IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 21-2480, 21-2573

WHOLE WOMAN'S HEALTH ALLIANCE, *et al.*,

Plaintiffs/Appellees,

v.

TODD ROKITA, in his official capacity as
Attorney General of the State of Indiana, *et al.*,

Defendants/Appellants.

On Appeal from the United States District Court for the
Southern District of Indiana, No. 1:18-cv-01904-SEB-MJD
The Honorable Sarah Evans Barker, Judge

BRIEF AND REQUIRED SHORT APPENDIX OF APPELLANTS

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 21-2480, 21-2573

Short Caption: Whole Woman's Health Alliance, et al., v. Todd Rokita, Attorney General of the State of Indiana, et al.

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N/A

(5) Provide Debtor information required by FRAP 26.1 (c) 1 & 2:

N/A

Attorney's Signature: /s/ Gene C. Schaerr Date: 10/01/2021

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N/A

Attorney's Signature: /s/ H. Christopher Bartolomucci Date: 10/01/2021

Attorney's Printed Name: H. Christopher Bartolomucci

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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Attorney's Signature: /s/ James A. Heilpern Date: 10/01/2021

Attorney's Printed Name: James A. Heilpern

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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Attorney's Signature: /s/ Scott D. Goodwin Date: 10/01/2021

Attorney's Printed Name: Scott D. Goodwin

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Attorney's Signature: /s/ Joshua J. Prince Date: 10/01/2021

Attorney's Printed Name: Joshua J. Prince

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☐ **No** ☑

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

CASES [CONT'D]

CASES [CONT'D]

STATUTES

STATUTES [CONT'D]

OTHER AUTHORITIES

JURISDICTIONAL STATEMENT

Plaintiffs Whole Woman's Health Alliance, All-Options, Inc., and Jeffrey Glazer, M.D. (collectively, Whole Woman's Health) filed this action for declaratory and injunctive relief on June 21, 2018, against Defendants the Attorney General of Indiana (previously Curtis T. Hill, Jr., now Theodore E. Rokita), Commissioner of the Indiana Department of Health Kristina Box, M.D., President of the Medical Licensing Board of Indiana John Strobel, M.D., and St. Joseph County Prosecuting Attorney Kenneth P. Cotter (collectively, the State). The case challenges many of Indiana's abortion regulations as violative of the First and Fourteenth Amendments under 42 U.S.C. section 1983. App. 1–3. The district court had subject matter jurisdiction over the case under 28 U.S.C. sections 1331 and 1343.

On August 10, 2021, the district court issued a partial final judgment and a permanent injunction prohibiting enforcement of several Indiana abortion laws. Short App. 156, 159–61. The district court reserved for later resolution both the facial constitutionality of Indiana's licensing law for abortion clinics under the Equal Protection Clause and the validity of that law as applied to the Whole Woman's Health South Bend Clinic. *Id.* at 10.

On August 12, 2021, Defendants timely filed a Notice of Appeal to the Seventh Circuit seeking review of the partial final judgment and permanent injunction. App. 179. On August 19, 2021, the district court issued an amended final judgment, which clarified that the court "expressly determine[d] pursuant to Fed. R. Civ. Pro. 54(b)" that "there is no just reason for delay in the entry of this judgment," Short App. 169,

and Defendants subsequently filed an amended notice of appeal on August 25, 2021, seeking review of that judgment, App. 191. This Court has jurisdiction over this appeal of final judgment under 28 U.S.C. section 1291.

STATEMENT OF THE ISSUES

The district court's partial final judgment invalidates a spate of longstanding abortion restrictions, which the State now appeals, as follows:

1. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, prohibit non-physicians from performing medication abortions?

2. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, require that second-trimester abortions be performed in a hospital or ambulatory surgical center?

3. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, require that mandatory informed-consent disclosures be provided "in the presence of the pregnant woman" before an abortion?

4. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, prohibit a physician from providing a medication abortion over telemedicine without first examining the woman in person?

5. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, require that surgical abortion clinics maintain scrub facilities as well as procedure rooms and corridors of a minimum size?

6. May Indiana, consistent with the Fourteenth Amendment Due Process and Equal Protection Clauses, require that medication abortion clinics maintain a housekeeping room with a sink, and does an abortion clinic that already complies with that requirement nevertheless have standing to challenge it?

7. May Indiana, consistent with the First Amendment Free Speech Clause and the Fourteenth Amendment Due Process and Equal Protection Clauses, require that women seeking abortion be informed that "human physical life begins when a human ovum is fertilized by a human sperm"?

8. May Indiana, consistent with the First Amendment Free Speech Clause and the Fourteenth Amendment Due Process and Equal Protection Clauses, require that women seeking abortion be informed that "objective scientific information shows that a fetus can feel pain at or before twenty weeks of postfertilization age"?

STATEMENT OF THE CASE

This case began on June 21, 2018, when Whole Woman's Health brought this "global assault" on the Indiana abortion code attacking nearly two dozen of Indiana's abortion laws. Short App. 1. In the three years since, Whole Woman's Health—pursuant to a preliminary injunction modified by an earlier decision of this Court, *see Whole Woman's Health All. v. Hill*, 937 F.3d 864, 868, 879 (7th Cir. 2019)—has begun operating a medication abortion clinic in South Bend, Indiana. *Id.* at 4–5.

At the same time, the disputed issues in the case have narrowed. The district court partially granted the State's motion for summary judgment, rejecting about a

dozen of Whole Woman's Health's claims—including its Due Process Clause challenges to the State's licensure requirement and the State's requirement that an ultrasound be performed at least 18 hours before the abortion. App. 164. And later, Whole Woman's Health filed an amended statement of claims that dropped several remaining claims. *Compare id.* at 164–65 *with id.* at 166–76.

Finally, following a two-phase, seven-day trial (in March and June of 2021), the district court issued a partial final judgment addressing all but two of the remaining claims (the equal-protection facial challenge and due-process as-applied challenge to Indiana's licensure law). Short App. 166. The district court granted judgment for the State on several claims but invalidated the eight provisions of Indiana law at issue in this appeal: (1) the physician-only requirement; (2) the second-trimester hospital/ASC requirement; (3) the in-person counseling requirement; (4) the in-person examination requirement/telemedicine ban; (5) the facility requirements for surgical abortion clinics; (6) the housekeeping room requirement for medication abortion clinics; (7) the human-physical-life disclosure requirement; and (8) the fetal-pain disclosure requirement. It concluded that these eight requirements violate "the Substantive Due Process and Equal Protection Clauses of the Fourteenth Amendment," *id.* at 166–67, and it issued a permanent injunction enjoining their enforcement, *id.* at 159–61, based on the evidence and rationales summarized below. This Court issued a stay of the injunction as to the physician-only law, the second-trimester hospital/ASC requirement, the in-person counseling law, and the in-person examination/telemedicine ban. *See Whole Woman's Health All. v. Rokita*, 2021 WL 4077549 (7th Cir. 2021).

I. The Physician-Only Law

For decades, Indiana has required abortions to be "performed by the physician," irrespective of the gestational age of the fetus or the abortion method used. Ind. Code § 16-34-2-1(a)(1). The Supreme Court has held that physician-only laws are constitutional. *Whole Woman's Health All. v. Rokita*, 2021 WL 4077549, at *1 (7th Cir. Sept. 8, 2021).

The State's experts testified that physicians—compared to less-credentialed medical professionals, such as advanced-practice clinicians (APCs)—are better able to determine the gestational age of the fetus, the location of the pregnancy, and the existence of any contraindications to medication abortion. Second Trial Tr., Vol. II, 152:15–153:25.

The district court made no finding that Indiana's physician-only law suppressed its abortion rates or prevented even one woman from obtaining an abortion. Instead, it found that a "shortage of available physicians" leads to "long wait times often upward of two weeks," that can in turn cause some women to be ineligible for a *medication* abortion—and that, if APCs could perform medication abortions, Indiana abortion clinics would have appointments "five days a week" and reduce the cost of medication abortions "by $70." Short App. 105–07. The district court criticized Indiana for not "updat[ing] its statute to reflect the evolution of medicine"—a failure the court deemed "not constitutionally acceptable," *id.* at 108 n.56—and based on those perceived burdens it held that the physician-only requirement, as applied to first-trimester medication abortions, imposes an undue burden, *id.* at 108–09. Notably, its

injunction categorically prohibits enforcement of this requirement and does not limit performance of medication abortions to APCs. *Id.* at 159.

II. The Second-Trimester Hospital/ASC Requirement

Indiana requires all abortions "after the first trimester of pregnancy" to be performed either "in a hospital or ambulatory outpatient surgical center [ASC]." Ind. Code § 16-34-2-1(a)(2). This rule, too, has already been upheld by the Supreme Court. *Rokita*, 2021 WL 4077549, at *2.

Regardless, the parties stipulated that the risks related to abortion increase with the gestational age of the fetus. Short App. 14. And the State's expert Dr. Byron Calhoun testified that deep sedation—which abortion clinics are not equipped to administer—is indicated for late-term abortions to help keep the patient still while sharp instruments pass through her body. Second Trial Tr., Vol. II, 105:20–106:05. Another of the State's experts, Dr. Nancy Goodwine-Wozniak, testified that hospitals and ASCs are better able to assist with pain management and to minimize the increased risks of complications. *Id.* at 157:22–158:15. Moreover, Calhoun testified that the American College of Surgeons (ACOS) recognizes second-trimester abortion procedures as surgeries and considers it necessary for surgeons to be accredited by a licensed hospital or ASC. *Id.* at 99:18–22.

Whole Woman's Health's witnesses testified that few Indiana hospitals and ASCs perform abortions, with Dr. Caitlyn Bernard explaining that many Indiana hospitals decline to perform abortions for religious reasons. Second Trial Tr., Vol. I,

40:12–18. Bernard further suggested that the hospitals that do provide second-trimester abortions do so only in limited circumstances (where there are severe fetal anomalies or serious risks to the mother's health)—because of policy decisions attributable to the hospital's governing body, not the State. *See id.* at 35:2–4, 40:19–25, 41:1–5, 52:14–16, 115:22–25. And Amy Hagstrom Miller, the President and chief executive officer of Whole Woman's Health, testified that she made a *business* decision not to open an ASC. *Id.* at 98:19–25.

The district court concluded that the hospital/ASC law is all burden and no benefit. It said, for example, that because "no ASC in Indiana provides abortion services" and "only four Indiana hospitals" do so, many Hoosier women seeking second-trimester abortions must travel to Indianapolis or out of State and "secure overnight lodging and child care for two days." Short App. 115. The district court further found that the abortion itself would typically cost "upwards of $20,000." *Id.* And it deemed these travel and financial costs to be "substantial obstacles" for which the State was "not off the hook" just because they result from private business decisions by hospitals and ASCs. *Id.* at 116 & 116 n.58.

On the benefit side of the ledger, the district court concluded that second-trimester D&E abortions "do not necessitate a sterile operating room"—such as those found in ASCs and hospitals—"given that [they] do not require" doctors to make "incisions into sterile tissue." *Id.* at 112. It also deemed complications associated with D&E abortions to be "rare" and declared that the procedure can be "safely performed in out-patient, office-based settings." *Id.* at 113.

III. The In-Person Counseling Requirement

Indiana requires medical personnel to make specified disclosures "in the presence" of the pregnant woman before she obtains an abortion. Ind. Code § 16-34-2-1.1(a)(1), (a)(4), (b)(1). This Court upheld this statute in *A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684 (7th Cir. 2002).

As the State's experts explained, a decision as important as abortion requires an in-person physician-patient interaction. First Trial Tr., Vol. III, 187:6–15, 188:2–13. By meeting with patients in person, physicians are better able to assist the many women who approach the abortion decision either uncertain of their choice or facing coercion from friends or family. *Id.* at 190:2–23; First Trial Tr., Vol. IV, 139:22–140:13, 148:1–18, 149:16–150:5, 153:4–9, 210:5–211:22. Indeed, the district court acknowledged that "in-person interactions yield some benefits in building a trusting relationship between patient and provider," Short App. 130, and that certain categories of vulnerable women "may benefit from in-person counseling as opposed to telemedicine," *id.* at 130 n.64.

