from doing so. Defendants also agree that second-trimester abortions are safely and routinely performed in physicians' offices and other health-center settings that do not meet hospital or surgical-center requirements, and that the procedure's exceedingly low complication rates do not justify requiring all second-trimester abortions to be performed in a hospital. Moreover, the record evidence shows that the two provisions at issue here harm patients instead of protecting them. These laws prevent qualified providers from treating women who come to their clinics, and limit where and when abortion services are available—drastically so for second-trimester abortions. These limitations delay and in some cases prevent abortion altogether, thereby subjecting patients to *increased* health risks and a range of other harms and burdens.

[1] The category "APCs" includes nurse practitioners, certified nurse-midwives, and physician assistants.

Although Plaintiffs' claims are fact-intensive, Mem. Op. ("MTD Op.") at 13, ECF No. 52, Plaintiffs are entitled to summary judgment as to these two laws because no genuine dispute of material fact exists to warrant trying them. Simply put, laws that have no medical benefit but limit women's access to legal abortion violate the Constitution. Judgment in Plaintiffs' favor on Counts III and IV should be entered accordingly.

THE CHALLENGED LAWS

Any person who provides an abortion in Virginia commits a Class 4 Felony punishable by up to ten years in prison and a fine of up to $100,000. Va. Code Ann. § 18.2-71. This criminal ban is the backdrop for the two laws challenged here, each of which provides a narrow exception to the statute. First, a 1975 Virginia statute exempts only licensed physicians from the state's general criminal ban on abortion (the "Physician-Only Law"). Va. Code Ann. §§ 18.2-72, -73. Virginia's abortion-facility licensing regulations also have physician-only provisions, violation of which is punishable by loss of facility and/or professional licensure, as well as criminal prosecution and civil fines. *See* 12 Va. Admin. Code §§ 5-412-190(B), -260(B); Va. Code Ann. §§ 32.1-27, 54.1-2915. Because they are not exempted from Virginia's general criminal ban by the Physician-Only Law, APCs are barred from providing abortion care in Virginia.

Second, another four-decades-old statute requires that second-trimester abortions be provided only in licensed hospitals (the "Hospital Requirement"). *See* Va. Code Ann. §§ 18.2-71, -73. The Virginia Department of Health ("VDH") requires facilities seeking to provide second-trimester abortions to comply, at a minimum, with regulations governing "Outpatient Surgical Hospitals."[2] Those regulations impose onerous physical plant requirements that are wholly

[2] A VDH regulation also prohibits licensed first-trimester abortion facilities, including those operated by Plaintiffs, from providing second-trimester abortion care. 12 Va. Admin. Code § 5-412-230(A) ("Abortions performed in abortion facilities shall be performed only on patients who

irrelevant to abortion care. 12 Va. Admin. Code §§ 5-410-10–160, -1150–1380. VDH's regulations also require a complex and lengthy Certificate of Public Need ("COPN") process before an Outpatient Surgical Hospital license can be issued. Va. Code Ann. §§ 32.1-102.1, -102.3. These statutory and regulatory provisions work in tandem to strictly limit the types of facilities that can offer second-trimester abortion in Virginia.

STATEMENT OF UNDISPUTED MATERIAL FACTS

I. Abortion Is a Safe Procedure.

1. Abortion is one of the safest medical procedures available today. Decl. of Mark D. Nichols, M.D. ("Nichols Decl.") ¶¶ 14, 20, 21, attached hereto as Ex. 1; Tr. of Dep. of Shanthi Ramesh, M.D., MSCR, FACOG ("Ramesh Dep.") 191:19–193:6, attached hereto as Ex. 6-A; Tr. of Dep. of Elizabeth Lunsford ("Lunsford Dep.") 182:2–6, attached hereto as Ex. 6-B.

2. There are two basic abortion methods: one by oral medication, the other by procedure. Nichols Decl. ¶¶ 35, 37.

3. Medication abortion is available in the first trimester of pregnancy,[3] up to ten weeks after the first day of the patient's last menstrual period ("LMP"). This method typically entails taking two medications, mifepristone and misoprostol, a day or two apart, ending the pregnancy in an experience similar to a miscarriage. Nichols Decl. ¶¶ 36–37; Tr. of Dep. of Paulette McElwain ("McElwain Dep.") 95:3–14, 96:2–3, attached hereto as Ex. 6-C. Indeed, physicians

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are within the first trimester of pregnancy meaning 13 weeks and 6 days after last menstrual period or based on an appropriate clinical estimate by a licensed health care provider."). This regulation does not apply to medical facilities "licensed as . . . a general hospital or an outpatient surgical hospital." 12 Va. Admin. Code § 5-412-40. This brief uses the term "surgical center" (short for "ambulatory surgical center," also abbreviated as "ASC") to refer to Outpatient Surgical Hospitals, as regulated by 12 Va. Admin. Code. §§ 5-410-10–160, -1150–1180.

[3] As defined by Virginia regulation, the first trimester lasts until thirteen weeks, six days after the first day of the patient's last menstrual period. 12 Va. Admin. Code § 5-412-230(A). The term "trimester" is undefined in the Virginia Code.

and APCs in Virginia commonly use these same medications to treat patients experiencing an incomplete miscarriage. Nichols Decl. ¶ 37; Lunsford Dep. 76:11–17. The U.S. Food and Drug Administration ("FDA") first approved mifepristone for abortion in 2000. Nichols Decl. ¶ 37.

4. Abortion by procedure is generally called "surgical abortion" to distinguish it from abortion by medications alone, even though it does not involve any incisions or cuts. Tr. of Dep. of Marc Nichols ("Nichols Dep.") 70:20–75:2, attached hereto as Ex. 6-D; Tr. of Dep. of M. Norman Oliver ("Oliver Dep.") 143:13–144:3, attached hereto as Ex. 6-E. There are two types of surgical abortion: aspiration, and dilation and evacuation ("D&E"). Nichols Decl. ¶¶ 38, 41. Aspiration abortion, a procedure performed in the first or early second trimester, is a simple and brief technique that uses gentle suction from a small tube to empty the patient's uterus. *Id*. ¶¶ 38–40. The procedure typically takes approximately five to ten minutes. *Id*. ¶¶ 38–40; Ramesh Dep. 57:18–20. It is the same procedure that physicians and APCs use to terminate an unsuccessful pregnancy or incomplete miscarriage. *Id*. ¶¶ 30, 38; Lunsford Dep. 70:12–17, 71:5–12, 79:20–80:5; Tr. of Dep. of Dr. Jane Doe ("Dr. Doe Dep.") 169:12–16, 170:2–8, attached hereto as Ex. 6-F.

