

**UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION**

NATALIE DAWN BINGHAM, M.D.,	)	
M.P.H., <i>et al.</i> ,	)	
	)	CASE NO. 2:25-cv-00163-RMG
<i>Plaintiffs,</i>	)	
	)	
v.	)	
	)	
ALAN McCRORY WILSON, in his official	)	
capacity as Attorney General of South	)	
Carolina, <i>et al.</i> ,	)	
	)	
<i>Defendants,</i>	)	
	)	
and	)	
	)	
HENRY DARGAN McMASTER, in his	)	
official capacity as Governor of the State of	)	
South Carolina,	)	
	)	
<i>Intervenor-Defendant.</i>	)	

**MEMORANDUM IN SUPPORT OF
PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

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INTRODUCTION

Plaintiffs Dr. Natalie Dawn Bingham and Dr. Jane Doe are highly respected OB/GYNs. Until 2023, when the Abortion Ban, S.C. Code Ann. §§ 44-41-610–690, took effect, they had provided abortions to patients in South Carolina for nearly seventeen years consistent with the standard of care. This included circumstances in which a patient’s pregnancy threatened her health or she had received a fetal anomaly diagnosis.

Since then, Plaintiffs have strived to continue caring for their patients within the Abortion Ban’s confines. But because the terms of the Health Exception, *id.* § 44-41-640(B)(1)–(C)(1), and Fatal Fetal Anomaly Exception, *id.* § 44-41-610(5), to the Abortion Ban lack any meaning in medicine, Plaintiffs and other physicians across South Carolina regularly struggle to apply the Exceptions to the high-stakes complexity of obstetrics. The vagueness of the Health and Fatal Fetal Anomaly Exceptions often prevents physicians from determining if or when a particular patient meets an Exception. This forces physicians to refer their patients out of state, or leaves physicians wracked with fear that someone will criminally prosecute and professionally discipline them for an abortion they provided based on their good-faith interpretation of the Abortion Ban.

Because the undisputed facts establish that the Abortion Ban links “criminal culpability to . . . wholly subjective judgments[,]” *United States v. Williams*, 553 U.S. 285, 306 (2008), and fails to “establish minimal guidelines to govern law enforcement,” *United States v. Lanning*, 723 F.3d 476, 482 (4th Cir. 2013) (citation omitted), the Health and Fatal Fetal Anomaly Exceptions are unconstitutional as a matter of law, and Plaintiffs are entitled to summary judgment on their vagueness claim.

STATEMENT OF UNDISPUTED FACTS

I. The Practice of Medicine, and Obstetrics Specifically, is Complex.

Both medicine overall and obstetrics in particular are very complex. App. 125, 131, 314, 409. Caring for a pregnant patient requires monitoring a range of variables that can affect the patient's health. App. 217–18, 316–17. Every pregnancy carries a risk of complications. App. 125–28, 231. In the United States, around 600–800 women die from pregnancy-related causes each year. App. 126. Black women in the United States are three times more likely to die of pregnancy-related causes than white women. App. 126–27. Other risks of pregnancy include, but are not limited to: hypertensive disorders such as preeclampsia, cardiovascular disorders such as cardiomyopathy (heart failure), hematologic complications such as severe intractable hemorrhage, and infection complications such as sepsis. App. 128, 403.

A. It Is Extremely Difficult to Predict If or When a Particular Patient Will Suffer Harm If She Continues a Pregnancy.

Even with extensive medical education and training, the complex nature of medicine and obstetrics makes it extremely difficult to predict if or when a particular patient will suffer harm if she continues a pregnancy. App. 37, 125, 407; *see* App. 270 (“[P]hysicians are famously often wrong in prognoses.”).

Every patient and clinical situation is unique. App. 8, 302, 325–26, 360. And patients surprise physicians. App. 217–18. Some pregnant patients' conditions improve when a physician thinks they are going to worsen, App. 217–18, some pregnant patients' conditions worsen when a physician thinks they are going to improve, App. 218, and some pregnant patients' conditions worsen with little warning and very quickly, App. 37, 200, 249–50, 318–20.

B. For Some Fetal Anomalies, It Is Impossible to Predict If They Will Result in a Stillbirth, How Long a Fetus That Is Born Alive Will Live, or What Medical Interventions May Benefit the Neonate.¹

There is a wide range of fetal anomalies and different presentations within each anomaly. App. 132, 400. For some fetal anomalies, it is impossible to predict if the anomaly will result in a stillbirth. App. 125, 130, 132, 397–98. And it can be impossible to predict how long a fetus that is born alive will live. App. 125; *see* App. 341–42 (Dr. Greig, one of Defendants’ experts, referring to fetal cases where physicians “just don’t know how the baby is going to do after birth”). It can also be impossible to predict what medical interventions may benefit the neonate. App. 125–26, 130.

II. The Standard of Care is to Offer a Patient an Abortion When Her Pregnancy Threatens Her Health or She Has Received a Fetal Anomaly Diagnosis.

The American Board of Obstetrics & Gynecologists (“ABOG”) certifies OB/GYNs. App. 247. The American College of Obstetricians & Gynecologists (“ACOG”) issues rigorously tested practice guidelines and committee opinions that make up some of the national guidelines for Board-certified OB/GYNs. App. 229–30, 247–48, 251; *see* App. 399. The American Medical Association (“AMA”) and the Society for Maternal-Fetal Medicine (“SMFM”), the professional organization for high-risk obstetricians (known as maternal-fetal medicine specialists (“MFMs”)), also help define physicians’ professional obligations. App. 177, 399.

There is a deep and wide body of research demonstrating that abortion is extremely safe. App. 31. At least seventy-five major medical societies consider abortion a standard and necessary medical treatment. App. 176. Medical ethics and national guidelines issued by ABOG, ACOG,

¹ The medical definition of “neonate” is within twenty-eight days of delivery. App. 280.

and the AMA instruct physicians to offer a patient an abortion as soon as her pregnancy begins to threaten her health. App. 393–95, 423; *see* App. 137. It is anathema to good medicine for a physician to wait for a patient to become sicker before trying to reduce the patient’s risk or prevent further risk. App. 8–9, 13, 138, 142, 170, 227–28. Likewise, physicians are taught, trained, and ethically and professionally obligated to offer an abortion to a patient with a fetal anomaly if an abortion comports with the patient’s goals. App. 125–26, 138, 398–99 (citing guidance from ACOG and the AMA), 411–12. Generally, physicians let parents of fetuses with “life-limiting conditions” decide what quality of life means to them rather than making that decision for the parents.² App. 17–18, 309–10.

III. Plaintiffs and Their Experts.

Plaintiffs Dr. Doe and Dr. Bingham are Board-certified OB/GYNs who each practiced medicine in South Carolina for approximately two decades. App. 5–6, 27–28, 225–26, 235, 298. In May 2025, after repeatedly being unable to determine if a patient’s condition met the Health Exception, Dr. Bingham left South Carolina to practice medicine in another state. App. 6, 239–41. She intends to resume practicing in South Carolina if the Court grants relief in this lawsuit. App. 6, 236–37.

² “Life-limiting conditions” refers to fetal conditions for which there is “little . . . prospect of long-term ex-utero survival without severe morbidity or extremely poor quality of life and for which there is no cure.” App. 46 (citing *Perinatal Palliative Care*, ACOG Comm. Op’n No. 786 (Sept. 2019), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/09/perinatal-palliative-care>), 305. This term is much easier for many physicians to understand and apply than the Fatal Fetal Anomaly Exception. App. 132–33, 179–80, 305–08, 410. Defendants’ experts and their colleagues regularly refer to the ACOG Committee Opinion and use “life-limiting” in treating patients. *See, e.g.*, App. 257, 260–62.

