UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

CAITLIN BERNARD, M.D., Plaintiff, v. THE INDIVIDUAL MEMBERS OF THE INDIANA MEDICAL LICENSING BOARD, *et al.*, Defendants.	)	Case No. 1:19-cv-1660-SEB-DML

DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

The State of Indiana seeks to ban a single specific abortion procedure—one that entails ripping a live fetus limb-from-limb from the mother's womb. The State has determined that this "brutal and inhumane procedure" will "coarsen society to . . . vulnerable and innocent human life," and the Constitution permits the State to prohibit the procedure in light of this judgment. *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007). In *Stenberg v. Carhart*, 530 U.S. 914, 938, 945 (2000), the Supreme Court invalidated a Nebraska law that prohibited partial-birth abortions because the law did not contain a medical-health exception. Seven years later, *Gonzales upheld* a federal ban on partial-birth abortions—which *also* did not have a medical-health exception—because the federal ban left open safe alternatives to obtain an abortion. 550 U.S. at 164–67. Under these precedents, Indiana's ban on live-fetus dismemberment satisfies the Constitution's requirements twice over: It not only expressly provides a medical-health exception—which by itself is sufficient to ensure the law's constitutionality—but it also, like the statute upheld in *Gonzales*, leaves open multiple safe alternative procedures for second-trimester abortions: labor induction, fetal demise via injection of digoxin, fetal demise via potassium chloride, and fetal demise via umbilical cord transection. The law's challenger, Dr. Bernard, is thus unlikely to succeed on the merits, and the Court accordingly should deny the motion for a preliminary injunction.

STATEMENT OF FACTS

I. The D&E Abortion Procedure

Dilation and evacuation (D&E) is a method of abortion used during the second trimester of pregnancy. Warren M. Hern, *Abortion Practice* 123 (1984). During the first trimester and the early part of the second trimester, doctors perform surgical abortion using aspiration (i.e., suction). *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* 135, 171 (Maureen Paul, E. Steve Lichtenberg, Lynn Borgatta, David A. Grimes, Phillip G. Stubblefield &

Mitchell D. Creinin, eds., 2009). But after 16 weeks of pregnancy, aspiration abortion is no longer feasible because the fetus is too large to be removed from the uterus using suction alone. *Id.* at 171. Consequently, some physicians use the D&E procedure to remove the fetus by dismembering it and removing each part individually. *Id.* at 172. In Indiana, all second trimester abortion procedures, including D&E, must be performed in a hospital or ambulatory surgical center. Ind. Code § 16-34-2-1(2).

A D&E abortion is normally performed as a two-day procedure. Exhibit 1, Patricia A. Lohr, *Surgical Abortion in the Second Trimester*, 16 Reproductive Health Matters 151, 153 (2008). At least 24 to 48 hours in advance of the procedure, the doctor will use osmotic dilators to dilate the cervix in preparation for the procedure. Exhibit 2, Francis Decl. ¶ 10; *Management of Unintended and Abnormal Pregnancy*, *supra* at 160–61. Before the insertion, the doctor may administer either a local anesthetic to the cervix, or the doctor may place the woman under full cervical anesthesia. *Id.* at 161. The doctor then uses a speculum to open the woman's vagina. *Id.* The doctor next inserts an osmotic dilator (most commonly laminaria, a type of seaweed that expands as it absorbs fluid) into the woman's cervix. *Id.* As the laminaria expands, it gradually dilates the woman's cervix. *Id.* The woman may go home overnight and return to the hospital or ambulatory surgical center the next day for the abortion procedure. *Id.* at 162. The woman may require insertion of additional laminaria to achieve the dilation necessary for a D&E procedure, and the doctor may place additional sets of dilators into the cervix between the initial insertion and the performance of the procedure. *Id*. at 163–64.

On the second day, the doctor will administer anesthesia and remove the laminaria, either by hand or by inserting a weighted speculum into the woman's vagina and then using forceps to remove the laminaria. Ex. 2 at 153. Next, the doctor may use a probe to open the cervix further.

Dilation and Evacuation, University of Michigan Medicine (Sep. 5, 2018), https://www.uofmhealth.org/health-library/tw2462. The doctor will then use a cannula connected to a suction machine to remove the amniotic fluid surrounding the fetus from the uterus. Hern, *supra* at 149; Ex. 2 at 153. The physician then uses metal forceps with teeth to reach into the uterus, grasp some part of the fetus, tear it off, and remove it from the woman's body. Ex. 2 ¶ 12. In this manner, the doctor removes the arms, legs, and torso piece-by-piece from the uterus. *Id.* As it is torn limb from limb, the fetus bleeds to death. *Stenberg v. Carhart*, 530 U.S. 914, 958-59 (2000) (Kennedy, J., dissenting).

The fetus's skull, however, is too large for the doctor to remove in one piece. Ex. 2 ¶ 12; Hern, *supra* at 151. The doctor must instead use the forceps to grasp the skull and crush it. Ex. 2 ¶ 12. The physician knows the skull has been crushed when a white substance, the fetus's brain, leaks out of the cervix. Hern, *supra* at 142–43. The doctor can then remove the skull in pieces. Ex. 2 ¶ 12; Hern, *supra* at 151. Finally, the doctor removes the placenta and any remaining fetal parts, and may explore the uterus with a curette to ensure all pieces and tissues have been removed. *Management of Unintended and Abnormal Pregnancy*, *supra* at 173. Suction may also be used to ensure there is no remaining tissue in the uterus. *Id.*

After the abortion procedure, the doctor must collect the removed fetal parts and put them back together to ensure that no fetal tissue remains inside the woman's uterus. *Id.* at 172–73. If the woman retains fetal tissue that did not pass from the uterus naturally, the doctor must surgically remove that tissue, lest it precipitate a serious infection. *Id.* at 228. Once the doctor has accounted for all the fetal parts and the placenta, the abortion is complete.

Possible complications of D&E abortion can arise out of retained tissue or as a direct result of the procedure. Retained tissue can cause bleeding, hemorrhage, and infection, as well as abdominal pain. *Id.* at 228, 230. Hemorrhage, infection, uterine injury (including perforation of the uterus and tearing of the cervix), thrombosis and embolism, and other complications can occur in relation to a D&E abortion. *Id.* at 228–46. Uterine perforations are particularly dangerous, as they can lead to life-threating blood loss, and can require hysterectomy, which results in loss of future fertility. Ex. 2 ¶ 31.

Dr. Bernard claims that the risk of death from childbirth is 10–14 times higher than that from abortion, Pl.'s Mem. 3, but this claim is based on seriously flawed studies, flawed data, and flawed comparisons of deaths from abortion and childbirth. Exhibit 3, Coleman Decl. ¶ 74. The study by Raymond and Grimes relied upon by Plaintiff's expert Dr. Davis, Davis Decl. ¶ 10 n. 5, does not even address abortion-related deaths past the first trimester, even though they constitute 10-12% of US abortions. Ex. 3 ¶ 77. Moreover, the comparison of abortion related death and childbirth related death is often itself flawed. The majority of deaths due to childbirth are the result of conditions or age that do not apply to the typical abortion patient—young healthy women—so maternal mortality statistics overestimate the risk of death associated with carrying to term for most women. Ex. 3 ¶ 81(c). When one uses appropriate data and comparisons, the risk of death resulting from abortion is at a minimum 2 to 4 times higher than that of childbirth. Ex. 3 ¶ 82.