5. At approximately fifteen to sixteen weeks LMP, the clinician uses additional instruments to empty the uterus, in a procedure called D&E. Nichols Decl. ¶¶ 41–42. D&Es take five to ten minutes, and may involve either mild or moderate sedation. *Id*. ¶ 43.

6. Surgical abortion need not be performed in a sterile operating room because the clinician accesses the uterus through the vagina, which is naturally colonized with bacteria, and through the natural, non-sterile opening of the cervix rather than through surgical incision. *Id.* ¶¶ 38, 43, 55; Ramesh Dep. 177:22–179:6; Dr. Doe Dep. 149:14–150:17.

II. The Challenged Laws Provide No Medical Benefit.

A. The Physician-Only Law Provides No Medical Benefit.

7. The Physician-Only Law does not provide any medical benefit. Lunsford Dep. 310:11–14, 19–20, 311:15–19; Nichols Dep. 148:6–9; Ramesh Dep. 162:18–22; Nichols Decl. ¶¶ 58–60.

8. It is uncontested that APCs are fully capable of performing the two most common forms of abortion—medication and aspiration abortion—in Virginia as they do elsewhere. Nichols Dep. 62:15–20, 99:12–14, 100:2–5; Nichols Decl. ¶¶ 58–66; Ramesh Dep. 84:17–21; Decl. of Joanne Spetz, Ph.D. ("Spetz Decl.") ¶¶ 56–61, attached hereto as Ex. 2.

9. Defendants' medical expert concedes that there is "no medical reason why [APCs] couldn't be trained" to safely provide medication and aspiration abortion. Lunsford Dep. 310:2–20; 311:15–19; *see also* Oliver Dep. 226:13–17, 235:8–236:5.

10. Defendants' medical expert admits that in other states APCs provide this care with complication rates as low as physicians'. Lunsford Dep. 310:2–6.

11. Defendants' medical expert, a licensed Virginia physician, also admits that APCs "can prescribe almost every medication that [she] could prescribe." *Id.* 309:3–13. Indeed, nurse practitioners and certified nurse-midwives in Virginia are authorized to prescribe Schedule II through Schedule VI drugs, including opioids and amphetamines. Va. Code Ann. § 54.1-2957.01. Physician assistants practicing under physician supervision (which need not involve the physician's physical presence) are authorized to prescribe and dispense medications, including controlled substances, and to perform invasive procedures within their competence. 18 Va. Admin. Code § 85-50-140.

12. APCs in Virginia routinely provide medical services that are comparable—and in some cases identical—to medication and aspiration abortion in technique and risk. Nichols Decl.

¶ 61; Ramesh Dep. 37:1–6, 84:17–21, 90:17–19, 184:13–185:10, 186:10–12; Nichols Dep. 61:21–62:3, 62:17–20, 92:18–22, 93:9–94:1; Dr. Doe Dep. 74:10–17. For example, if a patient is experiencing a miscarriage, or has retained tissue in her uterus after an abortion, APCs in Virginia can and do safely administer misoprostol and/or mifepristone to evacuate the uterus. Ramesh Dep. 24:3–7, 186:10–12. This treatment is procedurally identical to medication abortion. Lunsford Dep. 71:13–22, 72:15–19, 76:13–17. Indeed, the FDA has issued guidance recognizing that APCs can safely provide mifepristone to induce abortion. Nichols Decl. ¶ 64.

13. APCs in Virginia also routinely perform intrauterine-device ("IUD") insertions (involving insertion of a small tube through the patient's cervix into the uterus), endometrial biopsy (inserting a tube through the cervix into the uterus to suction a small piece of tissue from the uterine lining), and colposcopy (using instruments to dilate the cervix and, when appropriate, remove tissue for biopsy). Ramesh Dep. 116:1–9, 184:16–185:10, 88:5–15. In fact, APCs perform these procedures in Defendants' medical expert's office. Lunsford Dep. 308:15–309:2.

14. Additionally, APCs at Plaintiffs' health centers routinely administer intravenous sedation, just as physicians administer intravenous sedation as part of providing early abortion care. McElwain Dep. 29:10–16, 225:10–226:7.

15. Virginia also permits APCs to provide labor and delivery care to patients who give birth in their homes, Va. Code Ann. § 54.1-2957.03, Lunsford Dep. 308:9–12, even though the risk of maternal death from childbirth is fourteen times greater than that from first-trimester abortion, Nichols Decl. ¶¶ 23–28.

B. The Hospital Requirement Provides No Medical Benefit.

16. Virginia's second-trimester Hospital Requirement provides no medical benefit. Oliver Dep. 176:4–7 (VDH Commissioner stating that, in his opinion, "abortion services are outpatient services that do not need to be regulated in the same way as, say, surgical procedures");

201:20–202:1 ("I believe the standard of care for abortion services would be that first and second trimester terminations can be done on an outpatient basis.").

17. The detailed sterile-operating-room requirements and other physical-plant specifications entailed by this requirement are irrelevant to the provision of modern second-trimester abortion care. *See generally* Nat'l Acads. of Sci., Eng'g, and Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018) (hereinafter, "National Academies"); Nichols Decl. ¶ 49 (citing American College of Obstetricians and Gynecologists ("ACOG") guidelines, which do not require an Outpatient Surgical Hospital setting for second-trimester abortion); Oliver Dep. 176:4–7.

18. When the Hospital Requirement was enacted in 1975, the primary method of second-trimester abortion involved giving the patient an injection to end the pregnancy and inducing labor and delivery, a process that required significant medical intervention and close monitoring and pain control over several days. Nichols Decl. ¶ 44. Today, by contrast, second-trimester abortion is generally provided using either aspiration or D&E, two methods that are considerably safer than induction abortion and can be provided safely in an outpatient medical-office setting. *Id*. ¶¶ 14, 20, 46; Nichols Dep. 49:19–22; 76:6–9; Ramesh Dep. 126:6–17, 129:10–14, 131:11–14; Dr. Doe Dep. 85:19–89:8.