Plaintiffs’ expert Dr. Tarleton, a Board-certified OB/GYN and complex family planning specialist, practiced in South Carolina for seven years before her own struggles to interpret the Exceptions forced her to leave the State. App. 185–86, 190. Dr. King, also a Board-certified OB/GYN, holds clinical and academic appointments at Mass General Brigham and serves as the Director of Reproductive Bioethics at Harvard Medical School’s Center for Bioethics. App. 124, 153, 389–91. And Dr. Buchbinder, a medical anthropologist and Professor of Social Medicine at the University of North Carolina–Chapel Hill, has since 2023 been part of the Study of OB-GYNs in Post-*Roe* America (“SOPRA”), which examines how abortion bans that use the same or similar language as the Health and Fatal Fetal Anomaly Exceptions affect physicians. App. 57, 62–64.

IV. Physicians Often Struggle to Determine If or When a Particular Patient’s Condition Poses a “Serious Risk of a Substantial and Irreversible Physical Impairment of a Major Bodily Function.”³

The Health Exception permits an abortion “to prevent . . . the serious risk of a substantial and irreversible physical impairment of a major bodily function of the pregnant woman, not including psychological or emotional conditions.” S.C. Code Ann. § 44-41-640(C)(1); *see also id.* § 44-41-640(B)(1).

About two to three times a month, Dr. Doe and her colleagues are unable to determine if a particular patient’s condition meets the Health Exception. App. 479. When Dr. Bingham practiced

³ Some sections of the Health Exception refer to a “serious risk of a substantial *and* irreversible physical impairment of a major bodily function,” S.C. Code Ann. § 44-41-640(C)(1) (emphasis added), while others refer to a “serious risk of a substantial *or* irreversible impairment of a major bodily function,” *id.* § 44-41-640(B)(1) (emphasis added). Likewise, some sections of the Health Exception refer to a physician’s “reasonable medical judgment,” *id.* § 44-41-640(C)(1), while others refer to “standard medical practice,” § 44-41-640(B)(1).

in South Carolina, she was unable to determine if a particular patient met the Health Exception each day that she worked on a Labor and Delivery Unit. App. 494–95. When Dr. Tarleton worked in South Carolina, she referred many patients out of state for an abortion because she could not determine if they met the Health Exception. App. 422.

A. “Serious Risk” Is a Non-Medical, Elastic Term.

Although physicians sometimes use “serious risk” when counseling patients or speaking with colleagues, “serious risk” is not defined in medicine. App. 7–8, 35–36, 210–11, 299, 314, 396.

Because “serious risk” is not an absolute benchmark in medicine, each physician can have a different understanding of what makes a risk “serious.” App. 35–36. To illustrate, physicians have no way to determine if “serious risk” is a qualitative term, meaning whether it refers to the severity of a potential harm. App. 35–36, 142. Dr. Greig denies that “serious” refers to the severity of a potential harm. App. 338.

Likewise, physicians have no way to determine if “serious risk” refers to the likelihood of a harm. App. 142. For instance, physicians have no way to determine if “serious risk” refers to a risk that is more than 50% likely; approximately 25% likely; or simply possible, but impossible to predict how likely. App. 35–36, 70, 145. Physicians have no way to determine if a “serious risk” must be imminent. App. 145, 418–21.

Defendants’ own experts’ understanding of “serious risk” varies. Dr. Buskmiller believes that “serious risk” is a quantitative term that encompasses not only “high[,]” but also “moderate[,]” risks. App. 263–65. But her definition includes qualitative elements: “[I]f the low-risk group has a 10 percent risk of something, . . . then a patient with a moderate risk may have one or two risk

factors or may have a concerning clinical exam or ultrasound that day.” App. 266. Dr. Greig denies that “serious” refers to a statistical probability that something might occur because physicians consider even quantitatively low risks to be high when the percentage refers to a catastrophic outcome, such as death. App. 337. Further, Dr. Greig does not know what “moderate risk of harm” means. App. 343. And Dr. Draper does not believe that “serious risk indicate[s] any statistical probability” “because [she] often can’t get a statistical probability, especially in emergency situations.” App. 329–30.

Physicians also have no way to determine if “serious risk” permits them to account for patients’ understanding of what constitutes a serious risk for them. App. 35–36. Dr. Greig seems to believe that it does not, App. 345, despite his own practice of doing so, App. 344–45.

There is no clear point when a patient’s condition crosses from a “non-serious” to a “serious” risk. App. 13, 242–43. Defendants concede that “it is not always possible for a physician to determine whether or when a pregnant patient’s condition . . . will worsen during pregnancy and cause them to experience a substantial and irreversible physical impairment of a major bodily function during or after delivery.” App. 456 (emphases omitted).

B. “Substantial and Irreversible Impairment of a Major Bodily Function” Is a Non-Medical Term.

“Substantial and irreversible impairment of a major bodily function” is not defined in medicine. App. 7–8, 37, 125, 142–43, 396; *see* App. 267–77 (Dr. Buskmiller characterizing “major bodily function” as a “colloquial” term).

Physicians understand what “irreversible” means, but struggle to determine when a patient’s condition is approaching irreversibility. App. 253–54. For example, kidney function can change rapidly and without warning during pregnancy. App. 142–43. Physicians struggle to

determine if kidney dysfunction becomes irreversible when creatinine levels begin to rise, creatinine levels reach a certain point, there is protein in the urine, and/or protein in the urine reaches a certain level. App. 142–43; *see* App. 253–54, 455–56.

Additionally, physicians have no way to determine if “major bodily function” refers to “big organs,” “small organs,” mental activity, systems that contribute to digestion, touch, the hormonal system, movement, and/or the blood systems. App. 143, 402.

Each of Defendants’ experts has a different understanding of “major bodily function.” Dr. Austin cannot identify an exhaustive list of “major bodily functions.” App. 200–01. Dr. Buskmiller believes “major bodily function” is limited to life, organ function, sensory function, and limb function, and more specifically, the functions of the brain, heart, lungs, kidneys, and liver. App. 267–69. Dr. Greig believes that “major bodily function” refers to neurologic, cardiovascular, pulmonary, renal, hepatic, and reproductive functions. App. 381–82. Dr. Draper believes that “major bodily function” refers to neurologic, cardiovascular, pulmonary, gastrointestinal, and musculoskeletal functions, as well as the functions of the brain, sensory organs, endocrine organs, skin, heart, lungs, liver, pancreas, spleen, and kidneys. App. 321.

C. Physicians Have No Way to Determine if the Health Exception Permits Them to Account for Any Social Determinants of Health.

Social determinants of health include race, ethnicity, how far a patient lives from clinical care, and “the other burdens in her life.” App. 265–66, 272. Some physicians consider social determinants in assessing a patient’s medical risks. App. 271–72, 361–62, 344; *see* App. 173–74.

But physicians have no way to determine if the Health Exception permits them to account for social determinants of health when assessing a patient’s risks. *See* App. 173–74. Dr. Buskmiller

believes that the Health Exception allows physicians to account for social determinants, App. 281, while Dr. Greig thinks it generally does not permit such considerations. App. 362–63.

D. Illustrations of Physicians’ Struggles to Apply the Health Exception.

It is impossible to identify the countless conditions that physicians do or could encounter that arguably meet the Health Exception. *See* App. 38, 128–29.

1. Lupus

Lupus is a chronic condition in which the body’s immune system attacks healthy tissues and organs, including the kidneys. App. 39–41. For some pregnant lupus patients, it is impossible to predict if, or how quickly, their kidney function will worsen. App. 292; *see* App. 39–41, 349–51. Some pregnant lupus patients do not suffer exacerbation of their renal functioning until they can deliver. App. 41. Others develop severe hypertensive crises, renal insufficiency, or renal failure early in pregnancy. App. 41.

Dr. Doe struggles to determine what deterioration in renal function in a pregnant lupus patient is “serious” enough to meet the Health Exception. App. 39–41, 481.

