

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
CHARLESTON DIVISION**

NATALIE DAWN BINGHAM, *et al.*,

Plaintiffs,

v.

ALAN MCCRORY WILSON, in his official
capacity as Attorney General of South
Carolina, *et al.*,

Defendants,

and

HENRY DARGAN McMASTER, in his official
capacity as Governor of the State of South
Carolina,

Intervenor–Defendant.

Civil Action No.: 2:25-cv-163-RMG

**DEFENDANTS’ RESPONSE TO
PLAINTIFFS’ MOTION
FOR SUMMARY JUDGMENT**

Henry Dargan McMaster, in his official capacity as Governor of the State of South Carolina; Alan Wilson, in his official capacity as Attorney General of the State of South Carolina; David Pascoe, in his official capacity as Solicitor for South Carolina’s First Judicial Circuit; Bill Weeks, in his official capacity as Solicitor for South Carolina’s Second Judicial Circuit; Mike Burch, in his official capacity as Solicitor for South Carolina’s Fourth Judicial Circuit; Randy E. Newman, Jr., in his official capacity as Solicitor for South Carolina’s Sixth Judicial Circuit; Barry Barnette, in his official capacity as Solicitor for South Carolina’s Seventh Judicial Circuit; David Stumbo, in his official capacity as Solicitor for South Carolina’s Eighth Judicial Circuit; Micah Black, in his official capacity as Solicitor for South Carolina’s Tenth Judicial Circuit; Rick Hubbard, in his official capacity as Solicitor for South Carolina’s Eleventh Judicial Circuit; Edgar L. Clements, III, in his official capacity as Solicitor for South Carolina’s Twelfth Judicial Circuit;

Cindy Crick, in her official capacity as Solicitor for South Carolina's Thirteenth Judicial Circuit; Jimmy Arthur Richardson, II, in his official capacity as Solicitor for South Carolina's Fifteenth Judicial Circuit; and Kevin S. Brackett, in his official capacity as Solicitor for South Carolina's Sixteenth Judicial Circuit, submit this response in opposition to Plaintiffs' Motion for Summary Judgment (ECF No. 166).

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INTRODUCTION

Plaintiffs ask for the broadest form of constitutional relief at an unforgiving procedural stage: summary judgment on a facial claim. To prevail, they must show (at least) that the 2023 Act's exceptions lack a plainly legitimate sweep. It's "hard to win" that argument because Plaintiffs must show something more than "the law's unconstitutional applications substantially outweigh its constitutional ones." *Moody v. NetChoice, LLC*, 603 U.S. 707, 723–24 (2024). And if a law has a "constitutional 'core'" such that it "appl[ies] without question to certain activities," a court cannot strike it down wholesale. *Doe v. Cooper*, 842 F.3d 833, 842 (4th Cir. 2016).

The 2023 Act has that core. Both challenged exceptions turn on reasonable medical judgment, rather than absolute certainty. The maternal health exception adds defined terms (some that Plaintiffs admittedly use daily) and 11 presumed conditions. The fatal fetal anomaly exception similarly requires physicians to apply reasonable medical judgment to familiar medical situations. Plaintiffs themselves have applied both exceptions and identified myriad scenarios in which they can determine whether the exceptions permit an abortion. And DPH data confirms that physicians across South Carolina have applied both exceptions. That is a plain sweep, full stop.

Straining to avoid that sweep, Plaintiffs make two moves: They shrink the law and stretch the record. They shrink the law by ignoring the standard for a facial challenge and probing at the margins. And they stretch the record by turning a few anecdotes into claims about "physicians" statewide and clipping testimony to manufacture uncertainty where little exists.

Nor do criminal penalties change the result. Criminal laws may require more clarity, but "sufficient clarity" remains a "relatively low bar" in a facial challenge. *Martin v. Lloyd*, 700 F.3d 132, 137 (4th Cir. 2012). And reasonable medical judgment is not the problem. Rather, it is the State's answer: room for time-sensitive, patient-specific judgments in an objective legal standard.

Plaintiffs' arbitrary-enforcement theory fares no better. The statute gives prosecutors objective legal standards, not a roving license. Plaintiffs identify no prosecution, no investigation, and no example of discriminatory enforcement. Their theory is not evidence. It is speculation.

Plaintiffs may litigate hard cases if hard cases ever arise. What they cannot do is use imagined or isolated margins to strike down the 2023 Act in all applications, including the many constitutional applications discovery has revealed. Their motion should be denied.

RESPONSE TO STATEMENT OF UNDISPUTED FACTS

Plaintiffs spend over 18 pages recounting supposedly "undisputed facts." ECF No. 166-1, at 8–25, forming the basis of their legal analysis. But their recounting of the evidence is not a neutral account of an undisputed record. They repeatedly misread or misconstrue the evidence. Defendants explain how the record does not support Plaintiffs' "facts." *See* Local Civ. R. 7.05(A)(4) (D.S.C.).

A. Plaintiffs mischaracterize evidence about the maternal health exception.

1. They mischaracterize evidence about the exception's terms.

i. Plaintiffs claim that Defendants' experts have varying "understanding[s]" of "major bodily function." ECF No. 166-1, at 14. Context shows otherwise. Austin said it would be "difficult" to list every qualifying function because he might "leave at least one out," Ex. 9, at 77:1–18, but he explained that the category "generally concern[s] organ systems commonly related to maternal medicine including the cardiovascular system, nervous system, respiratory system, kidney function, and reproductive organs," Ex. 10, ¶ 25. Buskmiller identified the category functionally as "life, organ function, sensory function, and limb function," and later contrasted the traditional "vital organs"—the brain, heart, lungs, kidneys, and liver—with non-major functions. Ex. 11, at 98:21–99:19, 99:20–100:6; *see also* Ex. 12, ¶ 19.¹ Greig similarly identified "essential physiological functions, including

¹ Trying to sow confusion, Plaintiffs attempt to recategorize Buskmiller's position on what

neurologic, cardiovascular, pulmonary, hepatic, renal and reproductive functions,” without suggesting his list was wholly exhaustive. Ex. 15, at 294:23–295:7; *see also* Ex. 16, ¶ 49 (explaining what “major bodily function” “generally” means by referring to these functions “among others”). And Draper identified much the same core set, including neurologic, cardiovascular, pulmonary, gastrointestinal, musculoskeletal, sensory, endocrine, skin, heart, lung, liver, pancreatic, spleen, and kidney functions. Ex. 13, at 97:13–24; *see also* Ex. 14, ¶ 23. So the overlap is not hard to see.

On the term “irreversible,” Plaintiffs concede that “[p]hysicians understand what ‘irreversible’ means.” ECF No. 166-1, at 13. In a challenge focused on whether ordinary persons understand the words, that concession should be dispositive. And predicting when a condition is approaching irreversibility is a diagnostic question, *see id.*, not a statutory defect. Plus, the law only asks for a “reasonable” judgment about a “serious risk” of irreversibility—not a perfect prediction.

ii. Plaintiffs wrongly claim that the experts disagreed about what “serious risk” means, then use that supposed disagreement to argue that *no* physician can understand that term. *See* ECF No. 166-1, at 23. The record shows otherwise. Defendants’ experts consistently explained that physicians are trained to stratify risk and that risk assessment is not reducible to a single number divorced from the condition, baseline risk, patient presentation, and severity of the possible harm. *See* Ex. 12, ¶¶ 15, 18–20; Ex. 14, ¶¶ 21–22; Ex. 10, ¶ 23; Ex. 16, ¶ 33. Buskmiller explained that “serious risk” excludes “minimal or general-population-level risks” and requires an “elevated risk” above baseline, Ex. 11,

she “believes ‘major bodily function’ is limited to” as being “more specifically [about] the functions of the brain, heart, lungs, kidneys, and liver.” ECF No. 166-1, at 14. Not true. In fact, Plaintiffs’ statement doesn’t make sense. If Plaintiffs already acknowledge that Buskmiller “believes” these functions include “organ function, sensory function, and limb function,” how could that concept suddenly be narrowed “more specifically” to a category of several organs that in no way relate to sensory or limb functions? *Id.* Buskmiller did not limit her view of major bodily functions to just “the brain, heart, lungs, kidneys, and liver.” She had been asked to name “some bodily functions that aren’t major” and she listed that group of “vital organs” to draw contrasts to the “[f]unctions of other organs” as ones that “might not be considered in that category.” Ex. 11, at 99:20–100:6.

at 92:23–93:19, while recognizing that medicine assesses risk through relative percentages and clinical judgment about the individual patient, condition, and context, *id.* at 93:23–94:18. This tracks “the widespread practice of establishing risk categories.” *Id.* at 93:23–94:5. Greig also testified that “serious” means “significant” or “concerning” but depends on “the context of the medical situation” and the “specific circumstance.” Ex. 15, at 127:9–128:9. And Draper described “serious risk” as “a qualitative, severity-focused concept that reflects the realities of obstetric practice,” determined “in part by the gravity of the potential outcome,” not “solely by its likelihood.” Ex. 14, ¶ 22.

