

IN THE DISTRICT COURT OF OKLAHOMA COUNTY  
STATE OF OKLAHOMA

FILED IN DISTRICT COURT  
OKLAHOMA COUNTY

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No. CV-2019-2506

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SOUTH WIND WOMEN'S CENTER LLC, D/B/A59  
TRUST WOMEN OKLAHOMA CITY *et al.*,

*Plaintiffs,*

v.

MIKE HUNTER, in his official capacity as  
OKLAHOMA ATTORNEY GENERAL *et al.*,

*Defendants,*

Before: Judge Natalie Mai

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RESPONSE IN OPPOSITION TO  
MOTION FOR A TEMPORARY INJUNCTION

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## INTRODUCTION

For over 40 years, and like most other states, Oklahoma has limited the performance of abortions to licensed physicians only.<sup>1</sup> The U.S. Supreme Court has repeatedly approved such laws. Most forcefully, in 1997 the Supreme Court summarily rejected a challenge to Montana’s “physician-only” law and re-emphasized that “our prior cases left *no doubt* that, to ensure the safety of the abortion procedure, the States may mandate that only physicians perform abortions.”<sup>2</sup>

Nevertheless, less than four years after opening an abortion clinic in Oklahoma, Plaintiffs seek to upend this long-accepted status quo and have this Court enjoin our physician-only law as unconstitutional simply because they cannot convince Oklahoma doctors to work for them.<sup>3</sup> Plaintiffs also claim Oklahoma’s 2012 law clarifying that the attending physician must be physically present is unconstitutional.<sup>4</sup> But if there is “no doubt” that Oklahoma can require that abortion be performed by a physician, then surely the State can require this physician to be in the room.

Despite these simple, uncontroversial, and foundational laws having been on the books for almost a half-century combined, Plaintiffs claim they now pose an emergency necessitating a sweeping injunction. But “[t]he purpose of a temporary injunction is to preserve the status quo,” and injunctions revolve firstly around the likelihood of success on the merits.<sup>5</sup> The State has spent nearly 50 years enforcing these laws, and Plaintiffs are unlikely to prevail in their attempt to overturn reams of precedent. This Court should thus deny the motion and preserve a longstanding status quo that is supported by the Oklahoma State Medical Association, the Oklahoma Association of Nurse Practitioners, and the Telehealth Alliance of Oklahoma, among others.<sup>6</sup>

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<sup>1</sup> See 63 O.S. § 1-731(A) (enacted 1978); *Overview of Abortion Laws*, GUTTMACHER INSTITUTE (Jan. 1, 2020), available at <https://www.gutmacher.org/state-policy/explore/overview-abortion-laws>.

<sup>2</sup> *Mazurek v. Armstrong*, 520 U.S. 968, 974-75 (per curiam) (emphasis added) (citation omitted).

<sup>3</sup> See Plaintiffs’ Memorandum of Law (“Pls’ Memo”) at 8, 10.

<sup>4</sup> See 63 O.S. § 1-729.1.

<sup>5</sup> *Edwards v. Bd. of Cty. Comm’rs of Canadian Cty.*, 2015 OK 58, ¶¶ 10, 12, 378 P.3d 54, 58-59.

<sup>6</sup> See *infra* pp. 7-8.

## BACKGROUND

Forty-seven years ago, the U.S. Supreme Court found a constitutional right to abortion in *Roe v. Wade*.<sup>7</sup> In so doing, the Court placed immense import on the role of a woman's doctor. The Supreme Court observed, for instance, that the American Medical Association in 1970 stated abortion "should be performed by a licensed physician"<sup>8</sup>—a position the AMA still holds.<sup>9</sup> *Roe* embraced this view in its central paragraph, detailing factors that "the woman *and her responsible physician*" will consider in deciding to abort.<sup>10</sup> The Court then explained: "The State may define the term 'physician' ... to mean only a physician currently licensed by the State, and *may proscribe any abortion by a person who is not a physician as so defined.*"<sup>11</sup> Following this clear direction from the Supreme Court, the Oklahoma Legislature enacted our "physician-only" law by an overwhelming bipartisan vote in 1978<sup>12</sup>—joining the vast majority of other states.<sup>13</sup>

In 1983, the U.S. Supreme Court recounted in *Akron* that "in *Roe* and subsequent cases we have *stressed repeatedly the central role of the physician*" and "have left *no doubt* that, to ensure the safety of the abortion procedure, the *States may mandate that only physicians perform abortions.*"<sup>14</sup> Ten years later, the Supreme Court in *Casey* held that it was not an undue burden for a State to require the woman's physician to personally secure informed consent: "Our cases reflect the fact that the Constitution gives the States broad latitude to decide that particular

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<sup>7</sup> *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>8</sup> *Id.* at 143-44.

<sup>9</sup> Exhibit 1, Affidavit of Larry Bookman, M.D., ¶ 5 (quoting AMA Policy "Abortion H-5.995"). Dr. Bookman is the President of the Oklahoma State Medical Association (OSMA).

<sup>10</sup> *Roe*, 410 U.S. at 153 (emphasis added).

<sup>11</sup> *Id.* at 165 (emphasis added).

<sup>12</sup> Compare Exhibit 2, Okla. House & Sen. Journals, 36th Legis. (1978) (HB 1813, which contained this provision, was approved 39-1 in Senate and 69-27 in House); with Exhibit 3, Okla. Almanac excerpts (along with Ex. 2, shows that 30 Senate Democrats and 9 Senate Republicans voted yes).

<sup>13</sup> See *supra* n.1; *Mazurek*, 520 U.S. at 969 ("Similar rules exist in 40 other States in the Nation.").

<sup>14</sup> *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 447 (1983) (citation omitted) (emphases added), *overruled on other grounds*, *Planned Parenthood v. Casey*, 505 U.S. 833, 882 (1992).

functions may be performed only by licensed professionals,” *Casey* held, “*even if an objective assessment might suggest that those same tasks could be performed by others.*”<sup>15</sup>

Then in 1997, the Supreme Court again expressed “no doubt” in *Mazurek* about the validity of physician-only laws.<sup>16</sup> Montana’s law, the Court held, was not an undue burden despite the challengers’ contention (same as Plaintiffs here) that “all health evidence contradicts the claim that there is any health basis for the law.”<sup>17</sup> After another decade, the Supreme Court—for at least the fifth time—affirmed physician-only laws in 2007 when it cited *Mazurek* with approval in *Gonzales*.<sup>18</sup> Our state Supreme Court echoed these findings in *Davis v. Fieker*, when it recognized *Casey*’s upholding of “a provision requiring *the physician* provide certain information to the pregnant woman,”<sup>19</sup> as well as *Mazurek*’s declining to “enjoin the enforcement of a statute requiring abortions to be performed by *physicians only.*”<sup>20</sup> These precedents control.

