IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

ADAMS & BOYLE, P.C., on behalf of itself and its patients; *et al*.,

Plaintiffs,

v.

HERBERT H. SLATERY III, Attorney General of Tennessee, in his official capacity; *et al*.,

Defendants.

CASE NO. 3:15-cv-00705

JUDGE FRIEDMAN

MAGISTRATE JUDGE FRENSLEY

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

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

State Statutes

Regulations

Other Authorities

Pursuant to Federal Rule of Civil Procedure 65, Plaintiffs Adams & Boyle P.C., Choices Memphis Center for Reproductive Health ("Choices"), and Planned Parenthood of Tennessee and North Mississippi ("PPTNM"), and proposed Plaintiffs Knoxville Center for Reproductive Health and Dr. Kimberly Looney (collectively "the Providers") move for a temporary restraining order, followed by a preliminary injunction, to enjoin Governor Bill Lee's April 8, 2020, Executive Order No. 25, "An Order To Reduce The Spread Of Covid-19 By Limiting Non-Emergency Health Care Procedures" ("EO-25"), as it applies to procedural abortions in Tennessee. In light of EO-25's broad wording and criminal penalties, all procedural abortion care—that is, *all* abortions after 11 weeks of pregnancy, and all abortions from the *start of pregnancy* for patients who are ineligible for an early method of abortion involving medications alone—is now halted in the state of Tennessee. Every day that this ban remains in place, it forces pregnant people in Tennessee to remain pregnant against their wishes. Unless and until this court grants relief, they will continue to suffer constitutional injury, serious medical risk, and other forms of irreparable harm.

As applied to procedural abortion, EO-25 contravenes guidance issued by leading medical authorities in the wake of COVID-19. The American College of Obstetricians and Gynecologists ("ACOG") and seven other leading medical organizations[1] issued a public statement in response to the COVID-19 health pandemic explaining that abortion is "essential," "time-sensitive" health care that cannot be delayed without risking the health and safety of the patient.

[1] The medical organizations issuing this joint guidance were ACOG, the American Board of Obstetrics & Gynecology, the American Association of Gynecologic Laparoscopists, the American Gynecological & Obstetrical Society, the American Society for Reproductive Medicine, the Society for Academic Specialists in General Obstetrics and Gynecology, the Society of Family Planning, and the Society for Maternal-Fetal Medicine. *See Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

Most urgently, the Providers seek relief on behalf of patients who are particularly burdened by the Executive Order because of the time-sensitive nature of abortion care, including: ***First***, patients who, in the good faith professional judgment of the provider, will likely lose their ability to obtain an abortion in Tennessee if their procedures are delayed until after April 30, 2020. EO-25 will force such patients to either carry an unwanted pregnancy to term, and bear the far greater risks of illness, complications, and risk of death associated with ongoing pregnancy and childbirth, or attempt to seek abortion care out of state, which imposes significant costs, burdens, and emotional distress that the COVID-19 pandemic will exacerbate. ***Second***, patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a lengthier and more complex abortion procedure, which is only available at two clinics in Nashville and Memphis, if their procedures are delayed until after April 30, 2020. These patients will likely have to travel farther for abortion care as a result of EO-25, which increases the costs and burdens of accessing such care and will face greater health risks associated with the more complex procedure. ***Third***, patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a two-day procedure—which is only available at two clinics in Nashville and Memphis, and which requires at least three separate visits to the provider—if their procedures are delayed until April 30, 2020. In making such determinations, providers must be allowed take into account all of the factors bearing on an individual patient's ability to timely access abortion care and medical risk, including the patient's medical history, familial circumstances, and any logistical and financial obstacles faced by the patient.

The Providers' further request that during the pendency of the Executive Order, Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them be temporarily enjoined from enforcing the in-person counseling

requirement under Tenn. Code Ann. § 39-15-202(a)-(h) (the "48-hour Delay Law"), which requires that the physician provide state-mandated information to patients in person, at least 48 hours before the abortion, rather than by telephone (as comparable state laws allow, *see*, e.g., Ga. Code Ann. § 31-9A-3), or other telehealth technologies (as Tennessee Executive Order 15 encourages during the COVID-19 crisis, *see* Exec. Order 15, at 10 (Mar. 19, 2020)).[2] Such relief is necessary because the Delay Law imposes significant burdens on access to care, and requires the Providers to use more PPE than would otherwise be necessary if they were able to provide the same information to patients via telephone videoconference, or other telehealth technologies.

Decades of Supreme Court precedent categorically prohibit states from banning abortion before viability, or imposing burdens on abortion access that exceed the benefits conferred. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846, 871 (1992); *Roe v. Wade*, 410 U.S. 113, 166 (1973). Nor is it a permissible exercise of the state's police power to exploit a health pandemic to ban abortion. *Jacobson v. Mass.*, 197 U.S. 11, 31 (1905) (explaining State's police power may not violate fundamental rights and must serve State's asserted aims). Accordingly, federal district courts in Alabama, Ohio, Oklahoma, and Texas have already granted emergency requests to temporarily restrain those states from banning abortion through COVID-19 executive orders. *See Robinson v. Marshall*, No. 2:19-cv-365, at 28, 30 (M.D. Ala. Apr. 12, 2020) (ECF No. 137) ("Robinson," attached as Exhibit 1); *S. Wind Women's Center v. Stitt*, No. CIV-20-277-G, 2020 WL 1677094 (W.D. Okla. Apr. 6, 2020), *appeal dismissed*, No. 20-6045 (10th Cir. Apr. 13, 2020) (attached as

[2] Governor Bill Lee, *Executive Order No. 15, An Order Suspending Provisions Of Certain Statutes And Rules And Taking Other Necessary Measures In Order To Facilitate The Treatment And Containment of COVID-19* (Mar. 19, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee15.pdf.

Exhibit 2); *Preterm-Cleveland v. Att'y Gen. of Ohio*, No. 1:19-cv-360 (S.D. Ohio Mar. 30, 2020) (ECF No. 43) ("Preterm-Cleveland," attached as Exhibit 3);[3] *Planned Parenthood Ctr. for Choice v. Abbott*, No. A-20-CV-323-LY, 2020 WL 1815587 (W.D. Tx. April 9, 2020) ("Abbott").[4]

That same relief is warranted here. The Providers have already been forced to cancel dozens of procedural abortion appointments scheduled to take place after EO-25 took effect, including for patients who had already traveled to the Providers' clinics, as required by state law, to receive state-mandated counseling and then returned home to wait at least 48 hours before their abortion. Future appointments are now being cancelled, throwing abortion access into disarray.

Forcing patients to remain pregnant against their wishes for weeks or—as is far more likely given the trajectory of the pandemic, months[5]—*undermines*, rather than advances, EO-25's stated goals of "preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through nonessential patient-provider interaction."

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[3] The State of Ohio filed a motion with the Sixth Circuit to stay the Temporary Restraining Order ("TRO") and Plaintiffs moved to dismiss. The Court held it lacked jurisdiction because the TRO did not threaten to inflict irretrievable harms or consequences before it expires. *See Pre-Term Cleveland v. Att'y Gen. of Ohio*, No. 20-3365, 2020 WL 1673310, at *2 (6th Cir. Apr. 6, 2020) ("*Pre-Term Cleveland II*").

[4] The Fifth Circuit granted in part an administrative stay of the District Court's order, leaving in place the temporary restraining order as to medication abortion and as to "women who would be past Texas's legal limit—22 weeks LMP—for abortion by April 22." *In re Abbott*, No. 20-50296, at 3, 5 (5th Cir. Apr. 13, 2020) (attached as Exhibit 4). Plaintiffs have filed an emergency application with the Supreme Court to vacate the stay. *See* Applicants' Emergency Application to Justice Alito to Vacate Administrative Stay of Temporary Restraining Order Entered by the United States Court of Appeals for the Fifth Circuit, *Planned Parenthood Center for Choice, et al., v. Greg Abbott, Governor of Texas, et al.*, No. 19A1019 (Apr. 11, 2020).