The district court also recognized that, even in the absence of the in-person counseling requirement, Indiana women would have to make two trips—the first to an "abortion clinic or its affiliated facility eighteen hours in advance for their pre-abortion ultrasounds," and the second to the clinic for the abortion itself. *Id.* at 132. And because a trip must be made for the concededly valid ultrasound requirement—

and the unchallenged 18-hour waiting period—the in-person counseling (which Indiana law requires happen at the same time as the ultrasound, *see* Ind. Code § 16-34-2-1.1(a)(5)) imposes no *additional* burden.

In response to this difficulty for the plaintiffs, the district court proposed a burden theory no party had suggested—that in-person counseling imposes a burden by precluding the scenario where "[a] woman could … report to the clinic closest to her where a qualified technician conducts the ultrasound and completes the necessary intake information," which "could then be transmitted electronically to a remote physician or APC, who could conduct the counseling session." Short App. 133. The district court hypothesized that this model would "provide greater accessibility to appointments and flexibility in scheduling," *id.*, but it made no finding that Whole Woman's Health—which has only one Indiana facility—would follow it or that any women would experience shorter wait times or lower costs.

The district court concluded that by preventing abortion clinics from adopting the district court's own proposed business model, the in-person counseling requirement causes "an additional week or two" of abortion delay for some "significant number" of women. *Id.* at 131. It did not attempt to quantify the number of affected women, and it did not suggest that the in-person counseling requirement suppresses abortion rates or has ever prevented even one woman from obtaining an abortion—only that the requirement may mean that "a significant number of women" "may" be unable to get a *medication* abortion. *Id.*

IV. The In-Person Examination Requirement and Telemedicine Ban

Indiana requires physicians to "examine a pregnant woman in person before prescribing or dispensing an abortion inducing drug." Ind. Code § 16-34-2-1(a)(1). Until that in-person examination takes place, abortion providers cannot "issue a prescription to a patient … through the use of telehealth" for "an abortion inducing drug." *Id.* § 25-1-9.5-8(a)(4).

The State's experts testified that this requirement benefits Indiana women because a hands-on examination is one important method of detecting contraindications of medication abortions (*e.g.*, excess gestational age, ectopic pregnancy, porphyria, hemorrhagic disorders, pelvic inflammatory disease, fibroids, and the presence of an intrauterine device). First Trial Tr., Vol. III, 129:11–20, 130:8–11, 14–22, 175:1–15, 176:1–19. These requirements also respond to the reality that telemedicine without in-person interactions enables both coerced abortions and the diversion of abortion pills (and accompanying opioid painkillers) to human traffickers or the black market. *Id.* at 182:10–184:21.

The burden theory Whole Woman's Health advanced at trial was based on a proposed site-to-site model for dispensing abortion pills. Under that model, doctors would telecommute to the clinic, while women would still come in-person to the clinic to pick up the abortion medication. First Trial Tr., Vol. I, 9:1–24, 48:12–17. Whole Woman's Health suggested that this model would cut costs, on the theory that it could avoid reimbursing approximately $20,000 per year in physician travel expenses, which would save—at most—$54.64 per abortion (given the 366 abortions Whole

Woman's Health performed at its South Bend Clinic in 2020). *Id.* at 122:1–6, 126:18–25.[1]

Whole Woman's Health also suggested that the in-person examination requirement/telemedicine ban limits the availability of abortions, with Hagstrom Miller testifying that, without these laws, the South Bend Clinic would "be able to book probably half again as many patients" each week, *id.* at 110:14–23, which works out to about three-and-a-half additional appointment slots per week (366/52). But no one testified that more patients would seek abortions and fill those hypothetical additional slots.

The district court did not suggest that the in-person examination requirement or telemedicine ban has prevented any woman from obtaining an abortion. Instead, it focused (1) on how telemedicine would decrease the cost of physician travel by an unspecified amount and (2) on how invalidating those rules would allow providers to "increase appointment days from one or two days a week or month to five days a week." Short App. 138. In light of these costs, while the district court recognized that symptoms requiring an in-person examination "do occur," it concluded that this requirement is "simply unnecessary" for "most women." *Id.* at 43.

V. The Facility Requirements for Surgical Abortion Clinics

Indiana law imposes a variety of facility requirements on surgical-abortion clinics. These provisions require procedure rooms of "at least one hundred twenty

[1] Hagstrom Miller testified that even if travel costs were eliminated, Whole Woman's Health would pass on only "some" unspecified amount of "those savings on to the patient." First Trial Tr., Vol. I, 111:5–10.

(120) square feet," 410 Ind. Admin. Code 26-17-2(d)(1), with a "scrub facility" "provided near the entrance," *id.* 26-17-2(d)(4), and with corridors of a minimum "width" of "forty-four (44) inches," *id.* 26-17-2(e)(5).

Dr. Calhoun testified that these requirements enhance patient safety. Having procedure rooms at least 120 square feet allows adequate space to "get emergency equipment or other personnel" to a patient. Second Trial Tr., Vol II, 103:15–19. And the need for a scrub facility near the entrance of such rooms is self-apparent: "[E]very surgical suite or every outpatient surgical center has the scrub sink right before the door" to ensure clean hands as the physician takes care of the patient. *Id.* at 103:23–104:1. Calhoun further testified that having corridors at least 44-inches wide is "standard" because it allows medical professionals to "get a bed or gurney down the hall or emergency … equipment into the room or down the hallway." *Id.* at 104:2–9.

Whole Woman's Health's expert Dr. Daniel Grossman, meanwhile, opined that the State's room-size regulation is unnecessary because an abortion provider simply needs "a room that's big enough to hold the personnel and equipment," and "a standard exam room is sufficiently sized" (he did not, however, indicate what size makes a room "standard"). Second Trial Tr., Vol I, 186:2–6. Scrub facilities are also unneeded, in Grossman's view, because a first-trimester surgical abortion "is not a sterile procedure in that same way that involves cutting into the body." *Id.* at 187:15–18. And Grossman further testified that the corridor-width requirement is unnecessary be-

cause "[i]t's exceedingly unlikely and rare that a patient . . . ever needs to be transported out of a procedure room by a wheelchair or gurney, . . . and it would never happen to two patients . . . [who] need to pass at the same time." *Id.* at 188:25–189:4.

As to the burdens of these requirements, Hagstrom Miller testified that Whole Woman's Health's South Bend clinic *already* complies with the corridor requirement, *id.* at 86:16–17, and that its exam rooms—which are about 110 square feet—nearly comply with the 120-square-foot room-size requirement, *id.* at 90:9–10. She also explained that while she tried to find a location large enough to open a surgical-abortion clinic that complies with these requirements, no building owner would lease to her "because of the services" that Whole Woman's Health provides. *Id.* at 96:14–21. Hagstrom Miller further testified that she encountered similar difficulties when trying to bring her current location into compliance with the law: Contractors would charge high rates or even quit due to antiabortion sentiment in the area. *Id.* at 90:6–10, 98:14–25.

From this testimony the district court concluded that none of these physical-plant requirements are necessary for first-trimester abortions; indeed, it concluded that they provide no medical benefit at all. Short App. 117. To the district court, a "standard" procedure room (of unstated size) is large enough for first-trimester abortions (negating any need for regulation), gurneys and wheelchairs need not have space to pass in corridors (since emergencies are sufficiently rare), and scrub facilities are unneeded because "sterility" is "not required to safely provide first-trimester" abortions. *Id.* at 120–21. Concluding that these requirements "limit[] the ability of

otherwise qualified clinics to provide first-trimester aspiration" abortions, the district court held them unconstitutional. *Id.* at 121. Once more, however, the district court did not conclude that the requirements would place a substantial obstacle on a large fraction of women or prevent any woman from obtaining an abortion.

VI. The Housekeeping Room Requirement

Indiana requires abortion clinics to have a housekeeping room with a "service sink" and "adequate storage for housekeeping supplies and equipment." 410 Ind. Admin. Code 26-17-2(e)(1). The State's expert Dr. Christopher Stroud testified that such rooms are useful both to ensure that cleaning supplies are kept separate from medical supplies and to segregate hazardous waste. Second Trial Tr., Vol. III, 25:25–26:23.

Whole Woman's Health already has such a closet, but non-party Planned Parenthood, who has never challenged this requirement, does not have one at its Evansville health center (which is not an abortion clinic but might one day like to become one). Second Trial Tr., Vol. I, 90:24–91:6. Notwithstanding the absence of a party injured by this requirement, the district court invalidated it, concluding that abortion clinics can "maintain clean and sanitary medication abortion clinics regardless of whether they maintain housekeeping rooms," and that the requirement might lead women in Evansville to travel "250 miles round trip to obtain medication abortion services." Short App. 118. And again, the district court made no finding this law precluded any women from having an abortion, much less that it affects a "large fraction" of those for whom it is relevant.

VII. The Human Physical Life Informed-Consent Requirement

As part of the informed-consent process for abortions, Indiana law requires physicians to tell women seeking abortion that "human physical life begins when a human ovum is fertilized by a human sperm." Ind. Code § 16-34-2-1.1(a)(1)(E).

The State's expert Dr. Farr Curlin testified that there is "100 percent scientific consensus" on the question of when human physical life begins. Second Trial Tr., Vol. II, 7:9–15. "[A]ny biology textbook … makes clear that each organism, living organism, begins with a fertilized egg." *Id.* "That's when we come into existence. That's when our physical life begins." *Id.* at 7:20–21. He also testified that providing women seeking an abortion with this fact is essential because "[k]nowing that the human embryo or human fetus is a living human being, a living human organism, is important knowledge in deciding whether one is going to take an action that would kill that human being." *Id.* at 9:5–15. In contrast, Dr. Grossman testified that he does not "know what [this statement] means," and disputed that there is "medical consensus about when human life begins." Second Trial Tr., Vol. I at 196:12–197:11.

The district court sided with Whole Woman's Health. It discerned that "human physical life" is not a "medical term" and expressed "concerns" that the State is "attempt[ing] to save this statute through semantics," because—even though the statement as written "convey[s] only biological trivia"—some women might understand it as an "assertion about the moral or ethical personhood of a fetus." Short App. 147–48. The district court therefore concluded that the State cannot require physicians to

inform women that "human physical life begins when a human ovum is fertilized by a human sperm," Ind. Code § 16-34-2-1.1(a)(1)(E). Short App. 147–48.

VIII. The Fetal Pain Informed-Consent Requirement

Indiana's informed-consent disclosure law also requires abortion providers to inform their patients that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." Ind. Code § 16-34-2-1.1(a)(1)(G). And Dr. Maureen Condic, the State's expert in neurobiology, developmental neuroscience, and human embryology, Second Trial Tr., Vol. II, 176:24–177:5, testified that, based on her expertise and extensive review of the relevant literature, the language of the fetal-pain disclosure was "scientifically well-supported," *id.* at 207:5–23, and was therefore "both truthful and not misleading," *id.* at 227:7–15.

She testified that objective scientific evidence shows that the neural circuitry that transmits pain information to the thalamus develops between 12 and 18 weeks of fetal life; the connections between the thalamus and the cortex, meanwhile, do not begin to develop until around 24 weeks. *Id.* at 184:17–185:13; 185:17–186:13.