Defendants’ experts have different understandings of if or when a pregnant lupus patient could meet the Health Exception. *See* App. 214, 274, 331, 349–51. Dr. Draper believes that the Health Exception could “[p]ossibly” allow an abortion to a patient with lupus. App. 331. But because “[l]upus is very unpredictable,” she “tend[s] to send [lupus patients] to MFM for care.” App. 331. Dr. Austin is not sure if the Health Exception applies to lupus because “lupus is one of those waxing and waning diseases where . . . sometimes it’s horribly severe and other times it’s sort of in remission.” App. 214. Dr. Greig believes that a lupus patient would meet the Health Exception if her “kidneys were not functioning” and she “was going to die” if she could not obtain a higher

dose of medication. App. 349–51. Dr. Buskmiller believes that the failure of “any body system, especially the major bodily organs” due to lupus “could be a situation where we would be talking about the [Health Exception].” App. 274.

2. PPROM

Preterm premature rupture of the membranes (“PPROM”) is a relatively common condition in which the amniotic membrane ruptures, which can cause sepsis, infection, and hemorrhage. App. 44, 303–304, 356–57. Patients suffering from PPROM can go from fairly stable to critical very quickly. App. 132, 357. However, not all patients with PPROM become significantly sicker with expectant management. App. 132, 408; *see* App. 414–16.

Dr. Doe and her colleagues have determined, based on their good-faith interpretation of the Health Exception, that most cases of PPROM permit an abortion. App. 303–04. But they struggled to determine if they could provide an abortion to a PPROM patient who was pregnant with twins. App. 44–45. Only one amniotic sac had ruptured, but the patient faced a high risk of infection and hemorrhage. App. 44. Dr. Doe’s institution eventually determined that the patient was eligible for an abortion, but only after a significant delay. App. 44. While Dr. Doe and her colleagues were consulting about whether the patient was eligible for an abortion under the Health Exception, the patient “spontaneously labored[,] . . . delivered both fetuses[,] and suffered additional risk and pain.” App. 44.

Guidelines developed by a group of South Carolina physicians concerning the Abortion Ban state that even if a patient with PPROM is “currently without signs of infection and is not bleeding,” the patient is “considered a medical emergency due to the risk the patient could rapidly develop sepsis or abruption.” App. 521.

Conversely, both Dr. Austin and Dr. Greig deny that a patient suffering from PPRM meets the Health Exception if there are no signs of infection. App. 202, 353–57 (Dr. Greig opining that “it would be unreasonable under South Carolina’s law to rely on” the SMFM recommendation counseling against expectant management for patients with PPRM).

3. Pulmonary Embolism

Pregnant patients with a history of pulmonary embolism are at risk for a life-threatening blood clot recurring during pregnancy and in the post-partum period. App. 41. Physicians can administer treatments to reduce the risk of pulmonary embolism, but the treatments can be unsuccessful and carry their own risks. App. 41.

Dr. Doe could not determine if a pregnant patient with a history of pulmonary embolism faced a “serious risk of a substantial and irreversible physical impairment of a major bodily function” because it was unclear if treatment would work and if the patient would suffer negative side effects from the treatment. App. 481. This forced Dr. Doe to refer the patient to another state for an abortion. App. 481.

Defendants’ experts have different understandings of if or when a patient with a history of pulmonary embolism meets the Health Exception. Dr. Draper seems to think that the only circumstance in which such a patient could meet the Health Exception is if she were actively suffering a massive pulmonary embolism. App. 327–28, 332–33. Dr. Austin thinks that a patient with a history of pulmonary embolism usually does not meet the Health Exception “because pulmonary embolism now is very treatable.” App. 215. Dr. Buskmiller thinks that patients with a history of pulmonary embolism would not meet the Health Exception because they face only a 3.6% risk of recurrence with appropriate anticoagulation. App. 293. Dr. Buskmiller admits that anticoagulation

treatment is associated with risks, but cannot quantify them. App. 294–95. Dr. Greig thinks that a pregnant patient with a history of pulmonary embolism “might meet” the Health Exception if the patient had previously received appropriate treatment, but had still suffered a pulmonary embolism. App. 364–65.

V. Physicians Often Struggle to Determine If a Particular Fetal Anomaly is “Incompatible with Sustaining Life after Birth.”

The Fatal Fetal Anomaly Exception permits an abortion when, “in reasonable medical judgment, the unborn child has a profound and irremediable congenital or chromosomal anomaly that, with or without the provision of life-preserving treatment, would be incompatible with sustaining life after birth.” S.C. Code Ann. § 44-41-610(5).

About once a month, Dr. Doe and her colleagues are unable to determine if a particular patient meets the Fatal Fetal Anomaly Exception. App. 479. Physicians sometimes refer patients out of state for an abortion because they cannot determine if the patient meets the Fatal Fetal Anomaly Exception. App. 181.

A. “Incompatible With Sustaining Life After Birth” Is a Non-Medical Term.

“Incompatible with sustaining life after birth” is not defined in medicine. App. 46, 74, 126, 145–46. Dr. Buskmiller maintains that “incompatible with life” is found in older medical literature, but she cannot identify any of the specific literature. App. 283–84. Because Dr. Buskmiller thinks that “incompatible with life” confuses patients, she tends not to use the term in clinical settings. App. 285–86.

Physicians have no way to determine if “incompatible with sustaining life after birth” refers to a death that occurs within hours, months, and/or a year of birth. App. 17, 233–34, 246, 429.

Defendants' experts' understanding of "incompatible with sustaining life after birth" varies. App. 205–06, 219–20, 282, 322–23. Dr. Austin thinks that the term refers to when the neonate is unlikely to live more than a year, but he is not sure if there is professional consensus about that definition. App. 205–06, 219–20. Dr. Draper thinks that "incompatible" in the Fatal Fetal Anomaly Exception means "that the baby cannot live outside of the womb. And if they can, it's a very brief survival . . . [H]ours to days, sometimes weeks, very rarely a month or so." App. 322–23. Dr. Buskmiller thinks that "incompatible with sustaining life after birth" refers to death within approximately six months of birth. App. 282.

Physicians also have no way to determine if "sustaining life" refers to certain physiological functions, such as cardiac activity, brain activity, and/or the ability to communicate. App. 146.

Likewise, physicians have no way to determine if "incompatible with sustaining life after birth" permits physicians to account for patients' concerns that the anomaly will cause the neonate suffering or that the neonate will lack a quality of life. App. 17, 246, 425; *see* App. 179–80.

B. Illustrations of Physicians' Struggles to Apply the Fatal Fetal Anomaly Exception.

It is impossible to identify all the fetal anomalies that physicians do or could encounter that arguably meet the Fatal Fetal Anomaly Exception. *See* App. 130.

1. Trisomy 18

Trisomy 18 is a relatively common genetic condition that causes severe heart and lung abnormalities and profound intellectual disabilities. App. 130, 405–06. Defendants admit that it is unlikely (less than a 50% chance), but not impossible, for a fetus with Trisomy 18 to survive delivery. App. 457–58. A little more than half of neonates born with Trisomy 18 live beyond one

week. App. 180. Only 10–25% of neonates born with Trisomy 18 live beyond the first year, but those who do may live for years. App. 180.

Dr. Doe and her colleagues have generally been unable to determine if patients with a Trisomy 18 diagnosis meet the Fatal Fetal Anomaly Exception because there is a small chance that the fetus will survive birth and live for an unpredictable period. App. 48, 308. This has forced Dr. Doe to refer patients who wish to obtain an abortion in cases of Trisomy 18 out of state. App. 48, 473. The chair of Dr. Tarleton’s department in South Carolina would not advise physicians to provide abortions for Trisomy 18 “because it would be too legally risky given . . . the public perception.” App. 426–27.