While the role of nurses in the United States has expanded significantly in recent decades, the role of physicians has not diminished.<sup>21</sup> And it is only in the context of *physician*-performed procedures that the U.S. Supreme Court has recognized a right to abortion. In any event, Plaintiffs overstate or ignore several aspects of Oklahoma law and practice in regard to nursing. Foremost, although Plaintiffs admit that “APRNs in Oklahoma are ... closely regulated by the Oklahoma Board of Nursing,” and that this “ensures APRNs’ qualifications and competency through licensing and disciplinary actions,”<sup>22</sup> Plaintiffs never attempt to show that our State Board of

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<sup>15</sup> *Casey*, 505 U.S. at 884-85 (citing *Williamson v. Lee Optical of Okla.*, 348 U.S. 483, 487 (1955), which held that “[t]he Oklahoma law may exact a needless, wasteful requirement in many cases. But it is for the legislature, not the courts, to balance the advantages and disadvantages.”).

<sup>16</sup> *Mazurek*, 520 U.S. at 974-75 (quoting *City of Akron*, 462 U.S. at 447).

<sup>17</sup> *Id.* at 973.

<sup>18</sup> *Gonzales v. Carhart*, 550 U.S. 124, 163-64 (2007).

<sup>19</sup> *Davis v. Fieker*, 1997 OK 156, ¶ 32, 952 P.2d 505, 513 (citing *Casey*, 505 at 884).

<sup>20</sup> *Id.* at ¶ 34, 952 P.2d at 513-14 (citing *Mazurek*, 520 U.S. 968).

<sup>21</sup> *Cf. Hardee v. State*, 172 Wash. 2d 1, 13, 256 P.3d 339, 346 (Wash. 2011) (en banc) (detailing why “[p]hysicians hold a unique role in our society”).

<sup>22</sup> Pls’ Memo at 6.

Nursing considers abortion to be appropriate practice for an APRN, such that Plaintiffs could proceed sans the statutory bar. Oklahoma APRNs are not free to perform any procedure or prescribe any medication; rather, they must act within their scope of practice, training, and specialty area, as ultimately determined by the Nursing Board.<sup>23</sup> And that Board is authorized to discipline an APRN who, for example, fails “to conform to the minimal standards of acceptable nursing” and “unnecessarily exposes a patient or other person to risk of harm.”<sup>24</sup>

Medication abortion undeniably exposes women to a risk of serious harm, to say nothing of the unborn child.<sup>25</sup> The U.S. Food & Drug Administration-approved label for medication abortion warns that “[a]bout 85% of patients report at least one adverse reaction following administration of MIFEPREX and misoprostol, and many can be expected to report more than one such reaction.”<sup>26</sup> These reactions frequently include fever and vomiting and can also include hemorrhage, infections, and pelvic inflammatory disease<sup>27</sup>—not just minor side effects. The FDA also found that “[s]erious and sometimes fatal infections and bleeding occur” after medication abortion; the FDA claims these happen rarely, but it nevertheless has issued a black box warning to prescribers entitled “WARNING: SERIOUS AND SOMETIMES FATAL INFECTIONS OR BLEEDING” and—most tellingly—it has instituted a Risk Evaluation and Mitigation Strategy (REMS) because of “the risk of serious complications.”<sup>28</sup> “[O]nly a few medications” with “serious safety concerns” require a REMS, according to the FDA.<sup>29</sup> Per the FDA’s limited data,

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<sup>23</sup> See, e.g., 59 O.S. § 567.3a(5)-(8), (10).

<sup>24</sup> 59 O.S. § 567.8(A)(1)(d) & (B)(3).

<sup>25</sup> See, e.g., Exhibit 4, Declaration of Donna Harrison, M.D. (“Dr. Harrison Decl.”) ¶¶ 7-27.

<sup>26</sup> *Id.*, Attachment B, FDA Mifeprex Guide at 7.

<sup>27</sup> *Id.* ¶¶ 10, 19-23; Attachment B, FDA Mifeprex Guide at 7-8; Attachment L, ACOG Practice Bulletin No. 143, at 3 (March 2014, Reaffirmed 2016) (“[T]he woman is likely to have bleeding that is much heavier than menses (and potentially with severe cramping).”).

<sup>28</sup> *Id.* ¶ 11; Attachment B, FDA Mifeprex Guide at 1-2; Attachment C, FDA Mifeprex Info. at 1; & Attachment D, FDA Warning Letter: Rablon (March 8, 2019) at 2.

<sup>29</sup> *Id.*, Attachment E, FDA REMS at 1.

by 2019 over 4,000 U.S. women had experienced adverse events after medication abortion, including at least 24 deaths, 1,042 hospitalizations, 599 blood transfusions, and 412 infections.<sup>30</sup>

Plaintiffs omit this FDA information and focus instead on studies, claiming medication abortion complications are extremely low. Plaintiffs cite one study, for example, that found the “major” complication rate to be 0.31%. But that study defined “major” to exclude certain ER visits, hemorrhaging, and seizures; it also did not include deaths.<sup>31</sup> And that study’s “total” abortion-related complication rate was 5.2% for medication abortion,<sup>32</sup> which is much closer to the complication rate found by medication abortion expert Dr. Donna Harrison, who testifies for Defendants that complications are relatively common.<sup>33</sup> Moreover, as Dr. Harrison points out, the FDA’s documentation of adverse events, as well as Plaintiffs’ studies, are likely to be understating complications due to “widespread” inadequacies in reporting: Healthcare providers are not all required to report complications, follow-up is poor, and women have at times been encouraged not to report the source of complications.<sup>34</sup> Sue Thayer, for example, is a whistleblower who managed a Planned Parenthood clinic for over 17 years in Iowa—where Plaintiffs’ cited telemedicine studies originated, in large part<sup>35</sup>—and she testifies that her superiors instructed employees to “tell those reporting to the ER to just say they were having a miscarriage.”<sup>36</sup>

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<sup>30</sup> *Id.*, ¶ 12 & Attachment F, FDA Mifeprex Adverse Events Summary.

<sup>31</sup> *Id.*, ¶ 27 & Attachment I, Upadhyay, *Incidence of Emerg. Dep’t Visits and Complications After Abortion*, OBST. & GYN. Vol. 125, No. 1, at 175-176, 180, 182 (Jan. 2015).

<sup>32</sup> *Id.*, ¶ 27 & Attachment I, Upadhyay, *supra* n.31, at 175.

<sup>33</sup> Exhibit 4, Dr. Harrison Decl. ¶¶ 24-27.

<sup>34</sup> *Id.*, ¶¶ 13-14, 41-47; Attachment I, Upadhyay, *supra* n.31, at 175 (“Published complication rates are considered incomplete . . .”); & Attachment L, ACOG Practice Bulletin No. 143, at 9 (“further reports reported loss-to-follow-up rates as high as 45%”).

<sup>35</sup> Exhibit 4, Dr. Harrison Decl. Attachment N, Kohn, *Medication Abortion Provided Through Telemedicine in Four U.S. States*, OBST. & GYN. at 2 (2019) (“[P]ublished research about outcomes of telemedicine for medication abortion in the United States is currently limited to Iowa.”).