Condic then addressed Dr. Grossman's assertion that fetal pain is impossible before thalamic connection to the cortex at 24 weeks: She pointed to 12 separate lines of scientific evidence individually and collectively supporting the conclusion that the thalamus, but not the cortex, is necessary and sufficient for the fetus to consciously experience pain. *Id.* at 185:14–191:14. This evidence showed that:

1. animal species lacking a cortex are conscious and capable of suffering, *id.* at 192:7–193:25;

2. decorticate mammals evince consciousness and respond vigorously to painful stimuli, *id.* at 194:2–195:10;
3. humans with an impaired or largely absent cortex evince consciousness and awareness of pain, *id.* at 195:11–198:21;
4. large studies of human consciousness associate impaired consciousness with impairment of the thalamus, not the cortex, *id.* at 198:25–200:4;
5. human apprehension of pain remains fundamentally consistent for decades after birth, despite the cortex's immaturity and development during that time, *id.* at 200:11–201:10;
6. authoritative reviews of the scientific literature have concluded that the neural bases for consciousness and emotions reside at all levels of the nervous system, *id.* at 202:22–203:21;
7. anesthesia studies show that loss of consciousness is linked primarily to loss of activity in the thalamus rather than in the cortex, *id.* at 203:23– 204:24;
8. extensive studies of cortical stimulations show that the cortex processes, but largely doesn't produce, a conscious experience of pain, *id.* at 205:1–206:14;
9. chronic pain can be effectively treated by removing or stimulating parts of the thalamus, but not by similar interventions in the cortex, *id.* at 206:17–207:4;
10. fetuses between 18 and 22 weeks react to painful stimuli with hormonal and physiologic stress responses that anesthesia can relieve, *id.* at 208:25–209:13;
11. based on studies using anesthesia in painful fetal procedures, many anesthesiologists have concluded that the fetus should be anesthetized to prevent pain responses and the known impact of such pain on fetal brain development, *id.* at 209:14–210:21; and
12. as early as 23 weeks of development, premature infants display facial expressions recognizably and reliably associated with conscious suffering, *id.* at 202:14–211:19.

Neither Grossman nor any other witness rebutted any portion of Condic's testimony, nor did Whole Woman's Health present any evidence that even one woman was misled by the disclosure. Nevertheless, the district court accepted at face value Grossman's assertion that Condic's conclusion represents a "fringe view" and concluded that "while this disclosure may not be entirely 'false' in that there appears to be some scientific literature supporting it, it is clearly misleading in the manner in which this information is framed." Short App. 145–46.

SUMMARY OF ARGUMENT

In this "global assault" on Indiana's abortion code, the district court, taking on the role of clinic regulator, enjoined enforcement of eight abortion health-and-safety laws and two informed-consent laws. Multiple grounds justify reversing these injunctions, and a table at the end of this summary should help the Court track them.

This Court embraced some reasons for reversal when it issued a stay of the injunctions as to the physician-only, second-trimester facility, in-person counseling, and in-person-exam/telemedicine laws: Controlling precedents of the Supreme Court and this Court permit each of those laws. And with respect to these and the other laws subject to the undue burden test, multiple additional grounds exist for reversal.

First, the undue burden standard requires a threshold showing that the regulation imposes a "substantial obstacle" to abortion—that is, according to binding precedent, that the law prevents women from having an abortion. The plaintiffs here, however, expressly *disclaimed* that Indiana's abortion laws have caused abortion rates to decrease, and they provided no other proof that the challenged laws have prevented any women from having an abortion. The district court instead accepted as sufficient proof of "substantial obstacle" that an abortion law simply increases the cost of an abortion or causes a delay in obtaining one. Such proof is legally insufficient, and all the undue-burden claims in this case thus fail at this threshold level.

Second, even if incidental costs and delays attributable to an abortion law could constitute a "substantial obstacle" for some women in some instances, the laws at issue could not be facially invalidated unless they impose a substantial obstacle in

a "large fraction" of cases. Yet the district court did not even purport to reach a "large fraction" conclusion for any of the challenged laws except two—the in-person counseling requirement and the second-trimester facility requirement. And even there, its conclusions were groundless, since Whole Woman's Health failed to provide evidence of the proper numerator or denominator as to either law (and, because the 18-hour ultrasound requirement remains in force, the in-person counseling law in particular plainly does not create a substantial obstacle for anyone, let alone a large fraction of women seeking abortion).

Third, even if the "substantial obstacle" and "large fraction" thresholds were met, the district court erred, both legally and factually, in concluding that the burdens of the enjoined laws outweigh their benefits. The difficulty here, of course, is that there is no objective right answer to whether a law's benefits outweigh its burdens, which is why legislatures are ordinarily tasked with providing politically accountable answers to such questions. Regardless, the district court took an unlawful approach to this question, as it refused to accord weight to the State's experts merely because they do not perform abortions: It cannot be that to defend its regulations a State must convince abortion providers to support a regulation's validity in court.

And even beyond that problem, the district court applied the balancing test to flyspeck the details of state regulations—including ones that do not affect any of the parties. Consider its analysis of the facilities requirements (procedure-room size, corridor width, scrub facilities, and housekeeping closet). Even as it accepted the proposition that *some* minimal size was appropriate for a procedure room and a corridor in

a surgical abortion clinic, it deemed the particular sizes required by the State to be out-of-balance with the benefits. And it did so even though Whole Woman's Health's facility already meets the corridor-width standard (and it therefore lacks standing to challenge that requirement) and comes within 10 square feet of the requisite procedure-room size. It also accepted the idea that some means of handwashing is necessary, but rejected the State's requirement that a surgical abortion clinic have a scrub facility adjacent to a procedure room. And with respect to the housekeeping room, Whole Woman's Health again lacked standing to challenge the requirement, yet the district court invalidated it because a Planned Parenthood facility in Evansville—which is not a party to the case and which has never challenged that rule itself—has no such room. Such picayune matters are proper subjects of administrative regulation, not facial constitutional challenges.

Finally, the challenged informed-consent disclosures are truthful and not misleading. The statement that "human physical life begins when a human ovum is fertilized by a human sperm" is not scientifically debatable, and the district court once again invalidated the requirement because the State defended it with testimony from a physician who does not perform abortions. The only standard, however, is whether the statement is truthful and not misleading, which the human physical life statement manifestly is.

And so is the statement that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." The State provided expert testimony demonstrating 12 lines of scientific evidence demonstrating

the truthfulness of that statement. But the district court rejected it because (1) the State's expert is against abortion and (2) the American College of Obstetricians and Gynecologists (ACOG) refuses to subscribe to it. But again, being pro-life does not disqualify expert testimony (and the district court had no trouble overcoming the pro-abortion biases of plaintiffs' expert witnesses). And ACOG's preferred view of the science does not negate the truthful and non-misleading character of the statement, which states *not* that a pre-20-week fetus can definitely feel pain, but merely the more modest observation that objective scientific evidence shows as much.

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REASONS FOR REVERSAL

	No Standing	Binding Precedent	No Substantial Obstacle	No Large Fraction	Benefits Outweigh Harms	Truthful/Not Misleading
Physician-Only		✓	✓	✓	✓	n/a
Second-Trimester Hospital/ASC		✓	✓	✓	✓	n/a
In-Person Counseling		✓	✓	✓	✓	n/a
In-Person Exam/ Telemedicine		✓	✓	✓	✓	n/a
Procedure Room Size			✓	✓	✓	n/a
Corridor Width	✓		✓	✓	✓	n/a
Scrub Facility			✓	✓	✓	n/a
Housekeeping Room	✓		✓	✓	✓	n/a
Human Physical Life Disclosure			n/a	n/a	n/a	✓
Fetal Pain Disclosure			n/a	n/a	n/a	✓

STANDARD OF REVIEW

On appeal from a bench trial, legal conclusions are reviewed *de novo*, and "findings of fact shall not be set aside unless clearly erroneous." *Cerros v. Steel Techs., Inc.*, 288 F.3d 1040, 1044 (7th Cir. 2002) (quoting Fed. R. Civ. P. 52(a)). In abortion cases, a decision that the facts show an undue burden is a legal question meriting no deference. *A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684, 689 (7th Cir. 2002) ("That admixture of fact and law, sometimes called an issue of "constitutional fact," is reviewed without deference "to prevent the idiosyncrasies of a single judge or jury from having far-reaching legal effects").

ARGUMENT

I. The District Court Misapplied Binding Precedent that Bars the Challenges to the Health-and-Safety Laws

A. The district court refused to follow the decisions of the Supreme Court and this Court upholding several of the enjoined laws

Supreme Court decisions do not come with an expiration date. Lower courts are bound to follow these decisions until the Supreme Court itself decides to overrule them. *See, e.g., United States v. Krieger*, 628 F.3d 857, 869 (7th Cir. 2010). As this Court observed in its decision partially staying the district court's injunction, "the Supreme Court insists that it alone has the authority to modify its precedents"—even where a district court thinks changed facts justify a different result. *Whole Woman's Health All. v. Rokita*, No. 21-2480, 2021 WL 4077549, at *2 (7th Cir. Sept. 8, 2021). The same is true of this Court's decisions. *Id.* ("[A] district judge lacks the authority to use new findings to depart from established law."). The district court's decision

below contravened these bedrock principles, flouting both Supreme Court and Seventh Circuit precedent in striking down the physician-only law, the second-trimester hospital/ASC requirement, the in-person counseling requirement, and the in-person examination requirement and telemedicine ban.

1. The physician-only law is governed by *Mazurek v. Armstrong*, 520 U.S. 968 (1997). There, the Court held that "the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others*." *Id.* at 973 (emphasis in original) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 885 (1992)). Yet the district court did precisely that, holding that while limiting medication abortions to physicians "ensures that a person with extensive professional, educational, and specialized training performs abortions," the physician-only law is nevertheless unconstitutional because it "exclud[es] well-qualified care providers who are not physicians from providing medication abortions." Short App. 101.

The district court gave two justifications for its refusal to follow *Mazurek*. First, it "read *Mazurek* to apply only to challenges to the legislative purpose, and, where the challenged statute does not, in effect, create burdens for women accessing abortion services." Short App. 98. But in its stay order, this Court read *Mazurek* broadly to hold that "[s]tate laws requiring abortions to be performed by physicians . . . are constitutional," rejecting that argument. *Rokita*, 2021 WL 4077549, at *1. Moreover, no court has ever enjoined a physician-only requirement on federal constitutional

grounds, even though twenty-nine other States restrict the provision of medication abortions to physicians only. *See* Stay Mot. at 35 (collecting statutes).

The district court further contended that "the reach of Indiana's physician-only statute is substantially broader than Montana's statute in *Mazurek*." Short App. 99. But the Indiana statute at issue here is materially identical to the Montana statute upheld in *Mazurek*. *Compare* Ind. Code § 16-34-2-1(a) ("Abortion shall in all instances be a criminal act, except when . . . the abortion is performed by the physician.") *with* Mont. Code Ann. § 50-20-109 (1995) ("An abortion may not be performed within the state of Montana . . . except by a licensed physician.").

Second, the district court held that *Mazurek* no longer applies because "the nature of abortion care has evolved substantially in the years since *Mazurek* was decided." Short App. 99. Yet, as noted, Supreme Court precedents do not go bad with age. Nor, as this Court's stay decision observed, is there "any support in *Mazurek* or this court's decisions" for a medication-abortion exception to *Mazurek*'s endorsement of a physician-only rule. *Rokita,* 2021 WL 4077549, at *1 (citing *Whole Woman's Health All. v. Hill*, 937 F.3d 864, 874 (7th Cir. 2019); *Planned Parenthood of Indiana and Kentucky, Inc. v. Box*, 991 F.3d 740, 751 (7th Cir. 2021)). Indeed, this Court has thrice recently reaffirmed the validity of *Mazurek*. *See id.*; *Box*, 991 F.3d at 751 (explaining that "there is generally no serious doubt about the constitutionality" of "state laws [that] require that only persons with certain medical licenses may perform surgical or medical abortions"); *Hill*, 937 F.3d at 874 ("It is . . . uncontroversial to say that a state may require an abortion to be performed . . . by a licensed professiona.l").

Accordingly, none of the district court's justifications is sufficient to depart from *Mazurek*.

2. The district court further erred by invalidating Indiana's second-trimester hospital/ASC requirement, even though that very requirement was upheld by the Supreme Court in *Gary-Northwest Indiana Women's Services, Inc. v. Orr*, 451 U.S. 934 (1981). As this Court explained in its stay order, *Orr* "settled the validity of the contested statute even though it did not establish general principles." *Rokita,* 2021 WL 4077549, at *2.