Once again, Defendants’ experts have different understandings of if or when Trisomy 18 meets the Fatal Fetal Anomaly Exception. Dr. Greig thinks that Trisomy 18 meets the Fatal Fetal Anomaly Exception because it is “[v]ery, very rare[]” to survive birth and most neonates need long-term ventilation, but he acknowledges that physicians might disagree with that assessment because some fetuses with Trisomy 18 survive delivery. App. 352–53. Dr. Draper thinks that only some cases of Trisomy 18 meet the Fatal Fetal Anomaly Exception “based on the surrounding circumstances.” App. 334–35. Dr. Austin thinks that Trisomy 18 clearly meets the Fatal Fetal Anomaly Exception. App. 203–04. Dr. Buskmiller thinks that Trisomy 18 meets the Fatal Fetal Anomaly Exception because 1) there is no cure, and 2) it will inevitably lead to stillbirth, the death of the neonate within approximately six months, or more rarely, the death of a child regardless of “life-sustaining treatment.”⁴ App. 275–76, 278–80, 287–88.

⁴ The medical definition of “child” is a person under eighteen years old. App. 280.

2. Hypoplastic Left Heart Syndrome

Hypoplastic left heart syndrome (“HLHS”) is very likely to result in infant mortality without multiple surgical interventions, which may be extensive, costly, and fatal.⁵ App. 49, 130, 179. But some people with HLHS live for many years. App. 277 (Dr. Buskmiller recalling that she once shook hands with an adult man with HLHS). Only some infants with HLHS are eligible for complex open-heart surgery or a heart transplant. App. 130, 179, 459.

Dr. Doe was recently unable to determine if a case of HLHS met the Fatal Fetal Anomaly Exception, which forced her to refer her patient out of state for an abortion. App. 49–50, 473. Dr. Tarleton disagreed with an MFM who determined that a case of HLHS did not meet the Fatal Fetal Anomaly Exception, but she referred the patient out of state for an abortion because she feared inadvertently violating the Abortion Ban when another physician had already determined the Exception did not apply. App. 181–82, 424.

The Defendants’ experts have different understandings of if or when HLHS meets the Fatal Fetal Anomaly Exception. App. 207–08, 275–76, 287–88, 383–85, 339–40, 468. Dr. Austin holds that “depending on the severity,” the Exception could apply to cases of HLHS. App. 207–08. Dr. Buskmiller holds that HLHS meets the Fatal Fetal Anomaly Exception when any available curative treatment cannot provide a “sufficient likelihood of survival” beyond approximately six months after birth, even though it is exceedingly difficult to predict when a neonate will die from HLHS. App. 275–76, 287–88. Dr. Greig holds that a typical HLHS diagnosis on its own doesn’t qualify under the Fatal Fetal Anomaly Exception, but it could if the neonate will not survive surgery after

⁵ The medical definition of “infant” is within one year of delivery. App. 280.

birth. App. 383–85, 339–40. Defendants hold that HLHS may meet the Fatal Fetal Anomaly Exception if there are “extracardiac or genetic abnormalities and associated cardiac abnormalities such as total anomalous pulmonary venous return.” App. 468. *Infra* at 17.

3. Amniotic Band Syndrome

Amniotic Band Syndrome is a condition in which a fibroid band develops in the amniotic sac, which can strangle fetal body parts. App. 51. Dr. Doe struggles to determine if cases of Amniotic Band Syndrome meet the Fatal Fetal Anomaly Exception because it is difficult to determine how severe the diagnosis is by ultrasound, and often impossible to do so until after birth. App. 51. In one case, Dr. Doe and her colleagues understood that her patient had an amniotic band that was affecting the fetus’s spine and some of its limbs, but they could not determine the severity of the anomaly by ultrasound or if the neonate would survive multiple, extensive surgeries. App. 51, 483. This forced Dr. Doe to refer the patient out of state for an abortion. App. 483.

Defendants’ experts have different understandings of if or when Amniotic Band Syndrome meets the Fatal Fetal Anomaly Exception. App. 223, 289–91, 296, 386–87. Dr. Austin is unsure if Amniotic Band Syndrome ever meets the Fatal Fetal Anomaly Exception. App. 223. He would have to consult an MFM. App. 223. Dr. Greig thinks that Amniotic Band Syndrome could meet the Fatal Fetal Anomaly Exception if it is a “severe form.” App. 386–87. Dr. Buskmiller thinks that Amniotic Band Syndrome “rarely” meets the Fatal Fetal Anomaly Exception because “[m]ost bands affect extremities, which would lead to physical disability, which does not seem to be life-limiting.” App. 296. As she herself and ACOG recognize, however, prenatal prognoses can be uncertain partly because prenatal diagnostic techniques such as ultrasound are fallible. App. 289–91.

VI. Physicians Only Feel Confident Enough to Provide an Abortion Pursuant to the Health Exception or the Fatal Fetal Anomaly Exception in the Most Egregious Cases.

Dr. Doe, Dr. Tarleton, and other South Carolina physicians have only been confident enough to provide an abortion under the Health Exception or the Fatal Fetal Anomaly Exception in the most extreme cases, including for patients afflicted with comorbidities. App. 300, 311–13, 417, 488, 503–10; *see* App. 255. Even after only providing abortions in extreme cases, Drs. Doe and Tarleton worried someone would question their judgment and they would face criminal or professional consequences. App. 53–54, 300, 312–13, 417, 428; *see* App. 81–82, 255.

VII. Some Physicians Are Willing to Offer Testimony That Conflicts with the Overwhelming Medical Consensus on Abortion.

Defendants’ experts illustrate that some physicians are willing to offer testimony that conflicts with the overwhelming medical consensus on abortion. App. 209, 258–59, 324, 376–81.

For example, contrary to ACOG, Dr. Buskmiller maintains that hormonal contraception can cause an abortion by causing an embryo’s death after fertilization and before or in association with implantation. App. 258–59. Dr. Austin disclaims that “abortion is part of comprehensive obstetrics and gynecology.” App. 209; *see supra* at 3. Similarly, Dr. Draper does not consider abortion to be health care unless it is “to save the *life* of the mother.” App. 324 (emphasis added); *see supra* at 3. And Dr. Greig disagrees with the data on the safety of abortion. App. 376–81; *see supra* at 3.

VIII. The Attorney General’s Office and Circuit Solicitors’ Offices Do Not Know What the Health or Fatal Fetal Anomaly Exceptions Mean.

The Attorney General’s Office and the Office of the Solicitor for the Seventh Judicial Circuit (“Seventh Circuit Solicitor”) need to consult a medical professional to understand what

“serious risk of a substantial and irreversible physical impairment of a major bodily function” means.⁶ App. 431, 447–48. The Office of the Solicitor for the Thirteenth Judicial Circuit (“Thirteenth Circuit Solicitor”) needs to consult a medical professional or the Attorney General’s Office to understand what “serious risk of a substantial and irreversible physical impairment of a major bodily function” means.⁷ App. 441–42.

Similarly, the Seventh and Thirteenth Circuit Solicitors need to consult a medical professional to understand what “incompatible with sustaining life after birth” means. App. 443, 449–50. The Attorney General’s Office cannot fully explain what “incompatible with sustaining life after birth” means. App. 432–33.

The Attorney General’s Office cannot confirm if the Abortion Ban requires it to determine if a physician exercised reasonable medical judgment before charging the physician with a violation of the Abortion Ban. App. 435–37. Relatedly, the Attorney General’s Office cannot confirm if the Abortion Ban requires a prosecutor to prove beyond a reasonable doubt that a physician

⁶ The Seventh Circuit Solicitor prosecutes criminal offenses in Spartanburg and Cherokee Counties. S.C. Code Ann. § 14-5-610(A)(7). In 2024, abortions were provided in Spartanburg County, namely at Spartanburg Medical Center. S.C. Dep’t of Pub. Health, *A public report providing statistics compiled from all abortions reported to DPH*, Tbl. 8, 5 (2024), https://dph.sc.gov/sites/scdph/files/2025-06/2024-SC_Abortion_Report.pdf. Plaintiffs request that the Court take judicial notice of this official state publication. *See* Fed. R. Evid. 201(b)(2)–(c)(2), 902(5).