<sup>36</sup> Exhibit 5, Affidavit of Sue Thayer ¶¶ 2, 9.

In addition, evidence shows that medication abortion is riskier than first-trimester surgical abortion<sup>37</sup>—nearly six “times as likely to result in a complication,” per one of Plaintiffs’ cited studies.<sup>38</sup> And abortion in general increases the risk of mental health issues such as PTSD.<sup>39</sup> Indeed, “[n]umerous studies published in peer-reviewed medical journals ... demonstrate a statistically significant correlation between abortion and suicide.”<sup>40</sup> So even if the physician-only law was struck down, the Nursing Board would likely have to decide whether an APRN’s scope of practice includes performing a procedure that is much riskier than surgical abortion, that has “serious safety concerns” meriting FDA REMS treatment, and that increases the risk of mental health issues and suicide. Plaintiffs have not shown that the Board would say yes.

The Nursing Board’s Exclusionary Formulary doesn’t list mifepristone or misoprostol individually, so Plaintiffs claim APRN Van Treese could provide those medications for abortion.<sup>41</sup> But the Formulary states that “[p]rescriptions will comply with all applicable state and federal laws.”<sup>42</sup> So, in conjunction with State law, it does currently ban the use of mifepristone and misoprostol to induce an abortion. Absent this statute, the Formulary Advisory Council would likely have to determine whether to recommend that using these two drugs in tandem be added to the Formulary, and the Board would have to decide whether to accept that recommendation.<sup>43</sup> So again, Plaintiff Van Treese could be unable to perform abortions even absent a statutory bar.

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<sup>37</sup> See Exhibit 4, Dr. Harrison Decl. ¶¶ 15-18.

<sup>38</sup> See *id.* Attachment I, Upadhyay, *supra* n.31, at 181.

<sup>39</sup> See Exhibit 6, Affidavit of Martha Shuping, M.D., ¶¶ 12-18. This affidavit was submitted in October 2019 in opposition to injunction in a different abortion-related case in Oklahoma County. Dr. Shuping is a psychiatrist who has “known and worked with more than one thousand women who have had psychological distress associated with a past abortion.” *Id.* ¶ 10.

<sup>40</sup> *Planned Parenthood v. Rounds*, 686 F.3d 889, 898 (8th Cir. 2012) (en banc).

<sup>41</sup> Pls’ Memo at 7-8, 16-17.

<sup>42</sup> Exhibit 7, Okla. Bd. of Nursing, *Exclusionary Formulary for APRNs* (revised 5/21/19).

<sup>43</sup> See 59 O.S. § 567.4a(9).

Also, though they emphasize the expansion of nursing practice, Plaintiffs do not mention that Oklahoma in its discretion currently restricts APRNs more than the national “consensus model” for nursing.<sup>44</sup> There has been intense debate in the Legislature over the past several years on this issue, during which the outgoing president and current legislative chair of the Association for Oklahoma Nurse Practitioners (AONP) affirmed in a public editorial that “***Abortions do not fall within an NP’s scope of practice***” and that saying otherwise was a “shameful ... falsehood[.]”<sup>45</sup> (Nurse practitioners are a type of APRN.) AONP has stated as much in this case, as well,<sup>46</sup> and the nearly 4,000-member State Medical Association “strongly” concurs, with its president testifying that abortion is an “invasive procedure” that requires “trained and licensed physicians.”<sup>47</sup> In short, despite disagreements elsewhere, numerous Oklahoma doctors and advanced nurses jointly believe abortion is outside the scope of APRN practice. Plaintiffs have only shown that, in Oklahoma, a single doctor and a single APRN at one clinic believe otherwise.

In a similar vein to the physician-only law, in 2012 the Oklahoma Legislature enacted 63 O.S. § 1-729.1, which states that physicians performing medication abortion “shall be physically present, in person, in the same room as the patient when the drug or chemical is first provided.” This law passed easily, on a bipartisan basis,<sup>48</sup> and it has gone unchallenged for nearly a decade.

Oklahoma has taken large strides in telemedicine, but numerous restrictions still exist, according to the influential non-profit Telehealth Alliance of Oklahoma (TAO), whose

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<sup>44</sup> See Exhibit 8, Jackie Fortier, *Doctors question push for more independent nurses as lawmakers consider how to fill health gaps*, STATEIMPACT OKLAHOMA (April 12, 2018) (“Oklahoma is one of 11 states where nurse practitioners like Walker have to have a contract with a doctor in order to diagnose, treat patients and prescribe certain drugs.”). See also *APRN Campaign for Consensus: Moving Towards Uniformity*, NCSBN, available at <https://www.ncsbn.org/campaign-for-consensus.htm>.

<sup>45</sup> Exhibit 9, Toni Pratt-Reid, *Nurse practitioner: Mistruths sway Oklahoma legislators on health care bill*, The Oklahoman (May 11, 2018).

<sup>46</sup> See Notice of Intention to File *Amicus Curiae*, AONP, to be filed with the Court on Jan. 14, 2020.

<sup>47</sup> See Exhibit 1, Bookman Aff., ¶¶ 1, 4-5.

<sup>48</sup> See Ex. 10, Okla. House & Sen. Votes, 53rd Legis. (HB 2381: Senate 31-10, House 56-28).

telemedicine-promoting membership includes in-state hospitals, primary care clinics, telemedicine consultants, academics, and individual providers from urban, suburban, and rural areas.<sup>49</sup> Oklahoma’s approach to telemedicine “has been a cautious one,” and TAO “strongly advocates for responsible use of telemedicine” because “[n]ot all barriers should be removed.”<sup>50</sup> One of the appropriate barriers, TAO recognizes, is § 1-729.1.<sup>51</sup> TAO chairman Sandra Harrison testifies that allowing telemedicine abortions “in Oklahoma would be damaging to the telemedicine industry as a whole, and completely contrary to the principles that TAO advocates: using telemedicine in a medically appropriate manner.”<sup>52</sup>

Plaintiffs twice posit that “abortion is the *only* healthcare service that providers are statutorily prohibited from providing via telemedicine.”<sup>53</sup> This is inaccurate, as TAO chairman Harrison points out,<sup>54</sup> because 59 O.S. § 478.1(C) expressly states that telemedicine “shall not be used to establish a valid physician-patient relationship for prescribing opiates.”<sup>55</sup> (TAO educated legislators, favorably, about this provision.<sup>56</sup>) Plaintiffs also wrongly assert that “[a]ll other forms of healthcare other than medication abortion may be provided via telemedicine to the extent consistent with a physician’s professional judgment.”<sup>57</sup> Physicians cannot practice a form of telemedicine without any supervision merely because that form is not statutorily prohibited—a doctor, for example, could not perform open-heart surgery via webcam and avoid serious professional scrutiny and potential discipline.<sup>58</sup>

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<sup>49</sup> Exhibit 11, Affidavit of Sandra Harrison ¶¶ 3-5. The TAO also includes the Oklahoma Board of Medical Licensure and Supervision.