Dr. Bernard claims that women seeking second-trimester D&E abortions are doing so because "the fetus has been diagnosed as having either fatal or profound anomalies or because a physician has indicated that it would be dangerous for the woman to continue the pregnancy" and further claims that a large majority occur because of fatal or profound anomalies, Pl.'s Mem. 6, which is inconsistent with robust national data regarding abortion decisions. Ex. 3 ¶ 14. It is highly

unlikely that 100% of D&E procedures in Indiana occur because of health concerns about the fetus, or for health concerns about the mother or due to rape. Ex. 3 ¶ 16.

The negatives of D&E abortion reach beyond immediate physical complications. Over 150 studies have "shown a statistically significant link between surgical abortions and preterm delivery in future pregnancies." Ex. 2 ¶ 32. One of those studies found that surgical abortion (such as D&E) increased the risk of preterm birth in future pregnancies by 36% after one abortion, and by 96% after two abortions. Ex. 2 ¶ 32.

D&E abortions can also have serious effects on the mental health of both patients and providers. Studies have found that both support staff and physicians can be affected by the D&E procedure, reporting sleep disturbances, strong emotions, and, in the case of physicians, "disquieting" dreams. Ex. 3 ¶ 50. Providers have noted that "there is always violence involved in a second trimester abortion, which becomes acutely apparent at certain moments." Exhibit 4, Lisa Harris, *Second trimester abortion provision: breaking the silence and changing the discourse*, 74, 77 (2008); Ex. 3 ¶ 52. Hern and Corrigan conclude their investigation of the emotional impact of D&E on providers by illustrating the emotional impact the procedure can have: "Some part of our cultural and perhaps even biological heritage recoils at a destructive operation on a form that is similar to our own . . . . The sensations of dismemberment flow through the forceps like an electric current." Exhibit 5, Hern & Corrigan, *What About Us? Staff Reactions to D&E*, Reprinted from 15 Advances in Planned Parenthood, at 7 (1980); Ex. 3 ¶ 51.

The mental health effects can also be devastating for women, who "are not insulated from the violence within their wombs." Ex. 3 ¶ 54. Women, even if they are under sedation at the time of the procedure, will have knowledge of what is happening to them, and to the fetus, and that

knowledge can exacerbate the emotional distress that women receiving second-trimester abortions are already at a higher chance of experiencing. Ex. 3 ¶ 56.

The decision to seek abortion can also be difficult for women, especially in the second trimester. Decision ambivalence is often present in women seeking second-trimester abortion, and those women are often more likely to express difficulty making the decision to have an abortion, have moral or religious objections to the abortion, have a stronger attachment to the fetus, and are more likely to accede to an abortion based on the wishes of others. Ex. 3 ¶ 12.

II. Safe Alternative Procedures

Several safe alternatives to live D&E abortion are available during the second trimester. A physician may induce labor, causing the woman to deliver the fetus, which, not being viable, will die on its own in the comfort of the arms of either the mother or the medical staff. Alternatively, the physician can use a digoxin or potassium chloride injection to ensure fetal demise before dismembering the fetus and removing it from the woman's uterus. Finally, the doctor can transect the fetus's umbilical cord, which will cause the fetus to die before it is dismembered and removed.

A. Induction

A physician can safely abort a pregnancy by inducing delivery of a pre-term fetus that will not survive. Doctors induce labor by administering medication either orally, vaginally, transcervically, or sublingually. *Management of Unintended and Abnormal Pregnancy*, *supra* at 181–84. Several different medications are used to induce labor contractions that may last from a few hours to a full day before the fetus is expelled. *Id.* at 181*;* Exhibit 6, Lynn Borgatta & Nathalie Kapp, *Labor Induction Abortion in the Second Trimester*, 84 Contraception 4, 5 (2011).

During labor, the woman may receive epidural anesthesia to minimize pain. Michigan Department of Health & Human Services, *Second Trimester Labor Induction Abortion*,

https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4909_6437_19077-46297--,00.html. She may also receive additional pain medications and anesthesia if necessary. Exhibit 7, Juan Vargas & Justin Diedrich, *Second-Trimester Induction of Labor*, 52 Clinical Obstetrics and Gynecology 188, 191–92. Because live birth is not the intention of inducing labor in this scenario, the woman may receive as much pain medication as necessary without concern for the effect on the fetus. Ex. 2, ¶ 26. If a live birth does occur, the doctor may administer comfort care to the fetus until it passes naturally.[1] Ex. 2, ¶ 30. In some cases, the doctor may need to remove the placenta surgically, using a curette, as in a D&C abortion. Ex. 2, ¶ 27; *Management of Unintended and Abnormal Pregnancy*, *supra* at 186. However, in most cases, the woman will pass the placenta naturally after the fetus. *Id*. Once both the fetus and the placenta have been expelled from the woman's body, the induction procedure is complete.

Induction abortion, like D&E, has a risk of retained placenta after the delivery, a risk that ranges from 2–10%. Exhibit 8, Premila W. Ashok et. al., *Midtrimester medical termination of pregnancy: a review of 1002 consecutive cases*, 69 Contraception 51, 56-57 (2004); *Management of Unintended and Abnormal Pregnancy*, *supra* at 186; *see also* Ex. 2, ¶ 27. If surgical removal is necessary, it can be achieved using suction in a dilation and curettage procedure. Ex. 2 ¶ 27. This procedure is commonly used by all practicing OB/GYN's, and is much less invasive than a D&E, as it does not involve any fetal parts that could pierce or tear the uterus or cervix. Ex. 2, ¶ 27. Dr. Daniel Grossman, an abortion practitioner and leading abortion researcher, acknowledged that there are no adequate studies that directly compare negative outcomes of D&E and induction abortion, and thus no scientific basis to claim that induction of labor is a greater risk to women than a D&E abortion. Exhibit 9, Daniel Grossman *et al*., *Complications After Second Trimester Surgical*

[1] Abortion of a viable fetus is illegal in Indiana. Ind. Code § 16-34-2-1(a)(3).

and Medical Abortion, 16 Reproductive Health Matters 173 (2008). *See also* Ex. 2, ¶ 23. Induction has been established to be safe for women with a history of prior cesarean sections, with a lower risk of uterine rupture during induction than that posed by D&E, and much less than that of a woman going into full term labor after a cesarean. Ex. 2, ¶ 28.

The National Abortion Federation reports bleeding heavy enough to require a transfusion in less than 1% of second-trimester inductions, and a 2.6% rate of infection requiring antibiotics. *Management of Unintended and Abnormal Pregnancy*, *supra* at 186. Further, the risk of uterine rupture with misoprostol in women with a prior cesarean is 0.28%, a lower risk than is present in a D&E procedure, and far lower than the risk from delivery at term. Ex. 2, ¶ 28; Exhibit 10, Vinita Goyal, *Uterine Rupture in Second-Trimester Misoprostol-Induced Abortion After Cesarean Delivery: A Systematic Review*, 113 Obstetrics & Gynecology 1117, 1119 (2009).

B. Digoxin or potassium chloride injection

Another safe alternative to a standard, live D&E procedure is to induce fetal demise before removing it from the woman's uterus. This alternative ensures that the fetus is already dead and does not experience pain when it is dismembered. A physician can accomplish fetal demise by injecting digoxin either into the fetus or into the amniotic fluid surrounding the fetus, or by injecting potassium chloride directly into the fetus. Exhibit 11, Berry Decl. ¶ 9, 12. The doctor may administer a local anesthetic to numb the woman's abdomen before the injection. Ex. 11 ¶ 13.