[5] *See, e.g.*, Jake Lowary, *Vanderbilt Health Policy COVID-19 model finds evidence of flattening curve, recommends social distancing policies continue*, VUMC Reporter, Apr. 9, 2020, https://news.vumc.org/2020/04/09/vanderbilt-health-policy-covid-19-model-finds-evidence-of-flattening-curve-recommends-distancing-policies-continue/ (predicting that, in Tennessee, "if the current social distancing policies continue to reduce the spread of the disease, there would be an estimated peak of hospitalizations in mid-June. If the state were to experience additional gains from social distancing, under that more optimistic scenario the peak of hospitalizations could be lower and could be as early as mid-May").

EO 25 at 3. A person who wants to end a pregnancy but is unable to do so will have far more contact with the healthcare system in both the near and long-term, using up significantly more personal protective equipment ("PPE") and health care resources, than if they had been able to obtain an abortion without delay. Declaration of Dr. Kimberly Looney ("Looney Decl.," attached as Exhibit 5) ¶ 31. They will need prenatal care as pregnancy takes an increasing toll on their health, which will involve multiple trips to health care facilities, particularly if the patient has a high-risk pregnancy or underlying health care conditions exacerbated by pregnancy. *Id.* Some patients will have to seek care at an emergency room after experiencing a miscarriage—using not only PPE, but also the hospital's physicians, nurses, and beds, and exposing the patients to the risk of contagion. *Id.* ¶ 35. Patients who must carry a pregnancy to term and deliver will need multiple prenatal visits, screening tests, and, ultimately, a multi-day hospital admission, which is even lengthier if the patient had a cesarean-section. *Id.* ¶ 33.

Alternatively, some patients who have the means will attempt to obtain abortion care by traveling to another state, increasing the risk of COVID-19 transmission but conserving no PPE. Under either scenario, preventing patients from accessing procedural abortions in Tennessee will increase the risks, both to patients and the rest of Tennessee's population, of contracting COVID-19 and result in greater use of PPE and hospital resources—*contrary to the stated goals of EO-25 and to public health*.

The COVID-19 pandemic does not reduce the need for abortions; if anything, it makes timely access to comprehensive reproductive healthcare even more urgent, while raising additional obstacles for individuals seeking care. Absent injunctive relief from this Court, due to the burdens imposed by EO-25, in conjunction with the mandatory 48-hour delay and the backlog that already exists at clinics, many of the Providers' patients will lose their ability to access safe and legal pre-

viability abortion in Tennessee and be forced to carry pregnancies to term against their will. For those patients who are able to access abortion, some will be forced to have longer, more invasive procedures, which requires more PPE. The majority of abortion patients in Tennessee are poor or low-income and already face enormous obstacles in accessing healthcare; these obstacles are exacerbated by the extreme financial and logistical difficulties brought on by the COVID-19 public health crisis. Being delayed or denied a procedural abortion will jeopardize patients' physical health amidst a health crisis that has already overburdened the healthcare system. Moreover, denial and delay of abortion can cause significant emotional, social, and economic harms.

Accordingly, the Providers seek a temporary restraining order and preliminarily injunction to enjoin Defendants, their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them, from enforcing or complying with EO-25 to prohibit procedural abortions prior to viability and preserve the *status quo* for patients who are seeking that care. This relief is critical to prevent irreparable harms to patients' health and ongoing violation of their constitutional rights. This relief will also further the public interest and the public health.

STATEMENT OF FACTS

A. Abortion and Reproductive Healthcare in Tennessee

Legal abortion is a vital, safe, and common form of healthcare.[6] Tr. Vol. 2, 57:18-58:8 (Young);[7] Looney Decl. ¶ 9. Abortions rarely result in complications and do so at rates of no more

[6] Nat'l Acads. of Sci., Eng'g & Med., *The Safety & Quality of Abortion Care in the United States*, 77 (The National Academies Press 2018) ("The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.") [hereinafter "National Academies Report"].

[7] This Statement of Facts contains numerous references to the prior record in this case in light of the many applicable facts here. References to "Tr." refers to the trial record.

than a fraction of a percent.[8] *Id*. Additionally, every pregnancy-related complication is more common among women having live births than among those having abortions. *Id*. ¶ 10.[9] In fact, a 2012 study found the risk of death for those carrying pregnancies to term is approximately 14 times higher than for those obtaining abortions. *See id*.[10] More recent maternal mortality data in the United States reflect even higher maternal mortality rates, and Tennessee, in particular, has higher maternal mortality rates than national numbers. Tr. Vol. 2, 65:19-12 (Young). While abortion is an extremely safe procedure, the risks increase as pregnancy progresses. Looney Decl. ¶ 10; Tr. Vol. 2, 57:23-58:8 (Young); Tr. Vol. 1, 41:3-8 (Wallett).

There is no typical abortion patient: individuals seek abortion for a multitude of complex reasons, including medical, family, economic, and personal reasons. Tr. Vol. 1, 45:9-46:4 (Wallett); Looney Decl. ¶ 19. Approximately 1 in 4 women will have an abortion in their lifetime. Tr. Vol. 2, 57:18-22 (Young). The majority of the Providers' patients live below or close to the poverty line. Tr. Vol. 2, 91:6-14 (Young); Declaration of Rebecca Terrell ("Terrell Decl.," attached as Exhibit 6)). ¶ 14; Declaration of Corrinne Rovetti, FNP, APRN-BC ("Rovetti Decl.," attached as Exhibit 7) ¶ 19.

There are two methods of abortion care available in Tennessee: medication abortion or in-office procedural abortion (also referred to as "surgical abortion"). Tr. Vol. 2, 57:18-22 (Young); Looney Decl. ¶ 11. For a medication abortion, the patient takes mifepristone in the clinic and then, 24 to 48 hours later, takes misoprostol at a location of her choosing, typically at home. Looney Decl. ¶ 11. The pregnancy is then passed in a process similar to miscarriage. *Id.*; Tr. Vol. 1, 39:15-

[8] National Academies Report at 55, 60, 74-75.
[9] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Am. J. Obstetrics & Gynecology 215, 217 (2012).
[10] *Id.*

11 (Wallett). The use of mifepristone in combination with misoprostol is safe and effective to terminate pregnancies up to 11 weeks LMP (or 77 days). Looney Decl. ¶ 12.

Although procedural abortion is sometimes referred to as "surgical abortion," it is not what is commonly understood to be surgery, as a procedural abortion involves no incision or general anesthesia. Looney Decl. ¶ 14. In the majority of cases, a procedural abortion is performed using the "aspiration" technique, which involves the use of gentle suction to empty the uterus, typically takes about 5-10 minutes, and may at times involve local anesthesia or conscious sedation. *Id.*; Tr. Vol. 1, 40:12-20 (Wallett); Tr. Vol. 2, 58:9-59:1 (Young). Starting at 14-16 weeks, physicians typically use the dilation and evacuation ("D&E") technique, which requires additional skills and equipment to perform, and takes longer, including longer time spent by the patient in the recovery room. Looney Decl. ¶ 14; Tr. Vol. 1, 40:21-8 (Wallett). Starting around 18 weeks LMP, procedural abortion may be performed as a two-day procedure because a patient receives medications to dilate her cervix the day before the procedure itself. Looney Decl. ¶ 14. For some patients, procedural abortion is safer or medically indicated over medication abortion, such as for patients at increased risk of bleeding. *Id*. ¶ 13.