19. Aspiration abortions, which may be performed early in the second trimester, are identical to those Plaintiffs currently provide safely in licensed abortion facilities during the first trimester. *See supra* Part I.A.1; Nichols Decl. ¶ 51. At approximately fifteen to sixteen weeks LMP, the most common second-trimester method is D&E. Nichols Decl. ¶¶ 41–42.

20. Both aspiration abortion and D&E procedures are safe; complications are rare, and when they do occur, they can generally be managed in an outpatient clinic. Nichols Decl. ¶¶ 50,

122; Ramesh Dep. 92:4–18, 97:22–98:8, 102:2–8, 126:13–17; Nichols Dep. 49:6–9, 70:6–11, 75:21–76:9; Dr. Doe Dep. 215:8–216:21. In the exceedingly rare event that a higher level of care is needed, patients can be safely stabilized and transferred to a hospital. Nichols Decl. ¶ 122; Ramesh Dep. 99:14–19; Dr. Doe Dep. 215:8–216:21; National Academies at 14.

21. Throughout the country, second-trimester abortion is safely and routinely performed in physicians' offices and settings that would not meet Virginia's onerous physical requirements for Outpatient Surgical Hospitals. Nichols Decl. ¶¶ 49, 52; Ramesh Dep. 129:10–14, 130:1–13, 131:11–19; Nichols Dep. 49:19–22, 51:19–20, 82:22–83:3; Tr. of Dep. of Amy Hagstrom Miller ("Hagstrom Miller Dep.") 129:12–18, attached hereto as Ex. 6-G. In states that allow abortions to be provided in a medical office, both first- and second-trimester procedures are as safe in that setting as in a hospital. Nichols Decl. ¶ 49.

22. In Virginia, procedures with risks comparable to or higher than the risks from abortion—including endometrial biopsy, colposcopy, hysteroscopy (scoping of the cervix and uterus), Loop Electrosurgical Excision Procedure ("LEEP") (removing pre-cancerous cells from the cervix), and dilation and curettage for miscarriage management—are routinely performed in outpatient clinics and physicians' offices. Nichols Decl. ¶¶ 29–30; McElwain Dep. 74:14–75:6, 223:3–13, 224:5–6; Ramesh Dep. 17:21–22; Dr. Doe Dep. 56:8–58:6, 83:15–84:3, 121:3–5, 133:9–22; 166:15–167:6; Tr. of Dep. of Rosemary Codding ("Codding Dep.") 27:15–18, 193:22–194:3, attached hereto as Ex. 6-H. Defendants' medical expert testified that she performs aspiration, LEEPs, hysteroscopy, and polyp-removal procedures in an office-based setting. Lunsford Dep. 301:4–11.

23. Procedures much riskier than abortion—including colonoscopies and endoscopies, drug injections, and invasive cosmetic procedures requiring sedation, Nichols Decl. ¶ 31, Ramesh

Dep. 105:7–22—are routinely performed in medical offices throughout Virginia that are not licensed by VDH.

III. The Physician-Only Law and Hospital Requirement Impose Significant Burdens on Patients Seeking Abortion.

A. Both Laws Limit Where and When Abortion Can Be Accessed.

24. The Physician-Only Law restricts access to abortion by placing significant limitations on the locations and times at which abortion is available, particularly in medically underserved areas of Virginia. Ramesh Dep. 89:21–90:3, 184:6–20; McElwain Dep. 25:6–14, 26:7–18.

25. But for the Physician-Only Law, Plaintiffs would offer early abortion in more locations and at more appointment times. Ramesh Dep. 89:21–90:3, 184:6–20; McElwain Dep. 25:6–14, 26:7–18; Pls.' Objs. & Resp. to Defs.' Interrog. 1, attached hereto as Ex. 6-K.

26. For example, the Physician-Only Law deprives patients of consistent access to both medication and aspiration abortion at Virginia League of Planned Parenthood's ("VLPP") Hampton health center, located in an underserved part of Virginia. Ramesh Dep. 184:6–20. Expanding access at Hampton would reduce the clinic congestion—and resulting delays—at other health centers around the Commonwealth. *See* McElwain Dep. 62:16–64:19, 73:2–20.

27. But for the Physician-Only Law, more patients could access abortion in the first trimester, including medication abortion (which is only available in the earliest weeks of pregnancy). Ramesh Dep. 199:21–200:4; McElwain Dep. 192:13–193:22.

28. The Hospital Requirement limits the availability of generally-available second-trimester abortion care to only two sites in Virginia, a Commonwealth of nearly 43,000 square miles with more than 8.5 million people and nearly 2 million women of reproductive age. U.S. Census Bureau, State Area Measurements and Internal Point Coordinates,

https://www.census.gov/geo/reference/state-area.html; U.S. Census Bureau, 2018 National and State Population Estimates, Table 2: Cumulative Estimates of Resident Population Change for the United States, Regions, States, and Puerto Rico and Region and State Rankings: April 1, 2010 to July 1, 2018 (Dec. 19, 2018), https://www.census.gov/newsroom/press-kits/2018/pop-estimates-national-state.html. Those two sites are VLPP's surgical center in Virginia Beach; and the Virginia Commonwealth University ("VCU") Medical Center general hospital in Richmond, where VLPP has arranged to gain access to an operating room one day per week.[4] McElwain Dep. 28:7–10; Hagstrom Miller Dep. 64:20–65:5.

29. In Virginia Beach, VLPP operates one health center that meets the strict physical-plant requirements to be licensed as an Outpatient Surgical Hospital. *See* 12 Va. Admin. Code § 5-412-40; *id*. §§ 5-410-10–160, -1150–1380. This center provides second-trimester abortions two days per week (Tuesdays and Fridays), up to eighteen weeks and six days LMP. McElwain Dep. 28:7–14, 89:18–20.