The doctor may inject digoxin directly into the fetus, targeting either the head or the trunk, or into the amniotic fluid surrounding the fetus. Ex. 11 ¶ 9. When injected into the fetus, fetal demise occurs within a few hours. Ex. 11 ¶ 14. If the doctor injects digoxin into the amniotic fluid, it will be at least 85% effective in causing fetal death within 24 hours. Ex. 11 ¶ 14. The doctor can insert laminaria into the woman's cervix and inject digoxin or KCL at the same time to streamline

the procedure. Ex. 11 ¶ 8. If the first injection is unsuccessful in inducing fetal demise, the doctor may administer a second injection. Ex. 11 ¶ 16. Once the doctor confirms both fetal demise and proper dilation of the woman's cervix, the doctor may proceed to dismember the now-dead fetus using the same method as a standard D&E.

An abortion doctor can use potassium chloride injections to induce fetal death beginning from 6 weeks' gestation to term. Ex. 11 ¶ 9. Or the doctor can administer digoxin 12 weeks' gestation. Ex. 11 ¶ 12. The doctor must inject potassium chloride directly into the fetal trunk or head, or directly to the fetal heart. Ex. 11 ¶ 9. If administered properly, it will stop the fetus's heart within minutes. Ex. 11 ¶ 9.

Doctors frequently and safely use injections to induce fetal demise in order to avoid violating the federal partial-birth abortion ban. Exhibit 12, Aileen M. Gariepy et. al., *Transvaginal Administration of Intraamniotic Digoxin Prior to Dilation and Evacuation*, 87 Contraception 76, 76 (2013). Complications from the injection itself (as opposed to the subsequent D&E) are rare and usually minor and do not pose great risk of toxicity or infection to patients. Ex. 11 ¶ 11, 12. Complications could arise only from a grossly mistaken and rapid injection of potassium chloride into the body of a woman in a very high dose. Ex. 11 ¶ 11. Finally, there is no evidence that D&Es performed after inducing fetal demise are any more dangerous than D&Es performed on living fetuses. Ex. 11 ¶ 7–8.

C. Umbilical cord transection

Umbilical cord transection involves cutting the umbilical cord to ensure fetal demise. Once the doctor has dilated the woman's uterus using laminaria, the doctor can perform umbilical cord transection immediately before the D&E procedure. Exhibit 13, Kristina Tocce et. al, *Umbilical*

Cord Transection to Induce Fetal Demise Prior to Second-Trimester D&E Abortion, 88 Contraception 712, 713 (2013). The doctor may locate the umbilical cord using an ultrasound machine. *Id.* The doctor can then either use suction to draw out the umbilical cord to transect it, or use forceps to transect the cord near the placenta. *Id.* Transecting the umbilical cord will cause the fetus to hemorrhage, and the fetus will die within a few minutes. Ex. 13 at 714. The doctor may then extract the fetus from the woman's uterus using the same method as a standard D&E. *Id.* at 713. Though passing instruments through the cervix always entails a chance of cervical laceration or uterine perforation, these risks are already possible complications of the D&E procedure, which must necessarily involve the use of medical instruments to extract the fetus. *Management of Unintended and Abnormal Pregnancy*, *supra* at 171–73.

III. The Indiana Dismemberment Abortion Ban

On April 24, 2019, Governor Holcomb signed House Enrolled Act (HEA) 1211 into law. HEA 1211, or the "Dismemberment Abortion Ban," prohibits abortion performed by dismembering a living fetus. The Act defines "Dismemberment abortion" as "an abortion with the purpose of killing a living fetus in which the living fetus is extracted one (1) piece at a time from the uterus through clamps, grasping forceps, tongs, scissors, or another similar instrument that, through the convergence of two (2) rigid levers, slices, crushes, or grasps a portion of the fetus's body to cut or rip it off." Ind. Code § 16-18-2-96.4(a). The Act specifically exempts "an abortion that uses suction to dismember a fetus by sucking fetal parts into a collection container." *Id.* § 16-18-2-96.4(b). The Act then provides that "[a] person may not knowingly or intentionally perform a dismemberment abortion unless reasonable medical judgment dictates that performing the abortion is necessary: (1) to prevent any serious health risk to the mother; or (2) to save the mother's life." *Id.* § 16-34-2-1(c).

On April 25, 2019, Dr. Bernard, an IU Health-Methodist Hospital physician who performs D&E abortions on living fetuses at IU Health-Methodist Hospital and Eskenazi Hospital, Exhibit 14, Bernard Dep. 8:3–7, filed this lawsuit, claiming that the Dismemberment Ban imposes an undue burden on her patients' right to decide whether or not to carry a child to term and violates her patients' right to bodily integrity. Dr. Kathryn McHugh was originally a co-plaintiff in this lawsuit, but was voluntarily dismissed. ECF No. 21. On April 26, 2019, Dr. Bernard moved for a preliminary injunction against enforcement of the law, which will otherwise go into effect on July 1, 2019. Defendants urge this Court to deny that motion.

ARGUMENT

To determine whether a preliminary injunction should be granted, the Court weighs several factors: (1) whether the plaintiff has demonstrated at least a reasonable likelihood of prevailing on the merits; (2) whether the plaintiff has no adequate remedy at law, thus causing irreparable harm; (3) whether plaintiff's threatened injury outweighs the threatened harm the grant of the injunction will inflict on the defendant; and (4) whether granting the preliminary injunction would harm the public interest. *See, e.g.*, *HH-Indianapolis, LLC v. Consol. City of Indianapolis & Cty. of Marion*, 889 F.3d 432, 437 (7th Cir. 2018). Dr. Bernard cannot satisfy any of the preliminary injunction factors, and most particularly fails to demonstrate a likelihood of success on either of her facial constitutional challenges to Indiana's Dismemberment Abortion Ban.

DR. BERNARD CANNOT DEMONSTRATE A LIKELIHOOD OF SUCCESS ON THE MERITS OF HER CLAIMS

I. The Dismemberment Ban Does Not Impose an Undue Burden on a Woman's Right To Decide Whether or Not To Bear a Child

A. The State has a compelling interest in protecting the value and dignity of fetal life by banning a brutal and inhumane procedure

The Dismemberment Ban serves three compelling government interests: (1) it "expresses respect for the dignity of human life," *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007); (2) it "protect[s] the integrity and ethics of the medical profession," *id.*; and (3) it protects women's mental health by "ensuring so grave a choice is well informed," *id.* at 159.

First, the Dismemberment Ban protects the dignity and value of fetal life. When it enacted the federal partial-birth abortion ban at issue in *Gonzales*, Congress found that "[i]mplicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life." *Id.* at 157. The same is true in the case of dismemberment abortions, which entail ripping a living fetus limb-from-limb out of the mother's womb. "The fetus can be alive at the beginning of the dismemberment process and can survive for a time while its limbs are being torn off." *Stenberg v. Carhart*, 530 U.S. 914, 959 (2000) (Kennedy, J., dissenting). Despite evidence that a fetus may react to painful stimuli before 20 weeks' gestation, Ex. 2 ¶ 20, doctors administer no pain medication or anesthesia to the fetus before performing the D&E, Ex. 2 ¶ 21. With the fetus's heart still beating, "the abortionist . . . use[s] instruments to grasp a portion (such as a foot or hand) of a developed and living fetus and drag the grasped portion out of the uterus into the vagina." *Stenberg*, 530 U.S. at 958 (Kennedy, J., dissenting). "The fetus, in many cases, dies just as a human adult or child would: It bleeds to death as it is torn limb from

limb." *Id.* at 958–59. "[T]he abortionist is left with 'a tray full of pieces.'" *Id.* at 959 (citation omitted).