Pregnancy is generally 40 weeks in duration, and abortion care is only available during a limited window of time. *Id*. ¶¶ 15, 31. While patients usually seek abortion as soon as they are able, there are a host of logistical, financial, and legal obstacles that can delay patients who have made the decision to end a pregnancy. *Id*. ¶ 21. For example, patients must contact the clinic and schedule their pre-abortion mandatory counseling visit; they must come up with the necessary funds, as abortion is generally not covered by Tennessee insurance plans or the state Medicaid program; and they must make all of the necessary arrangements including finding transportation, taking unpaid time off work and finding and paying for childcare. *Id.*; Terrell Decl. ¶¶ 12-14;

Rovetti Decl. ¶ 19. Further, Tennessee law requires that patients make an initial counseling visit and then wait at least 48 hours before returning to the health center to obtain abortion care. Terrell Decl. ¶ 11; Rovetti Decl. ¶ 16. For patients who live in rural areas or for whom travel is especially difficult, there is no exception to the mandatory delay and two-trip requirement. Terrell Decl. ¶ 11. Patients under the age of 18 must obtain parental consent before they can obtain an abortion, unless they go to court and obtain a judicial bypass. *Id.* ¶ 12. Nor does Tennessee law permit providers to offer medication abortion—or even perform the mandatory counseling visit—via telemedicine, which could ease the travel and logistical burdens for patients living in rural areas or who must travel long distances to receive abortion care. *Id.*

The COVID-19 public health emergency exacerbates these burdens on the Providers' patients. *Id.* ¶ 15; Looney Decl. ¶ 22; Rovetti Decl. ¶ 17-19. It has caused unprecedented layoffs and other work disruptions, shuttered schools and childcare facilities, and otherwise limited patients' options for transportation and childcare support during a time of recommended social distancing and shelter-in-place orders.[11] Looney Decl. ¶ 22; Rovetti Decl. ¶¶ 17-19. Indeed, during the week ending on April 4, 2020, the number of unemployment claims in Tennessee rose to 116,141 initial claims—a 23,641 increase from the 92,500 initial claims filed the previous week.[12]

Access to abortion in Tennessee is limited by provider availability, with eight providers in only four cities. Tr. Vol. 2, 88:6-19, 89:18-90:7 (Young); Terrell Decl. ¶ 11. 96% of Tennessee

[11] *See* Governor Bill Lee, *Executive Order No. 22, An Order Directing Tennesseans To Stay Home Unless Engaging in Essential Activities To Limit Their Exposure To And Spread Of Covid-19* (Mar. 30, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee22.pdf; Governor Bill Lee, *Executive Order No. 23, An Order Amending Executive Order No. 22 Requiring Tennesseans To Stay Home Unless Engaging in Essential Activity Or Essential Services* (Apr. 2, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee23.pdf.

[12] U.S. Dep't of Labor, *Unemployment Insurance Weekly Claims Report / USDL 20-510-NAT* at 5 (Apr. 9, 2020), https://www.dol.gov/ui/data.pdf.

counties lack an abortion provider, and 63% of Tennesseans live in a county with no provider. Tr. Vol. 2, 88:6-19, 89:18-90:7 (Young). Abortions after 15 weeks are only available at PPTNM's Nashville and Memphis clinics, and only up to 19 weeks, 6 days LMP. Looney Decl. ¶¶ 2, 15.

Because the cost of abortion increases as pregnancy advances, some patients find themselves trapped in a vicious cycle: delaying their abortion care while they attempt to raise the necessary funds, and then having to delay even longer to raise the additional funds needed for a more costly abortion later in pregnancy. Tr. Vol. 2, 93:9-17 (Young). Delay can also increase the costs of travel, childcare, and—for patients who are delayed to the point when abortion becomes a two-day procedure—additional time off work, among other expenses. Rovetti Decl. ¶ 19. This is especially onerous for patients who must travel long distances to reach a clinic because travel requires additional logistical arrangements, including being away from home and work, needing childcare, and potentially needing to inform others of the reasons for appointments. Tr. Vol. 1, 99:17-100:2 (Wallett); Terrell Decl. ¶ 13; Rovetti Decl. ¶ 19. These burdens are compounded by the mandatory 48-hour delay requirement, which forces patients to make at least two separate visits and creates significant delay for patients (far greater than 48 hours) and which some patients are unable to do. Tr. Vol. 1, 286:25-287:8 (Terrell); Looney Decl. ¶ 23; Rovetti Decl. ¶¶ 16, 19, 25.

B. COVID-19 Pandemic and the Governor's Executive Order

In March 2020, the United States and the State of Tennessee declared a state of emergency related to the COVID-19 pandemic.[13] On April 8, 2020, Governor Lee signed EO-25 to "preserv[e]

[13] *See* President Donald J. Trump, *Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (Mar. 13, 2020), https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/; *Gov. Bill Lee Issues Executive Order Declaring State of Emergency in Response to COVID-19*, TN Office of the Governor (Mar. 12, 2020), https://www.tn.gov/governor/news/2020/3/12/gov--bill-lee-issues-executive-order-declaring-state-of-emergency-in-response-to-covid-19.html.

personal protective equipment for emergency and essential needs" and prevent "community spread of COVID-19 through nonessential patient-provider interactions." *See* EO-25 at 2.[14] EO-25 provides that "[a]ll healthcare professionals and healthcare facilities in the State of Tennessee shall postpone surgical and invasive procedures that are elective and non-urgent." *Id.* at 2. Elective and non-urgent procedures are defined as "those procedures that can be delayed until the expiration of this Order because they are not required to provide life-sustaining treatment, to prevent death or risk of substantial impairment of a major bodily function, or to prevent rapid deterioration or serious adverse consequences to a patient's physical condition if the surgical or invasive procedure is not performed, as reasonably determined by a licensed medical provider." *Id*. at 2-3. EO-25 took effect at 12:01 a.m., Central Daylight Time, on April 9, 2020, and remains in effect until 12:01 a.m., Central Daylight Time, on April 30, 2020.[15] A violation of an executive order is a class A misdemeanor, and may result in licensure penalties. Tenn. Code Ann. § 58-2-119; *see also* Apr. 10, 2020 Letter from Commissioner Lisa Piercey to Health Care Providers (Exhibit 8).

EO-25 explains that "the American College of Surgeons has recommended that each hospital, health system, and surgeon thoughtfully review all scheduled elective procedures with a plan to minimize, postpone, or cancel electively scheduled operations, endoscopies, or other invasive procedures and to immediately minimize use of essential items needed to care for patients, including, but not limited to, ICU beds, personal protective equipment, terminal cleaning supplies,

[14] EO-25 amends and supersedes the provisions of Executive Order No. 18, dated March 23, 2020, which prevented hospitals and ASTC's from performing non-essential procedures, but explicitly exempted "pregnancy-related visits and procedures" as well as "emergency or trauma-related procedures where postponement would significantly impact the health, safety, and welfare of the patient." *Id*. Executive Order 18 defined non-essential procedures as "any medical procedure that is not necessary to address a medical emergency or to preserve the health and safety of a patient, as determined by a licensed medical provider." *Id*.

[15] EO-25 is likely to be renewed or extended, as experts expect the current crisis to last beyond April 30, into May or June. *See, e.g.*, Lowary, *supra* note 5.

and ventilators." *Id.* at 1. EO-25 defines PPE as including, but not limited to, "medical gowns, N95 masks, surgical masks, TYVEK suits, boot covers, gloves, and/or eye protection." *Id.* at 3.

C. The Providers' Health & Safety Measures in Response to COVID-19

Since the COVID-19 crisis began, the Providers have been diligent in protecting the health of their patients and staff while continuing to provide access to high-quality, timely abortion care. Terrell Decl. ¶¶ 17-27; Looney Decl. ¶¶ 24-30; Rovetti Decl. ¶¶ 8-13. Even before EO-25 was issued, they proactively adopted recommendations and guidelines from the Centers for Disease Control and Prevention ("CDC"), National Abortion Federation to reduce the spread of COVID-19, while continuing to comply with all relevant Tennessee laws and regulations governing abortion. Terrell Decl. ¶ 19; Looney Decl. ¶ 25; Rovetti Decl. ¶ 8.

For example, the Providers have postponed or cancelled non-essential procedures such wellness visits. Terrell Decl. ¶ 26; Looney Decl. ¶ 26; Rovetti Decl. ¶ 8. They screen patients for symptoms over the telephone prior to their appointments and when they arrive at the clinics prior to entering the facilities to ensure that no one experiencing symptoms of COVID-19 enters the clinic. Terrell Decl. ¶¶ 20-21; Looney Decl. ¶ 27; Rovetti Decl. ¶¶ 9, 11. Based on the particularized needs of each facility, the Providers maintain social distancing by, for example, staggering appointments, asking patients to wait outside the clinic until their appointment, prohibiting patients from bringing a support person to their appointment, keeping patients in separate rooms whenever possible, and spacing patients a minimum of six feet apart during their time in the clinic. Terrell Decl. ¶ 22; Looney Decl. ¶ 28; Rovetti Decl. ¶¶ 9, 11-12. At any given time, the Providers have fewer people inside the clinic than they normally had before the COVID-19 pandemic. Terrell Decl. ¶ 23; Looney Decl. ¶ 26; Rovetti Decl. ¶¶ 8-9. Where medically appropriate, several of the Providers have reduced the number of staff in the clinic and restricted the number of staff in the room during procedural abortion to only those who are medically

essential or required by law. Terrell. Decl. ¶¶ 23-24; Rovetti Decl. ¶ 24. Additionally, the Providers continuously disinfect chairs, doorknobs, pens, clipboards, and other frequently touched surfaces throughout the day. Terrell Decl. ¶ 27; Looney Decl. ¶ 28; Rovetti Decl. ¶¶ 8, 12.