30. In Richmond, VLPP leases operating-room time at VCU's general hospital to provide second-trimester abortions. *Id*. 218:17–219:5. VCU allows only seven second-trimester procedures per week, on a single day (Fridays). Ramesh Dep. 61:16–62:8. When those spots fill up, patients must wait until the following week. *Id*. 122:14–22, 123:10–124:4. Moreover, because VCU is a trauma center, VLPP's second-trimester patients' appointments are often delayed at the

[4] There are no other VDH-licensed hospitals or outpatient surgical centers willing to provide generally-available second-trimester abortion, outside of rare medical circumstances involving established patients. Dr. Doe Dep. 20:1–3, 38:10–14; Codding Dep. 98:12–99:18; Hagstrom Miller Dep. 64:15–65:5; McElwain Dep. 217:14–20. Nor is there any evidence that Plaintiffs could meet the prohibitive physical and regulatory requirements for Outpatient Surgical Hospital licensure at any of their other locations. To the contrary, the Planned Parenthood member-affiliate that constructed the surgical center in Virginia Beach was forced to close because of the costs of that renovation. McElwain Dep. 19:22–20:2.

last minute or rescheduled so that patients requiring emergency care can be treated instead. *Id*. 124:11–22.

31. The circumstances of having an abortion at VCU, as opposed to in an outpatient setting, cause significant anxiety among patients. *Id*. 63:2–5, 15–20. In fact, VLPP has had to adopt a practice of offering its VCU patients anti-anxiety medication; it has not had to do this for patients at its other health centers. *Id*. 63:15–20, 188:8–13. These circumstances include the need to wait all day for the procedure, and possibly be displaced by emergency patients; the experience of being at a large general hospital and trauma center, surrounded by patients (including male patients) undergoing higher-risk procedures; and the experience of being cared for by staff not specialized in abortion care. *Id*. 61:2–4, 62:20–63:1, 63:15–20, 60:5–11, 60:19–61:1, 63:2–8.

32. Finally, the fees charged by VCU significantly increase the cost of a second-trimester procedure: at VCU, an abortion at fourteen weeks LMP costs $1,450, McElwain Dep. 89:12–14, far more than the cost of the procedure at VLPP's Virginia Beach Surgical Center. *See* Ramesh Dep. 135:12–15; Lunsford Dep. 133:1–20. This increased cost is especially burdensome because patients seeking access to abortion care are disproportionately poor, *see infra* Part II.B, and often cannot obtain insurance coverage for their procedure, *see* Va. Code Ann. §§ 32.1-325(A)(7), 38.2-3451(A).

33. The Hospital Requirement has no exception for cases in which a patient needs an immediate abortion because her health is at risk. *See* Va. Code Ann. §§ 18.2-71, -73, -74.1. Thus, when a pregnant person suffering serious health problems in the second trimester comes to a non-hospital center seeking abortion care, staff are barred by law from treating her there. For some conditions, such delay in care places the patient at risk, for example, if she is suffering from premature rupture of membranes or heavy bleeding.

B. Reduced Access To Abortion Harms Patients.

34. Both directly and in combination with Virginia's other abortion restrictions, the Physician-Only Law and the Hospital Requirement impose financial, logistical, and physical burdens on patients, delaying care and likely preventing some patients from ever accessing abortion. Decl. of Jane Collins, Ph.D. ("Collins Decl.") ¶¶ 10–12, 26, 49–50, 68–69, attached hereto as Ex. 3; McElwain Dep. 65:10–66:15, 80:21–81:5, 81:19–82:6, 160:22–161:16, 163:12–18, 171:5–9, 234:19–235:11; Ramesh Dep. 122:2–22, 123:10–124:4, 170:13–171:5; Dr. Doe Dep. 99:22–100:14, 130:3-12, 157:9–22.

35. Seventy-five percent of Virginia women of childbearing age live in a county without any abortion provider, and ninety-one percent live in a county without a second-trimester abortion provider who serves the general public. Decl. of Caitlin Myers ("Myers Decl.") ¶¶ 26, 33, attached hereto as Ex. 4. This means that most Virginians must travel to access abortion in the Commonwealth, and patients in the western and southern parts of the state must travel especially far. *Id*. ¶¶ 27–30, 34, 35, 37, 40, Fig. 5 (Ex. D), Fig. 7 (Ex. F), Table 2 (Ex. I), Table 4 (Ex. J); Collins Decl. ¶ 25, Ex. B, Ex. C, Ex. D.

36. Most patients who live less than one hundred miles from the health center where they are seeking abortion care must either make this trip twice or stay overnight near the clinic while they wait twenty-four hours between ultrasound and procedure, per Virginia's mandatory delay rule. Va. Code Ann. § 18.2-76(B). This travel can present significant obstacles, especially for people with low incomes—who constitute seventy-five percent of abortion patients in nationally representative samples. Collins Decl. ¶¶ 8, 10, 15, 26, 68–69; Myers Decl. ¶¶ 5, 29–31, 35, 37, 41, 42, Table 2; Tr. of Dep. of Jane Collins ("Collins Dep.") 157:1–158:4, attached hereto as Ex. 6-I. Residents of the poorest counties must travel farther to access the two second-trimester sites than residents of the richest counties. Myers Decl. ¶¶ 34, 35, Fig. 7 (Ex. F), Table 4 (Ex. J).

37. Patients seeking abortions often must take unpaid time off work and find or save money to pay for transportation and other travel-related expenses, all of which forces some patients to skimp on basic necessities such as food, rent, transportation, and utilities. Collins Decl. ¶¶ 10–11, 17–22, 28–38, 48. Many patients must also arrange for child care while they are away from home. *Id*. ¶¶ 10, 39–41. These necessities often force patients to disclose the reason for their trip to people they otherwise would have preferred not to tell—employers, parents, or partners. *Id*. ¶¶ 8, 36, 47, 67; Ramesh Dep. 50:13–22.

38. Contending with these financial and logistical obstacles routinely delays patients in getting care. Ramesh Dep. 123:10–124:4; Collins Decl. ¶¶ 49–50, 64, 68–69; Myers Decl. ¶¶ 30, 42; Tr. of Dep. of James Studnicki ("Studnicki Dep.") 198:20–201:9, attached hereto as Ex. 6-J; McElwain Dep. 66:4–15, 163:17–18, 171:5–9. A patient might be forced to delay her appointment while working to raise the money for the procedure and related costs. Collins Decl. ¶¶ 12, 43, 45–48, 49–50, 64.