Indeed, even those who perform the D&E procedure recognize its brutality and inhumanity. One former abortionist concluded that "tearing a developed fetus apart, limb by limb, . . . is an act of depravity that society should not permit," for "[w]e cannot afford such a devaluation of human life, nor the desensitization of medical personnel that it requires." George Flesh, *Perspective on Human Life: Why I No Longer Do Abortions*, Los Angeles Times (Sept. 12, 1991), https://www.latimes.com/archives/la-xpm-1991-09-12-me-2729-story.html. And Drs. Warren Hern and Billie Corrigan, who are associated with Planned Parenthood, once described the procedure as "an act of destruction." Ex. 5 at 7. Even Justice Ginsburg argued that the standard D&E "could equally be characterized as 'brutal' . . . involving as it does 'tear[ing] [a fetus] apart' and 'ripp[ing] off' its limbs." *Gonzales*, 550 U.S. at 182 (Ginsburg, J., dissenting) (internal citations omitted). For this reason, dismemberment abortion "requires specific regulation because it implicates additional ethical and moral concerns that justify a special prohibition." *Id.* at 158 (majority opinion).

Second, the Dismemberment Ban protects the integrity of the medical profession by ensuring that doctors do not participate in such a brutal and inhumane procedure. "There can be no doubt that the government 'has an interest in protecting the integrity and ethics of the medical profession.'" *Id.* at 157 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)). The "state's legitimate concern for maintaining high standards of professional conduct extends beyond initial licensing." *Barsky v. Bd. of Regents of Univ.*, 347 U.S. 442, 451 (1954). The State may further this interest by banning procedures that "undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming." *Glucksberg*, 521 U.S.

at 731. Dismembering a living fetus that may have the ability to feel pain, Ex. 2 ¶ 20, "confuses the medical, legal, and ethical duties of physicians to preserve and promote life." *Gonzales*, 550 U.S. at 157. Because "some doctors may prefer not to disclose precise details of the means that will be used," *id.* at 159, a woman who later discovers that her doctor whom she trusted ripped her child apart limb-from-limb may lose faith in the medical profession. The brutality of the procedure might also have an effect on medical professionals themselves, causing some to feel "burnt out." Ex. 5 at 5. The State has a strong interest in preventing such a result by prohibiting gruesome and inhumane procedures.

Finally, the Dismemberment Ban protects women's mental health by ensuring that women seeking abortion do not have a D&E only later to discover the brutal and inhumane way in which the fetus was killed. Again, physicians may prefer not to disclose the details of the procedure, Ex. 14 at 27:1–15, but "[i]t is . . . precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State." *Gonzales v. Carhart*, 550 U.S. at 159. Women who seek second-trimester abortions are "highly vulnerable to a wide range of adverse psychological reactions following an abortion." Ex. 3 ¶ 56. These adverse reactions include substance abuse, anxiety, major depression, suicidal ideation, and suicide. Ex. 3 ¶ 18. Knowledge of the "grossly inhumane" D&E process, combined with that vulnerability could lead to heightened emotional distress for women already vulnerable to adverse mental health outcomes. Ex. 3 ¶ 56.

None of these potential psychological consequences should be surprising. In *Gonzales*, the Court observed that "it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained," 550 U.S. at 159, and "[i]t is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not

know," *id.* at 159–60, that her living child was dismembered in her womb. Indiana's Dismemberment Ban represents an important step toward not only more humane treatment of the fetus, but also greater care for the mental health of the woman choosing abortion.

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The State has an "unqualified interest in the preservation of human life." *Cruzan by Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 262 (1990). The Dismemberment ban serves this interest in preserving human life by recognizing the inherent dignity of the living fetus, safeguarding the ethics of those medical professionals who protect life, and protecting the mental health of women who have abortions. Allowing the dismemberment of live fetuses will lead to the erosion of human dignity by blurring the line between abortion and infanticide. *See Gonzales*, 550 U.S. at 158. Just as the Supreme Court has condemned "such ancient practices as disembowelling while alive, drawing and quartering, public dissection, burning alive at the stake, crucifixion, and breaking at the wheel," *Glass v. Louisiana*, 471 U.S. 1080, 1084 (1985), Indiana now condemns the practice of ripping living children limb-from-limb from their mother's womb.

B. The Supreme Court's decisions in *Stenberg* and *Gonzales* allow bans of specific procedures as long as safe alternatives remain available

The Supreme Court has held that a statute banning a specific abortion procedure does not impose an undue burden on a woman's right to decide whether to bear a child if "other abortion procedures that are considered to be safe alternatives" remain available. *Gonzales v. Carhart*, 550 U.S. 124, 166–67 (2007); *see also Stenberg v. Carhart*, 530 U.S. 914 (2000) (invalidating Nebraska statute because it did not leave open alternative procedures).

The Dismemberment Ban addresses one specific abortion procedure—the standard, live-fetus D&E. It leaves open as alternative methods abortion by induction and D&E following fetal demise (whether caused by chemical injection of umbilical cord transection). The Supreme Court

did not confront this issue in *Gonzales* or *Stenberg*, which concerned partial-birth abortion, or *intact* D&E.

In *Stenberg*, the Court invalidated Nebraska's ban on partial-birth abortions because the statute did not contain an exception allowing the procedure if the health of the mother required it. The Court held that in light of the district court's finding "that D & X significantly obviates health risks in certain circumstances, a highly plausible record-based explanation of why that might be so, [and] a division of opinion among some medical experts over whether D & X is generally safer," the Constitution required Nebraska's law to have "a health exception." 530 U.S. at 936–37. It also discussed at length whether the Nebraska law prohibited D&E abortions as well as D&X abortions, but it concluded that the question "would not be determinative, in light of the [Court's holding that the Constitution required a health exception]." *Id.* at 945.[2] Critically, the statute challenged here *does* have a health exception, which ensures that women's health is protected in the "infrequent occasions" where the prohibited procedure is medically necessary. *Id.* at 934. That the Indiana law includes this exception is by itself sufficient to decide this case: By its very terms, the law will not impose "any serious health risk" on anyone. Ind. Code § 16-34-2-1(c). Unlike the Nebraska law invalidated in *Stenberg*, the Indiana law permits women to obtain the otherwise-prohibited procedure "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 530 U.S. at 921 (quoting *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 879 (1992) (plurality opinion)).

[2] Although the Court suggested that the Nebraska law's apparent prohibition on D&E abortions was an "independent reason[]" for finding the law unconstitutional, *Stenberg v. Carhart*, 530 U.S. 914, 938 (2000), the Court's conclusion on this point was explicitly premised on Nebraska's failure to "deny that the statute imposes an 'undue burden' if it applies to the more commonly used D & E procedure as well as to D & X." *Id.* at 938. *Stenberg* does not provide any reason to believe that the Constitution forecloses a state law that pairs a prohibition on D&E procedures *with* an exception for the mother's health.

On the heels of *Stenberg*, the Seventh Circuit ruled that the Illinois and Wisconsin partial-birth abortion prohibitions did "not differ in any material way from the Nebraska statute at issue in *Stenberg*," and accordingly enjoined enforcement of those statutes. *Hope Clinic v. Ryan*, 249 F.3d 603, 604 (7th Cir. 2001). Like the Nebraska statute in *Stenberg*, the Illinois and Wisconsin statutes did not contain a maternal health exception. *Id.* at 604. But as in *Stenberg*, the issue in *Hope Clinic* was not whether a particular procedure was entitled to constitutional protection, but whether sufficient alternatives for a safe, legal abortion remained such that banning a specific procedure would not produce an undue burden. The Seventh Circuit ruled against the Wisconsin and Illinois laws based solely on the *Stenberg* ruling and did not inquire into the availability of other safe alternatives for second trimester abortions.