The district court suggested that *Orr* "was abrogated by *Simopoulos* [*v. Virginia*, 462 U.S. 506 (1983)] and its companion cases, *City of Akron* [*v. Akron Center for Reproductive Health, Inc.*], 462 U.S. 416 [(1983)], and *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476 (1983)." Short App. 110–11. While *City of Akron* and *Ashcroft* struck down a pair of laws requiring a second-trimester abortion to take place in a hospital, however, *Simopoulos* upheld a Virginia law that allowed second-trimester abortions to be performed in a hospital or ASC. 462 U.S. at 519. Because Indiana's law is "materially identical" to the Virginia law, the constitutionality of Indiana's hospital/ASC requirement is well settled. *Rokita*, 2021 WL 4077549, at *2.

3. Indiana's in-person counseling requirement likewise "was contested and held constitutional in *A Woman's Choice v. Newman*, 305 F.3d 684 (7th Cir. 2002)." *Id*. There, this Court "concluded that the validity of such a statute was established" in *Casey*. *Id.* And as this Court explained in its stay order, the constitutionality of the

in-person examination requirement and telemedicine ban flow directly from the constitutionality of the in-person counseling requirement. *See id.* ("And if as *Casey* and *A Woman's Choice* hold a state may require in-person meetings with physicians before an abortion, the validity of the restriction on telemedicine . . . follows directly.").

B. Whole Woman's Health's disclaimer that any of the challenged laws prevented any women from having abortions forecloses its "undue burden" challenges to the enjoined laws

Reversal is also necessary because Whole Woman's Health failed to show that any of the challenged laws prevented a large fraction of women—or *any* woman—from choosing to have an abortion. This failure forecloses its "undue burden" claims.

Under *Whole Woman's Health v. Hellerstedt*, a court does not balance the benefits and burdens of a challenged abortion law unless it first concludes that the law imposes a "substantial obstacle" on a woman's decision whether to bear a child. 136 S. Ct. 2292, 2309 (2016) ("[U]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." (quoting *Casey*, 505 U.S. at 878)). As this Court recently indicated, to invalidate an abortion regulation, a court must *first* find that the regulation imposes a substantial obstacle to exercising the abortion right, before weighing any benefits against the alleged burdens. *See Box*, 991 F.3d at 751 n.7 (stating that the "debate over the role of balancing benefits and burdens . . . simply should not matter" where there are no countervailing benefits to a "substantial obstacle").

Hellerstedt did not change the *Casey* framework, but instead merely elaborated on *Casey* with a three-part analytical method: First, the challengers must show that

a regulation imposes a "substantial obstacle"; second, if the challengers satisfy that burden, the State must demonstrate that the law serves some legitimate governmental purpose; third, "courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. at 2309. Critically, this framework maintains the *Casey* rule that the State is required to prove the benefits of the law *only* if the challengers first show that it imposes a substantial obstacle.

And as this Court explained in *A Woman's Choice*, a challenger cannot make the substantial-obstacle showing simply by demonstrating that a regulation's "costs are positive and have *some* effect. 305 F.3d at 692 (emphasis in original). Instead, a regulation "might be deemed an undue burden" if the evidence were to show "that many women who *strongly want an abortion* have been *blocked* by the cost (in money and time)" of the rule. *Id.* at 691 (emphasis added). Because it is seeking to completely invalidate each of the challenged laws, Whole Woman's Health was obligated to provide data showing that the challenged laws have deterred or will deter a large fraction of women from obtaining abortions "*in Indiana*." *Id.* at 692 (emphasis in original).

Whole Woman's Health, however, specifically *disclaimed* any attempt to show that Indiana's abortion laws have decreased the overall number of women able to obtain an abortion in Indiana. *See* Phase 1 Pretrial Conference Tr. (Mar. 2, 2021), 26:6–9 ("[I]t's not relevant what the rate of the abortion rate is because this is a case basically about undue burdens, and so it doesn't have to do with overall rates of anything."); First Trial Tr., Vol II, 120:5–20 ("Dr. Grossman didn't testify about the rates of abortion care in Iowa or anywhere else. . . . [T]he testimony that we presented

today does not rely on the rates of abortion in Iowa or in any other state, including Indiana."). Instead, it tried to establish that various abortion laws impose a "substantial obstacle" to abortion by showing that such laws increase the cost or inconvenience of having an abortion. *See* ECF 326 at 4 ("Examining Indiana's abortion rate history in isolation sheds no light on whether any of the challenged laws poses substantial obstacles to abortion access in the form of delay; increased cost; or increased travel; for a large fraction of individuals for whom it is relevant."). And the district court concluded (erroneously) that such proof was legally sufficient.

The district court pointed first to evidence that some of the enjoined provisions would increase the cost of abortions. For instance, with respect to the physician-only requirement, the district court relied on evidence that "enjoining this law with respect to medication abortions would reduce the cost of abortion . . . by $70." Short App. 107. And it also relied on evidence of increased cost to invalidate the second-trimester hospital/ASC requirement,[2] the facility requirements,[3] the in-person counseling requirement,[4] and the in-person examination requirement and telemedicine ban.[5]

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[2] Short App. 115 ("[T]he costs of a second-trimester abortion provided by a hospital are significant—upwards of $20,000. . . . It cannot reasonably be argued that such costs would be a nominal burden for a large fraction of women seeking services.").

[3] Short App. 122 ("[C]onstruction is often cost-prohibitive for clinics providing services to primarily low-income women.").

[4] Short App. 131 ("[W]omen who do not live near clinics must choose between expending their resources either to travel on two separate days or to secure overnight lodging . . . .").

[5] Short App. 137 ("Incorporating telemedicine into healthcare services generally has resulted in . . . benefits in the form of reduced costs of care and expanded access thereto.").

The district court pointed second to evidence of delay. For instance, with respect to the in-person counseling requirement, it explained that the difficulty of making two trips to the clinic "causes a significant number of women to delay their second appointment for an additional week or two rather than scheduling back-to-back appointments, which may ultimately impact her eligibility to receive a medication abortion." Short App. 131. And it relied on evidence of delay in enjoining the physician-only law,[6] the in-person examination requirement, and the telemedicine ban.[7]

Evidence that a law delays or increases the cost of an abortion, however, is not a sufficient basis on which to conclude that a law imposes a "substantial obstacle" to abortion. "Not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right." *Casey*, 505 U.S. at 873. "[T]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id.* at 874; *see also id.* at 886 (upholding waiting period even though it increased the cost and risk of delay of abortions). This Court has repeatedly recognized this principle, including in *A Woman's Choice* and *Karlin v. Foust*. 188 F.3d 446, 479 (1999) ("[A]n abortion law is not rendered unconstitutional merely because it operates to make it more difficult or more expensive to procure an abortion.").

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[6] Short App. 105 ("The shortage of available physicians restricts clinics from being able to schedule appointments on more than one or two days a week, causing limited capacities and long wait times often upward of two weeks.").

[7] Short App. 138 ("Site-to-site telemedicine would allow Indiana's abortion clinics to dramatically expand the availability of appointments and reduce delays in care.")

The district court's discussion of the burdens of the in-person counseling requirement—which, as noted, was the same requirement at issue in *A Woman's Choice*—illustrates the problems with its approach. The delays and inconveniences the district court concluded this requirement imposes are the same costs the district court had found in *A Woman's Choice*. *See* 305 F.3d at 685. Yet this Court held that such costs are categorically insufficient to call a law into question, and it thus followed the Supreme Court in holding that so-called "two-trip" requirements do not impose a substantial obstacle. *See id.* at 692; *Casey*, 505 U.S. at 886–87. Indeed, this Court ruled that such costs and delays are an insufficient basis for finding a "substantial obstacle" even if they force some women to have a different type of abortion than they prefer. *See A Woman's Choice*, 305 F.3d at 685 (noting that for some women the law may "delay that procedure until the second trimester"); *see also Planned Parenthood of Sw. Ohio Region v. DeWine*, 696 F.3d 490, 497 (6th Cir. 2012) (rejecting the argument that the Constitution protects a right to have medication abortion rather than a surgical abortion). The "substantial obstacle" standard the district court applied contravenes that standard, which is a sufficient reason to reverse.

C. The district court misapplied the large-fraction test

Furthermore, a court cannot facially invalidate an abortion law on the ground that it imposes a "substantial obstacle" unless the substantial obstacle occurs in "a large fraction of the cases in which [the law] is relevant." *Casey*, 505 U.S. at 878, 895. This necessarily requires determining "which group of women is properly considered the numerator and which group of women is properly considered the denominator"—

and then determining whether the resulting fraction is "large." *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 377–78 (6th Cir. 2006) (Rogers, J., concurring) (citation and internal quotation marks omitted). The denominator 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. And the numerator is the number of women for whom the law is "likely to prevent … from obtaining an abortion." *A Woman's Choice*, 305 F.3d at 691 (quoting *Casey*, 505 U.S. at 893–94).

The district court purported to apply the large-fraction test to only two of the enjoined laws: the in-person counseling requirement, Short App. 132, and the second-trimester hospital/ASC requirement, *id.* at 115. It was reversible error for the district court to fail to apply the large-fraction test to the remaining enjoined laws, and even with respect to these two laws the district court's large-fraction conclusions are conclusory and legally deficient.

With respect to in-person counseling, the requirement applies to all abortions and thus the denominator is *all* women seeking abortions. But for how many such women is the law a "substantial obstacle"? Given the district court's approval of the ultrasound requirement, literally zero. The ultrasound, like the in-person counseling, must occur at least 18 hours before the abortion—indeed, it is to occur at the same time as the counseling. *See* Ind. Code § 16-34-2-1.1(a)(1). The in-person counseling thus adds no burden to the process—no additional trips, no additional scheduling problems. The set of burdened women is therefore necessarily null.

And even if one ignores that deficiency, no evidence in the record indicates how many women seeking abortion would experience in-person counseling as a substantial obstacle via "delays" and "travel" (even as it does not prevent them from having an abortion). *See A Woman's Choice*, 305 F.3d at 690–91 (explaining that a plaintiff who could show even that a law would reduce abortions by 10% would not necessarily prevail, but would instead need to further establish that the reduction comprised women "who strongly want an abortion," not just women "on the fence between ending the pregnancy and carrying the pregnancy to term"). The district court seems to have assumed that *all* women experience in-person counseling as a substantial obstacle, but that conclusion is implausible and entirely unsupported by evidence.

The district court's analysis of the second-trimester hospital/ASC requirement suffers from similar flaws. Even for women who obtain second-trimester abortions, one cannot simply assume that all such women experience the increased costs as a "substantial obstacle." Whole Woman's Health provided no evidence of the denominator for this fraction, and Dr. Caitlin Bernard, who performs second-trimester abortions in a hospital setting, testified that, in Indiana, such abortions occur only to address a serious health condition (rather than as a substitute for a first-trimester abortion), Second Trial Tr., Vol. I, 33:24–34:10, and that, accordingly, the costs for at least some such patients are covered by insurance. In any event, Whole Woman's Health provided no evidence regarding how many women who obtain second-trimester abortions in Indiana pay out-of-pocket, and again it disclaimed making a rates case, which

means it has not established that *any* women—much less a large fraction—experienced the hospital/ASC requirement as a "substantial obstacle."

The district court's failure to apply the large-fraction test *at all* (for all but two of the challenged laws) or *properly* (for the in-person counseling and hospital/ASC requirements) is an independently sufficient ground for reversal.

II. Even Apart from the Categorical Legal Deficiencies in Plaintiffs' Claims, the Enjoined Health-and-Safety Regulations Provide Benefits that Outweigh Their Burdens

The district court's failure to conduct a proper cost-benefit analysis of the challenged laws provides yet another independently sufficient ground for reversal. The undue burden standard requires courts to "consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016). This determination is a legal question "reviewed without deference in order to prevent the idiosyncrasies of a single judge or jury from having far-reaching legal effects." *A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684, 689 (7th Cir. 2002). Because the enjoined laws' benefits outweigh their burdens, this Court should reverse the district court's decision.