Abortion care does not require the use of any hospital resources that may be needed for COVID-19 response such as hospital beds, ICU beds, or ventilators. Looney Decl. ¶ 30. Indeed, procedural abortion takes place in an outpatient setting. *Id.* Procedural abortion involves only minimal use of PPE: typically gloves, a surgical mask or reusable plastic face shield, and either reusable scrubs or a disposable gown or smock. *Id.* ¶ 29; Terrell Decl. ¶¶ 30; Rovetti Decl. ¶ 24. None of the Providers stock the N95 respirators that are in short supply during this COVID-19 pandemic. Looney Decl. ¶ 30; Terrell Decl. ¶ 29; Rovetti Decl. ¶ 24. Procedural abortion after approximately 18 weeks LMP requires more PPE than a procedural abortion at an earlier point in pregnancy, because it is typically a two-day procedure at that stage. Looney Decl. ¶ 50. Nevertheless, as explained *infra*, abortion care requires vastly less PPE than continuing a pregnancy. The provision of abortion care in Tennessee does not deplete hospital resources and the Providers have made every effort to conserve PPE and minimize the spread of COVID-19 while still providing this time-sensitive, essential healthcare to patients. *Id*. ¶¶ 24, 30; Terrell Decl. ¶ 33; Rovetti Decl. ¶ 24.

D. EO-25's Threat to End Abortion Access and Harm Patients While Undermining Its Own Objectives

EO-25 threatens severe harms to patients while undermining its stated goals. These harms will only be exacerbated if, as experts predict, the COVID-19 crisis lasts well past April.

First, some patients will be unable to obtain an abortion at all because they will pass the limit when abortion care is available in Tennessee while EO-25 is in effect, or will be unable to obtain an appointment in Tennessee in time, even after EO-25 is lifted, because of a surge in

demand. Following the expiration of EO-25, there will be a severe backlog of patients seeking access to abortion. Looney Decl. ¶ 46. Only one provider in the state (PPTNM) provides abortions after 15 weeks LMP, and it will not have capacity to care for the number of patients who will need services *Id*. Forcing all of the patients still able to obtain an abortion in Tennessee to attempt to obtain them in the same narrow window of time—after EO-25 expires and before they reach the point in pregnancy at which abortion is no longer available in the state—will create a crush of demand that health centers are unlikely to be able to meet. *Id*.; Terrell Decl. ¶ 46. Further, there will be a cascading effect in which patients at earlier gestational ages will be forced to delay procedures so patients who would otherwise be denied care entirely can be treated first. Terrell Decl. ¶ 46. The 48-hour mandatory delay, in conjunction with this backlog, will push patients to have later procedures with greater risks and expense, or prevent women from accessing abortion in Tennessee entirely. *Id.*; Looney Decl. ¶¶ 47-50.

In addition to violating their fundamental right to determine if, when, and how to have a child or add to their existing families, these patients will face dramatically increased medical risks. Looney Decl. ¶¶ 10, 34-38. A patient who is forced to carry an unwanted pregnancy to term faces increased risk of death. Tr. Vol. 2, 65:19-66:7 (Young); Looney Decl. ¶ 10. More recent maternal mortality data in the U.S. reflect even higher maternal mortality rates, and Tennessee, in particular, has higher maternal mortality rates than the national average. Tr. Vol. 2, 65:19-12 (Young). In contrast, data published by the Centers for Disease Control and Prevention (CDC) concerning mortality associated with abortion confirms that rates are extremely low: 0.6 deaths per 100,000 abortions. Tr. Vol. 2, 66:13-19 (Young).

Even an uncomplicated pregnancy stresses the patient's entire physiology, including the increased risks associated with caesarean or vaginal delivery, which entails risks of hemorrhage,

infections like chorioamnionitis or endometriosis, and increased risks of preeclampsia or eclampsia. Tr. Vol. 2, 66:20-67:15 (Young); Looney Decl. ¶¶ 34, 36. Patients who are forced to carry unwanted pregnancies to term also face increased risks of preterm delivery and premature rupture of membranes. Tr. Vol. 2, 66:20-67:15 (Young); Looney Decl. ¶ 55.

Forcing patients to remain pregnant against their will is also directly at odds with EO-25's stated purposes: it *increases* in-person contact within the health care system and demands far greater quantities of PPE and other medical resources than allowing patients to end their pregnancies without needless delay.[16] Patients who are forced to continue a pregnancy will have to have prenatal visits—typically once a month, or more often for patients with high-risk pregnancies or preexisting conditions—as well as pregnancy-related screenings and tests, including multiple ultrasounds, blood tests, and glucose tests. Looney Decl. ¶ 31. Unlike abortion, for which complications and hospital transfers are extremely rare, *see* Terrell Decl. ¶ 29, Looney Decl. ¶ 9, one in five pregnant women will visit a hospital *prior* to delivery, Looney Decl. ¶ 31. Fifteen to twenty percent of pregnancies end in miscarriage, for which patients will often seek care at a hospital emergency room. Looney Decl. ¶ 35. For all others, the pregnancy will end in childbirth, which typically involves a multi-day hospital admission. Looney Decl. ¶ 33.

Every time a pregnant person presents to the hospital for evaluation prior to labor, which could happen multiple times, they will be interacting with more people and increasing the hospital's use of PPE. *Id*. An actual birth—attended by multiple medical care providers—could involve anywhere from seven to ten gowns, masks, and sterile gloves. *Id.* For an uncomplicated

[16] *See also* Rupsa C. Boelig et al., *Expert Review: MFM Guidance for COVID-19*, Am. J. Obstetrics & Gynecology MFM (Mar. 19, 2020) (recommending that, even during the COVID-19 pandemic, pregnant people should have multiple in-person visits for routine ultrasounds and laboratory work throughout pregnancy).

pregnancy, the patient is going to remain in the hospital at least 24-48 hours; for a caesarean section ("C-section") even longer; and for a more complicated pregnancy, potentially even longer still. *Id.* Again, this means that the patient will require use of a hospital bed or room, and will require the time and attention of hospital staff, who will have to use PPE during interactions with the patient. *Id.* Even an uncomplicated pregnancy can suddenly become life-threatening during labor and delivery and lead to injury. *Id.* ¶ 36. Furthermore, one-third of pregnancies result in a C-section delivery. *Id.* Even though C-section deliveries are relatively common, they are still significant abdominal surgeries that carry risks of hemorrhage, infection and injury to internal organs. *Id.*

Moreover, the COVID-19 crisis has increased the likelihood that pregnant people will be sent to an emergency department. *Id.* ¶ 37. ACOG has recommended that, "given the lack of data and experience with other coronaviruses such as SARS-CoV and MERS-CoV, diligence in evaluating and treating pregnant women is warranted."[17] *Id.* Accordingly, ACOG recommends that pregnant women reporting certain potential COVID-19 symptoms—including symptoms that are common during pregnancy for unrelated reasons, such difficulty breathing should "immediately seek care in an emergency department or equivalent unit that treats pregnant women," be isolated if possible, and "adhere to local infection control practices including personal protective equipment." *Id.*[18]

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[17] *See also* Ctrs. for Disease Control & Prevention, *Information for Healthcare Providers: COVID-19 and Pregnant Women*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/pregnant-women-faq.html (last updated Apr. 3, 2020) (indicating that pregnant women "have changes in their bodies that may increase their risk of some infections" and "have had a higher risk of severe illness when infected with viruses from the same family as COVID-19 and other viral respiratory infections, such as influenza.").