In *Gonzales*, the Court upheld the federal Partial-Birth Abortion Ban Act of 2003, which defined partial-birth abortion as an abortion where the fetus was vaginally delivered to specified anatomical landmarks, after which medical personnel took some intentional action to kill the fetus. 550 U.S. at 142. The Act was upheld by the Supreme Court, despite being quite similar to the statute at issue in *Stenberg*, because "alternatives are available to the prohibited procedure," such that the Act "d[id] not construct a substantial obstacle to the abortion right." *Id.* at 164–65. To be sure, the Court in *Gonzales* specifically mentioned standard D&E as an available alternative procedure, but the Court did not hold that standard D&E was either a *necessary* alternative or the *only* alternative to partial-birth abortion. As with the Nebraska statute in *Stenberg*, moreover, the federal partial-birth abortion ban in *Gonzales* did not include an exception for the health of the mother. But the Court nevertheless held that a health exception was unnecessary because safe alternatives existed, including "an injection that kills the fetus" which would then "allow[] the doctor to perform the procedure." *Id.* at 164. The same is true here.

Taken together, *Stenberg*, *Gonzales*, and *Hope Clinic* show the determinative issue is not whether a specific procedure has been banned, but whether a prohibition on a specific procedure will threaten the health of the mother. Where, as here, the statute includes an exception for the mother's physical health *and* safe alternatives remain available, the statute is clearly constitutional.

While other courts have blocked enforcement of statutes that ban D&E procedures, these decisions represent a misapplication of the "safe alternatives" standard from *Gonzales* and *Stenberg*. Some courts have misinterpreted *Gonzales* and *Stenberg* to invalidate bans on D&E abortion *per se*. *See Northland Family Planning Clinic v. Cox*, 487 F.3d 323, 330 (6th Cir. 2007); *Whole Women's Health v. Paxton*, 280 F.Supp.3d 938, 945 (W.D. Tex. 2017) (*appeal pending*); *see also Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127 (3d Cir. 2000); *Causeway Med. Suite v. Foster*, 221 F.3d 811, 812 (5th Cir. 2000). Notably, the statutes in *Northland Family Planning Clinic* and *Causeway Med. Suite* did not include health exceptions.

Other courts have confused the *Gonzales* "safe alternatives" standard with the balancing test of *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). In *Gonzales*, the Court held that "state and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty." 550 U.S. at 163. But then, in *Hellerstedt*, the Court, while citing *Gonzales* with approval, held that courts must not defer to legislatures to "resolve questions of medical uncertainty." 136 S. Ct. at 2310. The only way to reconcile these two cases is to apply the *Hellerstedt* standard to laws protecting maternal health and the *Gonzales* standard to laws banning specific abortion procedures. Yet in *West Alabama Women's Center v. Williamson*, the Eleventh Circuit rejected this argument, holding instead that *Hellerstedt* applies to "all abortion cases." 900 F.3d 1310, 1326 (11th Cir. 2018) (cert. pet. filed). Similarly, in *Planned Parenthood Southwest Ohio Region v. Yost*, the district court refused to "defer to the State's factfinding." No. 1:19-

CV-00118-MRB, 2019 WL 1758488, *15 (S.D. Ohio Apr. 18, 2019). And in *Hopkins v. Jegley*, the court declined to accept an argument that, where there is medical uncertainty, it is the place of legislatures to resolve the issue. 267 F.Supp.3d 1024, 1058 (E.D. Ark. 2017). *See also EMW Women's Surgical Center v. Meier*, No. 3:18-CV-00224-JHM, 2019 WL 2076553, at *10 (May 10, 2019) (appeal filed) (applying the *Hellerstedt* balancing standard).

These approaches all misunderstand the Supreme Court's abortion jurisprudence. Holding that D&E bans are invalid *per se* disregards *Gonzales*'s holding that a procedure-specific ban is constitutional as long as it leaves open safe alternative procedures. 550 U.S. at 165. Similarly, applying the *Hellerstedt* balancing test to a procedure-specific ban ignores the Court's command that where there is "documented medical disagreement," courts must "give[] state and federal legislatures wide discretion to pass legislation." *Id.* at 162–63. *Hellerstedt* simply held that, in the context of women's health regulations, "nothing in Texas' record evidence . . . shows that . . . the new law advanced Texas' legitimate interest in protecting women's health." 136 S. Ct. at 2311. Here, the State has introduced substantial evidence that the Dismemberment Ban does not impose an undue burden because adequate safe and legal alternative abortion methods exist.

C. Evidence demonstrates safe alternatives to dismemberment abortion

Here, not only does Indiana's statute have an exception where a D&E is necessary to safeguard the mental health of the woman, but also multiple safe, effective, and feasible alternatives to a live-fetus D&E abortion exist: (1) induction, (2) fetal demise by digoxin injection, (3) fetal demise by potassium chloride injection, and (4) fetal demise by umbilical cord transection.

1. Doctors may induce delivery of a non-viable fetus in the second trimester

Induction abortion is a safe alternative to dismemberment abortion that does not add a substantial amount of time, pain or risk to the abortion process. Where the woman's health is in danger

or the fetus has a lethal anomaly, the "most OB/GYN's who do not perform abortions . . . will induce labor," rather than perform a D&E procedure. Ex. 2 ¶ 24. This procedure is both safe and effective: There is no reliable evidence that labor induction is any more dangerous than D&E. Ex. 2 ¶ 35. And some women even prefer an induction abortion because it leaves them with an intact fetus to grieve. Ex. 2 ¶ 15.

Because fetal tissue and accompanying tissues (such as the placenta) will be expelled naturally as a result of the inducement, abortion-by-induction also does not carry with it the risks associated with the insertion of instruments into the cervix and uterus that is inherent with the D&E procedure. *Dilation and Evacuation*, University of Michigan Medicine (Sep. 5, 2018), https://www.uofmhealth.org/health-library/tw2462 (explaining that the risks of D&E include "injury to the uterine lining or cervix."). And the risk of uterine rupture in connection with an induction abortion is far less than in connection with a D&E because there is no insertion of metal instruments into the uterus and no sharp fragments of fetal body parts that could accidentally be left behind. Ex. 2 ¶ 27–28.

Induction abortions are also a feasible alternative to dismemberment abortions. In fact, both Dr. Bernard and her colleague Dr. Hua Meng currently offer inductions as an alternative for their patients. Ex. 14 at 25:20-25; Exhibit 15, Meng Dep. 22:11-14. When asked if she offers both D&E and inductions to her patients, Dr. Bernard replied "[a]lways" and "[a]bsolutely." Ex. 14 at 25:20, 26:2. The timeline for both procedures is thus roughly the same. Dismemberment abortions require one visit for insertion of laminaria to dilate the cervix, and a second visit, usually 24 hours later, to undergo the abortion procedure itself. For an induction abortion, that procedure is the induction of labor, a process that can take anywhere from a few hours to a full day. While labor may last several hours longer than the 15 to 30 minutes necessary for a D&E procedure, it does not require

an extra trip to the hospital to dilate the woman's cervix the day before the procedure. Consequently, the full amount of time needed for labor induction may actually be less than for D&E. *See* Ex. 2 ¶ 34.

Dr. Bernard claims that labor induction "may involve hours of pain." Pl.'s Mem. 8. But inducing labor to deliver a non-viable fetus does not entail significant discomfort, as pain medication can be administered at any time without concern for impact on the fetus because a live birth is not the goal of the process. Michigan Department of Health & Human Services, *Second Trimester Labor Induction Abortion*, https://www.michigan.gov/mdhhs/0,5885,7-339-73971_4909_6437_19077-46297--,00.html; Ex. 7 at 191–92. There is "no reason" for a woman undergoing an induction to feel any pain at all, as "[e]pidural analgesia or IV narcotics" can relieve "most, if not all," pain a woman may experience in the induction process. Ex. 2 ¶ 26.