That shared understanding is why Plaintiffs’ quantitative/qualitative contrast misses the point. *See* ECF No. 166-1, at 13–14, 29. Statistics matter, but they do not determine seriousness by themselves. Greig explained why: A one-percent risk of death may be serious, while a much higher risk of a minor harm may not be. Ex. 15, at 128:10–23; *id.* at 220:19–221:19.² Buskmiller made the same point from the other direction. “[M]oderate” or “high” risk, she said, is “purposefully not a number” because what counts as moderate depends on “the baseline or general population risk” for a condition. Ex. 11, at 95:14–96:12. Nor did Draper assert that “serious risk” ignores probability. *See* ECF No. 166-1, at 13. She clarified that obstetric practice often cannot assign fixed statistics, especially in emergencies, so physicians consider maternal and fetal risks, potential harm, and the clinical picture rather than “make everything fit into one category.” Ex. 13, at 161:22–162:21; *see also* Ex. 14, ¶¶ 21–22. As Greig said, assigning a fixed percentage would be “too limiting.” Ex. 15, at 149:3–22. By contrast, “the open-ended phrasing of the Maternal Health Exception allows

² Plaintiffs also try muddying the waters by stating that “Greig denies that ‘serious’ refers to a statistical probability that something might occur” and that “Draper does not believe that ‘serious risk’ indicate[s] any statistical probability.” ECF No. 166-1, at 13 (alteration in original). That’s wrong. Draper expressly said that the term doesn’t just refer to “statistical probability *alone*.” Ex. 13, at 161:13–19 (quoting Ex. 14, ¶ 21) (emphasis added). And Greig clarified that “there’s numbers to use” in risk assessment and that “it really depends on what exactly you’re talking about” to determine whether a percentage, for instance, is “serious” in context. *See* Ex. 15, at 128:2–23.

physicians to effectively work and make decisions, employing all their skills and training within their ‘reasonable medical judgment’ that the specific circumstances call for.” Ex. 16, ¶ 50.

Despite this overlap in understanding, Plaintiffs try to manufacture disagreement between Buskmiller and Greig by claiming that Greig “d[id] not know what a ‘moderate risk of harm’ is.” ECF No. 166-1, at 29. That’s false. Here’s what Plaintiffs cite for that position:

Q: And would you think that a doctor has exceeded the limits of their discretion if they provided care in a case where there was a moderate risk of harm?

A: I don’t know what that means. I mean, a moderate risk of harm, what is the harm and what’s – what’s the moderate risk? I mean, it would have to be defined a lot better than that.

Ex. 15, at 151:8–16. *That* exchange is the sole basis for Plaintiffs’ categorical statement that Greig does “not know what ‘moderate risk of harm’ means.” All Greig did there was refuse to opine on an abstract hypothetical that never identified the condition, the harm, or the risk.

Plaintiffs’ reliance on testimony about “social determinants” fails too. They treat contextual risk assessment as evidence of disagreement. *See* ECF No. 166-1, at 14–15, 29. Buskmiller said physicians may consider context like distance from care and “other burdens” when assessing risk, Ex. 11, at 94:10–95:6, but warned that social determinants should not be used “solely” for any decision, *id.* at 134:24–135:10. As to race specifically, she cautioned against using it as an “independent ground[]” for treatment, though it may matter as part of “risk stratification within certain conditions.” *Id.* at 135:25–136:14. Greig agreed. Physicians “[d]efinitely” consider “social determinants” in risk assessment, including whether outpatient management is safe, and race “might” matter if tied to documented risk of maternal death or permanent adverse outcome. Ex. 15, at 215:2–216:2, 216:12–217:6. But distance from an emergency room probably doesn’t, by itself, change whether the exception applies. *Id.* at 217:7–18. Ultimately “it’d have to . . . kind of be a

specific” situation to know “how much social determinants would play into” an individual application of the law. *Id.* at 216:7–11. That’s not uncertainty about the law’s meaning. It’s case-specific application of “reasonable medical judgment.”

Plaintiffs also claim that physicians cannot tell whether “serious risk” permits them to account for “patients’ understanding” of what counts as serious. ECF No. 166-1, at 13. But that confuses a patient’s choice after an exception applies with whether the exception applies at all. The statute asks whether, in the *physician’s* “reasonable medical judgment,” the patient faces the requisite medical risk. It does not let each patient define the statutory threshold for herself.³

The testimony thus shows a consistent understanding of “serious risk.” Plaintiffs’ attempt to clip the record to argue that the maternal health exception doesn’t “have a clear and consistent meaning” and “necessarily involves subjective line-drawing” falls flat. ECF No. 166-1, at 29.

iii. According to Plaintiffs, “Defendants concede ‘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).” ECF No. 166-1, at 13. And Plaintiffs use this “concession” to support the notion that “‘serious risk’ is a non-medical, elastic term” and that the maternal health exception offers “no guidance” on when risks become “serious” or impairment becomes “substantial.” ECF No. 166-1, at 12–13, 29–30; *see also id.* at 14 (using a similar “concession” to say “irreversible” is hard to apply to kidney dysfunction).

But Plaintiffs had to include an “emphasis omitted” parenthetical at the end of their statement

³ Plaintiffs’ use of Greig to bolster their position confirms the opposite. *See* ECF No. 166-1, at 13. When asked whether “a patient’s preferences . . . play[] into” whether they “qualify” for the exception, he answered that “they’re going to qualify regardless of what they say,” and that patient “preference” does not “fall[] under the exception at all.” Ex. 15, at 163:5–18.

because they de-emphasize a crucial aspect of Defendants’ statement. *See id.* at 13. Plaintiffs had asked in discovery if it’s “always possible” to determine what will happen to a particular patient. Defendants responded that “it is not *always* possible . . . because ‘there are few things in this world we know with absolute certainty.’” Ex. 8, at 2 (emphasis in original) (quoting *Victor v. Nebraska*, 511 U.S. 1, 27 (1994) (Ginsburg, J., concurring in part)). Of course, Defendants agree that *a* case can arise where predicting a patient’s outcome is difficult. *Cf.* Ex. 12, ¶ 19 (explaining how physicians can nevertheless “risk-stratify patients”). But the distinction between edge cases and core applications of the exceptions is critical in a facial challenge. That’s why Defendants emphasized the distinction—and it’s why Plaintiffs must de-emphasize it.

2. They mischaracterize evidence about specific health conditions.

Plaintiffs use illustrations of a few health conditions to try to show the exception is incomprehensible. Not only is that impermissible margin-probing on a facial challenge, but also the evidence doesn’t show the confusion that Plaintiffs say exists.

i. Plaintiffs misread the evidence on pulmonary embolism. They begin with Doe’s assertion in an interrogatory response that she “could not determine” if a pregnant patient with a “history of pulmonary embolism” qualified for the exception. ECF No. 166-1, at 17, 31. But when Defendants explored this situation in more detail during Doe’s deposition, Doe admitted that she and other doctors “determined that the maternal health exception likely did not apply since [they] could give her medication to reduce that risk” of pulmonary embolism. Ex. 2, at 198:18–23. So Doe actually understood the exception sufficiently to determine whether it permitted an abortion in this case.⁴

Plaintiffs’ claim that Defendants’ experts disagree on whether “patient[s] with a history of

⁴ This shift from the interrogatory response to the deposition testimony illustrates why unsubstantiated estimates of how many times Plaintiffs (or other unnamed doctors) could not understand the exceptions cannot carry Plaintiffs’ burden. *See* ECF No. 165, at 32–33.

pulmonary embolism” qualify is wrong. ECF No. 166-1, at 17. For one, Plaintiffs conflate answers to different questions. Sometimes they asked about a patient with a history of pulmonary embolism; other times they asked about an active pulmonary embolism. *Compare* Ex. 15, at 256:7–9, 22–25 (asking the two questions distinctly); *with* Ex. 13, at 178:23–25 (asking only about a “patient diagnosed with pulmonary embolism”). Indeed, Plaintiffs even discuss experts’ testimony with no regard for the question asked. Take Draper’s so-called belief that the “only circumstance” in which a patient with a history of pulmonary embolism would meet the exception is “if she were actively suffering a massive pulmonary embolism.” ECF No. 166-1, at 17, 32. That comes from Draper’s response to a question about whether a “patient [who] has cardiopulmonary compromise” could have an abortion. Ex. 13, at 146:12–24. Nothing in the question even suggested that Draper was being asked if this was the “only circumstance” for which a pulmonary issue could allow an abortion.

Contrary to Plaintiffs’ claim, Defendants’ experts held a shared understanding: A history of pulmonary embolism alone would not suffice, but additional complications could satisfy the exception. Austin testified that a history of pulmonary embolism on its own wouldn’t meet the exception because “pulmonary embolism is now very treatable,” but physicians would “heed” a pulmonologist’s advice if that doctor said termination was medically necessary. Ex. 9, at 132:16–133:4. Buskmiller too said history of pulmonary embolism alone wouldn’t qualify since “the risks of the treatment . . . do not confer a moderate or high risk on the patient,” and the “risks are low because of good medical management.” Ex. 11, at 195:4–11, 197:8–12, 198:2–8, 199:2–14. Yet she noted that “one thing that would help [her] understand whether the exception could apply in a case like this is if the patient had a prior pulmonary embolism on anticoagulation,” (i.e., the pulmonary embolism treatment), because then “she is at a very significant – maybe moderate, maybe high – risk of a recurrent pulmonary embolism,” so “additional context really can help.” *Id.* at 196:5–11.