⁷ The Thirteenth Circuit Solicitor prosecutes criminal offenses in Greenville and Pickens Counties. S.C. Code Ann. § 14-5-610(A)(13) (2025). In 2024, abortions were provided in Greenville County, namely at the Greenville Women’s Clinic and Prisma Health Greenville Memorial Hospital. S.C. Dep’t of Pub. Health, *A public report providing statistics compiled from all abortions reported to DPH*, Tbl. 8, 5 (2024), https://dph.sc.gov/sites/scdph/files/2025-06/2024-SC_Abortion_Report.pdf. Plaintiffs request that the Court take judicial notice of this official state publication. *See* Fed. R. Evid. 201(b)(2)–(c)(2), 902(5).

charged with providing an illegal abortion for health or fetal anomaly reasons did not exercise reasonable medical judgment. App. 437–38. The Thirteenth Circuit Solicitor cannot identify the elements of a violation of the Abortion Ban without first consulting medical personnel. App. 445.

The Attorney General’s Office, the Seventh Circuit Solicitor, and the Thirteenth Circuit Solicitor lack any policies, procedures, or guidelines concerning the enforcement of the Abortion Ban. App. 434, 444, 451. In fact, there is no legal guidance other than the text of the Abortion Ban that physicians can consult to determine if a particular abortion would be lawful. App. 439, 452. Further, the Attorney General’s Office, the Seventh Circuit Solicitor, and the Thirteenth Circuit Solicitor have not provided any training to their staff or law enforcement officers about the Abortion Ban. App. 434, 444, 451.

STANDARD OF REVIEW

Summary judgment is proper if “there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” Fed. R. Civ. P. 56(a). Summary judgment is not “a disfavored procedural shortcut, but rather . . . an integral part of the Federal Rules as a whole.” *Celotex Corp. v. Catrett*, 477 U.S. 317, 327 (1986). “The mere existence of a scintilla of evidence in support of the [non-movant’s] position” will not defeat a summary judgment motion. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 252 (1986). “Likewise, conclusory allegations or denials, without more, are insufficient to preclude granting the summary judgment motion.” *Wai Man Tom v. Hosp. Ventures LLC*, 980 F.3d 1027, 1037 (4th Cir. 2020).

ARGUMENT

I. Legal Standards for a Vagueness Claim.

A state law can be void for unconstitutional vagueness for either of two independent reasons: 1) if it “fails to provide a person of ordinary intelligence fair notice of what is prohibited,” or 2) if it “is so standardless that it authorizes or encourages seriously discriminatory enforcement.” *Williams*, 553 U.S. at 304; *see Kolender v. Lawson*, 461 U.S. 352, 357–58 (1983). Courts frequently grant summary judgment to plaintiffs where, as here, the evidence establishes that a law is unconstitutionally vague under one or both theories. *See, e.g., Carolina Youth Action Project v. Wilson*, 60 F.4th 770, 788 (4th Cir. 2023); *Doe v. Cooper*, 842 F.3d 833, 843–44 (4th Cir. 2016); *Planned Parenthood S. Atl. v. Stein*, 742 F. Supp. 3d 472, 484, 486 (M.D.N.C. 2024).

“The degree of vagueness that the Constitution tolerates—as well as the relative importance of fair notice and fair enforcement—depends in part on the nature of the enactment.” *Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc.*, 455 U.S. 489, 498 (1982). Criminal laws like South Carolina’s Abortion Ban warrant exacting scrutiny because “[t]he essential purpose of the ‘void for vagueness’ doctrine is to warn individuals of the criminal consequences of their conduct.”⁸ *Jordan v. De George*, 341 U.S. 223, 230 (1951); *see also Kolender*, 461 U.S. at 358 n.8. Additionally, laws that carry quasi-criminal penalties, including the threat of license revocation,

⁸ Physicians who violate the Abortion Ban are guilty of a felony and must be imprisoned for no more than two years, fined up to ten thousand dollars, or both. S.C. Code Ann. §§ 44-41-630(B), 640(B)(4)(b), 660(C).

warrant greater scrutiny than purely civil statutes.⁹ See *Vill. of Hoffman Ests.*, 455 U.S. at 499 (explaining that quasi-criminal penalties can have a “prohibitory and stigmatizing effect,” which warrants a “relatively strict test” for vagueness); *Stein*, 742 F. Supp. 3d at 485 (“[S]ignificant administrative penalties like license revocations . . . are quasi-criminal.”).

The Supreme Court has repeatedly affirmed that an unduly vague law is unconstitutional even if “there is some conduct that clearly falls within the provision’s grasp.” *Johnson v. United States*, 576 U.S. 591, 602 (2015); see also *Sessions v. Dimaya*, 584 U.S. 148, 159 n.3 (2018). For example, a law that forbids grocers from charging an “unjust or unreasonable rate” is void for vagueness “even though charging someone a thousand dollars for a pound of sugar would surely be unjust and unreasonable.” *Johnson*, 576 U.S. at 602–03 (citation omitted). When a statute is insufficiently clear under the appropriate level of scrutiny, it “can be invalidated on its face even where it could conceivably have . . . some valid application.” *Carolina Youth Action Project*, 60 F.4th at 781 (cleaned up).

II. Plaintiffs are Entitled to Summary Judgment on Their Vagueness Claim.

The Health Exception, S.C. Code Ann. §§ 44-41-640(B)(1)–(C)(1), and the Fatal Fetal Anomaly Exception, *id.* §§ 44-41-660(A), 610(5), fail to provide adequate notice of what they proscribe and permit, which links “criminal culpability to . . . wholly subjective judgments[.]” *Williams*, 553 U.S. at 306, and exposes physicians to arbitrary and discriminatory enforcement.

⁹ The State Board of Medical Examiners must revoke the professional licenses of physicians who “intentionally, knowingly, or recklessly” violate the Abortion Ban. S.C. Code Ann. § 44-41-690. Additionally, the State Board of Medical Examiners has broad authority to discipline a physician for a felony conviction. *Id.* § 40-47-110(A)–(B)(2). Such discipline can include revoking the physician’s license. *Id.* § 40-47-110(A).

A. The Abortion Ban Fails to Provide Fair Notice of the Circumstances in Which the Health Exception Permits an Abortion.

The Health Exception allows a physician to provide an abortion if it is necessary, in the physician’s “reasonable medical judgment” or “according to standard medical practice[,]” to prevent the “serious risk of a substantial and irreversible physical impairment of a major bodily function of the pregnant woman, not including psychological or emotional conditions.” S.C. Code Ann. § 44-41-640(B)(1)–(C)(1). Because the Health Exception often provides no guidance for physicians to determine if or when they can lawfully provide an abortion to a patient whose pregnancy threatens her health, it is void for vagueness.

1. “Serious Risk” and “Substantial and Irreversible Impairment of a Major Bodily Function” are Susceptible to Numerous Interpretations.

The Health Exception regulates medicine in the highly specialized and unpredictable setting of obstetrics. *See supra* at 9–12. Yet its terms have no medical definition, which makes them “susceptible to numerous interpretations” among physicians, *Manning v. Caldwell*, 930 F.3d 264, 274 (4th Cir. 2019). *Supra* at 6–8. Courts regularly invalidate laws regulating medical treatment when they rely on terms that lack a medical meaning or a clear and consistent understanding among physicians. *See, e.g., McCormack v. Herzog*, 788 F.3d 1017, 1031 (9th Cir. 2015) (invalidating medical regulation because its terms were not “terms of art with specific definitions in the medical context”), *abrogated by Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215 (2022); *Forbes v. Woods*, 71 F. Supp. 2d 1015, 1019–20 (D. Ariz. 1999) (invalidating a statute as unconstitutionally vague because “experimentation” and “routine” had “no single definition . . . in the scientific and medical communities” (cleaned up)).