Dr. Bernard argues that induction, like D&E, carries a risk of retained tissue after the procedure. Pl.'s Mem. 8. However, the risk of this complication occurs in only 2–10% of induction cases. Ex. 8 at 186; Exhibit 16, Ashlesha Patel et. al., *Adequacy and safety of buccal misoprostol for cervical preparation prior to termination of second-trimester pregnancy*, 73 Contraception 420 (2006). *See also* Ex. 2, ¶ 27. Should retained tissue need to be removed, a D&E would not be the only option, as Dr. Bernard asserts. The much less invasive and very common dilation and curettage procedure could be used, without the danger of sharp fetal parts to damage the cervix or uterus. Ex. 2 ¶ 27. Infection and heavy bleeding as a result of retained tissue are risks of both procedures. Ex. 2 ¶ 28; *Management of Unintended and Abnormal Pregnancy*, *supra* at 186, 228–230. While uterine rupture can occur as a result of induction, Pl.'s Mem. 8, the risk of uterine rupture with misoprostol in women with a prior cesarean is 0.28%, a *lower* risk than is present in a D&E procedure. Ex. 2, ¶ 28; Ex. 10 at 1117.

Finally, Dr. Bernard argues that "the vast majority of patients, when given the alternatives of labor induction or D&E, will elect D&E." Pl.'s Mem. 8. Dr. Bernard overlooks the evidence of a strong preference in D&E patients for *fetal demise* before a D&E. Exhibit 17, Rebecca A. Jackson et. al., *Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo-Controlled Trial* 97 Obstetrics & Gynecology 471, 474 (2001) (subjects of the study "reported a strong preference for fetal death before abortion"). *See also* Ex. 3 ¶ 10, 47–48.

Regardless, *Gonzales* requires that alternative procedures be safe, effective, and feasible, not preferable. Indeed, *Gonzales* specifically held that *Casey* should not be interpreted "so it becomes tantamount to allowing a doctor to choose the abortion method he or she might prefer." 550 U.S. at 158. "The Court has not extended constitutional protection to a woman's preferred method, or her 'decision concerning the method' of terminating a pregnancy." *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490, 516 (6th Cir. 2012) (quoting *Benten*, 505 U.S. at 1085 (Stevens, J., dissenting)).

2. Doctors may accomplish fetal demise through injection of digoxin or KCl

Causing fetal demise through chemical injection prior to a D&E abortion is an additional safe and effective method for complying with Indiana's live-fetus D&E ban. Like induction, this alternative does not involve substantial increased time or risk compared to a live-fetus D&E procedure. Inducing fetal demise may also have potential medical benefits, including better priming of the cervix, softening of the fetus, and decreased blood loss as a result of the procedure. Ex. 3, ¶ 45. Inducing fetal demise may also facilitate removal of the fetus from the uterus. *Id.*

a. Defendant's expert Dr. David Berry establishes that "an injection of digoxin is a viable means to cause fetal demise." Ex. 11 ¶ 12. One survey of surgeons indicated that digoxin-

induced fetal demise facilitated second-trimester D&E. Ex. 3, ¶ 45. And in contrast to Dr. Bernard's unsupported claim that digoxin is "almost never performed prior to 18 weeks," Pl.'s Mem. 9, Dr. Berry testifies that intra-amniotic and intra-fetal digoxin both can be administered beginning at 12 weeks' gestation. Ex. 11 ¶ 14.

For intra-cardiac or intra-fetal digoxin injections, a physician delivers the dose by navigating a thin needle to the fetal body with ultrasound guidance. Ex. 11 ¶ 9, 12. For intra-amniotic injection of digoxin, a physician navigates a thin needle through the abdominal wall of the patient, draws a small amount of amniotic fluid into the syringe to confirm the needle is correctly placed in the amniotic sac, and then administers the dose. Ex. 11 ¶ 13. Before the injection, the doctor may administer a local anesthetic to help with the discomfort of the procedure, *id.*, so that it is not "physically and emotionally painful to the patient." Pl.'s Mem. 9.

So long as the required informed-consent 18-hour waiting period has passed, at the same time a woman seeking an abortion receives laminaria into her cervix to start dilation, a physician can inject digoxin into either the fetus or the amniotic fluid. Ex. 11 ¶ 8. The digoxin will cause fetal death within 24 hours, such that fetal demise and full dilation will occur on roughly the same timeline. *Id.* In other words, when the woman returns in 24 hours for the D&E procedure, the digoxin will have had 24 hours to induce fetal death, and the doctor can carry out a D&E procedure on the deceased fetus. Likewise, the administration of this injection is simple and easily learned. According to Dr. Berry, Indiana abortion providers would be able to implement these injections after a small amount of basic hands-on training. Ex. 11 ¶ 10.

The National Abortion Federation notes a 98% efficacy rate within 5 hours of intra-fetal digoxin and cardiac asystole within 1 or 2 minutes after an intra-cardiac injection. *Management of Unintended and Abnormal Pregnancy*, *supra* at 167. *See also* Ex. 11 ¶ 13. Intra-amniotic digoxin

is at least 85% effective within 24 hours. Ex. 11 ¶ 14. If a digoxin injection were to fail, a second dose could be administered. Ex. 11 ¶ 16. If a second dose was for some reason not appropriate, a woman seeking abortion would not be without options, as Dr. Bernard argues. Rather, induction or hysterotomy could be used to complete the abortion procedure. Ex. 11 ¶ 16. If, for some reason, immediate fetal removal was necessary to avoid **"**any serious health risk to the mother" or "to save the mother's life," the law would permit a live-fetus D&E. Ind. Code § 16-34-2-1(c).

Digoxin injection is a safe procedure and, contrary to Plaintiff's contentions, does not "subject women to significant health risks." Pl.'s Mem. 12. Plaintiff's expert Dr. Davis claims that "digoxin has been shown to increase medical risks" and cites two studies to support this opinion. Davis Decl. ¶ 32. One study had several shortcomings (namely that it was a single-institution observational study, leading the authors to warn of the limited the ability to generalize its findings, and the precluded ability to draw conclusions about digoxin safety), and the other concluded not that digoxin created medical risk, but that "intrafetal digoxin injections up to 2 mg appear to be usually safe." Ex. 3 ¶ 44. Indeed, in *Gonzales* the Supreme Court recognized that injections to terminate pregnancies are a "safe alternative." 550 U.S. at 167. Completing a procedure this way does not require any extra insertion of instruments into the cervix and uterus, so it does not increase any risk of infection or tearing of the uterus. *Dilation and Evacuation*, University of Michigan Medicine (Sep. 5, 2018), https://www.uofmhealth.org/health-library/tw2462 (explaining that the risks of D&E include "injury to the uterine lining or cervix."). For that reason, some abortion doctors already use digoxin injections to comply with the federal partial-birth abortion ban. Davis Decl. ¶ 21.