That tracks Greig’s position. Just a “history” of pulmonary embolism “would not be an indication,” but if a patient “still had a pulmonary embolus” in a “previous pregnancy” despite being “on [the treatment],” “that might meet the criteria.”⁵ Ex. 15, at 257:4–22. So not only do Defendants’ experts agree with each other, but they also agree with Doe. Ex. 2, at 198:6–23.

ii. Plaintiffs assert that the exception is so hard to apply to lupus that “Defendants’ experts have different understandings of if or when a pregnant lupus patient could meet” the exception. ECF No. 166-1, at 15. But once again, the testimony doesn’t support that claim. Draper testified that the exception could “possibly apply,” “depend[ing] . . . what’s happening to the patient.” Ex. 13, at 173:10–17. And like Tarleton, Draper would typically rely on an “MFM” to make that call. *Compare id.*, with Ex. 5, at 60:20–61:3 (“in most cases the determination of whether or not the health exception applied” would be made by “an MFM”). Austin’s point was similar, saying that it would depend on the patient. “[P]atients who are horribly sick” would qualify but “other patients with lupus who really ha[ve] very little active disease” would not. Ex. 9, at 131:17–25. And Greig’s statement comes from a conversation where he was asked about other “conditions where [he] believe[d] it would be *clearly lawful* to terminate a pregnancy.” Ex. 15, at 184:14–20 (emphasis added). A condition “such as lupus that was worsening and not improving with medication could be” one of those cases. *Id.* at 185:10–14. In particular, he was “thinking of one patient” of his, whose experience was “severe” but “pretty uncommon,” and ultimately “obtain[ed] an abortion” because her renal and cardiac function were

⁵ Draper didn’t disagree with Defendants’ other experts. Plaintiffs say that Draper “seems to believe” that the maternal health exception applies “*only* if the patient were actively suffering a massive pulmonary embolism.” ECF No. 166-1, at 32 (emphasis added). Draper’s deposition doesn’t support that. She was asked if she “agree[d] that an abortion may be provided under the health exception when the patient has cardiopulmonary compromise.” She responded, “Yes, in certain situations, if a patient had a massive saddle pulmonary embolus, *for instance*, and the vascular surgeon felt that – that an abortion was necessary to optimize cardiac function, then I would think it would fall under the health exception.” Ex. 13, at 146:12–20 (emphasis added). If she said “*for instance*,” that’s an indication this wasn’t the “*only*” situation that would permit an abortion too.

worsening. *Id.* at 187:6–23. And that tracks Buskmiller, who said failure of those body systems, “especially major bodily organs,” would be times to invoke the exception. Ex. 11, at 118:13–23. The shared principle then is straightforward: Lupus alone does not automatically satisfy the exception, but lupus causing major organ failure or comparable deterioration can.⁶

iii. Plaintiffs also point to PPROM to “illustrat[e] . . . physicians’ struggles.”⁷ *See* ECF No. 166-1, at 16–17, 34. Yet both Doe and Tarleton have concluded that PPROM satisfies the exception. *See* ECF No. 165, at 30. And there’s widespread agreement that PPROM generally satisfies the exception among Defendants’ experts. Both Draper and Austin have performed abortions for women with PPROM. Ex. 13, at 104:15–24; Ex. 9, at 79:13–21. Greig acknowledged that PPROM would fall under the exception save for a “rare situation.” Ex. 15, at 194:14–23. And Buskmiller “counsel[s] on abortion as an option for . . . periviable PPROM.” Ex. 11, at 34:17–21.

B. Plaintiffs mischaracterize evidence about the fatal fetal anomaly exception.

1. They mischaracterize evidence about the exception’s terms.

i. Plaintiffs say that Defendants’ experts disagreed about how long a child could live after birth for the exception to apply. *See* ECF No. 166-1, at 19, 36–37. Plaintiffs are wrong. Defendants’ experts all responded to questions on this front by recognizing that there’s no one-size-fits-all answer. Buskmiller was explicit in testimony Plaintiffs don’t cite: This language “does not have a

⁶ Nor is Doe’s anecdotal discussion on lupus evidence of vagueness. ECF No. 166-1, at 15. She offers a single instance where she was unsure about a patient who “faced a risk of deterioration” (Doe offered no other details), ECF No. 166-23, at 4, and that she doesn’t know how the exception applies when her patient has—in her words—“*serious* lupus flares,” Ex. 3, ¶ 33 (emphasis added).

⁷ For multiple examples they invoke, Plaintiffs say things like PPROM is a “common medical scenario[,]” ECF No. 166-1, at 35, or Trisomy 18 is a “relatively common genetic condition,” *id.* at 19. Maybe these are common among maternal health situations or fatal fetal anomalies, but they are not common in general. PPROM occurs in only 2–4% of pregnancies, *see PPROM Facts*, PPROM Foundation, <https://tinyurl.com/3nthts6j> (last visited July 6, 2026), and Trisomy 18 affects less than 0.1%, *see Edwards Syndrome (Trisomy 18)*, Cleveland Clinic, <https://tinyurl.com/45rzwdaF> (last visited July 6, 2026).

hard and fast endpoint as there's a bit of variety." Ex. 11, at 139:2–7. She then explained that it often means "life is expected to be shorter than six months." *Id.* at 139:15–16. But not always—some children live longer than that. *Id.* at 139:16–19.

In the same way, Austin's response about "does not exceed one year" was not a sweeping answer but an example about Trisomy 13 and Trisomy 18. *See* ECF No. 166-1, at 36–37. When Plaintiffs asked what "incompatible with sustaining life after birth" meant, Austin's full answer was: "It means that without significant assistance like a normal, nonaffected newborn. Perfect example would be trisomy 13 and trisomy 18, where, with rare exceptions, life expectancy does not exceed one year." Ex. 9, at 86:12–18. So he wasn't drawing a bright line, but he instead gave an example. He later testified that few children with fatal fetal anomalies "make it that far" to one year. *Id.* at 173:23–174:11.

Draper explained that this term means a baby's survival after birth is "very brief." Ex. 13, at 107:24–108:3. She acknowledged "[i]t's hard to predict everything" about how long each child may survive. *Id.* at 108:6. Some will live "hours," "days," or "weeks," but in "rare[]" cases it could be a month. *Id.* at 108:12. But as a specific example, she recounted that "some anencephalic babies have lived for several months." *Id.* at 108:13–14. Plus, physicians' predictions need only be "reasonable."

ii. Plaintiffs claim "physicians" are unsure if the terms of the exception "permit physicians to account for patients' concerns" about suffering and quality of life. ECF No. 166-1, at 19. The exception does not, and that is clear. Why would a law assessing a *physician's* "medical judgment" ultimately hinge its applicability on *patients'* subjective preferences? If that were the case, King admitted "clinicians [would] offer" abortions even for "down syndrome" children, so long as "it's consistent with [the patient's] goals of care." Ex. 6, at 252:12–22. South Carolina need not—and does not—allow that.

2. They mischaracterize evidence about specific fetal conditions.

Plaintiffs try the same move of using a few illustrations in challenging this exception. Their effort fails for the same reasons of margin-probing and record clipping.

i. Plaintiffs point to supposed conflict over how to approach Trisomy 18. *See* ECF No. 166-1, at 37–38. They say “many” unborn children with Trisomy 18 will “die before birth,” but “some survive delivery” and “can live for years.” ECF No. 166-1, at 37. So “they cannot predict” which unborn child “will survive or for how long.” *Id.* But this argument wrongly assumes that the law requires physicians to *know* what *will* happen in each case. The standard is “reasonableness,” not “absolute certainty.” *See* Ex. 8, at 2.

Still, Plaintiffs claim even Defendants’ experts are divided on Trisomy 18. ECF No. 166-1, at 20, 37–38. But there’s little such division. Austin testified that the exception allows an abortion in these cases because that child is going to pass away “99 percent of the time within a year” and “[t]ypically . . . much sooner than that.” Ex. 9, at 88:14–16. Buskmiller agreed that the exception allows for an abortion in Trisomy 18 cases because “there is no cure” and “trisomy leads to death.” Ex. 11, at 127:6–7. “[V]ery few” children may live beyond “six months,” and it is not “clinically useful to comment on those rare cases.” *Id.* at 147:8–13.

Draper and Greig didn’t disagree either. Draper counseled a patient whose unborn child had Trisomy 18 that abortion was an option. Ex. 13, at 31:8–32:5. Plaintiffs say that “Draper believes that only some cases of Trisomy 18 meet” the exception, ECF No. 166-1, at 38, but they cite only her general testimony that “[e]very patient is different,” and that the same general “condition” may qualify or not “based on surrounding circumstances.” Ex. 13, at 206:18–207:6. There’s nothing radical about that proposition—*which wasn’t even in the context of Trisomy 18*. More on point is Draper’s counseling of a patient that abortion was an option with Trisomy 18. *Id.* at 31:8–32:5. Greig

did not disagree. Plaintiffs admit that he “thinks that Trisomy 18 meets the [exception] because it is ‘very, very rare’ to survive birth.” ECF No. 166-1, at 20 (quoting Ex. 15, at 138:9–12). So Plaintiffs rely instead on Greig’s observation that some other doctors might disagree in a particular case. *Id.* at 38. But what some hypothetical doctor might do in a future case cannot undo what all Defendants’ experts said: The fatal fetal anomaly exception applies to Trisomy 18.

ii. Plaintiffs also claim that Defendants’ experts have “different understandings” about hypoplastic left heart syndrome (or HLHS). ECF No. 166-1, at 21–22. Yet Plaintiffs never explain how Defendants’ experts’ testimony diverges, presumably because that testimony reflects a shared view: HLHS does not automatically satisfy the exception because treatments have improved, but it may qualify when severe or accompanied by other abnormalities that make survival unlikely.