<sup>50</sup> *Id.* ¶ 5-7.

<sup>51</sup> *Id.* ¶ 8.

<sup>52</sup> *Id.* ¶ 8.

<sup>53</sup> Pls’ Memo at 2 (emphasis in original); *id.* at 5 (similar wording) (emphasis in original).

<sup>54</sup> Exhibit 11, Sandra Harrison Aff. ¶¶ 6-7.

<sup>55</sup> Plaintiffs belatedly acknowledge the opioid carve-out in a late footnote. Pls’ Memo at 14 n.4.

<sup>56</sup> Exhibit 11, Sandra Harrison Aff. ¶ 7.

<sup>57</sup> Pls’ Memo at 14.

<sup>58</sup> *See, e.g.*, Exhibit 11, Sandra Harrison Aff. ¶ 6.

Rather, the State Board of Medical Licensure and Supervision (“Medical Board”) and the State Board of Osteopathic Examiners (“Osteopathic Board”) retain immense authority to disapprove of the actions of physicians—including the performance of telemedicine.<sup>59</sup> The Medical Board is granted “quasi-judicial powers ... for the purpose of revoking, suspending or imposing other disciplinary actions upon the license of physicians or surgeons.”<sup>60</sup> And the Board’s telemedicine regulations state that “[i]n the event a specific telemedicine program is outside the parameters of these rules, the Board reserves the right to approve or deny the program.”<sup>61</sup> The Osteopathic Board has similar authority, its telemedicine guidelines state that “some situations ... are appropriate for the utilization of telemedicine technologies ... while others are not,” and it has in the past prevented an applicant from obtaining a telemedicine license for OBGYN care.<sup>62</sup>

Neither Plaintiffs nor anyone else has consulted these boards about telemedicine abortion.<sup>63</sup> And Plaintiffs have not shown the boards would approve of the practice.<sup>64</sup> The testimony indicating the Telehealth Alliance would oppose it counsels firmly otherwise.

#### STANDARD OF REVIEW

“Injunction is an extraordinary remedy and relief by this means should not be granted lightly.”<sup>65</sup> Accordingly, “the power to issue injunctions should be exercised ‘sparingly and cautiously, and only in cases reasonably free from doubt.’”<sup>66</sup> To obtain a preliminary injunction, a plaintiff must establish by clear and convincing evidence that

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<sup>59</sup> See Exhibit 12, Affidavit of Lyle Kelsey (Medical Board exec. director); Exhibit 13, Affidavit of G. Robinson Stratton, III, (Osteopathic Board exec. director); Exhibit 11, S. Harrison Aff. ¶ 6.

<sup>60</sup> Exhibit 12, Kelsey Aff. ¶ 3 (quoting 59 O.S. § 513).

<sup>61</sup> *Id.* ¶ 5 (quoting Okla. Admin. Code 435:10-7-13).

<sup>62</sup> Exhibit 13, Stratton Aff. ¶¶ 2-5 & Attachment A (Osteopathic Board Telemedicine Policy).

<sup>63</sup> See Exhibit 12, Kelsey Aff. ¶ 6; Exhibit 13, Stratton Aff. ¶ 6. *Cf.* Ex. 11, S. Harrison Aff. ¶ 9.

<sup>64</sup> Nor have Plaintiffs shown that the Nursing Board would approve of nurses practicing abortion by telemedicine—which would be a logical consequence of Plaintiffs’ prevailing here.

<sup>65</sup> *Dowell v. Pletcher*, 2013 OK 50, ¶ 6, 304 P.3d 457, 460.

<sup>66</sup> *Loewen Group Acq. v. Matthews*, 2000 OK CIV APP 109, ¶ 12, 12 P.3d 977, 980 (citation omitted).

four factors weigh in his favor: 1) the likelihood of success on the merits; 2) irreparable harm to the party seeking injunction relief if the injunction is denied; 3) his threatened injury outweighs the injury the opposing party will suffer under the injunction; and 4) the injunction is in the public interest.<sup>67</sup>

Plaintiffs face a particularly uphill battle here. That is because “[t]he purpose of a temporary injunction is to preserve the status quo,”<sup>68</sup> and “a heavy burden is cast on those challenging a legislative enactment to show its unconstitutionality.”<sup>69</sup> “If there is any doubt as to the Legislature’s power to act in any given situation, the doubt should be resolved in favor of the validity of the action taken by the Legislature.”<sup>70</sup> On the merits, a law will be deemed unconstitutional only if it “is clearly, palpably, and plainly inconsistent with the Constitution.”<sup>71</sup> Courts “do[] not consider the ‘propriety, desirability or wisdom’ in a statute”; rather, their function “is limited to a determination of whether legislative provision is valid and nothing further.”<sup>72</sup>

## ARGUMENT

### I. Oklahoma’s physician-only law should not be enjoined.

#### A. Plaintiffs are highly unlikely to succeed on the merits against a 42-year-old law that has been repeatedly affirmed as reasonable by the United States Supreme Court.

##### 1. Plaintiffs may lack standing to bring these claims.

Plaintiffs purport to bring this lawsuit on behalf of their patients, though no specific patient is included, even by pseudonym, nor is hindrance shown.<sup>73</sup> The U.S. Supreme Court will decide this very term, in *June Medical*, whether abortion providers should continue to be “presumed

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<sup>67</sup> *Dowell*, 2013 OK 50, ¶ 7, 304 P.3d at 460.

<sup>68</sup> *Edwards v. Bd. Of Cnty. Comm’r*, 2015 OK 58, ¶ 10, 378 P.3d at 58.

<sup>69</sup> *Thomas v. Henry*, 2011 OK 53, ¶ 8, 260 P.3d 1251, 1254.

<sup>70</sup> *Draper v. State*, 1980 OK 117, ¶ 10, 621 P.2d 1142, 1146.

<sup>71</sup> *Lafalier v. Lead-Impacted Cmty’s. Relocation Assistance Trust*, 2010 OK 48, ¶ 15, 237 P.3d 181, 188.

<sup>72</sup> *Burns v. Cline*, 2016 OK 99, ¶ 3, 382 P.3d 1048, 1050 (citation omitted).

<sup>73</sup> See Plaintiffs’ Verified Petition, filed Nov. 8, 2019; see also *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004) (discussing “hindrance” to principal as a key factor in third-party standing).

to have third-party standing to challenge health and safety regulations on behalf of their patients.”<sup>74</sup> Defendants agree with the State of Louisiana in *June Medical* that “Plaintiffs’ attempt to stand in the shoes of their patients is inconsistent with longstanding, generally applicable principles of third-party standing.”<sup>75</sup> Here, among other things, there is a clear conflict of interest when an abortion clinic claims to represent its patients’ interests against laws that protect those very patients from “potentially dangerous” clinic practices like abortions by non-physicians.<sup>76</sup>

Further, Plaintiffs must show an injury that is not conjectural and will be redressed by the decision.<sup>77</sup> But Plaintiffs do not confront the critical question of whether the Nursing Board would actually approve APRN abortions. Thus, Plaintiffs have not demonstrated that the alleged “harm” to Van Treese can be redressed here.<sup>78</sup> There is substantial evidence indicating otherwise, including the State Medical Association and Association of Nurse Practitioners’ mutual belief that abortion is not within the APRN scope of practice.<sup>79</sup> While this Court need not fully decide these standing issues now, they do counsel against Plaintiffs’ likelihood of success for injunction purposes.