[18] *See* Am. Coll. of Obstetricians & Gynecologists and Soc. for Fetal-Maternal Med., *Outpatient Assessment and Management for Pregnant Women With Suspected or Confirmed Novel Coronavirus (COVID-19)* (Apr. 10, 2020), https://www.acog.org/-

Second, EO-25 will delay access to safe, essential, and time-sensitive abortion care for over two weeks, and likely longer if it is extended. *See* Terrell Decl. ¶ 15; Looney Decl. ¶¶ 57-58; Rovetti Decl. ¶¶ 22-23. This conflicts with medical and public health guidance. As ACOG and other leading medical organizations recently emphasized in a joint statement, "Abortion Access During the COVID-19 Outbreak," abortion is an essential procedure that cannot be delayed. Looney Decl. ¶ 20.[19] The statement stresses that: "To the extent that hospital systems or ambulatory surgical facilities are categorizing procedures that can be delayed during the COVID-19 pandemic, abortion should not be categorized as such a procedure" because it "is an essential component of comprehensive health care" and "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible." *Id.*[20]

The American Medical Association ("AMA"), American Nurses Association, and American Hospital Association also issued a statement "urging the public to #StayHome as we reach the critical stages of our national response to COVID-19," but stressing that "[o]f course, those with urgent medical needs, including pregnant women, should seek care as needed." *Id.*[21] Likewise, the AMA noted its regret that "elected officials in some states are exploiting this moment to ban or dramatically limit women's reproductive health care." *Id.*[22] This leading organization of American physicians—the very people on the front lines in fighting the virus—voiced its

/media/project/acog/acogorg/files/pdfs/clinical-guidance/practice-advisory/covid-19-algorithm.pdf?la=en&hash=2D9E7F62C97F8231561616FFDCA3B1A6.

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

[20] *Id.*

[21] Am. Med. Ass'n, Am. Hosp. Ass'n, and Am. Nursing Ass'n, *AMA, AHA, ANA: #StayHome to confront COVID-19* (Mar. 24, 2020), https://www.ama-assn.org/press-center/press-releases/ama-aha-ana-stayhome-confront-covid-19.

[22] Patrice A. Harris, President, AMA, AMA Statement on Government Interference in Reproductive Healthcare (Mar. 30, 2020), https://bit.ly/2X4OAjT.

opposition to "government intrusion in medical care" at this critical moment in our nation's history, emphasizing that physicians and patients "should be the ones deciding" which medical services "need to be performed, and which ones can wait." *Id.*

Although abortion is extremely safe throughout pregnancy, delay in accessing care may endanger patients' health. *Id.* ¶¶ 20, 49. The timing of when a patient is able to access abortion care is critical, because it determines which procedure(s) a patient may be eligible to receive. *Id.* ¶¶ 14, 50; Tr. Vol. 2, 64:1-14 (Young); Adams Dep. 79:25-80:17. Similarly, timing is important because while abortion is extremely safe throughout pregnancy, the risks increase as pregnancy progresses, and the later in pregnancy a patient accesses a procedural abortion, the more likely she is to experience a rare complication like hemorrhage, uterine perforation, cervical laceration or retained products of conception. Tr. Vol. 2, 64:15-23 (Young); Looney Decl. ¶ 49. Aside from the increased risks of the procedure, it is also distressing for patients to be forced to wait to have a procedure once they are certain of their decision. Tr. Vol. 2, 83:8-24 (Young); Looney Decl. ¶ 49.

Pushing patients to obtain care later in their pregnancies also directly contradicts EO-25's stated goals by *increasing* the duration and frequency of patient interactions with the outside world and the use of PPE, even for patients who are still able to obtain an abortion. Looney Decl. ¶ 50. EO-25 will delay some patients to the point when they must have a more complicated procedural abortion using the D&E technique rather than the aspiration technique, which requires more time in the clinic and a larger number of staff than aspiration abortion. *Id.*; Rovetti Decl. ¶ 23. Other patients will be delayed past 18 weeks LMP and so will need a two-day procedural abortion. *Id.* Patients will have to travel to Nashville or Memphis for these procedures, the only places where such procedural abortions are available. *Id.* ¶¶ 2, 15.

Third, some patients, rather than wait for EO 25 to expire—or because they simply cannot afford to wait—may attempt to travel hundreds of miles out of state to try to obtain an abortion. Looney Decl. ¶ 51; Rovetti Decl. ¶ 25. This requires them to overcome all of the logistical barriers and costs associated with accessing abortion care out-of-state, virtually all of which are exacerbated by the COVID-19 crisis. Looney Decl. ¶ 51. These patients are also likely to obtain abortions later than they would were they able to access care within the state, which—as noted above—entails greater risks and costs than an earlier procedure. *Id.* ¶ 52. And efforts to travel are also likely to expose both patients and other people to additional risk of contagion as patients navigate the childcare, transportation, food, and lodging necessary to make the trip at a time when states, including Tennessee, and public health experts have urged their citizens to reduce travel and stay at home as much as possible in order to reduce the rate of transmission of COVID-19. *Id.* This will only further undermine the State's efforts to contain the virus because these contacts increase the risk of contracting COVID-19 and bringing the virus back to families and communities in Tennessee. *Id.*

Fourth, when patients cannot access services to terminate a pregnancy within the healthcare system, some will find ways to do so outside the healthcare system, not all of which may be safe. Looney Decl. ¶ 56. If attempts to self-induce give rise to additional health problems, some patients may be forced to seek emergent medical care, increasing their interactions with the outside world and further taxing the medical system as it works to respond to the COVID-19 crisis. *Id.*

Failure to comply with EO-25 carries criminal penalties, which may in turn trigger disciplinary action against licensees. *See* Exhibit 7; Tenn. Comp. R. & Regs. 1200-08-10-.03(1); Tenn. Code Ann. § 63-6-214. Absent immediate relief from the Court, EO-25 will continue to ban

virtually all abortions in Tennessee after eleven weeks LMP, and even earlier among patients for whom medication abortion is not appropriate. Patients will experience extreme delays in seeking abortion care, if they are able to access it at all. Terrell Decl. ¶¶ 45-46; Looney ¶¶ 43-44. Some patients with the means to travel will seek abortion care outside the state, risking the spread of COVID-19 to others, to themselves, and to their community, and doing nothing to conserve the use of PPE. Looney Decl. ¶¶ 51-52. All of these severe and ongoing harms will fall hardest on poor and low-income people and families.

ARGUMENT

The Providers seek a temporary restraining order and preliminary injunction to prevent EO-25, as applied to pre-viability procedural abortions, from continuing to violate the constitutional rights of Tennessee patients and causing irreparable harm. In ruling on such a motion, the Court considers four factors, all of which weigh heavily in the Providers' favor: (1) a substantial likelihood of success on the merits; (2) substantial threat of irreparable injury; (3) that the injury to the Providers outweighs any harm the injunction might cause Defendants; and (4) that granting the injunction will not disserve the public interest. *Am. Civil Liberties Union Fund of Mich. v. Livingston Cty.*, 796 F.3d 636, 642 (6th Cir. 2015) (quoting *Bays v. City of Fairborn*, 668 F.3d 814, 818–19 (6th Cir. 2012)).

As several federal district courts have already held when faced with comparable executive orders prohibiting abortion care, the Providers are entitled to injunctive relief. EO-25 effectively bans pre-viability abortions in Tennessee after 11 weeks LMP (and even earlier for some patients), contravening decades of binding Supreme Court precedent. Even under the "undue burden" test that applies to laws regulating (rather than banning) abortion, EO-25 fails: it imposes substantial burdens on patients that outweigh any benefits. Indeed, rather than protecting public health, EO-

25 undermines its stated goals by forcing people to carry unwanted pregnancies to term, seek abortions later in pregnancy, seek abortion care out of state, or attempt to self-induce an abortion, leading to far more person-to-person contact with healthcare providers and greater use of essential resources, including hospital capacity and PPE. Accordingly, a temporary restraining order and injunctive relief is necessary to prevent severe and irreparable harm to the Providers' patients; is consistent with the balance of hardships; and serves the public interest.

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

The Providers are certain to succeed on the merits of their claim that EO-25 violates their patients' liberty rights under the Fourteenth Amendment and does not further its asserted interests. Indeed, several district courts have already rapidly reached that conclusion in similar cases. *See Preterm Cleveland* at 6; *Robinson* at 28; *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2, 5.