Austin explained that typical HLHS is less “clear-cut” because treatments have “significantly improved” and some patients now “can have a good quality of life,” so referral to MFM is appropriate. Ex. 9, at 175:9–176:5. Still, he recognized that, “depending on the severity,” HLHS could be among the anomalies for which “the vast majority of reasonable physicians would come to the same medical judgment.” *Id.* at 90:7–24. Buskmiller similarly testified that some HLHS cases qualify when treatment “cannot confer sufficient likelihood of survival,” and that severity (like “the severity of the smallness of the left ventricle”), associated anomalies, and genetic conditions can affect survivability. Ex. 11, at 122:4–10, 125:5–126:9, 132:4–23. Greig agreed. “[T]ypical hypoplastic left heart” is not fatal by itself because the child can “do pretty well” with “surgery” and have “long-term” survival. Ex. 15, at 331:25–333:5. But “severe” cases—like “absolutely zero left ventricle” or HLHS “with a combination of another abnormality”—would qualify. *Id.* at 332:7–21. And the “reasonable medical judgment standard” is “helpful” here, giving physicians a “wider berth” to apply “the exceptions to the different variations of [HLHS].” *Id.* at 335:6–16. Yet again,

Defendants' interrogatory response tracks the same line. *See* Ex. 7, at 9–10.

That shared view likely explains why in the HLHS cases Doe and Tarleton identified, neither purportedly severe, the exception did not permit an abortion. ECF No. 166-1, at 21; *see* Ex. 12, ¶ 41 (Doe's "case of HLHS lacks sufficient detail to determine its status."). Indeed, in Tarleton's case, another "MFM . . . determined that [the] case of HLHS did not meet" the exception. ECF No. 166-1, at 21. So again, Plaintiffs' isolated example shows physicians' general ability to apply the law.

iii. Amniotic band syndrome similarly shows no inconsistency among Defendants' experts. ECF No. 166-1, at 22. They all applied the same basic distinction that diagnosis alone does not answer the question. A physician must also know the band's location, severity, and effect on survivability. Austin said he would consult an MFM because the answer "depends on where the band is and what it's doing to the baby" because the unborn child "could be severely affected or minimally affected." Ex. 9, at 192:10–20.⁸ Buskmiller made the same point. Amniotic band "rarely" qualifies because "[m]ost bands affect extremities" causing only "physical disability," but "[s]ome cases" affect the "fetal trunk or head" and could be fatal. Ex. 11, at 212:9–25. Greig agreed, distinguishing "lethal" or "severe" cases where the band "wraps around the brain" or "cut[s]" through the "chest" from nonqualifying cases where only a leg is affected and "everything else looks good and unaffected." Ex. 15, at 340:13–341:9.

Nor does Plaintiffs' "ultrasound[s] are fallible" point create a conflict. ECF No. 166-1, at 22. Buskmiller's discussion of ACOG's warning about prenatal diagnostic uncertainty concerned "largely cardiac" cases where "there was a suspicion of a cardiac abnormality." Ex. 11, at 150:11–

⁸ So it's wrong to say Austin was categorically "unsure" about whether amniotic band could "ever" meet the exception. ECF No. 166-1, at 22. He'd just need to assess the specific case of amniotic band and consult an MFM about it, just as Doe "collaborat[ed] with maternal fetal medicine colleagues" on her case of amniotic band. Ex. 1, at 10.

19. That’s because, “for example, ultrasound can overcall some renal abnormalities” or “certain cardiac abnormalities.” *Id.* at 152:3–22. But on amniotic band specifically, Greig explained that severe cases can be “very weird looking on ultrasound” and that “in a lot of cases” incompatibility with life can be determined from just “looking at the baby.” Ex. 15, at 340:19–24, 341:10–15.

Doe’s single amniotic-band example changes nothing. She noted spine and limb involvement but gave no detail showing that the spine involvement was fatal or that limb involvement alone would make the condition incompatible with life. *See* ECF No. 166-1, at 22. Her difficulty assessing severity by ultrasound reflects a case-specific diagnostic problem, not statutory vagueness.

C. Plaintiffs mischaracterize evidence about the 2023 Act’s enforcement.

Plaintiffs say that the Attorney General and the Solicitors “are unfamiliar with even the most basic aspects of the law,” which means “that they cannot ensure fair and consistent prosecutions.” ECF No. 166-1, at 39. The record doesn’t support these assertions.

1. Plaintiffs claim that the Attorney General’s Office can’t “fully explain” what “incompatible with sustaining life after birth means.” ECF No. 166-1, at 24. That’s a misstatement. When asked what that phrase meant, the Attorney General’s Office referred to its discovery response on the topic. Ex. 17, at 26:6–11. Those responses defined that phrase. Ex. 7, at 6.

2. Plaintiffs claim that the Attorney General’s Office can’t confirm if the exceptions require it to determine whether a physician exercised reasonable medical judgment “before charging the physician.” ECF No. 166-1, at 24. That’s another misstatement. Asked that exact question, the Attorney General explained that he would “charge based upon the statutory terms” and, because “reasonable medical judgment” was a statutory term, it “certainly is a part of consideration about whether to charge a physician with a violation.” Ex. 17, at 47:20–49:4.

3. Plaintiffs claim that the Attorney General’s Office can’t confirm if the exceptions require

proof “beyond a reasonable doubt” that a physician didn’t exercise reasonable medical judgment. ECF No. 166-1, at 24–25. Another misstatement. Plaintiffs asked this specific question, and the Attorney General replied that “any prosecution would be based upon all applicable parts of the statute,” the “case law as to what the burdens of proof would be and, of course, the standard of guilty beyond a reasonable doubt that’s applicable in any criminal prosecution.” *Id.* at 50:12–19. In any event, any legal error on burdens of proof would be corrected by a court under ordinary criminal-law principles. It would not show that the statute itself invites arbitrary enforcement

4. Plaintiffs argue that the Thirteenth Circuit Solicitor “cannot identify the elements of a violation of the” 2023 Act “without first consulting medical personnel.” ECF No. 166-1, at 25. Again, that’s not quite right. The Solicitor agreed that “the medical expert would be helping the Solicitor’s Office determine whether a set of facts satisfied the statutory standards.” Ex. 18, at 31:12–21. But that’s a far cry from being unable to “identify the elements of a violation” of the 2023 Act. Rather, consultation with a medical expert shows the Solicitor understands the 2023 Act’s legal requirements but needs help understanding the medical facts.

LEGAL STANDARD

Summary judgment may be granted only when, with the evidence and reasonable inferences in the nonmoving party’s favor, *United States v. Stover*, 131 F.4th 199, 202 (4th Cir. 2025), “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).

ARGUMENT

I. Plaintiffs ignore the legal standard for facial vagueness claims.

Plaintiffs assert a facial claim, seeking the benefit of that sweeping relief. *See* ECF No. 10, at 48 (Prayer for Relief (B): seeking to enjoin the 2023 Act “on its face”). But they don’t litigate

their case as a facial challenge, presumably because that’s a high bar to clear. Under that proper framework, Plaintiffs fail to show they are entitled to judgment as a matter of law.

A. Facial vagueness requires more than hard cases at the margins.

1. Plaintiffs are right to say vagueness is a due process doctrine that ensures a law “provide[s] a person of ordinary intelligence fair notice of what is prohibited” and is not “so standardless that it authorizes or encourages seriously discriminatory enforcement.” *United States v. Williams*, 553 U.S. 285, 304 (2008) (cited at ECF No. 166-1, at 26). But Plaintiffs ignore binding precedent about how to determine whether a law fails to do those things on its face.

The Fourth Circuit—immediately after quoting this language from *Williams*—explained that the “first” step is to “determine whether the enactment implicates a substantial amount of constitutionally protected conduct.” *Martin*, 700 F.3d at 135. Because the 2023 Act does not implicate a substantial amount of constitutional conduct, *see Dobbs v. Jackson Women’s Health Org.*, 597 U.S. 215, 231 (2022), Plaintiffs’ facial “challenge should only succeed if the law is ‘impermissibly vague in all of its applications.’” *Martin*, 700 F.3d at 135 (quoting *Vill. of Hoffman Ests. v. Flipside, Hoffman Ests., Inc.*, 455 U.S. 489, 495 (1982)). Or, the Fourth Circuit continued, “a facial challenge is ineffective if the statute has a ‘plainly legitimate sweep.’” *Id.*

This “plain sweep” standard means that Plaintiffs cannot prevail on a facial vagueness challenge by margin probing. As the Seventh Circuit put it, “a finding of unconstitutional vagueness cannot be based on uncertainty at the margins, or on a parade of bizarre hypothetical cases.” *Levas & Levas v. Vill. of Antioch, Ill.*, 684 F.2d 446, 451 (7th Cir. 1982). “[P]roblems of that order can be resolved in challenges to the [law] as applied.” *Id.* That’s because any statute may raise “a close question” “in marginal situations.” *Cooper*, 842 F.3d at 842. A facial challenge thus does not dwell on “edge questions” or “uncertainties at the margins,” but it asks whether a law “has a discernable

core.” *Planned Parenthood of Ind. & Ky., Inc. v. Marion Cnty. Prosecutor*, 7 F.4th 594, 605 (7th Cir. 2021). So “it is inappropriate to speculate regarding a worst-case scenario” in “a facial challenge.” *Greenville Women’s Clinic v. Comm’r, S.C. DHEC*, 317 F.3d 357, 367 (4th Cir. 2002).