39. This delay can have a snowballing effect, as the cost of a first-trimester abortion often increases with gestational age. *Id*. ¶¶ 12, 43; Hagstrom Miller Dep. 72:18–73:6; FCMC Price List, https://fallschurchhealthcare.com/fees/. And second-trimester abortion costs several times as much as a first-trimester procedure (separate from the added cost of traveling to Richmond or Virginia Beach). McElwain Dep. 89:12–14; Ramesh Dep. 135:12–15; Lunsford Dep. 133:1–20.

40. Because the various methods of abortion care are available only up to certain gestational limits, delays caused by the Physician-Only Law and the Hospital Requirement regularly prevent patients from accessing their preferred abortion method. McElwain Dep. 65:10–21, 66:4–10; Dr. Doe Dep. 99:22–100:14.

41. Many patients strongly prefer medication abortion for a range of reasons including that they can complete the experience in the privacy and comfort of their home. Nichols Decl. ¶ 93. Patients with a history of sexual trauma may wish to avoid having instruments inserted vaginally. *Id.* Some patients have medical conditions that make medication abortion safer than a procedure. *Id.* ¶ 92.

42. By requiring greater travel and limiting the number of appointments Plaintiffs can offer, the Physician-Only Law (particularly in combination with other restrictions) often pushes patients past the ten-week gestational limit for medication abortion. Nichols Decl. ¶¶ 92–93; McElwain Dep. 65:10–21; 80:21–81:5, 96:2–3, 234:19–235:11; Dr. Doe Dep. 99:22–100:14.

43. If a patient misses her opportunity to access abortion care in the first trimester, she must travel to either Richmond or Virginia Beach—or to another state—for a second-trimester abortion, costing her significantly more time and money. Collins Decl. ¶¶ 8, 10–12, 49, 51, 53–63; Myers Decl. ¶¶ 32–37, 40–42, Fig. 7, Fig. 8; Collins Dep. 16:15–17:11; Codding Dep. 98:12–99:18; Hagstrom Miller Dep. 63:16–65:12. Moreover, by limiting the number of second-trimester abortion providers in the state to just two, the Hospital Requirement generates severe scheduling bottlenecks: a patient often must wait more than a week after her initial visit to have her procedure. Ramesh Dep. 122:2–22, 123:10–124:4, 170:20–171:5; McElwain Dep. 81:19–82:6, 160:22–161:16.

44. These delays likely prevent some patients from ever obtaining a second-trimester abortion. Collins Decl. ¶¶ 50, 64, 69; Ramesh Dep. 122:2–22, 123:10–22, 157:9–22; *see also* Myers Decl. ¶¶ 22, 38 (stating that the fraction of abortions occurring in Virginia that are provided in the second trimester is 2.5 percent, one-quarter of the national average (8.9 percent)).

45. Even patients ultimately able to obtain an abortion are physically burdened by delay: while abortion in both the first and second trimesters is extremely safe, risks increase as pregnancy progresses, as does the invasiveness of the procedure and the need for deeper levels of sedation. Nichols Decl. ¶¶ 12, 20, 49, 33; Ramesh Dep. 122:2–22; McElwain Dep. 170:8–17. And every day that a patient carries an undesired pregnancy constitutes an additional physical burden. Dr. Doe Dep. 173:8-17.[5]

LEGAL STANDARD

Summary judgment is proper where "there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Design Res., Inc. v. Leather Indus. of Am*., 789 F.3d 495, 500 (4th Cir. 2015) (citing Fed. R. Civ. P. 56(a)). A fact is material if it "might affect the outcome of the suit under the governing law," and a dispute is genuine if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). It is the nonmovant's burden to persuade the Court that there is an actual dispute of material fact. *See Design Res.*, 789 F.3d at 500. The nonmovant "must provide more than a scintilla of evidence—and not merely conclusory allegations or speculation—upon which a jury could properly find in its favor." *Id*.

[5] Plaintiffs also present unrebutted evidence that the Physician-Only Law and the Hospital Requirement stigmatize abortion patients and providers by singling out abortion from other obstetrician-gynecologist care, thereby creating and perpetuating the perception that abortion is morally wrong. Ramesh Dep. 45:12–46:9, 47:17–48:12, 48:13–49:4, 200:17–201:14, 201:20–202:14, 203:13–16; McElwain Dep. 184:2–185:13; Decl. of Janet Turan, Ph.D., M.P.H. ("Turan Decl.") ¶¶ 9, 15–18, 22–40, attached hereto as Ex. 5. The resulting stigma can increase the risk of poor psychological and physical health outcomes for patients. Turan Decl. ¶¶ 34–37. It also deters clinicians from providing abortion, Ramesh Dep. 194:20–195:9, and compounds the harassment and threats endured by providers and their families (which further deter clinicians from providing), *id*. 195:10–196:14; Nichols Dep. 126:4–127:1; McElwain Dep. 180:18–182:2, 182:10–183:3. Stigma thus further restricts access, with all the attending harms described above. McElwain Dep. 180:10–17; Ramesh Dep. 44:10–16, 45:3–11, 53:5–54:1.

ARGUMENT

Plaintiffs are entitled to summary judgment that the Physician-Only Law and the Hospital Requirement violate their patients' constitutional right to end a pregnancy before viability.

I. The Undue Burden Standard Applies.

Abortion restrictions are unconstitutional when they impose an "undue burden" on abortion access. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309–10 (2016) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992)). When a law fails to confer "benefits sufficient to justify the burdens," those burdens are "undue," and thus unconstitutional. *Id.* at 2300. The undue burden standard requires meaningful review of abortion restrictions—a court must not simply defer to the state's assertions about benefits and burdens, because such deference is inconsistent with the status of the abortion right as a "constitutionally protected personal liberty" and with the court's "independent constitutional duty" to closely review the state's assertions. *Id.* at 2309–10. Instead, a court should "place[] considerable weight upon evidence and argument presented in judicial proceedings," and, for the law to be upheld, the record must show that the law actually furthers the state's asserted interest. *Id.* at 2310. Similarly, as this Court previously recognized in denying Defendants' motion to dismiss, the burdens analysis under this standard is "contextual," and considers "the impact of the alleged regulatory burden as specifically applied." MTD Op. at 11 (citing *Whole Woman's Health*, 136 S. Ct. at 2310).