1. A COVID-19 ban on pre-viability abortions contravenes decades of U.S. Supreme Court and other precedent.

It is axiomatic that a State may not ban pre-viability abortion. *Casey*, 505 U.S. at 879 (holding that "a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability"); *see also Roe*, 410 U.S. at 163–64. Nearly a half-century ago, the U.S. Supreme Court recognized that the U.S. Constitution protects a woman's right to abortion, *Roe*, 410 U.S. at 153–54. A state may proscribe abortion only *after* viability, and even then it must allow abortion where necessary to preserve the life or health of the patient. *Id.* at 163–64. *Casey*'s adoption of the "undue burden" standard, under which "a provision of law [restricting pre-viability abortion] is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion," "d[id] not disturb the central holding of *Roe v. Wade*." 505 U.S. at 878-79. The Court again reaffirmed this core principle of constitutional law in 2016. *See Whole Woman's*

Health, 136 S. Ct. at 2299 (stating a law is invalid if it bans abortion "before the fetus attains viability" (quoting *Casey*, 505 U.S. at 878)).

Indeed, the Sixth Circuit has struck down laws that would inhibit "the vast majority of second-trimester abortion," recognizing that it would "clearly have the effect of placing a substantial obstacle in the path of a woman seeking a pre-viability abortion." *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201 (6th Cir. 1997); *see also EMW Women's Surgical Ctr., P.S.C. v. Meier*, 373 F. Supp. 3d 807 (W.D. Ky. 2019) (striking down ban on a second-trimester abortion method). Courts across the nation have come to the same conclusion.[23] This is because the availability of abortions for *some* women "does not [] alter the nature of the burden" that a ban on pre-viability abortion imposes on women who do not fall within an exception to that ban. *Isaacson v. Horne*, 716 F.3d 1213, 1227 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014).

Here, EO-25 operates as a ban on all abortions after 11 weeks LMP, and even earlier for patients ineligible for medication abortion. EO-25 acts as a complete ban on abortions in Tennessee, at minimum, for any person whose pregnancy will be past 19 weeks, 6 days LMP by April 30, 2020, the current expiration date of the Order. But in reality, it will act as a complete

[23] *See, e.g.*, *Edwards v. Beck*, 786 F.3d 1113, 1116 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 895 (2016); *Little Rock Family Planning Servs. v. Rutledge*, 397 F. Supp. 3d 1213 (E.D. Ark. 2019) (enjoining ban on abortions after eighteen weeks of pregnancy), *appeal docketed*, No. 19-2690 (8th Cir. Aug. 9, 2019); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 981 (2016) (ban on abortions after six weeks); *Jackson Women's Health Org. v. Dobbs*, 945 F.3d 265 (5th Cir. 2019) (ban on abortions starting at fifteen weeks); *Isaacson v. Horne*, 716 F.3d 1213, 1217, 1231 (9th Cir. 2013), *cert. denied*, 134 S. Ct. 905 (2014) (ban on abortions starting at twenty weeks); *Jane L. v. Bangerter*, 102 F.3d 1112, 1117–18 (10th Cir. 1996), *cert. denied*, 520 U.S. 1274 (1997) (ban on abortions starting at twenty-two weeks); *Sojourner T. v. Edwards*, 974 F.2d 27, 29, 31 (5th Cir. 1992), *cert. denied*, 507 U.S. 972 (1993) (ban on all abortions with exceptions); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1368–69, 1371–72 (9th Cir. 1992), *cert. denied*, 506 U.S. 1011 (1992) (ban on all abortions); *Bryant v. Woodall*, 363 F. Supp. 3d 611, 630–32 (M.D.N.C. 2019) (ban on abortions starting at twenty weeks).

ban for many more as the need for EO-25 is tied to the pandemic, which is expected to last for many more weeks, if not months.[24] Indeed, EO-25 itself supersedes a prior order that was scheduled to end on April 13, 2020.[25] Moreover, even if EO-25 is lifted on April 30, 2020, the backlog of patients will take several weeks to resolve, resulting in an even greater number of patients experiencing delays while trying to access abortion care or unable to get an abortion in Tennessee at all. Looney Decl. ¶¶ 46-48. For all these reasons, EO-25's application to procedural abortion should be struck down as an unconstitutional previability ban. *See Robinson* at 32-33 ("It is abundantly clear that the medical restrictions in the state health order are unconstitutional to the extent that they prevent a woman from obtaining an abortion before viability.").

2. EO-25 imposes an undue burden on people seeking access to abortion after 11 weeks LMP.

Defendants may argue that because of the current crisis, this Court should look to case law applying the "undue burden" balancing test to evaluate abortion *regulations* rather than the uniform precedent striking down pre-viability abortion *bans*. *See Whole Woman's Health*, 136 S. Ct. at 2309. That standard "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309. Even assuming *arguendo* that there could be emergency circumstances that could justify a State forcing people to remain pregnant against their will, the application of EO-25 to pre-viability abortions would be unconstitutional. Banning abortions after 11 weeks of pregnancy during the COVID-19 health and

[24] *See* Denise Grady, *Not His First Epidemic: Dr. Anthony Fauci Sticks to the Facts*, N.Y. Times, Mar. 8, 2020, https://www.nytimes.com/2020/03/08/health/fauci-coronavirus.html.
[25] *See* Governor Bill Lee, *Executive Order No. 18, An Order To Reduce the Spread of COVID-19 By Limiting Non-Emergency Healthcare Procedures* (Mar. 23, 2020), https://publications.tnsosfiles.com/pub/execorders/exec-orders-lee18.pdf.

economic crisis will undermine the very public health interests EO-25 purports to serve while causing other significant, irreparable harm.

As numerous district courts have already held, enforcing similar COVID-19 executive orders to ban procedural abortion is an "undue burden" on patients seeking to exercise their constitutional right. *Robinson* at 35 (finding it "substantially likely" that the medical restrictions at issue "pose an 'undue burden,' *Casey*, 505 U.S. at 786, that is so extreme that the restrictions effect 'a plain, palpable invasion of rights secured by the fundamental law,' *Jacobson*, 197 U.S. at 31"); *Preterm Cleveland* at 6 ("enforcement creates a substantial obstacle in the path of patients seeking pre-viability abortions"); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2-3 (holding Oklahoma imposed an "undue burden" on abortion access by imposing requirements that effectively deny a right of access to abortion).

EO-25, which operates as a ban on abortion after 11 weeks LMP, imposes severe burdens. The ban is in effect until at least April 30, 2020, and may be extended for weeks or even months, pushing many abortion patients past the date at which abortion care is available in Tennessee. Terrell Decl. ¶ 43; Looney Decl. ¶ 58. These patients will suffer far greater health risks associated with continued pregnancy and childbirth, as well as the emotional and financial burdens of carrying an unwanted pregnancy to term.

Moreover, even if some patients delayed by EO-25 are still eligible to obtain a legal abortion when EO-25 is lifted, many will be forced to undergo a procedure that entails greater risk and is more complicated and more expensive than a procedure available earlier in pregnancy. Looney Decl. ¶ 50. Abortion procedures after 15 weeks of pregnancy are only available at two health centers in the state, and none of the Providers perform abortions beyond 19 weeks and 6 days; patients pushed past this gestational age will not be able to obtain an abortion in the state at

all. Terrell Decl. ¶ 43; Looney Decl. ¶¶ 2, 15, 44. Thus, EO-25 overwhelmingly harms individuals seeking an abortion.

In addition to unnecessarily increasing the health risks to patients, delays caused by EO-25 will impose burden in the form of anxiety, anguish, and pain. *See supra* Section D. Delay can also increase the cost of abortion care, as well as the costs of travel, childcare, and in some cases time off work. *See, e.g.*, *Whole Woman's Health*, 136 S. Ct. at 2314-18; *Planned Parenthood of Wis. v. Schimel*, 806 F.3d 908, 919 (7th Cir. 2015); *McCormack v. Hiedeman*, 694 F.3d 1004, 1016-17 (9th Cir. 2012); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1356-60 (M.D. Ala. 2014). These burdens are exacerbated for poor and low-income patients in Tennessee. *See supra* Section D. The COVID-19 public health emergency deepens these burdens, leaving many people out of work, with children neither in school nor in childcare, and with restricted transportation options and limited or risky access to the support people on whom they might otherwise rely on for transport or childcare. *See supra* section A.