Possible complications are minor and relatively rare. Ex. 11 ¶ 14. One study found that "[i]ntrafetal digoxin injection at a dose of 1.0 mg is safe and effective for fetal demise prior to

pregnancy termination in the second trimester." Exhibit 18, Michael Molaei, et al., *Effectiveness and Safety of Digoxin to Induce Fetal Demise Prior to Second-Trimester Abortion*, 77 Contraception 223 (2008), https://www.sciencedirect.com/science/article/pii/S0010782407005112?via%3Dihub. Further, the National Abortion Federation reports no cases of infection from intra-amniotic digoxin and observes that infection from other injections are "extremely uncommon." *Management of Unintended and Abnormal Pregnancy*, *supra* 168. The injection could be harmful if the doctor injects the digoxin directly into the woman's bloodstream, but digoxin toxicity is "trivial to absent" in fetal demise injections due to the small amount administered into a space outside of the woman's circulation. Ex. 11 ¶ 15.

b. Like digoxin injection, potassium chloride injection is a safe and effective way to induce fetal death before a D&E procedure. Potassium chloride must be injected into the fetal heart or umbilical cord, and causes fetal death within minutes of administration. Ex. 11 ¶ 9. Thus, the injection adds no additional time to the abortion procedure—it can be done a few minutes before the doctor begins a D&E procedure.

Again, no evidence shows that intra-fetal potassium chloride injections cause maternal health problems. In the largest study of mid-trimester use of potassium chloride for termination of pregnancy (239 patients at a median gestational age of 22 weeks) no failures or complications occurred. Ex. 11 ¶ 11. And, on the whole, only a single, anomalous reported case of maternal cardiac complications from an attempted KCl injection exists. *Id.* Also like digoxin, this injection itself has minor complications that occur only rarely, so it adds no substantial risk to the D&E procedure. Ex. 11 ¶ 11. In fact, the risk of such an event occurring is so low that the National Abortion Federation's guidelines provide that routine monitoring of the patients' vital signs or

EKG is not even necessary during or after the KCl injection. Ex. 11 ¶11; *Management of Unintended and Abnormal Pregnancy*, *supra* at 167. It does not require the extra use of instruments in the cervix or uterus, and the risk to the mother of having potassium chloride injected into her body and not the body of the fetus exist only in cases of gross physician malpractice. Ex. 11 ¶ 11. Moreover, potassium chloride is, in the experience of Doctor Berry, 100% effective. Ex. 11 ¶ 9. Like digoxin injection, doctors currently use this to comply with the federal partial-birth abortion ban. Davis Decl. ¶ 21.

c. Digoxin and potassium chloride injections are not "technically difficult for the doctor." Pl.'s Mem. 9. On the contrary, Dr. Berry testified that "a provider who can perform a D&E safely has the skill needed to perform an intra-fetal injection," and "any provider capable of performing an amniocentesis, a common and simple procedure, can easily deliver an intra-amniotic injection of digoxin." Ex. 11 ¶ 12. Dr. Bernard admits she "know[s] of one physician who does or has" administered an injection to cause fetal demise. Ex. 14 at 28:16–19. She maintains that "the majority of physicians performing D&E abortions do not perform separate procedures aimed at inducing fetal demise prior to the abortion" Pl.'s Mem. 9. However, this assertion is contradicted by published empirical data. Ex. 3 ¶ 41, 84. No data supports the proposition that most physicians do not attempt to induce fetal demise, and one study found that 52% of 105 providers routinely induced fetal demise before abortion. Ex. 3 ¶ 42, 46.

Dr. Bernard says she is "not sure" whether anyone at IU Health could teach her to perform fetal demise procedures or how long it would take her to learn how to do it. Ex. 14 at 29:5–22. When asked whether he would learn fetal demise procedures if the Dismemberment Ban goes into effect, Dr. Meng simply responded, "I do not know," and "I do not have an answer to that." Ex. 15 at 25:9–16. In contrast, Dr. Berry testified that "a single, hands-on weekend conference" would

be sufficient and that he personally would be willing "to train physicians nationwide . . . if they are simply willing." Ex. 11 ¶ 18.

3. Doctors may induce fetal demise through umbilical cord transection

Umbilical cord transection is yet another safe, effective, and feasible method of inducing fetal demise and complying with Indiana's dismemberment abortion ban, for it poses no additional risks compared to a standard D&E procedure. While it does involve inserting instruments into the cervix and uterus, so does a standard D&E procedure. To argue that one additional insertion of instruments creates a substantial amount of increased risk ignores the nature of the D&E procedure itself, which requires many passes with either forceps or a curette to clear the uterus of all fetal parts. *Dilation and Evacuation*, University of Michigan Medicine (Sep. 5, 2018), https://www.uofmhealth.org/health-library/tw2462. This method has not been studied as extensively as the other three methods, but there is no evidence that it is in any way riskier than the standard D&E procedure that it would precede.

The umbilical cord transection procedure, by causing the fetus to hemorrhage, is also very effective and does not add a significant amount of extra time to the abortion procedure—it takes only a few minutes to complete. Ex. 13 at 713–14.

Dr. Bernard argues that there is no way for a physician to know if the tissue grasped during this procedure is the umbilical cord or fetal tissue, and thus no way to protect against performing an unlawful dismemberment abortion. However, Tocce et. al., in their study of umbilical cord transection, noted that though rarely needed, ultrasound guidance can be used to extract the umbilical cord. *Id.* at 713. If a physician is concerned about grasping fetal tissue, ultrasound guidance can be used to locate the umbilical cord and make sure it is the only tissue grasped before transection. And because the law prohibits "knowingly or intentionally perform[ing] a dismemberment

abortion" only "with the purpose of killing a living fetus," physicians performing this procedure who unintentionally or accidentally damage to the fetus before death would not be subject to criminal penalties. Ind. Code §§ 16-34-2-1(c), 16-18-2-96.4(a).

D. The Dismemberment Ban will not impose an undue burden on a large fraction of women between 16 and 20 weeks' gestation

To determine if a regulation would place an undue burden on women seeking abortion, courts must determine if the regulation would "operate as a substantial obstacle to a woman's choice to undergo an abortion" in a "large fraction" of the cases in which the regulation is relevant. *Planned Parenthood of Se. Pennsylvania v. Casey*, 505 U.S. 833, 895 (1992). Notably, Dr. Bernard does not even bother to apply this standard. *See* Pl.'s Mem. 18–24.

In order to apply the "large fraction" test, this Court must first calculate the relevant denominator. "The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894. The law is unconstitutional only if it imposes an undue burden on a large fraction of these women.

Here, the relevant denominator for purposes of the large fraction test is those women who, absent the ban, would have a dismemberment abortion, and the numerator is the subset of those who, because of the ban, would be unable to have an abortion all. Dr. Bernard testified that she can perform aspiration abortions—which are specifically exempted from the Dismemberment Ban, Ind. Code § 16-18-2-96.4(b)—up to 15 weeks' gestation. Ex. 14 at 11:10–20. However, some sources say that doctors may perform aspiration abortions up to 16 weeks' gestation using a 16 mm large-bore cannulae. *Management of Unintended and Abnormal Pregnancy*, *supra* at 171; Ex. 1 at 153–54. Even if the doctor needs to use forceps to extract some of the larger fetal parts, such as the calvarium or spine, *see Management of Unintended or Abnormal Pregnancy*, *supra* at 171,

the doctor can still use aspiration to induce fetal demise, making the statutory prohibition inapplicable, *see* Ind. Code § 16-18-2-96.4(a). On the other end, Indiana law prohibits abortion past 20 weeks' gestation. *Id.* § 16-34-2-1(a)(3). Consequently, the Dismemberment Ban is an actual, rather than irrelevant, restriction at most for women seeking abortion between 16 and 20 weeks' gestation, and of those, who would otherwise have a live-fetus D&E (rather than, for example, abortion-by-induction or pre-D&E fetal demise).