Applying this analysis, the Supreme Court in *Whole Woman's Health* invalidated two state restrictions that, like those at issue here, were originally advanced as "health and safety" regulations. The Court did so based on findings that, *inter alia*: abortion is already extremely safe, "with particularly low rates of serious complications," *Whole Woman's Health*, 136 S. Ct. at 2311 (quoting *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)); "it is extremely unlikely that a patient will experience a serious complication at the clinic that requires

emergent hospitalization," *id*.; and the challenged restrictions unduly burdened patients by preventing clinics that were not surgical centers from providing abortion, *id*. at 2312–13, 2316–17.

Here, based on uncontested facts similar to the findings in *Whole Woman's Health*, Virginia's Physician-Only Law and Hospital Requirement fail the undue burden standard because, like the restrictions invalidated in that case, they impose burdens on patients that are not offset by *any* medical benefits (let alone benefits sufficient to outweigh the burdens).[6] Thus, summary judgment is warranted.

II. The Challenged Restrictions Fail the Undue Burden Standard Because They Confer No Health Benefit.

To withstand balancing under *Whole Woman's Health*, an abortion restriction must provide some evidence-based benefit based on credible evidence—not speculation. *Id*. at 2309–10. The Physician-Only Law and Hospital Requirement fail this requirement. There is *no* evidence that these laws provide *any* benefit to patients; indeed, there is substantial and uncontroverted evidence to the contrary. Because the challenged restrictions do not advance any asserted benefit and instead burden abortion access by limiting who can provide care and where care can be provided, they "do[] not benefit patients and [are] not necessary." *Id*. at 2315.

A. The Physician-Only Law Does Not Confer Any Medical Benefit.

The Physician-Only Law provides no medical benefit—a fact Defendants' own medical expert conceded during sworn deposition testimony. *See supra* Statement of Undisputed Material Facts ("SUMF") ¶ 7. She did so because, as the undisputed record demonstrates, APCs could

[6] Indeed, Defendants themselves have conceded lack of benefits by noting that these requirements "warrant reconsideration by the Virginia General Assembly," Mem. of Law in Supp. of Defs.' Mot. to Dismiss Pls.' Compl. ("MTD Br.") at 1, ECF No. 21.

provide medication and aspiration abortion in the Commonwealth with no increased risk to patient health or safety. In fact, APCs in Virginia already provide medical services that are comparable—and in some cases identical—to medication and aspiration abortion in technique and level of risk. *See supra* SUMF ¶ 12–14. And in other states, APCs provide medication and aspiration abortion just as safely and effectively as physicians. *Id*. ¶ 10. In fact, expanding access through APC provision of care would *reduce* the risks associated with abortion by enabling patients to obtain care earlier in pregnancy. *Id*. ¶¶ 25–27, 45.

APCs in Virginia—including those at some of Plaintiffs' health centers—already provide misoprostol and/or mifepristone to patients who have experienced a miscarriage. *Id*. ¶ 12. These are the same drugs typically provided to patients during a medication abortion. *Id*. ¶ 3, 12. The ***only*** difference between APCs providing medication abortion and APCs providing these drugs for miscarriage treatment is the underlying purpose of the procedure. *Id*. ¶ 12. But for the Physician-Only Law, APCs could and would provide these drugs to patients for medication abortion just as they already safely and legally do for other procedures.

APCs are already legally authorized in Virginia to prescribe drugs that carry significantly greater risks of side effects and that have a high risk of addiction. Va. Code Ann. § 54.1-2957.01. Indeed, nurse practitioners and certified nurse-midwives in Virginia can prescribe Schedule II through Schedule VI drugs, including opioids and amphetamines. *Id*. And physician assistants (practicing under physicians' supervision) are permitted to prescribe and dispense medications, including controlled substances. 18 Va. Admin. Code § 85-50-140. That Virginia law already allows APCs to prescribe more dangerous drugs to Virginians further demonstrates that the Physician-Only Law lacks any benefit with respect to medication abortion.

Similarly, there is no medical benefit to Virginians in restricting APCs' ability to perform aspiration abortion. APCs in Virginia are already permitted to perform similar procedures and do so routinely: IUD insertions, endometrial biopsies, and colposcopies. *See supra* SUMF ¶ 13. APCs at Plaintiffs' health centers routinely administer intravenous sedation. *Id*. ¶ 14. APCs in Virginia also provide labor and delivery services to patients who give birth in their homes, despite that the maternal mortality rate for childbirth is fourteen times greater than for first-trimester abortion. *Id*. ¶ 15. And Virginia law specifically authorizes physician assistants to perform procedures more invasive than aspiration abortion. 18 Va. Admin. Code § 85-50-110(2).

There can be no valid disagreement that APCs can provide medication and aspiration abortion as safely and effectively as physicians do. In other states, APCs already provide both medication and aspiration abortion as safely and effectively as physicians. *See supra* SUMF ¶¶ 8–10. And the Physician-Only Law actively *undermines* patient safety by delaying abortion access even though abortion is safer the earlier it occurs during a pregnancy. *See supra* SUMF ¶ 45. Accordingly, there is no genuine dispute that the Physician-Only Law "simply is not based on differences" between doctors and APCs "'that are reasonably related to' preserving women's health." *Whole Woman's Health*, 136 S. Ct. at 2315 (quoting *Doe v. Bolton*, 410 U.S. 179, 194 (1973)).

B. The Hospital Requirement Does Not Confer Any Medical Benefit.

It is similarly uncontested that the Hospital Requirement has no medical benefit. There is no evidence that the restriction has improved the safety or health of Virginians. Nor is there any evidence that Plaintiffs could not safely provide second-trimester abortions in their licensed abortion clinics. Tellingly, Defendants took the position in their Motion to Dismiss that Plaintiffs' licensed abortion clinics *satisfy* the Virginia Supreme Court's definition of "hospital," as used in the Hospital Requirement statute. MTD Br. at 7. While that position failed to account for the other

legal restrictions preventing Plaintiffs from providing second-trimester abortion in their licensed abortion clinics, *see* MTD Op. at 20–24, it belies Defendants' subsequent suggestion that somehow these clinics are not a *medically safe* setting for second-trimester abortions. As a result, there is "no significant health-related problem" that Virginia's Hospital Requirement "help[s] to cure." *Whole Woman's Health*, 136 S. Ct. at 2311 (so finding in the context of an admitting-privileges requirement); *see also*, *e.g.*, *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 917 (9th Cir. 2014) (holding that a preliminary injunction was appropriate for an abortion restriction based on "non-existent" medical grounds).