Instead of providing necessary guidance to physicians, the Health Exception’s terms raise more questions than answers. For example, does “serious risk” set a quantitative or qualitative benchmark? *See supra* at 6–7. What is a “major” as opposed to a “minor” bodily function? App. 37, 142–43. Does the Health Exception allow physicians to consider social determinants of health when assessing a patient’s risk? *Supra* at 8–9. These significant, unanswered questions are precisely the type of questions that courts consider when enjoining unconstitutionally vague laws. *See, e.g., City of Chicago v. Morales*, 527 U.S. 41, 57, 59–60 (1999) (“[H]ow long must the loiterers remain apart? How far must they move?”).

Because the Health Exception’s language does not have a clear and consistent meaning in medicine or among physicians, determining if a patient faces a “serious risk of a substantial and irreversible impairment of a major bodily function” necessarily involves subjective line-drawing, which results in widely divergent interpretations among physicians. *See, e.g.,* App. 263–65 (Dr. Buskmiller explaining that she “understand[s] ‘serious risk’ to be moderate or high risk”), App. 337 (Dr. Greig opining that “serious” does not refer to a statistical probability because, “if your risk is death, a 1 percent risk of death is serious”), App. 343 (Dr. Greig explaining that he does not know what a “moderate risk of harm” is). *Compare* App. 265–66, 281 (Dr. Buskmiller opining that the Health Exception allows physicians to consider “how far away the patient lives from any clinical care” and other “social determinants of health”), *with* App. 363 (Dr. Greig explaining that he “can’t think of an instance” where it would be reasonable to consider a patient’s geographic location or distance from an ER under the Health Exception).

The Health Exception offers no guidance for a physician to discern when a risk transitions from mild to “serious,” or when an impairment crosses from insubstantial to “substantial.” *See*

App. 456 (Defendants admitting that “it is not always possible for a physician to determine whether or when a pregnant patient’s condition” meets the Health Exception (emphases omitted)); *see also Connally v. Gen. Const. Co.*, 269 U.S. 385, 392 (1926) (holding that a criminal law that prohibited “crowded” railway cars lacked meaningful standards for determining “[w]hat may be regarded as a crowded car[.]” and improperly left “[t]his important element . . . to conjecture”); *Manning*, 930 F.3d at 275 (“General definitions of the term ‘drunkard’ do not identify how much alcohol a person must consume before such consumption is considered ‘excessive’ or . . . what frequency of behavior constitutes a ‘habit.’”). In this way, the Health Exception’s terms often do not allow physicians to distinguish between permissible and forbidden abortions, just as the statute in *Carolina Youth Action Project* did not allow students and enforcement officers to “distinguish *criminally* disorderly, boisterous, obscene, or profane childhood misbehavior from *garden-variety* disorderly, boisterous, obscene, or profane childhood misbehavior[.]” 60 F.4th at 782–83.

Importantly, the vagueness analysis does not turn on whether a law’s terms can be defined in isolation, but rather, whether they provide sufficient clarity *in context* to the people they regulate and those tasked with enforcement. *See City of Chicago*, 527 U.S. at 57 (“[T]he vagueness that dooms this ordinance is not the product of uncertainty about the normal meaning of ‘loitering,’ but rather about what loitering is covered by the ordinance and what is not.”); *cf. Jake’s Fireworks Inc. v. Acosta*, 893 F.3d 1248, 1258 (10th Cir. 2018) (holding that the relevant question is whether “a reasonable person responsible for the safety of employees . . . would be able to apply the language” of a business safety regulation to a real “situation” arising in the workplace (citation omitted)).

Here, the absence of medical consensus on the meaning of “serious risk” and “substantial and irreversible impairment of a major bodily function” often prevents physicians from applying the Health Exception in the very complex, high-stakes context of obstetrical care. *Supra* at 9–12. In treating pregnant patients for the conditions that arise “as a matter of medical reality” during pregnancy, *Moyle v. United States*, 603 U.S. 324, 328 (2024) (Kagan, J., concurring), physicians must grapple with an endless array of variables, such as a patient’s medical history, comorbidities, and test results. *Supra* at 2, 9–11, 17. What is more, physicians must often make treatment assessments under immense time pressure, knowing that their patients’ health can deteriorate rapidly and with little warning. *Supra* at 2. *Cf. Vill. of Hoffman Ests.*, 455 U.S. at 498–99 (explaining that civil economic regulations are subject to less exacting scrutiny than criminal laws “because businesses . . . can be expected to consult relevant legislation in advance of action” and “the consequences of imprecision are qualitatively less severe”).

For example, pregnant patients who have a history of pulmonary embolism have a heightened risk of developing a life-threatening blood clot during and after pregnancy. *See supra* at 11. Although some treatments can reduce the risk of pulmonary embolism, those treatments are not always successful and can cause negative side effects. *See supra* at 11. Because it is unclear if treatment will be successful for a patient with a history of pulmonary embolism or if the treatment could lead to additional health risks, Dr. Doe struggles to determine if patients with a history of pulmonary embolism face a “serious risk of a substantial and irreversible impairment of a major bodily function.” *Supra* at 11.

Defendants’ own experts have different understandings of if or when a pregnant patient with a history of pulmonary embolism could meet the Health Exception. *Supra* at 11–12. Dr.

Austin and Dr. Buskmiller believe that a patient with a history of pulmonary embolism is unlikely to meet the Health Exception, but Dr. Buskmiller acknowledges that treatment carries its own health risks. *Supra* at 11–12. By contrast, Dr. Greig believes that a patient with a history of pulmonary embolism could meet the Health Exception if the patient had previously received treatment to prevent a pulmonary embolism, but still suffered one. *Supra* at 12. And Dr. Draper seems to believe that a pregnant patient could meet the Health Exception only if the patient were actively suffering a massive pulmonary embolism. *Supra* at 11.

Many courts have held that considerable disagreement among experts about a law’s application demonstrates that the law lacks meaningful standards. *See, e.g., Causeway Med. Suite v. Foster*, 43 F. Supp. 2d 604, 617 (E.D. La. 1999) (granting summary judgment to plaintiffs where “the record reflects that there is . . . a great deal of disagreement among the experts . . . over which procedures are prohibited by the Act”); *United States v. Forbes*, 806 F. Supp. 232, 233 (D. Colo. 1992) (citing the “great diversity of opinion” on the scope of the law as evidence of its vagueness). Likewise, Defendants’ experts’ divergent interpretations of the Health Exception in the context of concrete conditions regularly encountered by physicians across South Carolina demonstrate the Health Exception’s failure to provide sufficient notice of the abortions it permits and prohibits. *See, e.g., City of Chicago*, 527 U.S. at 57.

2. The “Reasonable Medical Judgment” Standard Exacerbates the Health Exception’s Vagueness.

The Health Exception lacks a scienter requirement, conditioning criminal and quasi-criminal liability on whether a physician exercised “reasonable medical judgment.” S.C. Code Ann. § 44-41-640(C)(1); *see also id.* § 44-41-610(13). The “basic principle of criminal law [is] to ‘separate those who understand the wrongful nature of their act from those who do not.’” *Rehaif v.*

United States, 588 U.S. 225, 229, 231 (2019) (citation omitted) (explaining that there is a “longstanding presumption, traceable to the common law, that Congress intends to require a [criminal] defendant to possess a culpable mental state”). Because the Health Exception lacks a scienter requirement, however, “a physician may act in good faith and yet still be held criminally and civilly liable if, after the fact, other physicians determine that the physician’s medical judgment was not reasonable.” *Women’s Med. Prof’l Corp. v. Voinovich*, 130 F.3d 187, 204 (6th Cir. 1997) (holding that provisions allowing physicians to provide a post-viability abortion when they determined in the “exercise of reasonable medical judgment” that an abortion was medically necessary were unconstitutionally vague because “a physician need not act wilfully [sic] or recklessly in determining whether . . . medical necessity exists in order to be held criminally or civilly liable”), *abrogated by Dobbs*, 597 U.S. 215; *see United States v. Forbes*, 806 F. Supp. at 238 (invalidating a law in part because, in the absence of a scienter requirement, “criminal culpability will turn solely on a ‘battle of the experts’ at trial”).