That’s all margin-probing is: pointing to worst-case scenarios. It’s taking some hard cases near the statutory line and insisting that—because of those edge cases—the statute as a whole cannot be understood. That, however, ignores the Supreme Court’s instruction that a court should focus on situations that are “most likely to be constitutional,” rather than “on hypothetical scenarios [that] might raise constitutional concerns.” *United States v. Rahimi*, 602 U.S. 680, 701 (2024). By focusing on the hard, potentially unclear cases, a court would wrongly be “slaying a straw man.” *Id.*

As an illustration of how Plaintiffs weaponize a wrong legal standard, consider their argument about the meaning of “major bodily function.” They treat it as a “gotcha” that Defendants’ experts did not recite exactly the same exhaustive list of every possible major bodily function, even though their answers substantially overlap and Plaintiffs identify no material disagreement about the term’s core applications. *See, e.g.*, ECF No. 166-1, at 14 (faulting Austin for not “identif[ying] an exhaustive list”). But a facial vagueness challenge is not won by pointing to one or two possible differences at the margins while ignoring the term’s settled sweep. The question is not whether every expert used identical phrasing or anticipated every conceivable application. The question is whether the statute gives notice in a core of ordinary applications. And on that question, Defendants’ experts gave consistent answers. *See* Response to Statement of Undisputed Facts (“RSUF”) A.1.i. Even Plaintiffs’ own testimony shows a shared understanding of core applications of “major bodily function.” *See, e.g.*, Ex. 4, at 168:23–24, 185:24–25, 197:20–21; Ex. 6, at 98:20–25.

2. Try as they might, *Johnson v. United States*, 576 U.S. 591 (2015), does not let Plaintiffs avoid this plain sweep inquiry. They cite *Johnson* for the proposition that a law may be

unconstitutionally vague even if “there is some conduct that clearly falls within the provision’s grasp.” ECF No. 166-1, at 27 (quoting *Johnson*, 576 U.S. at 602). But that proposition is limited.

Johnson simply means that the “in all its applications” standard may no longer apply in certain circumstances. And Plaintiffs have not adequately explained why it should not apply in the context of their facial vagueness challenge. See 576 U.S. at 603; *Carolina Youth Action Project v. Wilson*, 60 F.4th 770, 785 (4th Cir. 2023). But Plaintiffs seem to think *Johnson* means the plain sweep standard no longer applies either. That’s wrong. Even post-*Johnson*, the Supreme Court has explained that in “a facial challenge” “other” than First Amendment ones (so, this case), a plaintiff must still “establish that no set of circumstances exists under which the law would be valid” or, at least, “that the law lacks a plainly legitimate sweep.” *Moody*, 603 U.S. at 723 (cleaned up). In practice, that means the plaintiff must show “the law’s unconstitutional applications [more than] substantially outweigh its constitutional ones.” *Id.* at 724. That’s why a defendant need only show that a law has a “constitutional core” to win.⁹ *Cooper*, 842 F.3d at 842.

That’s entirely consistent with *Johnson*’s “thousand dollars for a pound of sugar” hyperbolic hypothetical. 576 U.S. at 602 (cited at ECF No. 166-1, at 27). Although one extreme example might not save an otherwise vague statute, a law that “appl[ies] without question to certain activities” will survive a facial challenge. *Cooper*, 842 F.3d at 842.

Johnson has even less force here because it involved “the peculiar double-indeterminacy posed by applying the residual clauses’ imprecise qualitative standards to the judicially imagined ordinary case of a crime required by the categorical approach.” *United States v. Hasson*, 26 F.4th

⁹ In their summary judgment motion, Defendants explained that the “no set of circumstances” standard governs this facial challenge. See ECF No. 165, at 11–12. Defendants maintain that argument, but as in their motion, they focus on the “plainly legitimate sweep” argument here to show that Defendants win even under that standard, which is more favorable to Plaintiffs.

610, 620 (4th Cir. 2022) (cleaned up). So rather than applying the allegedly vague statute to “a defendant’s real-world conduct,” *id.*, a court applying the “residual clause” had to apply that statute to a hypothetical crime. But the 2023 Act applies in the ordinary way: to facts in a real case.

B. Criminal penalties are not the burden-shifter that Plaintiffs say they are.

Plaintiffs don’t ignore the vagueness law on criminal penalties the way they do the plain sweep standard. Indeed, they are quick to note that laws with criminal penalties and license revocation (like the 2023 Act) require greater scrutiny. *See* ECF No. 166-1, at 26–27. But Plaintiffs vastly overstate the point when they insist that these consequences require “exacting scrutiny” of the 2023 Act’s exceptions. ECF No. 166-1, at 26.

These laws face only a “*relatively* strict test.” *Hoffman Ests.*, 455 U.S. at 499 (emphasis added). Relative to what? To the even lower standard that applies to laws with only civil penalties. It is not, as Plaintiffs seem to imply, tantamount to strict scrutiny. *See, e.g., Copeland v. Vance*, 893 F.3d 101, 114 (2d Cir. 2018) (applying a “moderately stringent” test).

Even that heightened clarity requirement for criminal laws remains modest in a facial challenge. *Martin*, for example, involved a challenge to a South Carolina law criminalizing certain gaming machines. 700 F.3d at 134. The Fourth Circuit recognized that criminal penalties require more clarity than civil ones, *id.* at 135, but nevertheless upheld the law because it had “sufficient clarity to meet *the relatively low bar* for this facial challenge.” *Id.* at 137 (emphasis added).

Close cases may remain, but that is true of any criminal law that draws a line. “[T]he law is full of instances where a man’s fate depends on his estimating rightly, that is, as the jury subsequently estimates it, some matter of degree.” *Nash v. United States*, 229 U.S. 373, 377 (1913) (Holmes, J.). But “[t]hat there may be marginal cases in which it is difficult to determine the side of the line on which a particular fact situation falls is no sufficient reason to hold the language too ambiguous to

define a criminal offense.” *Petrillo*, 332 U.S. at 7. Plaintiffs’ demand for “exacting scrutiny” cannot be squared with that settled rule or with the law governing facial challenges. ECF No. 166-1, at 26.

C. Plaintiffs misconstrue the impact of the reasonableness standard.

Plaintiffs also take issue with the requirement that physicians employ “reasonable medical judgment” in determining whether an exception applies. *See id.* at 32, 38. This standard, Plaintiffs say, leaves them too unsure to perform abortions. All their arguments, however, miss the mark.

1. Start with first principles. Reasonableness standards do not make criminal laws vague. As the Supreme Court held long ago, “[t]he mere fact that a penal statute is so framed as to require a jury upon occasion to determine a question of reasonableness is not sufficient to make it too vague to afford a practical guide to permissible conduct.” *United States v. Ragen*, 314 U.S. 513, 523 (1942). That’s no surprise, given that States may even “create strict criminal liabilities by defining criminal offenses without any element of scienter.” *Smith v. California*, 361 U.S. 147, 150 (1959). And *Hoffman Estates* held only that “a scienter requirement may *mitigate* a law’s vagueness”—not that its absence *creates* vagueness where it otherwise isn’t. *Vill. of Hoffman Ests.*, 455 U.S. at 499.

Reasonableness standards abound in criminal law. Federal law is full of them. *See, e.g.*, 18 U.S.C. § 933(a)(1) (criminalizing firearm transport when the person has “reasonable cause to believe” the firearm will be used in a felony); *id.* § 2339(a) (criminalizing harboring a person one has “reasonable grounds to believe” committed a terrorist act). So is state law. *See, e.g.*, S.C. Code Ann. § 16-3-830 (affirmative defense where defendant “reasonably believed” minor was at least 18).

2. Plaintiffs’ pre-*Dobbs* abortion cases do not turn an objective medical judgment standard into a categorical vagueness problem. *See* ECF No. 166-1, at 33–34, 38. Start with *Colautti v. Franklin*, 439 U.S. 379 (1979). Plaintiffs ignore the question the Court expressly did “not . . . decide”: “whether, under a properly drafted statute, a finding of bad faith or some other type of

scienter would be required before a physician could be held criminally responsible for an erroneous determination of viability.” 439 U.S. at 396. That alone defeats their *Colautti* argument.