## **2. Oklahoma’s physician-only law does not constitute an undue burden.**

Remarkably, Plaintiffs never bother to inform this Court that *Roe*, *Akron*, *Casey*, and *Gonzales* affirmed the constitutionality of physician-only laws. Plaintiffs do claim in a footnote that *Mazurek* is not controlling because the plaintiffs there just asserted an improper *purpose*, and here “Plaintiffs have demonstrated that the *effect* of the Challenged Laws is to impose an undue

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<sup>74</sup> Conditional Cross-Petition, *Gee v. June Medical Services*, 2019 WL 2241856 at \*i (May 20, 2019), *certiorari granted* 140 S. Ct. 35 (Oct. 4, 2019).

<sup>75</sup> Brief for Resp./Cross-Pet., *June Medical Services v. Gee*, 2019 WL 7372920, at 24 (Dec. 26, 2019).

<sup>76</sup> See Exhibit 1, Bookman Aff. ¶¶ 6-7; *Kowalski*, 543 U.S. at 130; *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15 (2004) (no standing where father/daughter were “potentially in conflict”).

<sup>77</sup> *Toxic Waste Impact Group, Inc. v. Leavitt*, 1994 OK 148, ¶¶ 8-9, 890 P.2d 906, 910-911.

<sup>78</sup> *Cf. Weems v. State*, 440 P.3d 4, 14-15 (Mont. 2019) (Rice, J., dissenting in a 4-3 decision) (arguing that there was insufficient evidence to show abortion was within an APRN’s scope of practice).

<sup>79</sup> See Exhibit 1, Bookman Aff. ¶ 6 (OSMA view); see *supra* nn.45-46(AONP view).

burden.”<sup>80</sup> This ignores the rest of *Mazurek*, however, which indicates that those plaintiffs made the same core argument as Plaintiffs here: that “all health evidence” counseled in their favor. The Supreme Court was not moved: “[T]his line of argument is squarely foreclosed by *Casey*,” which upheld a physician-only requirement “*even if an objective assessment might suggest that those same tasks could be performed by others.*”<sup>81</sup> *Mazurek* then criticized the Ninth Circuit for ignoring (like Plaintiffs) the Court’s “repeated statements” in essentially every major abortion case in U.S. history that left “*no doubt*” that States may pass physician-only laws.<sup>82</sup>

Rather than acknowledge controlling Supreme Court precedent, Plaintiffs cite a recent Ninth Circuit district court decision.<sup>83</sup> But that court failed to recognize that *Roe*, *Akron*, and *Gonzales* affirmed physician-only laws, and it merely denied the defendants’ motion to dismiss “at this stage” after assuming the allegations were true.<sup>84</sup> Furthermore, that court wrote that Idaho’s law was a potential burden in a way the *Mazurek* law was not because in Idaho at least six allegedly qualified non-physicians were ready to perform abortions, whereas in Montana there was one—just like here.<sup>85</sup> That is, it distinguished *Mazurek* in way that counsels *for* dismissal here. In any event, a different federal district court even more recently declined to enjoin Virginia’s physician-only law in part due to this “seamless” and “formidable line” of Supreme Court authority.<sup>86</sup>

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<sup>80</sup> Pls’ Memo at 22 n.10 (emphasis in original). Despite *Mazurek*, Plaintiffs also say Oklahoma’s “purpose in continuing to enforce laws that burden abortion access ... is constitutionally highly suspect.” Pls’ Memo at 20. Plaintiffs point to no evidence from the late 1970s to demonstrate this.

<sup>81</sup> *Mazurek*, 520 U.S. at 973 (citing *Casey*, 505 U.S. at 885) (emphasis in original).

<sup>82</sup> *Id.* at 974 (emphasis added) (quoting *City of Akron*, 462 U.S. at 447).

<sup>83</sup> Pls’ Memo at 22 n.10 (citing *Planned Parenthood v. Wasden*, 406 F. Supp. 3d 922 (D. Idaho 2019)).

<sup>84</sup> *Wasden*, 406 F. Supp. 3d at 932. The Montana Supreme Court decision Plaintiffs cite is similarly distinguishable. See *Weems*, 440 P.3d 4. There, the majority never mentions the multiple U.S. Supreme Court precedents on point or discusses the likelihood of success on the merits. *Id.* Even so, three justices dissented (correctly) on justiciability grounds. *Id.* at 14-17 (Rice, J., dissenting).

<sup>85</sup> *Wasden*, 406 F. Supp. 3d at 928-29.

<sup>86</sup> *Falls Church Med. Ctr. v. Oliver*, No. 3:18CV428, 2019 WL 4794529 at \*17 (ED Va. Sept. 30, 2019).

Plaintiffs also rely on the U.S. Supreme Court’s 2016 decision in *Hellerstedt*.<sup>87</sup> But there, the Supreme Court gave no hint that its bedrock stance on physician-only laws had changed. Rather, *Hellerstedt* held—relying on *Roe* and *Casey*, not overturning them—that Texas could not require abortion doctors to have active admitting privileges at a nearby hospital, in part because that requirement (supposedly) added no benefits and “led to the closure of half of Texas’ clinics.”<sup>88</sup> This is not remotely the same as saying that states cannot require a physician at all, or that states must allow non-physicians to perform abortions so an existing clinic can maximize its productivity. In the end, it is fanciful to imply that *Hellerstedt* overturned or undid nearly every major abortion decision that came before it when *Hellerstedt* expressly relied on some of those very decisions.

Plaintiffs nevertheless insinuate that *Hellerstedt* requires pure *de novo* balancing of benefits and burdens by courts, without allowing the Legislature discretion to make difficult judgments. But *Hellerstedt* began its analysis “with the standard, **as described in *Casey***.”<sup>89</sup> And *Casey* upheld a physician-only law even though an “objective assessment might suggest” otherwise, which implies the very standard that *Casey* made explicit: a law poses an undue burden only if it “has the purpose or effect of placing a **substantial obstacle** in the path of a woman seeking an abortion” in a “**large fraction**” of relevant cases.<sup>90</sup> A “substantial obstacle” is “likely to prevent a significant number of women from obtaining an abortion.”<sup>91</sup> To be sure, *Hellerstedt* says benefits and burdens must generally be analyzed, but nowhere does it abandon the substantial obstacle test, nor does it

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<sup>87</sup> Pls’ Memo at 20 (citing *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016)).

<sup>88</sup> *Hellerstedt*, 136 S. Ct. at 2299, 2309, 2313.