A. The physician-only law advances the State's interests in protecting patient health because physicians are better qualified than APCs to screen for contraindications and to treat complications

Although the district court acknowledged that "[t]he benefits cited by the State conferred by the Physician-Only law reflect the state's interest in promoting the health and safety of women seeking abortions," Short App. 100, it concluded that the burdens of the law—which has been in force for decades, Ind. Code § 16-34-2-1(a)(1)—

outweigh its benefits. This conclusion not only disobeys precedent, but also misapplies the legal standard and defies the record evidence as well.

As the evidence at trial demonstrated, the physician-only requirement increases the safety of medication abortions. A physician is better able than an APC to determine gestational age, location of pregnancy, and contraindications. Second Trial Tr., Vol. II, 132:5–23, 150:7–152:23. A physician is also better suited than an APC to identify when a patient is experiencing complications. *Id.* at 95:23–96:11, 152:24–153:5. The district court recognized this, stating that "[t]his restriction on care limiting it to a physician ensures that a person with extensive professional, educational, and specialized training performs abortions, thereby reducing the risk of procedure-related complications and enhancing the level of care if complications do occur." Short App. 100. Yet it concluded that "there is no advancement of the State's interest" because, in its view, APCs are also qualified to provide medication abortions. *Id.* at 103. Rather than making any specific findings as to APCs' qualifications, it simply asserted that "APCs provide other kinds of care that are comparable in risk, or even riskier, than medication abortions, the most obvious of which is miscarriage management care." *Id.* at 100.

The district court's holding that the State may not restrict the provision of abortion to physicians because it does not impose similar restrictions on other procedures amounts to a narrow tailoring requirement. But the undue burden standard does not require narrow tailoring. *See Planned Parenthood of Se. Pa. v. Casey*, 505

U.S. 833, 871 (1992) (explaining that cases applying strict scrutiny to abortion regulations are not consistent with *Roe v. Wade*). A state legislature "may take one step at a time, addressing itself to the phase of the problem which seems most acute to the legislative mind." *Williamson v. Lee Optical*, 348 U.S. 483, 489 (1955). Federal courts, on the other hand, must "give[] state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). Here, some experts testified that APCs are comparable to physicians; others testified that APCs are not comparable. In light of this disagreement, the court failed to accord the State its "broad latitude" under the Constitution to decide that abortions may be performed only by physicians, "even if an objective assessment might suggest that those same tasks could be performed by others." *Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) (quoting *Casey*, 505 U.S. at 885).

As for the burdens, again no evidence demonstrated that the physician-only law prevented any woman from receiving an abortion; the only supposed burdens are cost and inconvenience. The district court opined that enjoining this requirement "would reduce the cost of abortion care . . . by $70" and would increase availability by making scheduling more flexible. Short App. 105–07. But again, a law that "has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874; *see also Karlin v. Foust*, 188 F.3d 446, 481 (1999) ("[I]nconvenience, even severe inconvenience, is not an undue burden.").

The resolution of this issue comes down to whether the numerous medical benefits of requiring a physician to perform a medication abortion are worth $70. Indiana thinks yes. Judge Barker thought no. While this Court could conceivably offer its own view of this policy- and value-laden question, the Supreme Court has directed a different approach—defer to the legislative judgment that the safety benefits provided by a physician are worth an additional $70 in cost. *See Gonzales*, 550 U.S. at 163.

B. The second-trimester hospital/ASC requirement advances the State's interest in protecting patient health because hospitals and ASCs are better equipped to avoid and treat complications

The district court also erred in enjoining Indiana Code section 16-34-2-1(2), which requires that all second-trimester abortions be performed in a hospital or ambulatory surgical center. It concluded that the law "does not provide benefits that support or advance Indiana's interest in promoting the health and safety of women." Short App. 115. This is a legal conclusion, but even if it is treated as a factual finding, the evidence demonstrates that the court's assertion is clearly erroneous.

Second-trimester abortions are performed using one of two procedures: dilation and curettage (D&C) or dilation and evacuation (D&E). Both procedures become more dangerous as gestational age increases. Joint Stipulation of Facts, ECF 347 ¶ 73. The most common complications of second-trimester suction D&C abortions happen when "the suction catheter or the curette . . . create[s] . . . a false passage" that "would be an entry into the muscle of myometrium, which then would, of course, either cause a perforation or perhaps a laceration laterally into the uterine arteries or ovarian arteries." Second Trial Tr., Vol. II, 94:5–14.

Hospitals and ASCs are better equipped to handle the increased risk of such complications. They have "direct access to resuscitative equipment, surgical personnel, other people who would be able to assist you in the event you have to do a laparotomy or surgical procedure to correct any laceration or other complication you might have." *Id.* at 104:22–105:4. They also have better access "to a higher level of medications and also anesthetics that you might need for the care of a complication with a surgical—advanced surgical abortion." *Id.* at 105:1–4.

Furthermore, the leading professional organization of American surgeons recognizes second-trimester abortions as surgeries and considers it necessary for surgeons to be accredited by a licensed hospital or ASC; by requiring second-trimester abortions to be performed in either a hospital or an ASC, Indiana ensures such accreditation. *Id.* at 99:19–21; 100:16–22.

The same is true for D&E abortions. Dr. Calhoun testified that D&E abortions are multi-day procedures involving the removal of the fetus in pieces by forceps. *Id.* at 105:5–15. "Since those [forceps] are sharp crushing instruments, they are liable to cause increased risk of laceration because of the thinner uterine wall and the access to the vasculature as well as the suction catheter that you would use to remove the placenta." *Id.* at 105:16–19. "[D]eep sedation" is necessary to ensure that the patient remains still "because, when patients move, that's when you're at the most increased risk for having something surgically happen, laceration or perforation." *Id.* at 105:22–

106:2. Performing D&E abortions in a hospital or ASC—where deep sedation is available and where there is "direct access to" the equipment and personnel needed to respond to a complication—clearly provides health and safety benefits to the patient.

No one disputes that only hospitals and ASCs provide deep sedation. Indeed, Amy Hagstrom Miller testified that, absent this law, Whole Woman's Health would provide second-trimester abortions *without* deep sedation. Second Trial Tr., Vol. I, 99:5–7.

Moreover, Calhoun's testimony that deep sedation improves patient safety is undisputed. One of Whole Woman's Health's experts testified that "the majority of [their] patients do receive deep sedation" for second-trimester abortions. *Id.* at 138:23–25, 139:5–6. Although the district court cited to Dr. Grossman's testimony, Grossman never refuted Calhoun's testimony about the benefits of deep sedation. And he did not, as the district court claimed, testify that "no benefit flows from performing a D&E at an ASC as compared to an outpatient clinic." Short App. 114. Grossman testified that a hospital or ASC "might be better equipped to handle some kinds of complications" even if "[he] d[id not] think that it's necessarily the case that they would be better equipped to handle all complications." Second Trial Tr., Vol. I, 192:25–193:5. The district court therefore clearly erred when it concluded that the benefits of this requirement "are nominal or nonexistent." Short App. 116.

The district court also erred in assessing the burdens of this law. It determined that, because there are few hospitals and no ASCs in Indiana willing to perform sec-

ond-trimester abortions, the result is "significant geographical and financial disadvantages in seeking second-trimester care," particularly because "D&Es often must be performed over a period of twenty-four to forty-eight hours." *Id.* at 115. These putative "disadvantages" include "secur[ing] overnight lodging and childcare for two days" and costs "upwards of $20,000" for hospital expenses—which, the district court concluded, "combined with the sparse availability of facilities, force most Indiana women to travel out of state to receive second-trimester abortions." *Id.* at 115–16. According to the district court, "[t]hese burdens of travel are particular [sic] crippling for the demographic that includes women in need of abortion services." *Id.* at 116.

It is well-established, however, "that a law which serves a valid purpose . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874; *see also Karlin*, 188 F.3d at 481. And in any event, the record demonstrates that many of the burdens the district court cited are the result of circumstances outside the State's control, including Whole Woman's Health's own business decision not to open an ASC, Second Trial Tr., Vol. I, 98:19–25, and the decisions of individual hospitals and ASCs not to provide abortions or to do so only in limited circumstances, *id.* at 35:2–4; 40:12–25; 41:1–5; 52:14–16; 115:22–25. The district court made no attempt to isolate or quantify the burdens imposed by the second-trimester hospital/ASC requirement itself, and given the gravity and severity of the possible complications that may arise in second-trimester abortion, any such burdens are outweighed by the benefits of the requirement.

"The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Simopoulos v. Virginia*, 462 U.S. 506, 516-17, 519 (1983). The State's experts testified that there are enormous benefits in requiring second-trimester abortions be performed where the patient can be deeply sedated to avoid complications and where there is direct access to the best equipment and personnel to respond in the event of a complication. *Id.* at 516–17 ("[The State] does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed."). These benefits to the patient's health and safety outweigh any increase in cost. And while the district court held that "no benefit flows from performing a D&E at an ASC as compared to an outpatient clinic" because such clinics "are subject to a myriad of licensure regulations," Short App. 114 n.57, it also enjoined three of these regulations without regard to how they might benefit the safety of women seeking second-trimester abortions, *id.* at 117–22.

The hospital/ASC requirement imparts significant health and safety benefits for second-trimester abortions that outweigh the incidental burdens of cost and inconvenience. It is therefore constitutional.

C. The in-person counseling requirement advances the State's interest in protecting fetal life and women's health because it improves the informed-consent process

The district court—despite acknowledging the importance of informed consent before medical procedures— also erroneously concluded that the in-person counseling requirement constitutes an undue burden.

The district court determined that "given the broad-based societal advancements to telemedicine technology and the successful incorporation of videoconferencing into preabortion counseling care elsewhere, we find the benefits imposed by this requirement to be at best slight." Short App. 130. But the benefits of this law are far from "minimal." *Id.* at 132. The in-person counseling requirement protects fetal life and maternal health by improving the informed-consent process. *See* First Trial Tr., Vol. III, 188:10–13, 191:6–16. And while the district court made much of the fact that this requirement is not ubiquitous before all medical procedures, the abortion decision has unusually grave consequences. *See Harris v. McRae*, 448 U.S. 297, 325 (1980) ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life.").

At the same time, the district court did not identify any evidence rebutting the State's expert testimony that "in-person counseling inspires better engagement between provider and patient" and promotes "the development of a person-to-person relationship." Short App. 129; *see* First Trial Tr., Vol. IV, 20:21–21:20. Indeed, it acknowledged that these opinions are "true in a general sense" and stated that it "w[ould] not quarrel with the fact that in-person interactions yield some benefits in building a trusting relationship between patient and provider." Short App. 129–30. Despite that finding, the court then focused on how women might "prefer" counseling via telemedicine and how telemedicine has advanced in recent years. *Id.* at 130.

The district court further accepted that in-person interactions can help detect and prevent coercion by a partner. *Id.* at 129. It observed that "because an abortion

patient will always be required to report in person to the clinic to receive her abortion, clinic staff are not deprived of an opportunity for in-person contact with patients to provide resources to those who may be suffering from intimate partner violence." *Id.* But the fact that a woman might "still report to a clinic," *id.*, does not mean that she will receive the full benefits of in-person counseling—especially since she could be under coercion during the informed-consent phase, the very time devoted to ensuring the informed, voluntary nature of the abortion decision. As a result, such coercion and abuse may go undetected in the absence of the in-person counseling requirement.

More fundamentally, the in-person counseling requirement imposes no burden beyond the requirement that the ultrasound be performed 18 hours in advance, which the district court acknowledged is "not challenged in this litigation." *Id.* at 126 n.61. Whole Woman's Health clearly recognized that this inconsistency is fatal to its argument—it said as much in its motion to amend or alter the judgment upholding the ultrasound requirement: "The Ultrasound Requirement in practice imposes many of the same travel burdens on patients as the In-Person Counseling Requirement—a patient must travel to a clinic for an ultrasound and then make a second visit for the abortion." ECF 444 at 7. Exactly so. The in-person counseling requirement creates no additional burden; its only consequence is the same two-trip requirement with the same effects on cost and availability.