Properly understood, *Colautti* helps Defendants, not Plaintiffs. It held only that a State “must allow the attending physician the room he needs to make his best medical judgment.” *Id.* (internal quotation mark omitted). The Pennsylvania law in *Colautti* was unclear about whether it imposed a purely subjective or a mixed objective-subjective standard, and this, in the Court’s view, “subject[ed] the physician to potential criminal liability without regard to fault.” *Id.* at 394. Plus, “[t]he perils of strict criminal liability” there were “particularly acute . . . because of the uncertainty of the viability determination itself,” which the Pennsylvania law appeared to treat as an either-or, black-or-white decision. *Id.* at 395. *Colautti* thus condemned a statute that obscured the standard while exposing physicians to faultless criminal liability for an uncertain medical determination. That’s not the case with the 2023 Act, which gives physicians the breathing room to exercise reasonable medical judgment—something Doe said physicians should already do. *See* Ex. 2, at 165:9–13.

Plaintiffs try to force this case into *Colautti* by claiming “profound disagreement,” ECF No. 166-1, at 31, but that claim narrows quickly. They identify one example, or at most three. *See id.* Doe has been able to apply the exception for two of the three. And as explained above, Plaintiffs have not shown genuine disagreement among Defendants’ experts about those examples.

Even where reasonable physicians could disagree, that is not a vagueness problem. “In any given medical situation there is likely to be a number of reasonable medical options and disagreement between doctors over the appropriate course of action does not, of course, render one option reasonable and another unreasonable.” *Karlin v. Foust*, 188 F.3d 446, 464 (7th Cir. 1999). Like Texas’s abortion law, the 2023 Act “leaves to *physicians*—not judges—both the discretion and the responsibility to exercise their reasonable medical judgment, given the unique facts and

circumstances of each patient.” *In re State*, 682 S.W.3d 890, 893 (Tex. 2023). Still, the law “requires more than a doctor’s mere subjective belief.” *Id.* at 894. It requires that “medical facts support the need for an abortion,” and any evaluation of whether an abortion was permitted looks at those facts, not the physician’s subjective intent. *State v. Zurawski*, 690 S.W.3d 644, 663–64 (Tex. 2024). In other words, the 2023 Act does not impose “strict criminal liability,” as *Colautti* prohibited. 439 U.S. at 395. It allows for punishment only if a physician acts unreasonably. So it lets physicians make decisions under the complex constraints and circumstances that obstetrics sometimes presents.

Greig’s testimony about Trisomy 18 illustrates the point. Although he acknowledged that a Trisomy 18 case could be “a hard decision,” he would be “able to defend that” decision “100 percent in court” if someone challenged him. Ex. 15, at 191:19–23. That’s because of “that standard of reasonable medical judgment,” *id.* at 191:24–25, a “buffer” that gives “doctors the flexibility to operate” and “apply their training and expertise to the unique facts of the situation.” Ex. 16, ¶ 61.

Women’s Medical Professional Corp. v. Voinovich, 130 F.3d 187 (6th Cir. 1997), doesn’t help Plaintiffs either because it turned on abortion’s then-constitutional status. The Sixth Circuit derived from *Casey* a more permissive standard for when “an abortion law” is unconstitutional “on its face”—one that displaced the “no set of circumstances” test only “in the abortion context.” 130 F.3d at 194; *id.* at 206 n.18 (extending that standard to “vagueness”). The court did not fault the exception’s actual terms. Its holding turned on the lack of scienter alone (meaning any statutory definition would’ve failed), and that scienter holding was tied to the court’s abortion-specific (pre-*Dobbs*) constitutional standard. *See id.* at 205–06.

But after *Dobbs*, there’s no such “abortion exceptionalism.” *SisterSong Women of Color Reprod. Just. Collective v. Governor of Ga.*, 40 F.4th 1320, 1328 (11th Cir. 2022). So the better guide is not a post-*Roe* circuit decision shaped by *Casey*, but a Supreme Court decision applying

ordinary vagueness principles. An example would be *United States v. Vuitch*, where the Court rejected a facial vagueness challenge to a maternal health exception far less precise than the 2023 Act's. *See* 402 U.S. 62, 68 (1971) (upholding law that criminalized abortions "unless . . . as necessary for the preservation of the mother's life or health").

In this context, it makes sense that a State would choose an objective standard when the State has expressed its "compelling interest from the outset of a woman's pregnancy in protecting . . . the life of the unborn child." 2023 Act, § 1(3). Otherwise, the exception would turn on a physician's subjective belief, even where no fair-minded doctor would take that position.

3. Plaintiffs next try to turn abortion's disputed status into a vagueness rule. Because abortion is "contested" and some physicians may disagree, Plaintiffs say, the reasonableness standard is vague. ECF No. 166-1, at 33. But no such "contested-issue" rule exists. The Court effectively put this idea to bed pre-*Roe*. *See Vuitch*, 402 U.S. at 72 n.7. Plus, criminal cases often turn on conflicting expert testimony. For instance, a federal civil rights prosecution under 18 U.S.C. § 242 asks whether a law enforcement officer used "unreasonable force." *United States v. Perkins*, 470 F.3d 150, 151 (4th Cir. 2006). Such cases often involve competing testimony from law-enforcement experts about whether force was reasonable. *E.g., id.* at 156; *United States v. Slager*, No. 2:16-CR-00378-DCN, 2018 WL 445497 (D.S.C. Jan. 16, 2018) (discussing expert testimony at sentencing in § 242 case). Plaintiffs' contention could be made against any objective standard. There's no reason to start writing reasonableness requirements out of criminal law. Plus, Plaintiffs' effort to show disagreement on edge-case examples fails on its own terms. *See supra* RSUF A.2.; B.2.

4. Plaintiffs fare no better when they insist that the exceptions conflict with "evidence-based medicine." ECF No. 166-1, at 35. That's a policy point dressed up as a vagueness argument. And it confuses whether abortion may be a "reasonable" medical treatment in the abstract with whether a

physician used “reasonable medical judgment” as to whether the statutory terms applied. South Carolina’s standard does not have to match ACOG’s. It just needs to have an understandable core. Plaintiffs’ admissions show it does. *See infra* Part II; ECF No. 165, at 18–19, 22–25, 29–32, 36–38.

D. The vagueness cases on which Plaintiffs rely do not help them here.

Plaintiffs’ reliance on a handful of other cases does little. Plaintiffs invoke those cases for broad propositions: qualitative terms can be vague, competing interpretations can matter, objective medical-judgment standards can raise concerns, and vague laws can invite arbitrary enforcement. *See* ECF No. 166-1, at 28–30. But themes are not enough. Vagueness is statute- and record-specific. Saying that other plaintiffs prevailed in other vagueness cases proves no more than saying that other plaintiffs prevailed in Fourth Amendment cases. The question is whether *these* exceptions, in *this* statutory context and on *this* record, fail to provide fair notice or invite arbitrary enforcement.

They do not, and these cases don’t show otherwise. Start with *Manning v. Caldwell for City of Roanoke*, 930 F.3d 264 (4th Cir. 2019), *see* ECF No. 166-1, at 28, 30, which held Virginia’s “habitual drunkard” law vague. That law imposed a binary label—habitual drunkard or not—with no room for reasonable judgment. The 2023 Act does the opposite. It gives physicians room to exercise reasonable medical judgment, including the ability to reach different—yet reasonable—conclusions. *See* Ex. 9, at 195:25–196:8; Ex. 11, at 153:15–19; *see* Ex. 17, at 26:12–25; *Karlin*, 188 F.3d at 464. That is familiar in law. Reviewing courts routinely affirm reasonable decisions even if they might have decided differently in the first instance. *See, e.g., Mercer v. Duke Univ.*, 401 F.3d 199, 211 (4th Cir. 2005) (review of attorney’s fee award).

Then there’s *McCormack v. Herzog*, 788 F.3d 1017 (9th Cir. 2015), and *Forbes v. Woods*, 71 F. Supp. 2d 1015 (D. Ariz. 1999), neither of which supports Plaintiffs’ proposed rule that medical regulations are vague whenever they use terms that lack a technical medical definition. *See* ECF No.

166-1, at 28. *McCormack* involved whether an abortion facility was “properly” staffed and had “satisfactory” hospital arrangements—words the Ninth Circuit likened to “consideration,” “respect,” “dignity,” and “individuality” because they turned on subjective viewpoints rather than objective facts. 788 F.3d at 1031. *Forbes* involved “experimentation,” “investigation,” and “routine”—terms that gave no stable line between lawful treatment and forbidden research, leaving the statute with “simply . . . no core.” 71 F. Supp. 2d at 1020. The 2023 Act, by contrast, has that “core.” The Act lists presumed conditions, Plaintiffs have applied the exception, physicians have reported abortions under it, and Plaintiffs themselves identify circumstances where it plainly does not apply. And unlike the words in *McCormack* and *Forbes*, Plaintiffs use the 2023 Act’s words regularly in the medical context. *See, e.g.*, Ex. 3, ¶ 31; Ex. 2, at 83:6–11, 118:7–10, 121:19, 155:14–15, 194:19, 231:1–10, 237:21, 255:3–6; Ex. 4, at 46:3–9, 83:24–84:3, 175:13–16, 212:19–21.