<sup>89</sup> *Hellerstedt*, 136 S. Ct. at 2309.

<sup>90</sup> *Casey*, 505 U.S. at 877, 895 (emphasis added). Notably, Plaintiffs style this case an “as-applied” challenge, but they do not just seek permission for Van Treese to provide abortions or for a particular woman to receive an abortion from her. Rather, they seek a court order for *all* APRNs, which is more akin to a facial challenge given that it could plausibly affect every woman receiving a first-trimester abortion in Oklahoma. Thus, the “large fraction” test is appropriate.

<sup>91</sup> See *id.* at 893-94; see also *id.* at 875 (regulations should be upheld if they “in no real sense deprive[] women of the ultimate decision”); *Karlin v. Foust*, 188 F.3d 446, 482 (7th Cir. 1999) (“challenged state regulation must have a strong likelihood of *preventing* women from obtaining abortions”).

suggest that *de novo* balancing is required for bedrock laws the Supreme Court has repeatedly affirmed; rather, in striking down a new law *Hellerstedt* found immense burdens and no benefits.<sup>92</sup>

Plaintiffs do not claim or show that a large fraction of Oklahoma women seeking abortions are substantially burdened by the physician-only law. This is itself disqualifying.<sup>93</sup> Regardless, Plaintiffs are incorrect even by their own standard. The benefits of a physician-only law are already enshrined in precedent: the Supreme Court has repeatedly stated that these types of laws “ensure the safety of the abortion procedure.”<sup>94</sup> Plaintiffs cite various affidavits and authorities, but Defendants have countered with binding precedent as well as the views of the American Medical Association, Oklahoma State Medical Association, and Association of Oklahoma Nurse Practitioners, who believe abortion should be limited to physicians for safety and other reasons.<sup>95</sup> When an issue is disputed like this, it is within the province of the Legislature to make a judgment in one direction even if objective evidence “might suggest” otherwise.<sup>96</sup> At a bare minimum, Plaintiffs have not shown they are likely to succeed in undermining the obvious benefits.

As for burdens, Plaintiffs make almost no effort to quantify the situation. Nor do they acknowledge the U.S. and Oklahoma Supreme Courts have emphasized that “not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right,”<sup>97</sup> and the “fact that a regulation increases the cost or ***decreases the availability*** of an abortion is insufficient to

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<sup>92</sup> See, e.g., *Hellerstedt*, 136 S. Ct. at 2313.

<sup>93</sup> See *Planned Parenthood of Arkansas & E. Oklahoma v. Jegley*, 864 F.3d 953, 959 (8th Cir. 2017) (reversing court’s undue burden finding where it did not make large fraction evaluation and “focused [instead] on amorphous groups of women to reach its conclusion”); *Falls Church Med. Ctr.*, 2019 WL 494529 at \*17 (declining to enjoin physician-only law where number of women facing particularly burdensome situation was “unquantified”).

<sup>94</sup> *Mazurek*, 520 U.S. at 974-75 (quoting *City of Akron*, 462 U.S. at 447).

<sup>95</sup> See, e.g., Exhibit 1, Bookman Aff. ¶¶ 5-7 (labeling APRN abortions “potentially dangerous”).

<sup>96</sup> *Gonzales*, 550 U.S. at 166 (“[M]arginal safety [considerations], including the balance of risks, are within the legislative competence when the regulation is rational . . .”).

<sup>97</sup> *Casey*, 505 U.S. at 873; see also *Davis*, 1997 OK 156, ¶ 30, 952 P.2d at 512.

invalidate [it].”<sup>98</sup> In *Hellerstedt*, and in the Oklahoma Supreme Court’s follow-up decision in *Burns v. Cline*, the courts emphasized that the burden on availability was undue in part because the laws in question had or could lead to the closing of half of the state’s respective clinics.<sup>99</sup> Nothing of the sort has been shown here. If anything, the opposite is true, as the number of abortion clinics in State has doubled from two to four in the past several years while these laws were in effect.<sup>100</sup>

Moreover, many of the burdens cited by Plaintiffs are not attributable to Defendants. Plaintiffs claim that the physician-only law “constrain[s] the number of days when Trust Women Oklahoma City is able to offer”<sup>101</sup> care, but Plaintiffs could provide abortions seven days a week if they want—assuming they utilize a physician. Thousands of doctors work in Oklahoma. Their unwillingness to work for Plaintiffs cannot be the grounds for tossing out a 40-year-old law. Plaintiffs’ logic would threaten every abortion regulation in the State. Plaintiffs also claim that the physician-only law “sharply limit[s] the number of medical providers who provide medication abortion in this state.”<sup>102</sup> But *any* law detailing who can provide abortions is going to “sharply limit” this number. Even Plaintiffs’ proposal excludes thousands of medical personnel. An “undue burden” does not exist just because Plaintiffs cannot operate at maximum capacity.

### 3. Oklahoma’s physician-only statute is not a special law.

The Oklahoma Constitution provides that “[l]aws of a general nature shall have a uniform operation throughout the State, and where a general law can be made applicable, no special law shall be enacted.”<sup>103</sup> Courts ask three things when analyzing laws under this provision: “1) Is the

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<sup>98</sup> *Davis*, 1997 OK 156, ¶¶ 13, 30, 34, & 39, 952 P.2d 505 (citing *Casey*, 505 U.S. 833).

<sup>99</sup> *Burns v. Cline*, 2016 OK 121, ¶ 17, 387 P.3d 348, 353.

<sup>100</sup> Sean Murphy, *Second new abortion clinic opens in OKC area*, ASSOCIATED PRESS (Nov. 15, 2016).

<sup>101</sup> Pls’ Memo at 22.

<sup>102</sup> *Id.*

<sup>103</sup> OKLA. CONST. art. V, § 59.

statute a special or general law? 2) If the statute is a special law, is a general law applicable? And 3) If a general law is not applicable, is the statute a permissible special law?”<sup>104</sup>

To start, whether the statute is a special law turns on the affected class.<sup>105</sup> General laws are those statutes that “relat[e] to all persons or things of a class,” whereas special laws “single out less than an entire class of similarly affected persons or things for different treatment.”<sup>106</sup> Put differently, a special law “imposes peculiar disabilities or burdensome conditions in the exercise of a common right on a class of persons arbitrarily selected from the general body of those who stand in precisely the same relation to the subject of the law.”<sup>107</sup> Plaintiffs do not specify precisely what they consider the relevant class, so their request for an injunction fails at the outset.

In places, Plaintiffs insinuate that “medicine” or “healthcare” or “medical procedures” in general are the relevant class.<sup>108</sup> But *Casey* held that “***Abortion is a unique act*** . . . fraught with consequences for others,”<sup>109</sup> and the Supreme Court held in *Harris* that abortion is “***inherently different*** from other medical procedures, because no other procedure involves the termination of potential life.”<sup>110</sup> As such, in *Harris* the Court held it was not “irrational that Congress has authorized federal reimbursement for medically necessary services generally, but not for certain medically necessary abortions.”<sup>111</sup> That logic applies here; *i.e.*, the “unique” and “inherently different” attributes of abortion allow the Legislature to focus on abortion alone.<sup>112</sup>

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<sup>104</sup> *Okla. for Reproductive Justice v. Cline*, 2016 OK 17, ¶ 22, 368 P.3d 1278, 1287 (quoting *Reynolds v. Porter*, 1988 OK 88, ¶ 13, 760 P.2d 816, 822).