And the district court's alternative burden theory fares no better. The district court suggested that eliminating the in-person counseling requirement would "provide greater accessibility to appointments and flexibility in scheduling" because it

would permit a woman to "report to the clinic closest to her where a qualified technician conducts the ultrasound and completes the necessary intake information," with the information then "transmitted electronically to a remote physician or APC, who could conduct the counseling session." Short App. 133. But no evidence suggests that Whole Woman's Health—which has only one Indiana facility—would follow that model or that the model would lead to shorter wait times or lower costs. Such groundless speculation is insufficient to invalidate an abortion law under *Casey*. *See, e.g., A Woman's Choice*, 305 F.3d at 691–92.

Because the district court found that in-person counseling provides some benefits, the benefits must outweigh the nonexistent burden. Thus, the in-person counseling requirement does not impose an undue burden.

D. The in-person examination requirement and telemedicine ban protect women's health, encourage a relationship between physician and patient, aid in obtaining informed consent, and prevent the diversion of abortion-inducing drugs and painkillers

The district court's conclusion that the in-person examination requirement "does not offer *any* benefits," Short App. 135 (emphasis added), is a legal conclusion, but even if it is considered a factual finding, it is clearly erroneous. Far from "unidentifiable," *id.* at 138, the benefits of requiring in-person care are numerous, and the district court did not point to evidence that rebuts the State's expert testimony describing them.

As Dr. Goodwine-Wozniak testified without contradiction, a physical exam provides the physician "an opportunity to get to know the patient by her history, past surgeries, past complications," and "can be either confirmatory of your impression or

you may find something that is completely different than what you expected." First Trial Tr., Vol. III, 172:24–173:5. Requiring in-person examination ensures the physician has an accurate understanding of the woman's health, helps avoid misdiagnosis, and better detects contraindications, including "anything from infections to risk factors for preterm labor." *Id.* at 173:1–5, 174:10–13. The exam also ensures pregnancy is dated precisely, which is crucial to determine whether a medication abortion is safe for the woman. *Id.* at 175:2–5.

As explained above, moreover, in-person interactions also allow the physician to observe body language, eye contact, comfort level, and decisional certitude, which is especially important for detecting and preventing coercion and abuse. *Id.* at 178:18–179:2, 180:16–21. The State's experts explained, and the district court did not cite evidence refuting, that a physical examination can reveal "evidence of trauma" and other physical indications that the woman has experienced abuse. First Trial Tr., Vol. IV, 30:2–15. Indeed, the district court acknowledged the benefits of in-person care where "there are concerns of coercion" when it noted the benefit of "provid[ing] an opportunity for the patient to be segregated from the perpetrator in order to confer with her provider in a confidential, private setting." Short App. 129. Inexplicably, though, the district court has eliminated that opportunity for women seeking medication abortions by enjoining the in-person examination requirement and the telemedicine ban.

These rules also prevent the diversion of abortion-inducing drugs and painkillers. First Trial Tr., Vol. III, 182:10–14. Indeed, as written, the district court's injunction authorizes mailing abortion pills directly to patients, at least so long as the FDA's Risk Evaluation and Mitigation Strategies (REMS) for Mifeprex, which require abortion pills to be dispensed "only in certain health care settings," are suspended.[8] The in-person examination requirement and telemedicine ban impart numerous benefits, and the district court clearly erred in finding none.

As for the burdens, the district court determined that banning telemedicine and requiring an in-person examination increase cost and result in delay. But just because new technology may be more convenient, a state is not obligated to update its abortion regulatory regime to permit its use. *See Brown v. Entm't Merchs. Ass'n*, 564 U.S. 786, 790 (2011) (holding that "whatever the challenges of applying the Constitution to ever-advancing technology," the Constitution's meaning does "not vary" with it). "Courts are not authorized to rewrite a statute because they might deem its effects susceptible of improvement." *Badaracco v. Comm'r*, 464 U.S. 386, 398 (1984). Even if telemedicine is more widely utilized today, the Constitution does not require that new technology to be available for abortions. Precluding telemedicine does not impose a substantial obstacle merely by foregoing previously unavailable technological conveniences.

[8] *See* Food & Drug Admin., *Mifeprex (mifepristone) Information*, https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

Accordingly, the health and safety benefits flowing from requiring an in-person examination and prohibiting telemedicine clearly outweigh the burdens of cost and delay identified by the district court.

E. The facility requirements for surgical abortion clinics advance the State's interest in protecting patient health

The district court further erred in enjoining three separate requirements for surgical abortion clinics—(1) the requirement that procedure rooms be a minimum of 120 square feet, 410 Ind. Admin. Code 26-17-2(d)(1); (2) the requirement that surgical abortion clinics have scrub facilities, 410 Ind. Admin. Code 26-17-2(d)(4); and (3) the requirement that corridors be at least forty-four inches wide, 410 Ind. Admin. Code 26-17-2(e)(5).

1. The district court refused to credit the State's expert witnesses because they do not perform abortions, which is legally improper

At trial, the State's experts Dr. Calhoun and Dr. Stroud testified to the benefits of these three requirements. Because the State permits surgical (*i.e.*, D&C) abortions to be performed in clinics—that is, outside hospitals or ASCs—these facility requirements are necessary to ensure clinics performing surgical abortions meet the emergency-response and sanitation standards such procedures require. Indeed, Calhoun summed up the general importance of these requirements by observing that, due to a "concern about risk of complications," he always performs D&Cs in full-on surgical suites, complete with anesthesia and surgical assistants: Calhoun "would never do them in a medical office," and no one he has "been familiar with in the last 30 years would do them in their office" either. Second Trial Tr., Vol. II, 102:2–12.

The district court, however, disregarded the testimony of the State's experts as to the facility requirements on the theory that their testimony is unreliable because they do not perform abortions—a theory the district court applied to nearly every other area of the case as well. *See* Short App. 118 (rejecting Stroud's and Calhoun's testimony on the facility requirements because it "lacked any basis in their personal experiences in this area of medical practice or their review of any relevant medical research").[9]

First, Drs. Stroud and Calhoun do perform D&Cs as a function of miscarriage management. Second Trial Tr., Vol. II, 91:17–22; Second Trial Tr., Vol. III, 14:16–17. Second, it does not take an abortion provider to testify as to the need for minimal facility requirements. The State's experts had ample experience with various comparable OB/GYN procedures, and the district court disregarded their testimony for only the most hyper-technical, and ultimately illegitimate, reasons—which amounts to an abuse of discretion.

Indeed, the district court cited no authority for its novel theory for rejecting expert witness testimony. Nor could it do so: The district court's reasons for rejecting

[9] *See also* Short App. 102 (rejecting testimony of the State's experts as to the physician-only requirement because their opinions were based on "their personal medical experiences and beliefs, which do not include any provision of medication abortion care by them"); *id.* at 130–31 n.65 (disregarding testimony of States' experts on benefits of the in-person counseling requirement because "these experts' opinion [sic] are far removed from . . . perspectives of providers and patients who have utilized telemedicine in this setting); *id.* at 136 (finding "little value" in testimony of States' experts on benefits of the telemedicine ban/physical-examination requirement because "none of the State's experts even perform medication abortions"); *id.* at 148 (discounting Curlin's testimony supporting the State's disclosures due to his "overall belief that abortion is the killing of an innocent human being").

the State's expert witness testimony in this case would prevent the State from offering any meaningful expert testimony in every abortion case, since it is hard to imagine any abortion provider offering testimony in favor of *more* state regulation. Indeed, the Supreme Court implicitly rejected this notion in *Gonzales v. Carhart*: One of the lower courts had refused to permit the government's experts to testify in favor of the partial-birth abortion ban because they did not personally perform late-term abortions, *see Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 982 (N.D. Cal. 2004), but the Supreme Court nevertheless accepted this expert testimony and relied on it to conclude that "[t]here is documented medical disagreement whether the Act's prohibition would ever impose significant health risks on women." 550 U.S. 124, 162 (2007). So, while the court properly certified—largely without objection—all of the State's witnesses as experts with the requisite knowledge and experience to testify about the benefits of the State's laws, it nonetheless categorically rejected that testimony for legally deficient reasons, *i.e.*, because, in its view, only abortion providers can testify credibly about abortion regulations.

Furthermore, even apart from the State's expert testimony on the benefit side of the ledger, the challenges to these requirements fail as a matter of law because Whole Woman's Health has not shown that the facility requirements impose a substantial obstacle. Indeed, Whole Woman's Health has already come into compliance with the corridor requirement, Second Trial Tr., Vol. I, 86:16–17, and has not explained how this requirement injures it or burdens Hoosier women seeking abortions.

And as for procedure-room-size and scrub-sink requirements, Hagstrom Miller testified only that "multiple landlords . . . declined to lease" compliant space "because of the services we provide, specifically abortion." *Id.* at 96:14–22. And while she spoke to contractors about the cost to bring her current space into compliance, she chose not even to request a bid. *Id.* at 97:23–98:4. The district court deemed the necessary renovations "cost-prohibitive" without saying what the cost would be or how much would be passed on to patients. Short App. 81. In any case, as explained above, increased cost is not legally sufficient to impose an undue burden. *See supra* Part I.B.

Moreover, as explained below, these requirements benefit the health and safety of women, and those benefits outweigh any minimal burdens they impose.

2. The requirement that surgical abortion clinics maintain 120-foot procedure rooms ensures adequate space for emergency personnel and equipment

The district court's finding that the 120-square-foot procedure room requirement "does nothing to enhance the safety of aspiration abortion care," Short App. 120, is clearly erroneous. Dr. Calhoun testified at trial that procedure rooms "need an adequate number of square footage to be able to safely take care of [a] patient." Second Trial Tr., Vol. III, 103:15–17. Furthermore, the requirement ensures adequate space "to get emergency equipment or other personnel" into the procedure room if needed. *Id.* at 103:17–19. Clearly, the requirement has *some* benefit.

Indeed, the district court, Dr. Grossman, and the publications on which Grossman relied consistently refer to "facility standards," and thereby essentially concede that mandating *some* minimum size is permissible. *See* Short App. 76; Second Trial

Tr., Vol. I, 174:15–18, 178:8–14. Relying on Grossman's testimony and those opinions, the district court found that Whole Woman's Health's procedure rooms, which "are approximately 110 square feet," are "suffic[ient] to provide safe and effective first-trimester abortion[s]." Short App. 120 & n.59. From that, it facially invalidated the 120 square foot standard for *all* surgical abortion clinics. Yet even as it did so, the court plainly assumed that *some* minimal size requirement is constitutionally permissible.

The question of *what* size is permissible is surely not a question of constitutional dimension. *See Gonzales*, 550 U.S. at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty."). Regardless, it is difficult to see how the ten-foot difference between the 110-square-foot rooms that the district court found acceptable, Short App. 120 n.59, and the 120-square-foot minimum that the State set using its regulatory judgment is constitutionally suspect. The district court clearly erred in finding that "this requirement does nothing to enhance the safety of aspiration abortion care," *id.* at 120, and it legally erred in deeming those benefits outweighed by non-existent burdens on abortion access.

3. The requirement that surgical abortion clinics maintain minimally wide corridors ensures adequate space for emergency personnel and equipment

Similarly, the district court's ruling that "the 44-inch corridor requirement offers no medical benefits to women receiving aspiration abortion services" is reversible

legal error because the Constitution says nothing about a State's ability to set appropriate corridor width in licensed medical facilities. Short App. 120.

It is also clearly erroneous as a factual matter. Dr. Calhoun testified that 44 inches is the "standard width" for corridors in health facilities that provide surgical procedures. Second Trial Tr., Vol. II, 104:5–6. This standard width provides adequate space "so you can get a bed or gurney down the hall or emergency—or equipment into the room or down the hallway to take care of your patient. . . Or in case you need EMS to come in and provide care." *Id.* at 104:6–11. Similarly, Dr. Stroud explained that the State regulates corridor widths because there are occasions where "we may need to get a gurney through that hallway quickly"—he recalled an incident where he called an ambulance and emergency personnel "needed to get through the front door, through our hallways, into the birthing suite quickly and get out again very quickly to save a woman's life," and "[t]hat would not have been the time to realize that our hallways are too narrow and they can't fit." Second Trial Tr., Vol. III, 233:14–23. And as Whole Woman's Health's expert Dr. Allison Cowett admitted on cross-examination, such emergencies happen in abortion clinics at least "two or three times a year." Second Trial Tr., Vol. I, 139:8–12. Clearly, the medical benefit of having adequate space for emergency personnel and equipment is not nil.