Of these women, only those for whom a safe alternative procedure is not available are unduly burdened by the Dismemberment Ban. *See Gonzales*, 550 U.S. at 166–67 ("The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health, given the availability of other abortion procedures that are considered to be safe alternatives."). Between 16 and 20 weeks' gestation, multiple safe alternative procedures are available: induction, digoxin injection, potassium chloride injection, and umbilical cord transection. *See supra* Part I.C. (explaining that each alternative is safe, effective, and feasible). None of these procedures would add a substantial amount of time or pain to the procedure.

Both Dr. Bernard and Dr. Meng testified that they *already* offer induction abortions in addition to D&E. Ex. 14 at 25:20–26:5; Ex. 15 at 22:11-14. And Dr. Bernard offers no evidence showing that a large fraction of the 27 abortions in 2018 that were achieved using the live-fetus D&E procedure could not have been achieved through induction (or some other method). With only two Indiana physicians even providing D&Es, and with such a small number occurring each year, it is entirely plausible that all could be accomplished using induction.

What is more, Dr. Berry's testimony makes clear that fetal demise procedures are simple to perform and easy to learn. Dr. Berry himself learned potassium chloride injection not in medical school, but during his fellowship, as "a physician's training does not end after completion of

his/her residency." Ex. 11 ¶ 10. Dr. Berry states that learning the procedure is easy, and that a single, hands-on weekend conference would provide enough training to learn the procedure, Ex. 11 ¶ 18.

The independent personal choices of a two doctors not to learn a new procedure to better serve patients does not constitute a state-imposed burden on a woman's abortion decision. For example, in *June Medical Services. v. Gee*, the Fifth Circuit found that the failure of some abortion doctors "to seek admitting privileges in good faith" was an "independent personal choice" that severed the link of causation between Louisiana's admitting privileges requirement and any burden imposed by the doctors' failure to comply with the law. 905 F.3d 787, 810–11 (5th Cir. 2018). Similarly, Dr. Bernard's and Dr. Meng's unwillingness to learn a new procedure severs the link of causation between the Dismemberment Ban and any unavailability of alternative procedures.

II. The Dismemberment Ban Does Not Violate a Woman's Right to Bodily Integrity

The Dismemberment Ban does not threaten a violation of bodily integrity. Unconstitutional violations of bodily integrity occur when the government intrudes into a citizen's life and exerts some kind of force upon their person, not when the government regulates elective choices. *See Rochin v. California*, 342 U.S. 165, 209–10 (1952) (holding that police officers then demanding a physician forcibly pump the stomach of a suspect was a violation of the Due Process Clause). The Dismemberment Ban only acts to regulate the D&E procedure when it is chosen electively, *not* when it is medically required. Ind. Code § 16-34-2-1(c). Regulation of elective choice is not the same as imposing governmental force on an individual. The government in this instance plays a passive, regulatory role, not the active role that characterizes cases involving violations of bodily integrity.

Proscription or limitation of a specific medical procedure is not, in general, a violation of a constitutional right. In *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997), the Court upheld a total ban of physician-assisted suicide in the State of Washington. There, under Fourteenth Amendment Due Process analysis, the court held that there was no right to assistance in the commission of a suicide, and that the interests of Washington were legitimate and rationally related to the statute. *Glucksberg*, 521 U.S. at 728, 735. In coming to its decision, the Court stated though "many of the rights and liberties protected by the Due Process Clause sound in personal autonomy," the "sweeping conclusion that any and all important, intimate, and personal decisions are so protected" was not warranted. *Id*. at 727 (citing *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33–35 (1973)). The Court also recognized Washington's interests in the preservation of human life, protecting the integrity of the medical profession, protecting vulnerable groups, and avoiding the path towards euthanasia as "unquestionably important and legitimate." *Id.* at 728–35.

Plainly, the right to abortion stands as an exception to the rule exemplified by *Glucksberg*. But, accordingly, any claim that an abortion regulation violates a constitutional right must be addressed under the abortion-right framework, not under some novel, free-standing theory of a right to bodily integrity. Consequently, the Supreme Court and circuit courts have applied the undue burden test to analyze abortion cases since the decision in *Casey*. *See, e.g.*, *Planned Parenthood Sw. Ohio Region v. DeWine*, 696 F.3d 490, 509 (6th Cir. 2012) ("The Supreme Court has made clear that abortion regulations, even those limiting access to a certain kind of procedure, are analyzed under the undue-burden framework and not the classic physical-intrusion framework."); *see also W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1326 (2018) ("[T]he question in all abortion cases is whether 'the purpose or effect of the [law at issue] is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'" (quoting *Whole*

Woman's Health v. Hellerstedt, 136 S. Ct. 2292, 2300 (2016))). The undue burden test, not the right to bodily integrity, is the correct lens through which courts must view abortion rights. Accordingly, Plaintiff is unlikely to succeed on the merits of her "right to bodily integrity" claim.

PLAINTIFF HAS NOT DEMONSTRATED IRREPARABLE HARM

In order to prevail on a motion for a preliminary injunction, Dr. Bernard must establish that the denial of such an injunction will result in irreparable harm. *Winter v. Nat'l Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). "'Irreparable' in the injunction context means not rectifiable by the entry of a final judgment." *Walgreen Co. v. Sara Creek Prop. Co., B.V.*, 966 F.2d 273, 275 (7th Cir. 1992) (citations omitted). For the reasons provided above, the Dismemberment Ban challenged by Dr. Bernard is constitutionally permissible because "[a]lternatives are available to the prohibited procedure." *Gonzales v. Carhart*, 550 U.S. 124, 164 (2007). These alternatives, as well as the Indiana law's "serious health risk" exception, demonstrate that Dr. Bernard will continue to be able to provide abortions safely. "The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Id.* at 163. Accordingly, neither Dr. Bernard nor her patients face an imminent risk of irreparable harm.

PUBLIC POLICY AND THE BALANCE OF EQUITIES FAVOR THE STATE

To prevail on a motion for preliminary injunction, Plaintiff "must show that the probability of success on the merits is sufficiently high—or the injury from the enforcement of the order sufficiently great—to warrant a conclusion that the balance of error costs tilts in favor of relief." *Ill. Bell Tel. Co. v. WorldCom Techs., Inc.*, 157 F.3d 500, 503 (7th Cir. 1998). When the party opposing the motion for preliminary injunction is a political branch of government, the restraint for issuing such an injunction is particularly high due to public policy considerations, as "the court

must consider that all judicial interference with a public program has the cost of diminishing the scope of democratic governance." *Id.*

The citizens of Indiana have a strong interest in the implementation of the laws passed by their duly elected representatives. *United States v. Rural Elec. Convenience Coop. Co.*, 922 F.2d 429, 440 (7th Cir. 1991) ("[T]he government's interest is in large part presumed to be the public's interest."); *see also Fargo Women's Health Org. v. Schafer*, 819 F. Supp. 865, 867 (D.N.D. 1993) (denying motion for stay and injunction pending appeal of an abortion statute and reasoning that "the public interest lies in enforcement of statutes enacted by the people's legislature").

The Dismemberment Ban serves the public interest by "express[ing] respect for the dignity of human life," "protecting the integrity and the ethics of the medical profession," and protecting women's mental health by "ensuring so grave a choice is well informed." *Gonzales v. Carhart*, 550 U.S. 124, 157–59 (2007). As in the case of partial-birth abortion, dismemberment abortion "requires specific regulation because it implicates additional ethical and moral concerns that justify a special prohibition." *Id.* at 158. "Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life." *Id.* at 157.

Accordingly, the State's interests in enforcement of the Dismemberment Abortion Ban outweigh the harms that Dr. Bernard's patients might suffer in the near term, pending a final decision on the merits. The law should not be preliminarily enjoined.

CONCLUSION

The Court should deny the Motion for Preliminary Injunction.

Respectfully submitted,

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