More specifically, the Hospital Requirement's detailed operating-room requirements and other physical-plant specifications are irrelevant to providing safe, modern second-trimester abortion care.[7] When the Hospital Requirement was enacted in 1975, the primary method of second-trimester abortion involved medications to induce labor and delivery, a process that required significant medical intervention, close monitoring, and pain control over several days. *See supra* SUMF ¶ 18. Today, by contrast, second-trimester abortion is generally provided using either aspiration or D&E, two methods that are considerably safer than induction and can be provided safely in an outpatient medical-office setting. *Id*. Indeed, aspiration abortions performed early in the second trimester are identical to those Plaintiffs currently provide safely in their licensed abortion clinics during the first trimester. *See supra* SUMF ¶ 19. At approximately fifteen to sixteen weeks LMP, the most common second-trimester method is D&E. *Id*. ¶ 5, 19. Both aspiration abortion and D&E are also very safe—complications are rare, and when they do occur, they can generally be managed in an outpatient setting. *Id*. ¶ 20. And neither aspiration abortion nor D&E requires a sterile surgical field since, in both procedures, the clinician accesses the uterus

[7] *See generally supra* SUMF ¶ 17.

through the vagina, which is naturally colonized with bacteria, and through the natural opening of the cervix. *Id*. ¶ 6.

Throughout the country, second-trimester abortion is safely and routinely provided in settings that would not meet Virginia's onerous physical requirements for Outpatient Surgical Hospitals. *Id*. ¶ 21. In states where abortion may be provided in an office, both first- and second-trimester procedures are as safe in that setting as in a hospital. *Id*. And by unreasonably limiting second-trimester abortion care, the Hospital Requirement restricts access, causes delay, and *undermines* patient safety since abortion is safer the earlier it occurs in pregnancy. *See infra* Part III.

Furthermore, in Virginia, procedures with comparable or higher risks are routinely performed in outpatient clinics and physicians' offices: endometrial biopsy, colposcopy, hysteroscopy, LEEP, and dilation and curettage for miscarriage management. *See supra* SUMF ¶ 22. And medical offices offering procedures much riskier than abortion—including colonoscopies, penicillin injections, and cosmetic procedures requiring sedation—are neither licensed, regulated, nor inspected by VDH. *Id*. ¶ 23.

The undisputed record in this case mirrors the evidence before the Court in *Whole Woman's Health*. There, the Supreme Court highlighted "peer-reviewed studies showing that the highest complication rate found for . . . second trimester abortion was less than one-half of 1%." 136 S. Ct. at 2311. The Court pointed to evidence that abortion is safer than many surgical procedures that routinely take place in doctors' offices, including colonoscopies and certain plastic surgeries. *Id.* at 2315. Finally, the Court cited evidence that surgical-center requirements aimed at maintaining a sterile surgical field and protecting heavily sedated patients were wholly irrelevant to safe abortion care, which does not require either a sterile surgical field or heavy sedation. *Id*. at

2316. On this evidence, the Supreme Court endorsed the district court's findings that "risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities" and that women would "not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center." *Id.* at 2315 (citing *Lakey*, 46 F. Supp. 3d at 684). Because the same is true for women having abortions in general hospitals as compared with other facilities, the Hospital Requirement does not further the state's interest in ensuring patient safety and health and fails under *Whole Woman's Health*.

III. The Challenged Restrictions Fail the Undue Burden Standard Because They Burden Patients' Access To Abortion.

In the absence of any demonstrated benefit, the undue burden balancing test necessarily renders any burden on patients' right to seek abortion "undue." *See*, *e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) ("The feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous."); *cf. Wis. Right to Life State Political Action Comm. v. Barland*, 664 F.3d 139, 154 (7th Cir. 2011) (noting, in the application of a First Amendment balancing test, that "something . . . outweighs nothing every time" (quoting *SpeechNow.org v. F.E.C.*, 599 F.3d 686 (D.C. Cir. 2010)). Here, though, it is undisputed that these laws have no medical benefit, rendering the burdens they impose undue. Plaintiffs have, nonetheless, also provided extensive and uncontested evidence of the many ways that these laws burden Virginia women in practice. The laws significantly reduce access to abortion in Virginia, thereby delaying patients, increasing their risks and costs, and likely preventing some patients from accessing care at all.

Specifically, the Physician-Only Law restricts access to the two most common forms of abortion care, medication and aspiration abortion, by placing significant limitations on the locations and times at which these methods are available, particularly in medically underserved

areas of Virginia. *See supra* SUMF ¶ 24. These limitations are especially harmful for patients with lower incomes, who often contend with transportation limitations, childcare constraints, inflexible work schedules, and lack of paid time off. *Id*. ¶ 37. The law makes it more likely that women seeking an abortion will be prevented from having their preferred method of abortion and will be pushed into the second trimester of their pregnancy, when access is even more restricted by the Hospital Requirement. *Id*. ¶¶ 24–28, 40–43.

As a result of the Hospital Requirement, patients who need a second-trimester abortion must travel to one of two providers: VLPP's surgical center in Virginia Beach, or to VCU in Richmond. *Id*. ¶ 28. They face additional scheduling delays because these two sites can only see a limited number of patients each week. *See id.* ¶¶ 29–30. Patients must pull together financial resources to cover the cost of travel (including transportation, time away from work, and often childcare), and to pay for a procedure that is more complex, takes more time, and is therefore more expensive. *See id.* ¶¶ 32, 35–39. At VCU in Richmond, the procedure costs far more than what it would elsewhere due to hospital fees. *Id*. ¶ 32. For patients with particularly low incomes, these expenses will necessitate forgoing basic necessities for themselves and their families. *Id*. ¶¶ 37–39. And patients face serious additional stresses from having their second-trimester procedure at a large trauma center, where they must wait all day to be seen between emergency cases that arise unpredictably. *See id.* ¶ 31.