The threat of criminal and quasi-criminal penalties under the Abortion Ban is magnified in an area as contested as abortion, where it is “unlikely that the prosecution could not find a physician willing to testify that the physician did not act reasonably.” *Voinovich*, 130 F.3d at 205. Indeed, Defendants’ experts’ opinions illustrate that some physicians are willing to offer testimony that conflicts with the overwhelming medical consensus on abortion that Plaintiffs have relied on for decades. *Supra* at 17.

Additionally, like “the determination of whether medical . . . necessity exists [or] whether a fetus is viable,” the determination of if or when a particular patient meets the Health Exception “is fraught with uncertainty and susceptible to being subsequently disputed by others.” *Voinovich*,

130 F.3d at 205; *Colautti v. Franklin*, 439 U.S. 379, 395–96 (1979), *abrogated by Dobbs*, 597 U.S. 215; *see also supra* at 9–12. In *Colautti*, for example, the Supreme Court held a law unconstitutionally vague where it imposed strict liability on physicians who incorrectly determined that a fetus was not viable. 439 U.S. at 395–96. The Court explained that fetal viability was often “uncertain[]” and depended on a multifaceted analysis encompassing complex variables. *Id.* (“Because of the number and the imprecision of these variables, the probability of any particular fetus’ obtaining meaningful life outside the womb can be determined only with difficulty.”). Likewise, here, determining a pregnant patient’s risks involves an imprecise analysis, and “it is not unlikely that experts will disagree” about the risks that a particular patient faces. *Id.* at 396.

Indeed, the Record shows that physicians, including Defendants’ experts, profoundly disagree about how to apply the Health Exception to patients’ medical conditions. *Supra* at 9–12. For example, Dr. Doe, her colleagues, and a group of South Carolina physicians hold that most cases of PPROM meet the Health Exception even if a patient is “currently without signs of infection and is not bleeding.” App. 521; *see supra* at 10. By contrast, both Dr. Austin and Dr. Greig believe that a patient suffering from PPROM does not meet the Health Exception unless there are signs of infection. *See supra* at 11.¹⁰

These disputes are not mere uncertainties “in marginal situations.” *Cooper*, 842 F.3d at 842. To the contrary, they reflect the Health Exception’s failure to provide discernible standards

¹⁰ It is undisputed that physicians often disagree with their colleagues’ medical judgment. *See* App. 347–48 (Dr. Greig stating, “I could sit here and give you all kinds of examples just because I’m a real stickler for detail and the best patient outcome. And I see patients, sometimes doctors don’t always follow up as quickly. They don’t repeat labs as often as I think they should.”).

to guide physicians in common medical scenarios, and the ease with which a prosecutor could find physicians willing to testify against a particular physician's good-faith judgment. *See supra* at 9–12.

The “reasonable medical judgment” standard also exacerbates the Abortion Ban’s vagueness because the Abortion Ban sometimes conflicts with evidence-based medicine. For example, the standard of care is to offer an abortion to any patient as soon as her pregnancy begins to threaten her health. *Supra* at 3–4. Yet the Health Exception requires physicians to wait to offer an abortion until the threat to their patient’s health reaches an uncertain threshold. *Supra* at 5–9. Such conflicts leave physicians with serious doubts that exercising their reasonable medical judgment will protect them from criminal and quasi-criminal penalties. *See App.* 176 (Dr. Tarleton explaining that, “[b]ecause abortion is . . . standard medical treatment[,] . . . [using] a ‘reasonable medical judgment’ standard to determine which abortions are legal for medical indications is nonsensical.”).

“Vague laws trap the innocent by not providing fair warning” of the conduct they criminalize, *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972), and the Health Exception’s lack of clarity has a “profound chilling effect on the willingness of physicians to perform abortions” in accordance with their good-faith interpretation of the Exception, *Colautti*, 439 U.S. at 396. The Record establishes that physicians’ inability to determine if or when a particular patient meets the Health Exception often forces them to refer their patients to other states for an abortion. *Supra* at 5–6, 11. Further, Plaintiffs have presented undisputed evidence that, even when they feel confident enough to provide an abortion based on their good-faith interpretation of the Health Exception, they remain “fear[ful] that someone else could come and . . . question [their] judgment.” *App.* 300;

supra at 17. The grave uncertainty generated by the Health Exception justifies these fears. *See supra* at 6-12.

B. The Abortion Ban Fails to Provide Fair Notice of the Circumstances in Which the Fatal Fetal Anomaly Exception Permits an Abortion.

The Fatal Fetal Anomaly Exception allows a physician to provide an abortion in South Carolina if, in the physician’s “reasonable medical judgment,” “the unborn child has a profound and irremediable congenital or chromosomal anomaly that, with or without the provision of life-preserving treatment, would be incompatible with sustaining life after birth.” S.C. Code Ann. §§ 44-41-660(A), 610(5). Because the Fatal Fetal Anomaly Exception fails to provide adequate notice of the fetal conditions that permit an abortion, it is unconstitutionally vague. *See Carolina Youth Action Project*, 60 F.4th at 786 (invalidating a law that prohibited “interfer[ing] with or . . . disturb[ing]” a school because it failed to identify the “specific conduct” it covered).

1. “Incompatible with Sustaining Life after Birth” is Susceptible to Numerous Interpretations.

Like the terms in the Health Exception, “incompatible with sustaining life after birth” is neither a “term[] of art” nor defined “in the medical context.” *McCormack*, 788 F.3d at 1031; *see supra* at 12; *Manning*, 930 F.3d at 274. As a result, the terms raise a host of essential, but unanswered, questions about their scope: How long must life last to be “sustain[ed] after birth”? *Supra* at 12. Does “incompatible with sustaining life after birth” permit physicians to account for patients’ concerns that the anomaly will cause the neonate suffering or that the neonate will lack a quality of life? *Supra* at 13.

These questions invite subjective determinations that are untethered from any statutory standard. *Compare* App. 203 (Dr. Austin stating that ““incompatible with sustaining life after birth”

mean[s] . . . with rare exceptions, life expectancy does not exceed one year”), *with* App. 322–23 (Dr. Draper stating that “incompatible mean[s] . . . that the baby cannot live outside of the womb. And if they can, it’s a very brief survival . . . , [H]ours to days, sometimes weeks, very rarely a month or so[.]”), *and* App. 282 (Dr. Buskmiller explaining that “incompatible with life” means that “life is expected to be shorter than six months”). But “[t]he imposition of significant criminal penalties cannot rest on the use of such subjective standards.” *Manning*, 930 F.3d at 276. The Fatal Fetal Anomaly Exception provides “no reliable way to choose between . . . competing accounts” of the meaning of “incompatible with sustaining life after birth,” *Johnson*, 576 U.S. at 598, which leaves physicians unsure whether their interpretation of the Exception is correct. *See, e.g., McCormack*, 788 F.3d at 1031 (explaining that the terms “properly” and “satisfactorily” are “widely variable” and raise an important question: “according to whom or what standard?”).