While the Providers share the Governor's commitment to preserving "personal protective equipment for emergency and essential needs" and preventing "community spread of COVID-19," a ban on all abortion care after 11 weeks LMP does not serve those interests. Nearly all abortions in Tennessee are provided in outpatient facilities, not hospitals, and require limited use of PPE. Looney Decl. ¶ 29; Terrell Decl. ¶ 29; Rovetti Decl. ¶ 24. In contrast, under current medical guidelines, even during the COVID-19 emergency, pregnant patients are advised to make multiple trips to healthcare facilities to obtain prenatal care, pregnancy screening, and, ultimately, labor and delivery, and possible C-section procedures, requiring vastly more PPE, hospital resources, and contact than procedural abortion care. *See supra* Section D. By preventing abortions from going

forward, EO-25 will lead to greater use of PPE, not less. *See id.*[26] Indeed, ACOG recommends close monitoring of pregnant patients and immediate hospitalization upon display of common pregnancy symptoms because they could be a manifestation of COVID-19. *Id.* Ultimately, pregnant patients will require care from health care providers using PPE, and much more so if they carry to term. *Id.*

Likewise, delaying patients in accessing abortion ultimately requires increased use of PPE. Even if EO-25 is limited to April 30, 2020, this delay will push patients to have longer and more complex procedures, including in some cases two-day procedures, that require more person-to-person contact and PPE. Looney Decl. ¶ 50; *see Pre-Term Cleveland II*, 2020 WL 1673310, at *2 (noting that a procedural abortion performed later in pregnancy requires more PPE). Alternatively, women will face increased travel and contacts outside of their communities to obtain an abortion in another state, potentially using public transportation, even though public health experts have advised the public to minimize activities outside the home. *See supra* Section D.

Well before EO-25 was issued, the Providers had already implemented extensive precautionary measures to prevent transmission of COVID-19 while continuing to offer essential care. Terrell Decl. ¶¶ 17-27; Looney Decl. ¶¶ 24-30; Rovetti Decl. ¶¶ 8-13. The Providers could make further progress in preserving PPE, as well as reducing overall contagion risks during the pandemic, were Defendants willing to temporarily waive medically unnecessary abortion restrictions that limit the Providers' ability to adapt to this crisis—such as Tennessee's requirement that patients make an extra trip to the health center 48 hours in advance to receive state-mandated

[26] *See, e.g.*, Rupsa C. Boeling, et al., *MFM Guidance for COVID-19*, Am. J. of Obstetrics & Gynecology (*available online* Mar. 19, 2020), https://www.sciencedirect.com/science/article/pii/S2589933320300367 (recommending reduced prenatal visits and increased use of telemedicine where possible, but providing that certain in-person visits, such as ultrasound and lab work, are necessary).

information before returning for an abortion. *See* Tenn. Code Ann. § 39-15-202(a)-(h); Rovetti Decl. ¶¶ 8-13.

In sum, even if banning or restricting abortion during the COVID-19 crisis would result in some small, temporary preservation of PPE at abortion clinics and small, temporary reduction in person-to-person interactions at abortion clinics, it will only be pushing those same pregnant patients into other medical settings where they will need more PPE and have more in-person encounters. Because EO-25 provides no benefit while causing significant harm, it violates the undue burden test.

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

The State may argue that language plucked from a 1905 case, *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), rather than the Supreme Court's articulation in *Roe, Casey,* and *Whole Woman's Health* of the applicable standard when the right to abortion is at stake, governs the determination of whether EO-25's previability ban on abortion is constitutional. Such a suggestion, however, would be premised on a fundamental misunderstanding of *Jacobson*.

Far from granting states unfettered authority, modern constitutional law recognizes *Jacobson* as one of the early cases recognizing a liberty interest in declining medical treatment and treats *Jacobson* as having "balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990). Accordingly, when citing *Jacobson* today, courts recognize that it does not supplant the modern substantive constitutional test applied to the right in question. *See, e.g.*, *Kanuszewski v. Mich. Dep't of Health & Human Servs.*, 927 F.3d 396, 419–20 (6th Cir. 2019) (applying strict scrutiny to substantive due process claim, even where the challenged program "may be an example of a state's proper exercise of its *parens-patriae* role" (citing *Jacobson*, 197 U.S. at 38)); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348, 352–

54 (4th Cir. 2011) (assuming strict scrutiny applies to free exercise challenge to vaccination requirement) (citing *Jacobson*, 197 U.S. at 12). The Supreme Court in *Casey* characterized *Jacobson* as "recognizing limits on government power" and cited *Jacobson* in support of its holding that "a State's interest in the protection of life falls short of justifying a plenary override of individual liberty claims." *Casey*, 505 U.S. at 857.

Jacobson itself recognizes that a state's powers to secure the health and safety of the public are limited. Here, EO-25 is not a proper exercise of that power for two reasons: *first*, a state may not, "under the guise of exerting a police power," invade rights guaranteed by the Constitution; *second*, a state may not exercise its police power in an arbitrary manner that fails to actually serve the State's asserted interests. *Jacobson*, 197 U.S. at 25, 28-29, 31 ("[N]o rule prescribed by a state . . . shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument.").

First, the plaintiff in *Jacobson* failed to demonstrate that the challenged mandatory smallpox vaccination violated his constitutional rights under the Fourteenth Amendment. *Id*. at 31.[27] Here however, by banning abortions prior to viability, EO-25 contravenes decades of Supreme Court precedent. Among those "rights secured by the fundamental law" recognized by the Supreme Court since it decided *Jacobson* is the right to reproductive autonomy. The Supreme Court has repeatedly recognized that the right to control one's reproductive life is "central to personal dignity and autonomy," and "central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992). *See* Alabama

[27] The liberty interest against vaccination remains weaker than the liberty interest in abortion. Even outside of the context of crises like the smallpox outbreak in *Jacobson* (i.e., when state police power is heightened), courts have rejected arguments that mandatory vaccinations violate the Constitution's protections for liberty. *See, e.g., Phillips v. City of New York*, 775 F.3d 538, 542 (2d Cir. 2015).

decision f. 10 ("The *Jacobson* Court--writing long before the development of modern substantive-due-process jurisprudence--found no clear invasion of any fundamental right. . . . But here, a fundamental right is clearly at issue."). As discussed at greater length above at Section I.1, under binding Supreme Court precedent, states cannot ban abortion prior to viability. Just four years ago, the Supreme Court reiterated that, because the right to abortion is fundamental, state intrusions on that right are subject to heightened judicial review. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309-10 (2016). Where, as here, the burdens outweigh the benefits, then the state's action constitutes "a plain, palpable invasion of rights" under *Jacobson.* See Alabama decision (holding under either the undue burden or *Jacobson* framework, "the plaintiffs have shown a substantial likelihood that, if read to effect a postponement of any abortion not required to protect the life and health of the mother, the medical restrictions are unconstitutional."); *see also Wong Wai v. Williamson*, 103 F. 1 (N.D. Cal. 1900) (enjoining state action targeting Chinese population because it deprived them of equal protection and liberty).[28]

As to the second limit on a state's police power recognized in *Jacobson*, the Court explained that the "means prescribed by the state" must bear a "real or substantial relation to the protection of the public health and the public safety." *Jacobson*, 197 U.S. at 31; *see also Women's Kansas City St. Andrew Soc'y v. Kansas City*, 58 F.2d 593, 598 (8th Cir. 1932). In other words, the State's action must *actually serve* its asserted interests. In *Jacobson*, the plaintiff sought to avoid smallpox vaccination, alleging harms to his health, but because "most of the members of the medical profession" and "high medical authority" agreed that smallpox vaccination furthered the

[28] Federal courts across the country have refused to abdicate their duty to step in where, as here, states have exercised their police powers to eliminate or unduly burden abortion access. *See S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *5 (citing *Jacobson*, 197 U.S. at 31); *Preterm Cleveland* at 6; *Robinson* at 6.

state's interest in protecting public health and safety, the Court held the statute was a proper exercise of police power. 197 U.S. at 23-24, 31, 35.

Here, however, as discussed *supra* in Section D, EO-25 frustrates, rather than serves, its stated goals of preserving personal protective equipment for emergency and essential needs and preventing community spread of COVID-19 through nonessential patient-provider interactions. And unlike *Jacobson*, in the instant case, ACOG and seven other leading medical groups have stated that abortion care constitutes an essential healthcare service that, if delayed or denied, will impose severe health consequences on patients. *See supra* Section D. Likewise, the AMA opposes "government intrusion in medical care" during the COVID-19 crisis, including ""elected officials . . . exploiting this moment to ban or dramatically limit women's reproductive healthcare." *See S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *2-3; *cf. Jew Ho v. Williamson*, 103 F. 10 (N.D. Cal. 1900) (holding resolution quarantining the "Chinese Quarter" after reported diagnoses of bubonic plague "had no real or substantial relation" to the purported public health purpose). Accordingly, Plaintiffs are likely to succeed on the merits of their claim that EO-25's ban on abortion after 11 weeks LMP is unconstitutional.