<sup>105</sup> *Reynolds*, 1988 OK 88, ¶ 14, 760 P.2d at 822.

<sup>106</sup> *Id.*

<sup>107</sup> *Wall v. Marouk*, 2013 OK 36, ¶ 5, 302 P.3d 775, 779.

<sup>108</sup> Pls’ Memo at 14-15 (arguing, *e.g.*, that “[a]bortion is the only area of medicine where it appears the Oklahoma Legislature has seen fit to unconstitutionally ‘restrict’ the ‘use of certain practices’).

<sup>109</sup> *Casey*, 505 U.S. at 852 (emphasis added).

<sup>110</sup> *Harris v. McRae*, 448 U.S. 297, 325 (1980) (emphasis added).

<sup>111</sup> *Id.* at 325.

<sup>112</sup> *See also* 63 O.S. § 1-730(A)(4) (“‘Unborn child’ means the unborn offspring of human beings from the moment of conception . . .”).

The Oklahoma Supreme Court has never found an abortion regulation to be a special law. In the 2016 *Clune* case, our high Court upheld medication abortion regulations against a special law challenge.<sup>113</sup> The plaintiffs there claimed the law “classifies only women who seek and doctors who provide abortions from all other women seeking or doctors providing medical care.”<sup>114</sup> But the Court held the law was “reasonably and substantially connected to protecting women.”<sup>115</sup> With no Supreme Court support, Plaintiffs cite to an Oklahoma County case,<sup>116</sup> but that decision contained little analysis and was affirmed under the *Casey* standard, not on special law grounds.<sup>117</sup>

Plaintiffs alternatively hint that the relevant class is those “who seek to provide medication abortion.”<sup>118</sup> But Oklahoma law doesn’t single out APRNs from this class—it treats APRNs the same as every other non-physician who seeks to perform an abortion. Nothing about limiting abortion to physicians is arbitrary, nor do APRNs stand in “precisely the same relation” to the performance of abortion as physicians. Their education is less, their scope of practice is narrower, and their independence is restricted.<sup>119</sup> Plaintiffs claim medication abortion is within the scope of practice for Oklahoma APRNs, but that again ignores (1) the State Medical Association and Association of Nurse Practitioners; (2) the FDA’s treating medication abortion differently because of “serious safety concerns,” and (3) medication abortion being riskier than surgical abortion.<sup>120</sup>

If, despite this, the physician-only law is found to be a special law, this Court must then determine “if there is a special situation possessing characteristics impossible of treatment by

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<sup>113</sup> 2016 OK 17, 368 P.3d 1278.

<sup>114</sup> *Id.* at ¶ 25, 368 P.3d at 1287.

<sup>115</sup> *Id.* at ¶¶ 28, 32, 368 P.3d at 1288-89.

<sup>116</sup> Pls’ Memo at 13-14 (citing Order, *Nova v. Pruitt*, CV-2010-533 (Mar. 28, 2012)).

<sup>117</sup> *See Nova v. Pruitt*, 2012 OK 103, ¶ 1, 292 P.3d 28, 28.

<sup>118</sup> Pls’ Memo at 15.

<sup>119</sup> *See* Exhibit 1, Bookman Aff. ¶¶ 2-3, 6; *see supra* nn.43-45.

<sup>120</sup> *See supra* pp.2-9. Notably, if they prevail, Plaintiffs will soon seek judicial intervention for Van Treese to perform surgical “aspiration” abortions, as well. Pls’ Memo at 2 n.1.

general law.”<sup>121</sup> Courts look to the “nature and objective of the legislation as well as the conditions and circumstances under which the statute was enacted” here.<sup>122</sup> The abortion procedure is incapable of general medical treatment because of its “unique” nature. In addition to the risks involved, a successful abortion results in the death of a human being whose dignity the state has a legitimate interest in protecting. This combination of factors exists in no other procedure.

If the Court agrees, under the third prong it should allow a special law “if the statute is reasonably and substantially related to a valid legislative objective.”<sup>123</sup> For permissibility, “there must be some distinctive characteristic warranting different treatment that furnishes a practical and reasonable basis for discrimination.”<sup>124</sup> Here, the fact that abortion involves the intentional death of an unborn child is undeniably a “distinctive characteristic.” Similarly, the FDA has deemed medication abortion to have serious risks worthy of special treatment, and those risks are greater than surgical abortion.<sup>125</sup> And the level of training and experience for APRNs is undeniably lower than that of physicians.<sup>126</sup> If “no doubt” exists that a State may “ensure the safety of the abortion procedure” with a physician-only law, then such a law cannot be unreasonable.<sup>127</sup>

**B. Plaintiffs’ “harms” are not cognizable, significant, or traceable to Defendants.**

Plaintiffs claim that constitutional violations standing alone constitute irreparable injury—

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<sup>121</sup> *Grant v. Goodyear Tire & Rubber Co.*, 2000 OK 41, ¶ 8, 5 P.3d 594, 597-98.

<sup>122</sup> *Reynolds*, 1988 OK 88, ¶ 15, 760 P.2d 816, 822.

<sup>123</sup> *Lafalier*, 2010 OK 48, ¶ 35, 237 P.3d 181, 195.

<sup>124</sup> *Grant*, 2000 OK 41, ¶ 10, 5 P.3d at 598.

<sup>125</sup> Exhibit 4, Dr. Harrison Decl. ¶¶ 11, 15-18 & Attachments C, D, E, & I.

<sup>126</sup> Exhibit 1, Bookman Aff. ¶¶ 2-3, 5-6.