Plaintiffs’ remaining cases fare no better. *United States v. Forbes* involved a “great diversity of opinion” about a law “*as applied to*” a particular drug, 806 F. Supp. 232, 238 (D. Colo. 1992) (emphasis added)—unlike Plaintiffs’ *facial* claim. Vagueness in *Planned Parenthood South Atlantic v. Stein* focused on grammatical questions and undefined terms, 742 F. Supp. 3d 472, 483–86 (M.D.N.C. 2024), whereas the terms here are either defined or ones that Plaintiffs admit they regularly use. And *Causeway Medical Suite v. Foster* is doubly inapposite. The experts here do not disagree about the law’s application, and abortion is not a federal constitutional right. *See* 43 F. Supp. 2d 604, 619 (E.D. La. 1999).

Finally, *Connally v. General Construction Co.*, 269 U.S. 385 (1926), does not help. Plaintiffs say this case “h[e]ld[] that a criminal law that prohibited ‘crowded’ railway cars lacked meaningful standards.” ECF No. 166-1, at 30. That’s wrong. *Connally* merely quoted a D.C. Circuit railway-car case. *See* 269 U.S. at 392. *Connally* itself involved an Oklahoma wage law that created “a double

uncertainty” by tying wages to different and inconsistent metrics. *Id.* at 388, 393. So Plaintiffs’ reliance on *Connally* fails too.

* * *

All of this confirms what the Supreme Court has held: “[F]acial challenges” are “hard to win.” *Moody*, 603 U.S. at 723. Plaintiffs never acknowledge as much. But they cannot avoid it. This standard matters, and failing to “pa[y] much attention to that issue” while “treat[ing a] case[] more like as-applied claims than like facial ones” is no path to success. *Id.* at 724.

II. The exceptions provide fair notice.

A central theme of Plaintiffs’ argument is that legislatures must use a field’s jargon—as ordained by the medical establishment—to regulate a “highly specialized” field like medicine, otherwise the statute is vague. ECF No. 166-1, at 28. That’s not so. The State’s power to regulate medicine predates the Founding, *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 703–04 (D.C. Cir. 2007), so “regulation by the State” is a “well established” practice, *360 Virtual Drone Serv. LLC v. Ritter*, 102 F.4th 263, 271 (4th Cir. 2024).

If medical regulations must reflect “medical consensus,” that regulatory power shifts from the State to the medical establishment. The Supreme Court has never suggested the State hitch itself to medical “consensus,” nor have Plaintiffs pointed to any history indicating as much. Plaintiffs thus gain no traction from the fact that the 2023 Act does not use hypertechnical, establishment-blessed terms—especially when these terms are more common in medicine than Plaintiffs admit. *See* ECF No. 165, at 18–21, 22–25. The question is simply whether the exceptions have a plain sweep that gives fair notice of what the 2023 Act prohibits. They do. The evidence proves it.

A. The maternal health exception has an understandable core.

1. Plaintiffs don’t dispute the many instances in which the exception can be—and has been—

understood and applied. There are the abortions that Plaintiffs have performed under the exceptions, the presumed conditions, and the express exclusion of psychological conditions. *See* ECF No. 165, at 29–32 (Defendants’ summary judgment motion discussing these instances and citing evidence). There are even the cases Plaintiffs try citing for purported confusion. Both Doe and Tarleton recognize that PPROM satisfies the exception. *See* Ex. 2, at 117:13–17; Ex. 5, at 38:17–39:2. And Doe understood the exception in a case of pulmonary embolism, concluding abortion was not permitted. Ex. 2, at 198:18–23. Defendants’ experts reached that conclusion too. *See* RSUF A.2.i.

And then there is the DPH data. This is one of the most compelling pieces of evidence about the 2023 Act’s plain sweep, which Plaintiffs somehow say shows that some generalized but unidentified group of “physicians” “only feel confident” providing abortions under the exceptions “in the most egregious cases.” ECF No. 166-1, at 23. Even that strained reading admits a core. *See* Part II.B. But the actual data show a broader one. Physicians have applied the exception in more than a dozen unique conditions beyond the exception’s 11 presumed conditions. *See* Ex. 20. There is no reasonable basis to conclude that any physician legitimately fears prosecution after performing one of these abortions. ECF No. 166-1, at 23. Plaintiffs cannot point to any prosecutions (or even any investigations). *See* Ex. 2, at 165:19–166:6; Ex. 4, at 204:18–205:11.

This all matters in a facial challenge. Plaintiffs cannot invalidate the maternal health exception by spotlighting alleged uncertainty at the margins while ignoring the obvious constitutional applications. *See Moody*, 603 U.S. at 724; *Cooper*, 842 F.3d at 842. To prevail, Plaintiffs must account for both sides of the ledger: the allegedly unconstitutional applications and the plainly constitutional ones. But they don’t even try. That failure alone defeats their motion.

2. Rather than considering instances when the exception is “most likely to be constitutional,” Plaintiffs dwell on ones that “might raise constitutional concerns.” *Rahimi*, 602 U.S. at 701. But

even their fixation on just that one side of the ledger is flawed because they generalize from a few anecdotes to make sweeping claims about “physicians” statewide. *E.g.*, ECF No. 166-1, at 7 (the “vague[]” language “often prevents physicians from determining” whether an exception applies and “physicians across South Carolina regularly struggle to apply” it); *see also id.* at 28, 30–31, 35.

Yet Plaintiffs have no generalizable support for those claims. Their evidence comes from the experience of just a few doctors. They repeatedly use anecdotes from Doe, Bingham, and Tarleton. *See, e.g.*, ECF No. 166-1, at 15–18, 31–32. But there’s no evidence about the nearly 1,500 other OB-GYNs in this State. And Plaintiffs cannot draw a reasonable conclusion about these physicians when just as many South Carolina OB-GYNs (Austin, Draper, and Greig) testified that they had no issues understanding the exception. At bottom, Plaintiffs cannot speak for ordinary “physicians” and what they “often” face beyond the evidence they cite. And most of the situations they invoke to show confusion or conflict really show consistent understanding. *See* RSUF A.1–2.

At most, Plaintiffs identify one narrow disagreement. They note that “Doe, her colleagues, and a group of South Carolina physicians” believe that PPROM allows an abortion even if the pregnant woman is “currently without signs of infection and is not bleeding,” and emphasize that two experts might not agree. ECF No. 166-1, at 34. That is hard to square with Plaintiffs’ earlier assertion that PPROM only allows an abortion in “*most* cases.” *Id.* at 16 (emphasis added). But even taking it at face value, one edge-case disagreement does not show that the 2023 Act lacks a plain sweep or that “the law’s unconstitutional applications [more than] substantially outweigh its constitutional ones.” *Moody*, 603 U.S. at 724.

B. The fatal fetal anomaly exception has an understandable core.

1. The fatal fetal anomaly exception has a plain sweep. Most pregnancies do not involve a fatal fetal anomaly. *See* Ex. 2, at 46:12–18 (only 2% of Doe’s patients obtain an abortion for a fetal

anomaly). And for pregnancies where an anomaly is present, physicians—Plaintiffs included—have repeatedly invoked the exception. *See* Ex. 20 (more than 50 abortions under the 2023 Act for fatal fetal anomalies). Plaintiffs have also identified many anomalies to which the exception would not apply. *See, e.g.,* Ex. 4, at 168:3–24, 268:17–269:3; Ex. 5, at 61:6–10. The record therefore demonstrates an “ascertainable standard for inclusion and exclusion,” *Smith v. Goguen*, 415 U.S. 566, 578 (1974)—that is, a “constitutional ‘core.’” *Cooper*, 842 F.3d at 842. Plaintiffs cannot obtain facial relief while admitting that physicians can identify many cases on both sides of the line.

2. Just as Plaintiffs understate the plain sweep of the fatal fetal anomaly exception, they overstate the supposed difficulties. Again, Plaintiffs rely on generalized claims about unnamed “physicians” without any general evidence. Their factual section says that “physicians often struggle” to apply the fatal fetal anomaly exception. ECF No. 166-1, at 18. But the proof they cite is much narrower: Doe’s claimed monthly uncertainty, Tarleton’s broad referral testimony, manufactured differences among Defendants’ experts, and three examples—Trisomy 18, HLHS, and amniotic band syndrome—drawn largely from Doe and Tarleton. *See id.* at 18–22; *see also* RSUF B.2 (showing no material disagreement on those examples).

Their legal argument repeats the same move. Plaintiffs claim “the lack of professional consensus” on the terms “often prevents physicians” from applying the fatal fetal anomaly exception, but that claim rests on the same narrow proof: Doe, Tarleton, three example conditions, and supposed conflicts among Defendants’ experts. *Id.* at 37. That is not evidence about what “physicians” “often” experience. Plaintiffs cannot extrapolate from those few examples to all South Carolina OB-GYNs.

Those few examples backfire anyway. On Trisomy 18, HLHS, and amniotic band, the testimony shows a general ability to apply the exception and a consensus among the physicians. *See* RSUF B.2. So rather than showing vagueness, these examples confirm that physicians can

understand and apply the exception. And even if Plaintiffs could find a point or two of disagreement, that wouldn't be enough to prevail on a facial challenge. *See Moody*, 603 U.S. at 723–24.