Regardless, the district court accepted the testimony of Whole Woman's Health's expert, Dr. Grossman, "debunking any purpose served by the 44-inch corridor requirement" and concluded that the requirement "offers no medical benefits to women receiving aspiration abortion services." Short App. 120. But just as with the

size of the procedure room, some minimum requirement for the width of corridors is necessary, and the Constitution leaves that decision to the State. *See Gonzales*, 550 U.S. at 163. Otherwise, the question becomes a micromanaged assessment of what requirement less than 44 inches is constitutionally permissible.

Furthermore, because no basis exists for inferring that the corridor width requirement burdens women's access to abortion—particularly given that Whole Woman's Health's South Bend clinic *already* satisfies the requirement—the hallway-width requirement's health and safety benefits outweigh its (hypothetical) burdens. Accordingly, this Court should reverse the district court's legal conclusion that the burdens of the corridor-width requirement outweigh its benefits.

4. The requirement that surgical abortion clinics maintain scrub facilities ensures proper sterilization

The district court also erred in discerning "no basis in the evidence to support the necessity of [the scrub facility] requirement to ensure safe aspiration abortion care." Short App. 121. This is the wrong inquiry: the undue burden test is not a strict scrutiny standard that requires a showing of "necessity." *See Casey*, 505 U.S. at 871. Instead, it merely requires that abortion laws have some medical benefit. *Hellerstedt*, 136 S. Ct. at 2309.

Regardless, the district court's assertion that "no benefits flow from this requirement" because "sterility (not to be confused with cleanliness) is not required to safely provide first-trimester abortion services," Short App. 120–21, cannot justify invalidating the requirement. Dr. Calhoun testified that the final "thing you want to do as you're going to do a procedure is, obviously, to wash your hands and sterilize

your hands." Second Trial Tr., Vol. II, 103:22–24. And Dr. Stroud explained the obvious benefits of requiring scrub facilities to prevent infection. Second Trial Tr., Vol. III, 27:16. A D&C is an "invasive procedure where there is a material risk of infection" because the physician is "taking objects and placing them from the outside world into the inside world of the uterus that is not designed to have foreign objects in it." *Id.* at 27:23–28:1. In light of this risk, "[o]ne of the most important ways to prevent an infection at a procedure like that is to try to minimize bacterial counts on [physicians'] hands." *Id.* at 27:10–12. Doing so is accomplished by "wear[ing] sterile gloves" and "thoroughly cleans[ing] [one's] hands in a way that is taught through surgical education." *Id.* at 27:10–15. Failure to do so could "introduce infection and all that goes along with infection, including destroying a woman's fertility, causing sepsis, all sorts of problems." *Id.* at 28:1–5.

The district court rejected this testimony and instead credited Dr. Grossman's testimony that "no benefits flow from this requirement that are not already satisfied by other requirements" (*i.e.,* the requirement that the procedure room have a handwashing station). Short App. 121. Not even Grossman, however, said that scrub facilities and handwashing stations are identical; he simply asserted that a scrub facility is unnecessary because a "first-trimester abortion. . . is not a sterile procedure." Second Trial Tr., Vol. I, 187:15–16. The district court's judgment that the Indiana legislature may not go so far as to treat a first-trimester surgical abortion as a sterile procedure is a legal conclusion to which this Court owes no deference.

In any case, the district court's conclusion on this point assumes that some sort of cleanliness requirement is constitutionally permissible. As with the size of procedure rooms, determining what precise regulations are sufficient to ensure that abortions are provided in a clean, safe manner is within the purview of state legislatures, not federal courts. This Court should therefore reverse the district court's legal conclusion and uphold the State's scrub-facility requirement.

F. The housekeeping room requirement for medication abortion clinics is not properly challenged and in any case advances the State's interest in protecting patient health

The district court also erred in invalidating the State's requirement that a clinic providing medication abortions maintain "[a]t least one (1) housekeeping room with: (A) a service sink; and (B) adequate storage for housekeeping supplies and equipment." 410 Ind. Admin. Code 26.5-17-2(e)(1). Whole Woman's Health has no standing to challenge the requirement, and even if it did the requirement's benefits outweigh any minimal burdens it might impose.

1. Whole Woman's Health does not have standing to challenge the housekeeping room requirement

It is well-established that standing "is not dispensed in gross" and that a plaintiff therefore "must demonstrate standing for each claim he seeks to press and for each form of relief' that is sought. *Davis v. Fed. Election Comm'n*, 554 U.S. 724, 734 (2008) (internal quotation marks and citations omitted). For every regulation challenged, plaintiffs must demonstrate—with evidence—that, as a result of the regulation, they have "suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Spokeo,*

Inc. v. Robins, 136 S. Ct. 1540, 1547–48 (2016) (citations omitted). Critically, abortion providers' ability to invoke third-party standing does not relieve them of their duty to show injury-in-fact to itself. *See Shimer v. Washington*, 100 F.3d 506, 508 (7th Cir. 1996) ("To establish third-party-standing, we require that a litigant, *in addition to alleging injury-in-fact*, allege a sufficiently close relationship with the third party so that the court is assured that the litigant will be an effective proponent of the cause." (emphasis added)).

Neither Whole Woman's Health nor its patients is harmed by the housekeeping room requirement. Indeed, all parties agree that Whole Woman's Health *already has* a housekeeping room consistent with this requirement. Second Trial Tr., Vol. I, 90:24–91:6. Nor have the other plaintiffs alleged that they are harmed by the housekeeping room requirement.

Yet the district court enjoined the housekeeping room requirement because a non-party—a Planned Parenthood health center in Evansville, Indiana—lacks a housekeeping room and thus may not provide medication abortions. Short App. 76–77. The plaintiffs have not alleged, however, that the refusal of Planned Parenthood to maintain a housekeeping room in its Evansville health center affects them—or their patients— "in a personal and individual way." *Spokeo*, 136 S. Ct. at 1548.

The district court failed even to address this lack of standing in its order, even though counsel for the State raised the issue at closing argument. *See* Second Trial Tr., Vol. III, 76:21–77:2. Whole Woman's Health failed to assert any particularized challenge to this requirement at any point in the litigation until its trial brief (filed

simultaneously with the State's trial brief), so the State had no opportunity to object on standing grounds before trial. Regardless, "it is well established that the court has an independent obligation to assure that standing exists, regardless of whether it is challenged by any of the parties." *Summers v. Earth Island Inst.*, 555 U.S. 488, 499 (2009). This Court should therefore reverse the district court's invalidation of the housekeeping room requirement for lack of standing without reaching its merits.

2. Regardless, the housekeeping room requirement ensures proper cleanliness

Even if this Court reaches the merits of the housekeeping room requirement, moreover, it should uphold the requirement because it advances the State's interest in protecting women's health and safety and does not impose an undue burden.

The district court's finding that "there are no[]" benefits associated with the housekeeping requirement is clearly erroneous. *See* Short App. 117. Dr. Calhoun testified at trial that a housekeeping room with a storage sink is the "standard of care in every clinic or surgical suite that I've ever worked in so you could keep the most sterile, clean and dirty instruments and materials away from each other and provide safety for our patients." Second Trial Tr. Vol. II, 102:17–23. And Dr. Stroud testified that in his birthing center, which is subject to a similar requirement, there are many "chemicals, some of them rather toxic, bleaches, medical hazardous material containers and the like, that need a place to be, obviously, in the building, but they also need to be out of patient care and potential for unsafe interaction with those chemicals. They live in the janitorial closet." Second Trial Tr. Vol. III, 25:25–26:9. He further explained that the sink is beneficial because "[t]here needs to be a place to clean

cleaning materials that's separate and segregated from sinks that we would use to wash our hands or for families to wash their hands." *Id.* at 26:10–18. Clearly, the housekeeping room provides *some* benefit.

On the burden side, the district court found that as a result of the housekeeping room requirement, "women residing in Evansville are required to travel at a minimum of 250 miles round trip to obtain medication abortion services," which "extracts incredible investments of time and money." Short App. 118. But Planned Parenthood has never thought such a trip was too long for its Evansville patients, as it has never applied for an abortion clinic license for its Evansville health center (through which it might request waiver of this requirement). *See* Ind. Code § 16-21-1-9. And, despite filing numerous challenges to Indiana abortion laws over the years, it has never brought a claim for as-applied relief from the requirement.

Moreover, the supposed burdens cited by the district court arise not from the housekeeping requirement itself, but from Planned Parenthood's own business decision not to install a housekeeping room in its Evansville health center, perhaps because doing so would not be cost-justified by the number of abortions it could likely provide in Evansville. And, again, such burdens are not legally sufficient to constitute an undue burden under *Casey*, which upheld the Pennsylvania waiting period requirement despite the additional travel and expense imposed by the requirement on women seeking abortion. 505 U.S. at 885–86.

Apart from those deficiencies, the cleanliness benefit supplied by the regulation easily outweighs the potential convenience for some women of having an abortion

clinic in Evansville. If one must put it in such terms, having a clean and safe abortion clinic is surely worth the cost of driving 125 miles from Evansville to Bloomington. This Court should reverse the district court's legal conclusion that the burdens of the housekeeping room requirement outweigh its benefits.

III. Indiana's Informed-Consent Disclosures Concerning Human Physical Life and Fetal Pain Are Valid

Finally, the State also appeals the district court's injunction as to two specific provisions of Indiana's informed-consent law: (1) the requirement that the physician (or qualified designee) inform the woman "[t]hat human physical life begins when a human ovum is fertilized by a human sperm," Ind. Code § 16-34-2-1.1(a)(1)(E); and (2) the requirement that the physician (or qualified designee) inform the woman "[t]hat objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age," *id.* § 16-34-2-1.1(a)(1)(G). The Supreme Court has held that a State may "require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992). The Constitution requires only that such disclosures be "truthful and not misleading." *Id.* These requirements meet this standard and are thus permissible under both the First and Fourteenth Amendments.

A. It is truthful and not misleading to tell a woman seeking abortion that "human physical life begins when a human ovum is fertilized by a human sperm"

Indiana requires the physician (or qualified designee) to inform a woman having an abortion that "human physical life begins when a human ovum is fertilized by

a human sperm." Ind. Code § 16-34-2-1.1(a)(1)(E). This statement is truthful and non-misleading.

Dr. Farr Curlin, the State's expert on medical ethics, testified at trial there is "a 100 percent scientific consensus" that this statement is true. Second Trial Tr., Vol. II, 6:21–7:21. From the moment the egg and sperm unite, the fertilized egg has a complete and unique set of human DNA. *See id.* The fertilized egg is undeniably human—it has human DNA—and unmistakably alive—growth and development begin almost immediately after fertilization. *See id.*

The district court discounted the testimony of Curlin because his opinions "are informed by his overall belief that abortion is the killing of an innocent human being." Short App. 148. But it cannot be the rule that an expert's personal beliefs about the morality of abortion render his or her scientific opinions invalid; otherwise, no expert witness would be qualified to testify about abortion at all. Certainly no one seriously disputes that *plaintiffs'* experts have beliefs about abortion, but the district court had no trouble crediting their opinions. That the district court would even presume to assess the value of Curlin's factual, scientific testimony—on which there is, and can be, no scientific dispute—based on his moral views on abortion underscores exactly why questions about abortion regulations do not belong in federal court at all. As Judge Easterbrook noted in *Planned Parenthood of Indiana & Kentucky, Inc. v. Box*, "[h]ow much burden is 'undue' is a matter of judgment . . . which one judge is apt to do differently from another, and which judges as a group are apt to do differently

from state legislators." 949 F.3d 997, 999 (7th Cir. 2019) (Easterbrook, J., concurring in denial of rehearing en banc).