II. THE PROVIDERS' PATIENTS WILL SUFFER IRREPARABLE HARM IF THE BAN IS ENFORCED.

The Providers' patients will suffer serious and irreparable harm in the absence of a temporary restraining order and preliminary injunction. EO-25 prevents Tennessee patients from exercising their fundamental constitutional right to terminate a pregnancy. The Sixth Circuit has made clear that if "a constitutional right is being threatened or impaired, a finding of irreparable injury is mandated." *Am. Civil Liberties Union of Ky. v. McCreary Cty.*, 354 F.3d 438, 445 (6th Cir. 2003) (emphasis added) (*citing Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *accord Mich. State A. Phillip Randolph Inst. v. Johnson*, 833 F.3d 656, 669 (6th Cir. 2016) ("[W]hen constitutional

rights are threatened or impaired, irreparable injury is presumed." (internal citations omitted)); *Obama for Am. v. Husted*, 697 F.3d 423, 436 (6th Cir. 2012) (same); *see also Taubman Co. v. Webfeats*, 319 F.3d 770, 778 (6th Cir. 2003) ("[T]he loss of constitutional rights for even a minimal amount of time constitutes irreparable harm."). Because EO-25, as applied to procedural abortion care, impairs the Providers' patients' rights guaranteed by the Fourteenth Amendment, it necessarily inflicts irreparable harm and should be enjoined in this application. *See Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 803 (S. D. Ohio 2019) (determining that Ohio's six-week abortion ban "would, per se, inflict irreparable harm" if enforced).

In addition, as many medical professional organizations emphasize, abortion is "a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks [to patients] or potentially make it completely inaccessible."[29] Indeed, for some patients, such a delay will deprive them of their liberty and autonomy to choose abortion at all. Forcing patients to forgo abortion care and remain pregnant against their will inflicts serious physical, emotional, and psychological consequences that alone constitute irreparable harm. *See e.g.*, *Elrod*, 427 U.S. at 373–74; *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 911 (9th Cir. 2014); *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013). Likewise, a delay in obtaining abortion care causes irreparable harm by "result[ing] in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r of Ind. State Dep't of Health*, 896 F.3d 809, 832 (7th Cir. 2018) (alteration in original) (quoting *Van Hollen*, 738 F.3d at 796), *petition for cert. filed*, No. 18-1019 (Feb. 4, 2019). This "disruption or denial of . . . patients' health care cannot be undone after a trial on the merits." *Planned Parenthood of Kan. & Mid-Mo. v. Andersen*, 882 F.3d 1205, 1236 (10th

[29] ACOG et al., *supra* note 1.

Cir. 2018) (internal quotation marks omitted), *cert. denied sub nom. Andersen v. Planned Parenthood of Kan. & Mid-Mo.*, 139 S. Ct. 638 (Mem.) (2018).

Every district court that has considered this question has found that the deprivation of abortion care for a period of weeks or longer would result in irreparable injury. *Robinson* at 53 (holding that any denial of women's "fundamental right to privacy" constitutes irreparable injury); *Abbott*, 2020 WL 1815587 at *6 ("Plaintiffs and their patients will suffer irreparable harm in the absence of a temporary restraining order"); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *6 ("Plaintiffs here have demonstrated imminent, irreparable harm absent entry of injunctive relief, as their patients will be substantially delayed in or prevented from exercising their right to abortion access."); *Preterm-Cleveland* at 7 ("enforcement would, per se, inflict irreparable harm"). This Court should reach the same conclusion here.

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

The Providers' patients will suffer numerous irreparable harms without an injunction, and the requested relief will simply preserve "the status quo that has been in place for more than 40 years since *Roe* was decided, and some 25 years since *Casey* followed." *Preterm-Cleveland*, 394 F. Supp. 3d at 803. As the Sixth Circuit has made clear, "[w]hen a constitutional violation is likely . . . the public interest militates in favor of injunctive relief because it is always in the public interest to prevent violation of a party's constitutional rights." *Am. Civil Liberties Union Fund of Mich.*, 796 F.3d at 649 (alternations in original) (quoting *Miller v. City of Cincinnati*, 622 F.3d 524, 540 (6th Cir. 2010)); *accord Mich. State*, 833 F.3d at 669 (same); *Am. Freedom Def. Initiative v. Suburban Mobility Auth. for Reg'l Transp.*, 698 F.3d 885, 896 (6th Cir. 2012) ("[T]he public interest is promoted by the robust enforcement of constitutional rights . . . ."); *G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994) (same).

Moreover, as set forth more fully above, EO-25 provides no benefits in the context of pregnant patients, who will need medical care in any scenario. And, even if EO-25, as applied to people seeking to end a pregnancy, in fact resulted in a temporary reduction of PPE (which it does not), that benefit would be vastly outweighed by the harm of eliminating abortion access in the midst of a pandemic that increases the risks of either continuing an unwanted pregnancy or traveling to other states in search of time-sensitive medical care. *Robinson* at 54-55 (finding that the "substantial" injuries to patients that would result if some women were "forced to carry their pregnancies to term" vastly outweigh any benefits of the state's order, which did "relatively little" to "preserve healthcare resources and prevent close personal contact"); *Preterm-Cleveland* at 7 ("There is no demonstrated "beneficial amount of net saving of PPE…such that the net saving of PPE outweighs the harm of eliminating abortion."); *S. Wind Women's Ctr. LLC*, 2020 WL 1677094, at *6 (holding that the executive order's plain and palpable deprivation of a fundamental right outweighed the injury the public may suffer if those procedures are allowed to occur).

IV. A BOND IS NOT NECESSARY IN THIS CASE.

Plaintiffs respectfully request a waiver of the Federal Rule of Civil Procedure 65(c) bond requirement. *Appalachian Reg'l Healthcare, Inc. v. Coventry Health & Life Ins. Co.*, 714 F.3d 424, 431 (6th Cir. 2013); *see also Moltan Co. v. Eagle-Picher Indus.*, 55 F.3d 1171, 1176 (6th Cir. 1995) (affirming district court decision to require no bond because of "the strength of [the plaintiff's] case and the strong public interest involved"); *Preterm-Cleveland*, 394 F. Supp. 3d at 804 (waiving bond). This Court should use its discretion to waive the bond requirement here, where the relief sought will result in no monetary loss to Defendants.

CONCLUSION

This Court should grant the Providers' motion for a temporary restraining order and/or preliminary injunction to enjoin Defendants and their officers, agents, servants, employees, and

attorneys, and any persons in active concert or participation with them from enforcing or requiring compliance with the EO-25 as applied to procedural abortions. Most urgently, the Providers seek relief on behalf of patients who are particularly burdened by EO-25 because of the time-sensitive nature of abortion care, including: (1) patients who, in the good faith professional judgment of the provider, will likely lose their ability to obtain an abortion in Tennessee if their procedures are delayed until after April 30, 2020; (2) patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a lengthier and more complex abortion procedure, which is only available at two clinics in Nashville and Memphis, if their procedures are delayed until after April 30, 2020; or (3) patients who, in the good faith professional judgment of the provider, will likely be forced to undergo a two-day procedure—which is only available at two clinics in Nashville and Memphis, and which requires at least three separate visits to the provider—if their procedures are delayed until April 30, 2020. Providers must be allowed to consider all relevant factors, including the patient's medical history, familial circumstances, and any logistical and financial obstacles faced by the patient, in making such a determination.

The Providers' further request that this Court Grant such other and further relief as this Court may deem just, proper, and equitable, including that, during the pendency of EO-25, Defendants and their officers, agents, servants, employees, and attorneys, and any persons in active concert or participation with them be temporarily enjoined from enforcing the Delay Law's in-person counseling requirement.

Dated: April 13, 2020

Respectfully submitted,

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*Admitted *pro hac vice*
**Application for admission *pro hac vice* forthcoming

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing *Memorandum of Law in Support of Motion for Temporary Restraining Order and/or Preliminary Injunction* has been served on the following counsel of record through the Electronic Filing System on this 13th day of April, 2020:

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