The lack of professional consensus on the meaning of “incompatible with sustaining life after birth” often prevents physicians from applying the Fatal Fetal Anomaly Exception to actual fetal anomalies. *See City of Chicago*, 527 U.S. at 57; *Jake’s Fireworks, Inc.*, 893 F.3d at 1258; *supra* at 12–16. Indeed, the Record establishes that fetal diagnoses are extremely complex, and the lifespan and outcomes associated with some relatively common conditions can be unpredictable. *Supra* at 3. For example, while many fetuses with Trisomy 18 die before birth, some survive delivery. *See supra* at 13. Of the neonates that survive, some can live for years. *See supra* at 14. At the time of diagnosis, physicians cannot predict which fetuses will survive or for how long. *Supra* at 13–14. The Record reveals significant disagreement among Defendants’ experts about how to apply the Fatal Fetal Anomaly Exception to such fetal conditions. *Supra* at 14–16. *See Cooper*, 842 F.3d at 842. To illustrate, while Dr. Austin describes Trisomy 18 as a condition that will

always meet the Fatal Fetal Anomaly Exception, App. 203–04, Dr. Draper believes that only some cases of Trisomy 18 meet the Fatal Fetal Anomaly Exception, App. 334–35, and Dr. Greig acknowledges that Trisomy 18 is a difficult condition to assess under the Fatal Fetal Anomaly Exception and that doctors could disagree on its application, App. 340, 352. *See Colautti*, 439 U.S. at 396 (invalidating law where there was a “prospect” of disagreement among physicians about whether a fetus had reached viability); *United States v. Forbes*, 806 F. Supp. at 237 (holding a law vague where “[t]he government’s own chemists cannot agree on [the law’s application, and] . . . [t]he scientific community cannot even agree on a methodology to use to determine [whether the law applies]”).

2. The “Reasonable Medical Judgment” Standard Exacerbates the Fatal Fetal Anomaly Exception’s Vagueness.

Like the Health Exception, the Fatal Fetal Anomaly Exception lacks a scienter requirement and instead carries a reasonable medical judgment standard. S.C. Code Ann. § 44-41-610(5); *Rehaif*, 588 U.S. at 231. Thus, instead of “mitigat[ing] [the Abortion Ban’s] vagueness,” *Vill. of Hoffman Ests.*, 455 U.S. at 499, the “reasonable medical judgment” standard imposes criminal and quasi-criminal penalties on even those physicians who provide an abortion pursuant to the Fatal Fetal Anomaly Exception in good faith. *See Voinovich*, 130 F.3d at 204.

The determination of whether a particular patient meets the Fatal Fetal Anomaly Exception “is fraught with uncertainty and susceptible to being subsequently disputed by others,” *id.* at 205, which underscores the risk that another physician will deem a physician’s good faith interpretation unreasonable. *See Colautti*, 439 U.S. at 396; *supra* at 13–16. “The prospect of . . . disagreement” between physicians, “in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination” under the Fatal Fetal Anomaly Exception, has a “profound chilling

effect” on physicians’ willingness to provide abortions under the Fatal Fetal Anomaly Exception. *Id.* Indeed, the Record shows that physicians’ inability to determine if or when a particular patient meets the Fatal Fetal Anomaly Exception often forces physicians to refer their patients to other states for an abortion. *See supra* at 12, 14–16. And, as with the Health Exception, even when physicians provide an abortion based on their good-faith interpretation of the Fatal Fetal Anomaly Exception, they remain uncertain whether the law permitted their conduct. *Supra* at 17. *See United States v. Ragen*, 314 U.S. 513, 524 (1942) (describing the absence of a scienter requirement as “a trap for those who act in good faith”).

C. The Abortion Ban is So Standardless that it Authorizes and Encourages Arbitrary and Discriminatory Enforcement.

Finally, the Health and Fatal Fetal Anomaly Exceptions are unconstitutionally vague because they fail to “establish minimal guidelines to govern law enforcement.” *Lanning*, 723 F.3d at 482 (citation omitted) (describing the prevention of arbitrary or discriminatory enforcement as “perhaps the most meaningful aspect of the vagueness doctrine”).

The undisputed evidence shows that the Attorney General and certain Circuit Solicitors responsible for enforcing the Abortion Ban lack a clear and consistent understanding of the Health and Fatal Fetal Anomaly Exceptions. *Supra* at 17–19. To the contrary, their offices testified that they cannot determine the meaning of either Exception without first consulting medical professionals. *Supra* at 17–18. The fact that the Attorney General and these Circuit Solicitors are unfamiliar with even the most basic aspects of the law, including its burden of proof, *supra* at 18–19, betrays that they cannot ensure fair and consistent prosecutions. As in *Carolina Youth Action Project*, the absence of meaningful standards invites officers to “deploy a glorified smell test to determine whether” a physician has violated the law. 60 F.4th at 783.

Defendants’ assertion that they would determine whether a physician acted reasonably under the Health and Fatal Fetal Anomaly Exceptions by assessing “the totality of a particular patient’s circumstances,” App. 465–68, echoes the unconstitutional enforcement scheme in *Carolina Youth Action Project*. There, law enforcement officials’ failure to identify the analysis they would use to determine if a student engaged in criminal conduct led the Court to invalidate the law. 60 F.4th at 783. Although “law enforcement officials routinely consider the totality of the circumstances in assessing whether a person in fact did something that violates [a] law . . . , we are unaware of any crime . . . requiring a multifactored balancing test to determine *whether a thing a person undisputedly did* is unlawful in the first place.” *Id.* at 784; *see also Kolender*, 461 U.S. at 358 (explaining that vague laws “vest[] virtually complete discretion in the hands” of law enforcement).

So, too, here: the fact that the Attorney General and certain Circuit Solicitors are unable to identify objective standards for determining how a physician runs afoul of the Health and Fatal Fetal Anomaly Exceptions illustrates their “impermissibl[e] delegat[ion of] basic policy matters to policemen, judges, and juries for resolution on an *ad hoc* and subjective basis.” *Vill. of Hoffman Ests.*, 455 U.S. at 498 (citation omitted). Importantly, the Health and Fatal Fetal Anomaly Exceptions’ unconstitutionality does not stem from the fact that “a policeman [might] appl[y] his discretion wisely or poorly in a particular case,” but rather from the fact that law enforcement officials “enjoy too much discretion in *every* case.” *City of Chicago*, 527 U.S. at 71 (Breyer, J., concurring in part and concurring in the result). There is nothing to stop investigators or prosecutors from drawing on their own biases when investigating and prosecuting a physician under the Abortion Ban. *See supra* at 17–19; *Stein*, 742 F. Supp. 3d at 484 (“Elected officials hold wide-ranging moral

and political opinions about abortion, and the political environment in a particular jurisdiction might also affect how law enforcement officials evaluate their role and responsibilities under this vague provision.”). Because “every application” of the Exceptions “represents an exercise of unlimited discretion” in the absence of meaningful guidelines, the Exceptions are “invalid in all” of their applications. *City of Chicago*, 527 U.S. at 71 (Breyer, J., concurring in part and concurring in the result); *see also supra* at 17–19.

Finally, neither the Attorney General nor these Circuit Solicitors have provided or received guidance or training on the Abortion Ban, and they lack policies, procedures, or guidelines concerning its enforcement. *Supra* at 19; *see Stein*, 742 F. Supp. 3d at 484 (observing that the district attorney defendants had “remained silent” on an important question about the law’s meaning, which exacerbated the risk of “arbitrary and uneven enforcement”). The Health and Fatal Fetal Anomaly Exceptions “leave[] open the widest conceivable inquiry,” allowing law enforcement officials to rely entirely on “‘the prohibition philosophy of the particular’ individual enforcing the scheme at the moment.” *Manning*, 930 F.3d at 276 (citation omitted). This unfettered discretion is unconstitutional as a matter of law, and Plaintiffs are entitled to summary judgment. *See, e.g., Papachristou v. City of Jacksonville*, 405 U.S. 156, 170 (1972) (holding that the lack of enforcement standards “furnishes a convenient tool for ‘harsh and discriminatory enforcement . . . against particular groups deemed to merit their displeasure’” (citation omitted)).

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully ask the Court to grant summary judgment on their vagueness claim. Counsel for Plaintiffs believe that oral argument would aid the deliberative process in this case and request that this Court grant oral argument.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that, on June 16, 2026, the foregoing was electronically filed with the Clerk of the Court using the CM/ECF system, which will cause a copy to be served upon all counsel of record.

/s/ John L. Warren, III

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