In any event, the informed-consent statement refers to "human physical life" and thereby avoids questions of legal and moral personhood. The district court dismissed this critical distinction because "the mandatory disclosure at issue here . . . references the beginning of human life—a question ripe for debate among 'those trained in the respective disciplines of medicine, philosophy, and theology,' about which neither *the State nor the judiciary* may 'speculate as to the answer.'" Short App. 148 (quoting *Roe v. Wade*, 410 U.S. 113, 159 (1973)) (emphasis added). But the full quote from *Roe* does not mention *the State* at all. *See Roe*, 410 U.S. at 159 ("When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, *the judiciary* . . . is not in a position to speculate as to the answer." (emphasis added)). And *Casey* clarified that the First and Fourteenth Amendments "permit *a State* to further its legitimate goal of protecting the life of the unborn by enacting legislation aimed at ensuring a decision that is mature and informed, even when in so doing *the State* expresses a preference for childbirth over abortion." *Casey*, 505 U.S. at 883 (emphasis added).

Indeed, at least five other States also require doctors to inform abortion patients that life begins at conception. *See* Kan. Stat. Ann. § 65-6709(b)(5) ("[T]he abortion will terminate the life of a whole, separate, unique, living human being."); Mo. Ann. Stat. § 188.027.1(2) ("The life of each human being begins at conception. Abortion will terminate the life of a separate, unique, living human being."); N.D. Cent.

Code § 14-02.1-02.11.a(2) ("The abortion will terminate the life of a whole, separate, unique, living human being."); Okla. Stat. tit. 63, § 1-783.3.A.2.d ("Abortion shall terminate the life of a whole, separate, unique, living human being."); S.D. Codified Laws § 34-23A-10.1(1)(b) ("[T]he abortion will terminate the life of a whole, separate, unique, living human being.").

Since *Casey*, no circuit has invalidated such a requirement, and the Eighth Circuit has expressly rejected a challenge to South Dakota's law. *See Planned Parenthood of Minn., N.D., S.D. v. Rounds*, 530 F.3d 724, 735–36 (8th Cir. 2008). There, the court rejected Planned Parenthood's challenge to the statement that "the abortion will terminate the life of a whole, separate, unique, living human being" on the grounds that one of its experts admitted that "a living embryo or fetus in utero is a developing organism of the species Homo Sapiens which may become a self-sustaining member of the species if no organic or environmental incident interrupts its gestation." *Id* at 736. The court concluded that "the biological sense in which the embryo or fetus is whole, separate, unique and living should be clear in context to a physician." *Id.*

The district court further faulted the State for "present[ing] no evidence that this mandatory disclosure has actually ever served to inform or enhance the decision-making of a single woman." Short App. 148. But *Casey* does not require such evidence. Instead, the Court there held that "most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision." 505 U.S. at 882.

Because the statement that "human physical life begins when a human ovum is fertilized by a human sperm" is truthful and not misleading, this Court should reverse the district court's injunction against that provision.

B. The statement that "objective scientific information shows that a fetus can feel pain at or before twenty weeks of postfertilization age" is truthful and not misleading

Indiana's fetal-pain disclosure requirement meets the "truthful and not misleading" standard as well. This requirement obligates the physician or physician's designee to inform a woman having an abortion that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." Ind. Code § 16-34-2-1.1(a)(1)(G). At least seven other States similarly require by statute that a woman be told or given information concerning fetal pain. *See* Ark. Code Ann. § 20-16-1703(b)(5)(A); Ga. Code Ann. § 31-9A-3(2)(D); Kan. Stat. Ann. § 65-6709(b)(6); La. Stat. Ann. § 40:1061.17.C(1)(h); Minn. Stat. Ann. § 145.4242(a)(2)(iii); Mo. Ann. Stat. § 188.027.1(5); Utah Code Ann. § 76-7-305.5(2)(s)(i). And the United States District Court in Kansas upheld Kansas's fetal-pain law, which is materially identical to the law at issue in this case, against First and Fourteenth Amendment challenges. *Comprehensive Health of Planned Parenthood of Kan. & Mid-Mo., Inc. v. Templeton*, 954 F. Supp. 2d 1205, 1216–19 (D. Kan. 2013).

Here, the evidence supporting Indiana's laws was clear and unrebutted. Dr. Maureen Condic, the State's expert in fetal pain, testified at trial that, based on her own expertise and her review of "well over a hundred" peer-reviewed and well-supported studies, Second Trial Tr., Vol. II, 174:25–176:9, the language of the fetal pain

disclosure was "scientifically well-supported," *id.* at 207:5–23, and thus was "both truthful and not misleading," *id.* at 227:7–15. She began by noting that uncontroverted scientific evidence shows that the spinal reflex necessary for the detection and withdrawal from a painful stimulus develops "[b]etween 8 to 10 weeks postfertilization age," and that "between 12 weeks and roughly 18 weeks of fetal life, information regarding the detection and response to pain will be sent to the thalamus." *Id.* at 183:22–185:1. Condic further explained that "the circuitry present within the thalamus that is connected to the body and responsive to pain beginning at 12 weeks and more or less completing its development by 18 weeks is both necessary for a conscious experience of pain and sufficient for a conscious experience of pain." *Id.* at 188:3–8.

The scientific debate on fetal pain thus centers not on whether a fetus can detect and respond to pain from the late first trimester onward—it unquestionably can—but rather on the developmental stage at which that ability becomes psychologically and emotionally *meaningful*—both to the fetus and society.

Dr. Grossman testified that this ability to feel pain is not meaningful until sometime later in the pregnancy, when the thalamus and cortex are connected. Second Trial Tr., Vol I, 198:14–200:16. Condic, however, pointed to "12 independent lines of evidence" that refute the idea that connections between the thalamus and the cortex, which do not begin developing until 24 weeks, are necessary for a fetus to consciously experience pain. Second Trial Tr., Vol. II, 190:3–191:14.

1. First, "the assertion that . . . a fetus is incapable of experiencing pain because connections between the thalamus and the cortex don't develop until 24 weeks of fetal life . . . is counterindicated by the fact

that many animals that don't even have a cortex . . . are conscious, and all of those animals respond to pain." *Id.* at 192:10–19.

2. Second, "even if we start with an animal that naturally has a cortex . . . if these animals have their cortex experimentally removed . . . such decorticate animals continue to be conscious and continue to respond very vigorously to painful stimuli, again demonstrating that the cortex cannot be necessary for a conscious awareness of pain." *Id.* at 194:2–12.
3. Third, "children that are born without a cortex or without large regions of the cortex . . . remain conscious . . . and they remain responsive to painful input." *Id.* at 195:11–20.
4. Fourth, studies of "people who, due to stroke or injury or some other medical condition, have impaired consciousness . . . very strongly and unambiguously conclude that a loss of consciousness in mature patients is associated with loss of tissue in the thalamus, not in the cortex." *Id.* at 198:25–199:6.
5. Fifth, although "infants and children have very, very immature cortical circuitry[,] . . . our experience of pain is remarkably constant across our childhood into adulthood." *Id.* at 200:11–201:1.
6. Sixth, studies show that "older areas of the brain, the parts of the brain that are common between us and, say, birds or fishes, are necessary for the experience of emotions and consciousness rather than the cortex." *Id.* at 203:1–11.
7. Seventh, studies using anesthesia show that "when an animal or a human becomes unconscious, it's associated with a loss of activity in the thalamus, not in the cortex, that loss of activity in the cortex only happens later because the cortex is no longer getting information from the thalamus." *Id.* at 204:6–20.
8. Eighth, studies of people undergoing brain surgery show that "[y]ou don't elicit an experience of pain by stimulating the cortex." *Id.* at 205:25–206:6.
9. Ninth, "removing parts of the thalamus or stimulating parts of the thalamus . . . can provide very significant relief of pain experiences to patients, whereas similar stimulation of the cortex provides no effective treatment of chronic pain." *Id.* at 206:17–207:2.
10. Tenth, "a human fetus between 18 and 22 weeks shows a hormonal and circular tower response to pain," meaning that "their body reacts to a painful experience in the same way that more mature individuals react, by elaborating increases in hormones and other physiologic changes associated with stress." *Id.* at 208:25–209:8.

11. Eleventh, "anesthesiologists have recommended that fetuses be given anesthesia to prevent a pain response and in particular to prevent . . . the known impact of painful experiences on brain development." *Id.* at 209:18–210:8.
12. Twelfth, based on "the application of . . . systems for encoding pain based on facial gestures in premature infants [born as early as 23 weeks,] . . . it's pretty unambiguous that these premature infants do experience pain in response to painful procedures." *Id.* at 210:24–211:4.

Moreover, Condic's unrebutted testimony showed that not only were Grossman's claims of a scientific "consensus" against fetal pain before 24 weeks grossly overstated, but his lone citation to a one-page advocacy statement on fetal pain, self-published by the American College of Obstetricians and Gynecologists (ACOG), was unsupported by either of that statement's two citations.[10] ACOG relied exclusively on two older literature reviews, one commissioned by the Royal College of Obstetricians and Gynaecologists in 2010 (the "RCOG review") and one published by attorney Susan J. Lee and others in 2005 (the "Lee review"). Though well-supported in other respects, the RCOG review cites only three papers for its key assumption that the cortex is necessary for pain perception, but two of the three papers *contradict* that assertion, and the third does not address the perception of pain. Second Trial Tr., Vol. II, 217:9–220:18. And while the Lee review likewise presumes the necessity of the cortex for conscious pain, it fails to cite a single study supporting that assertion; none of its citations even directly addresses the role of the cortex in consciousness or pain perception. *Id.* at 213:13–215:7.

[10] Grossman admitted that he has no expertise in either neurobiology or embryology, and that his claims of scientific consensus were based solely on the positions of two professional organizations outside those disciplines. Second Trial Tr., Vol. I, 222:1–223:6.

Neither Grossman nor any other witness rebutted any portion of Condic's testimony or the substantial body of scientific literature supporting fetal capacity for pain before 18 weeks, nor did they attempt to refute her assessment that ACOG and Grossman had entirely failed to support their key assumptions with scientific evidence. Despite the State's thorough demonstration that "plaintiffs and their sources rely on nothing more than the ipsi dixits of self-interested professional organizations," Second Trial Tr., Vol. III, 66:3–4, however, the district court discounted these twelve independent lines of evidence as a "fringe view" simply because the implications of that scientific literature "directly conflict[]" with the position taken by ACOG leadership—a professional organization supported by many abortion providers. Short App. 145. The district court's conclusion on this point was clearly erroneous. *See Reed-Union Corp. v. Turtle Wax, Inc.*, 77 F.3d 909, 911 (7th Cir. 1996) (acknowledging clear error where judge "disbelieves testimony supported by unrefuted documents").

Even without that absence of scientific support, no legal rule prevents state legislatures from disagreeing with ACOG or imbues its pronouncements with constitutional weight. On the contrary, the Supreme Court upheld the federal partial-birth abortion ban over Justice Ginsburg's objection that the ban conflicted with the recommendations of ACOG. *See Gonzales v. Carhart*, 550 U.S. 124, 166 (2007) (rejecting an evidentiary standard that "would strike down legitimate abortion regulations . . . if some part of the medical community were disinclined to follow the proscription"); *id*. at 170–71 (Ginsburg, J., dissenting) (noting ACOG's opposition).

Far from subjecting state-mandated disclosures to the veto of professional advocacy groups, *Casey* requires only that such disclosures be "truthful and not misleading." 505 U.S. at 882. Not one of Whole Woman's Health's witnesses testified that the fetal pain disclosure was either untruthful or misleading. Even if Whole Woman's Health had countered with its own scientific evidence, the State's own substantial showing of overwhelming scientific evidence showing fetal capacity for a conscious experience of pain at or before 20 weeks suffices to ground the disclosure in scientific proof. It thus establishes that it is truthful and not misleading to inform women seeking abortions that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age." Ind. Code § 16-34-2-1.1(a)(1)(G).

CONCLUSION

For the foregoing reasons, the State respectfully requests that this Court reverse the district court and vacate the permanent injunction.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on September 30, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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