Nor do the exception's terms pose a problem. Plaintiffs demand a degree of certainty about how long a child will live that medicine cannot give and the 2023 Act does not require. Although physicians can predict what is generally likely to happen with certain conditions, no one can know for sure how a specific case will turn out. That's why the fatal fetal anomaly exception requires doctors to exercise "reasonable medical judgment." S.C. Code Ann. § 44-41-610(5). If 99% of unborn children with a certain condition pass away in well under a year, a doctor could reasonably conclude that the exception permits an abortion, even if the doctor can't say for sure that the child won't be in the 1%. Ex. 9, at 88:11–16. Plaintiffs' demand for a fixed survival clock is thus just another demand for certainty that vagueness doctrine does not require.

Finally, come at this dispute from a different angle. Plaintiffs say that physicians have "no way" to determine what the exception means. ECF No. 166-1, at 18–19. If that were the case, why is the record replete with physicians—including Plaintiffs—repeatedly applying the exception?

III. Plaintiffs fail to show the exceptions invite arbitrary or discriminatory enforcement.

As a second attack on the 2023 Act, Plaintiffs insist that the exceptions give the Attorney General and Solicitors responsible for enforcing them "unfettered discretion." ECF No. 166-1, at 39, 41. Plaintiffs are wrong.

A. The exceptions do not grant prosecutors "unfettered discretion."

1. The statute itself constrains prosecutors. The exceptions provide clear guidelines, including defined terms physicians have proven they can apply, presumed conditions, and the reasonable medical judgment standard. S.C. Code Ann. §§ 44-41-610(5), (9), (13); 44-41-640(C)(2). And under that standard, a physician can't be arrested on a "subjective basis." ECF No. 166-1, at 40

(quoting *Hoffman Ests.*, 455 U.S. at 498). So the 2023 Act gives law enforcement a discernible legal question to investigate—not a roving license to prosecute abortions they dislike.

Testimony confirms that point. For example, the Thirteenth Circuit Solicitor understood the maternal health exception to ask whether “a practicing doctor, based on their training, experience, [and] education,” made a reasonable medical judgment to “prevent death or . . . serious risk of substantial impairment of a pregnant woman.” Ex. 18, at 13:15–14:6. So law enforcement would have to determine that a physician deviated from that objective standard before charging her. That is not “unfettered discretion.” And unlike *Stein*, where plaintiffs challenged North Carolina’s law “soon []after” it was enacted and prosecutors “remained silent on the [law’s] meaning” and “on whether criminal penalties [we]re available,” 742 F. Supp. 3d at 477, 484, 486, this record shows how prosecutors understand and would enforce the 2023 Act. The Constitution does not require prosecutors to have office guidelines for a statute to be constitutional. *See* ECF No. 166-1, at 25, 41.

2. Plaintiffs next treat expert consultation as some constitutional defect, arguing that prosecutors are “unfamiliar with even the most basic aspects of the law.” ECF No. 166-1, at 23–24, 39. But consulting medical experts isn’t a shortcoming of the 2023 Act. It’s what objective enforcement looks like in medically complex scenarios. That approach makes sense because the exceptions require doctors to use “reasonable medical judgment.” Prosecutors and law enforcement officers do not purport to possess “medical judgment,” so they should not prosecute based on their own medical instincts. *See* Ex. 19, at 26:2–18 (Solicitor recognizing prosecutors’ lack of medical judgment and need for an expert); Ex. 18, at 13:23–25, 14:10–17 (similar); Ex. 17, at 18:11–21 (similar).

None of that is surprising. Prosecutors rely on expert consultation all the time. In child-sex-abuse cases, prosecutors use pediatricians to perform medical forensic examinations or interpret

medical reports. *See* Ex. 19, at 14:17–15:18; *see also Pavel v. Hollins*, 261 F.3d 210, 224 n.17 (2d Cir. 2001) (“There is little question that child sexual abuse cases often present a fertile, indeed, a necessary, area for expert assistance.” (cleaned up)). And in sexual assault cases, law enforcement consults “sexual assault nurse examiners.” Ex. 19, at 22:10–18. More generally, medical professionals are often used to help “understand the facts” or help “make sure that [prosecutors] have a clear picture of what took place.” Ex. 18, at 18:22–19:2. Even courts rely on medical experts. *E.g., Hall v. Florida*, 572 U.S. 701, 710 (2014) (“it is proper to consult the medical community’s opinions” to determine whether a capital defendant is “intellectually disabled”).

B. Plaintiffs’ arbitrary-enforcement theory is speculative.

Plaintiffs’ arbitrary-enforcement theory is speculation. They identify no investigations, no prosecutions, and no evidence that anyone has enforced the 2023 Act discriminatorily. *See* Ex. 2, at 165:19–166:6; Ex. 4, at 204:18–205:11. Courts reject these “somewhat speculative” facial vagueness challenges, *Gonzales v. Carhart*, 550 U.S. 124, 150 (2007), where “no evidence has been, or could be, introduced to indicate whether the ordinance has been enforced in a discriminatory manner,” *Hoffman Ests.*, 455 U.S. at 503.

Plaintiffs’ related fear that prosecutors will “find physicians willing to testify” against another physician or will “draw[] on their own biases” fares no better. ECF No. 166-1, at 33, 35, 40. Not only has the Supreme Court rejected this specific argument in an abortion case, *Vuitch*, 402 U.S. at 72 n.7, but Plaintiffs also can’t square their fears with the “presumption of legitimacy accorded to the Government’s official conduct,” *Nat’l Archives & Records Admin. v. Favish*, 541 U.S. 157, 174 (2004), including “prosecutorial decisions,” *United States v. Armstrong*, 517 U.S. 456, 464 (1996). It takes “clear evidence” of bad faith, not “bare suspicion,” to assume otherwise. *Favish*, 541 U.S. at 174. That abortion is contested does not make it plausible—much less facially inevitable—that

prosecutors will ignore the law and pursue physicians based on bias. If that ever occurs, “this abuse must be dealt with if and when a pattern of unlawful favoritism appears,” not by assuming at the outset that state officials will administer the law unlawfully. *Thomas v. Chi. Park Dist.*, 534 U.S. 316, 325 (2002). So when plaintiffs “fail[] to cite *any* example of arbitrary or discriminatory enforcement,” “mere conjecture about potentially arbitrary or discriminatory enforcement scenarios dooms [their] claim.” *Green v. City of Raleigh*, 523 F.3d 293, 306 (4th Cir. 2008).

C. *Carolina Youth* does not help Plaintiffs.

Plaintiffs put more weight on *Carolina Youth* (which wasn’t a facial challenge) than it can bear. The law there made it a misdemeanor “to conduct oneself in a disorderly or boisterous manner” or “use obscene or profane language” in certain places. 60 F.4th at 776 (cleaned up). The court said it invited officers to “deploy a glorified smell test” because it supplied no “meaningful standards” for distinguishing criminal misbehavior from “garden variety” misbehavior. *Id.* at 782–84.

The 2023 Act is different. As explained above, the exceptions say what is “unlawful in the first place,” *id.* at 784: an abortion after a fetal heartbeat is detected, unless an exception applies, S.C. Code Ann. § 44-41-630(B). And those exceptions are not a free-floating “totality of the circumstances” or “multifactor balancing” test. ECF No. 166-1, at 40; *Carolina Youth*, 60 F.4th at 784. They incorporate defined terms, presumed conditions, and an objective “reasonable medical judgment” standard. Those defined terms include phrases used by physicians—including Plaintiffs—every day. *See, e.g.*, Ex. 2, at 83:6–11, 87:10–12, 255:3–6. And that “reasonable medical judgment” standard is tied to what a “reasonably prudent physician,” “knowledgeable about the case and the treatment possibilities,” would decide “with respect to the medical conditions involved” in a specific case. S.C. Code Ann. § 44-41-610(13). So the standard accounts for patient-specific medical facts within an objective framework, not some subjective smell test.

Prosecutors explained how that framework works. If a case ever arises, they would thoughtfully consult medical experts and review all the facts to determine whether the objective reasonableness standard has been met. *See* Ex. 19, at 16:6–17; Ex. 18, at 17:10–21, 20:11–16, 21:24–22:4, 37:12–21; Ex. 17, at 18:15–21, 29:1–7, 46:14–47:4.

That objective framework gives prosecutors what *Carolina Youth* lacked: a legal line between criminal and “garden-variety” conduct. 60 F.4th at 782–83. In that case, ordinary childhood misbehavior became criminal only if an officer decided it crossed some undefined line. But the 2023 Act defines the prohibited conduct—abortion after a detected fetal heartbeat—and then identifies objective exceptions. Prosecutors understand that those exceptions turn on reasonable medical judgment. *See* Ex. 17, at 47:20–48:17; Ex. 19, at 27:10–24. And because prosecutors do not possess “medical judgment,” they consult medical experts to know whether that objective standard is met under the circumstances—what they “always” do “in cases like this.” *See* Ex. 19, at 26:2–18.

The record is different here too. In *Carolina Youth*, “the record confirm[ed]” that officers deployed a “smell test.” 60 F.4th at 784. That was no “empty threat,” as those plaintiffs had identified 3,735 examples. *Id.* at 776. Here, Plaintiffs have nothing comparable. They identify no prosecution and no investigation—not a single example, much less an arbitrary one.

CONCLUSION

The Court should deny Plaintiffs’ Motion for Summary Judgment.¹⁰

¹⁰ Defendants request that the Court stay any injunction pending appeal under Federal Rule of Civil Procedure 62 and Federal Rule of Appellate Procedure 8(a)(1).

Respectfully submitted,

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