These burdens constitute a substantial obstacle to abortion access and are unquestionably undue because, when balanced, they stem from laws that provide no medical benefit. In *Whole Woman's Health*, the Supreme Court considered burdens that included "increased driving distances," delay, "fewer doctors, longer waiting times, and increased crowding," with patients "less likely to get the kind of individualized attention, serious conversation, and emotional

support" that they might have received "at less taxed facilities." 136 S. Ct. at 2313, 2318. The Court put great weight on the district court's findings that these burdens would "erect a particularly high barrier for poor, rural, or disadvantaged women." *Id*. at 2302.

The record here shows similar logistical hurdles. The effect of the Hospital Requirement is to limit Virginia—a Commonwealth of nearly 43,000 square miles, with more than 8.5 million people and nearly 2 million women of reproductive age—to only two second-trimester providers, each with extremely limited availability. *See supra* SUMF ¶¶ 28–30.

Courts of appeals, both before and after *Whole Woman's Health*, have not hesitated to strike down abortion restrictions that burden access without conferring any significant benefits. For example, the Seventh Circuit blocked a requirement that women have an ultrasound performed eighteen hours before they may obtain an abortion based on "the lengthy travel that [the law] required" and the strain this imposed in the "realm of finances, employment, child care, and domestic safety," particularly for low-income patients. *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 819 (7th Cir. 2018). And the Eleventh Circuit recently affirmed an injunction against an abortion restriction that would increase patients' medical risk and "increase the costs of travel and lodging for women who do not live near the plaintiff clinics," an outcome "especially burdensome for low-income women." *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1326–27 (11th Cir. 2018); *see also Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015) (affirming injunction of law that would delay women in obtaining abortions, causing some "to forgo first-trimester abortions and instead get second-trimester ones, which are more expensive and present greater health risks"); *Humble*, 753 F.3d at 915 (holding that a law restricting the availability of medication abortion burdened patients, including those who preferred medication abortion over the surgical alternative and would have to

spend more money to obtain an abortion); *Van Hollen*, 738 F.3d at 796 (affirming preliminary injunction against an admitting-privileges requirement that would lead to a shortage of abortion providers and consequent delays in abortion, which could "result in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal").[8]

The Physician-Only Law and the Hospital Requirement impose significant burdens, individually and collectively, on a patient's right to choose abortion. *See id.* ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered."). Because the provisions' benefits do not outweigh these burdens—indeed, because there are *no* benefits from these provisions—the restrictions violate the Fourteenth Amendment and should be permanently enjoined.

IV. The Hospital Requirement Is Unconstitutional Because It Lacks a Health Exception.

The Hospital Requirement is also unconstitutional as a matter of law because it includes no health exception for patients facing serious health risks who need immediate care at a licensed abortion clinic, and there is no basis on which this court can craft a remedy less than full invalidation. For more than forty years, the Supreme Court has held that a state may not restrict access to abortions that are "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe v. Wade*, 410 U.S. 113, 165 (1973); *see also Ayotte v. Planned*

[8] Additionally, five state attorneys general have interpreted state law to permit APCs to provide abortion. *See* Wash. Att'y Gen. Op. 2019 No. 1, 2019 WL 495734 (Feb. 1, 2019) ("[W]e reach these conclusions, in part, because we recognize that doing so avoids serious constitutional concerns raised by a contrary reading of the statutes."); Vt. Att'y Gen. Op. 2005-1, 2005 WL 6083035 (Mar. 14, 2005) (recognizing that *Roe* and *Casey* "significantly narrowed the scope" of Vermont's general abortion ban, and that Vermont law "must be construed in light of federal and state constitutional requirements"); Ill. Att'y Gen. Op. 09-002, 2009 WL 596125 (Mar. 5, 2009); N.Y. Att'y Gen. Op. (June 29, 2001); Conn. Att'y Gen. Op. 2001-003, 2001 WL 223439 (Feb. 7, 2001).

Parenthood of N. New Eng., 546 U.S. 320, 327–28 (2006); *Casey*, 505 U.S. at 879; *cf. Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) ("The prohibition in the Act would be unconstitutional, under precedents we here assume to be controlling, if it 'subject[ed] [women] to significant health risks.'" (quoting *Ayotte*, 546 U.S. at 327–28)); *see also Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 511–12 (6th Cir. 2006) (affirming in part preliminary injunction against law that banned medication abortion after forty-nine days LMP for failing to adequately protect women's health). Accordingly, in addition to the undue burden standard that abortion restrictions must meet, there is "a specific and independent constitutional requirement that an abortion regulation must contain an exception for the preservation of the pregnant woman's health." *Ayotte*, 546 U.S. at 325 (citing *Planned Parenthood of N. New Eng. v. Heed*, 390 F.3d 53, 58 (1st Cir. 2004).

The Supreme Court has never wavered from its holding that a restriction must contain a health exception to be constitutional if it imposes significant health risks on women seeking abortion. *Ayotte*, 546 U.S. at 330–32. (affirming requirement of health-exception requirement and noting that the lower court's decision to facially invalidate the law was "understandable" given the Court's ironclad insistence on a health exception; remanding solely for the lower court to assess legislative intent regarding scope of the remedy).

Some women in Virginia face serious health harms because the Hospital Requirement prohibits them from receiving a second-trimester abortion at the clinic to which they present. *See supra* SUMF ¶ 33. No matter how small the number of women affected, the statute's lack of a health exception renders it unconstitutional as a matter of law.

CONCLUSION

For the foregoing reasons, this Court should enter summary judgment in favor of Plaintiffs on Counts III and IV; should declare unconstitutional the Hospital Requirement, the Physician-

Only Law, and, as to medication and aspiration abortion provided by APCs and second-trimester abortion provided outside of hospitals, the general criminal ban on abortion; and should permanently enjoin the enforcement of those provisions.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 11, 2019 a copy of the foregoing has been served upon all counsel of record in this action by electronic service through the Court's CM/ECF system.

/s/ D. Sean Trainor
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