<sup>127</sup> *See Planned Parenthood Arizona v. AAPLOG*, 257 P.3d 181, 194 (Ariz. Ct. App. 2011) (“The Legislature could also reasonably conclude that consultation with a physician was superior ....”). Plaintiffs assert Oklahoma’s laws are suspect because the Legislature made no legislative findings. But Plaintiffs cite to no case enjoining a law merely because it lacked legislative findings. Plaintiffs’ reliance on the 2016 *Cline* case is misplaced, as the Oklahoma Supreme Court didn’t indicate that legislative findings were *required*. Rather, *Cline* stated that “[b]ecause the evidence is mixed, we must defer to the Legislature.” *OCRJ*, 2016 OK 17, ¶ 32, 368 P.3d 1278, 1289.

but that is only when the violations are likely to have occurred.<sup>128</sup> Here, Plaintiffs are highly unlikely to succeed, so an allegation alone cannot support irreparable harm.<sup>129</sup> For example, Plaintiffs claim their patients are harmed because, absent the law, Plaintiffs would open for more days, weekends, and evenings and decrease wait times and so on.<sup>130</sup> If physician-only laws are constitutional, which they plainly are, then these aren't harms at all, but rather a result of Plaintiffs' own inability to convince unwilling physicians to work at their clinic. After all, nothing in Oklahoma law expressly prohibits Plaintiffs from opening all week or from lowering their costs—it just prohibits them from using non-physicians for abortions. Plaintiffs complain elsewhere that physicians aren't willing to work for them because of harassment, stigma, violence, and “diminished professional opportunities,” but none of these unproven barriers are attributed or attributable to Defendants.<sup>131</sup>

Plaintiffs also claim irreparable harm because their APRN is not allowed to perform abortions, but they fail to demonstrate that the Board of Nursing would ever allow APRNs to do so. Rather, substantial authority shows that abortion is not within the scope of practice of Oklahoma APRNs.<sup>132</sup> Plaintiffs harm claims are also weakened by the fact that there are three other clinics in the State that women can visit. Plaintiffs contend this is a small amount, but they represent a significant increase in Oklahoma, and it is more than exist in several nearby states.<sup>133</sup>

Plaintiffs let the mask slip when they claim that “[a]ll these barriers are exacerbated by Oklahoma laws that limit when, where, and under what conditions women may obtain

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<sup>128</sup> See *Planned Parenthood v Herbert*, 828 F.3d 1245, 1263-64 (10th Cir. 2016).

<sup>129</sup> See *Planned Parenthood v. Adams*, 937 F.3d 973, 990 (7th Cir. 2019) (“In applying the undue burden standard to a restriction on abortion, it is hard to separate the merits from irreparable harm.”).

<sup>130</sup> Pls' Memo at 23-24.

<sup>131</sup> See *Harris*, 448 U.S. at 316 (Government “need not remove those [obstacles] not of its own creation.”) To the extent that Plaintiffs are describing protected First Amendment activity, some of the alleged actions may not be redressable at all, even if true. Protesting abortion is not illegal, nor should the exercise of free speech rights count as a “harm” for injunction purposes.

<sup>132</sup> See *supra* pp.2-9.

<sup>133</sup> See *supra* n.100; Holly Yan, *These 6 states have only 1 abortion clinic left*, CNN (June 21, 2019) (listing North Dakota, South Dakota, Missouri, Kentucky, West Virginia, and Mississippi).

abortions.”<sup>134</sup> Plaintiffs’ real complaint, then, is that they are harmed by any effort to regulate the abortion industry. In Plaintiffs’ view, anything the State or private parties do that in any way keeps Plaintiffs from maximizing their business is “harm.” To accept Plaintiffs’ arguments here would eventually require throwing out every abortion regulation on the books, and then some.

Finally, Oklahomans will suffer harm from an injunction in this case. “[A]ny time a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury.”<sup>135</sup> Allowing an aggrieved litigant to enjoin duly enacted state laws makes the courts an agent to reverse the political process. Enjoining the physician-only law will harm the Legislature’s ability to represent Oklahomans and undermine the rule of law, and it will be “potentially dangerous” to Oklahoma women, per the State Medical Association.<sup>136</sup>

### **C. Equity and the public interest disfavor enjoining a 42-year-old law.**

The Oklahoma Supreme Court has stated that the very “purpose of a temporary injunction is to preserve the status quo.”<sup>137</sup> That purpose is especially served here, where the challenged law is over 40 years old, was passed on an overwhelming bipartisan basis, and is backed by several on-point U.S. Supreme Court precedents. Plaintiffs contend that injunctions may alter the status quo “when the need is urgent and the right is clear.”<sup>138</sup> But this “right is clear” language merely ties this factor back into the likelihood of success on the merits<sup>139</sup>—and that likelihood is nil.

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<sup>134</sup> Pls’ Memo at 9.

<sup>135</sup> *Maryland v. King*, 133 S. Ct. 1, 3 (2012) (Roberts, C.J., in chambers) (quoting *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 434 U.S. 1345 (1977) (Rehnquist, J., in chambers)).

<sup>136</sup> Exhibit 1, Bookman Aff. ¶ 7; *see also* Exhibit 4, Dr. Harrison Decl. ¶¶ 28-48.

<sup>137</sup> *Edwards*, 2015 OK 58, ¶¶ 10, 378 P.3d at 58.

<sup>138</sup> Pls’ Memo at 12 (quoting *Waveland Drilling Partners v. New Dominion*, 2019 OK CIV App 8, ¶ 14, 435 P.3d 114, 119). Notably, the court in *Waveland* actually upheld the status quo. *Id.* Same goes for *Thompson v. North*, 1942 OK 346, 129 P.2d 1011, which Plaintiffs cite.

<sup>139</sup> *Cf. Free the Nipple v. City of Fort Collins*, 916 F.3d 792, 805 (10th Cir. 2019) (overturning status quo only where “Plaintiffs made a strong showing of their likelihood of success on the merits”).

Plaintiffs complain that “Trust Women Oklahoma City only began operating a few years ago, and therefore could not have challenged these laws prior to their enactment.”<sup>140</sup> But various other clinics, who are by no means litigation averse, have been around for much longer than that and they haven’t brought claims. This strongly suggests that the physician-only law is not burdensome. Regardless, Plaintiffs’ argument actually cuts against them as they admit that they waited nearly four years to challenge this law—hardly a delay befitting an emergency.

In the end, Plaintiffs make no real case for why laws that have been on the books for nearly a half-century combined have suddenly become an emergency meriting the “extraordinary” remedy of injunction. What Plaintiffs really want is for this Court to legislate from the bench, directly in the face of decades of contrary precedent stretching back to *Roe* itself. It is not this Court’s prerogative to change or strike down a law because it is “outmoded,” as Plaintiffs allege. Rather, this Court’s duty is to follow precedent, faithfully—precedent that is crystal clear.

## **II. Oklahoma’s in-person physician law should not be enjoined.**

If there is “no doubt” that Oklahoma can restrict the performance of abortion to physicians, then surely it can require those physicians to be present, physically, for the procedure. These are very nearly the same point. As a result, much of the above argumentation applies equally to Oklahoma’s law barring telemedicine abortions, and it will not be repeated in full below.

### **A. Plaintiffs are unlikely to succeed on the merits against a law that merely requires a physician to be physically present for a procedure that results in the death of a human being and carries significant risks of serious complications.**

#### **1. Plaintiffs may lack standing to bring these claims.**

Plaintiffs’ due process standing is problematic because of the same conflict of interest mentioned above. As for special law standing, Plaintiffs do not confront the critical question of whether the Medical Board or Osteopathic Board would actually approve of telemedicine

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<sup>140</sup> Pls’ Memo at. 12.

abortions even if the challenged laws were enjoined. Some evidence indicates otherwise, including the fact that the practice is opposed by the Telehealth Alliance of Oklahoma.<sup>141</sup> Thus, Plaintiffs have not demonstrated that their “harms” can be redressed here.

## **2. The telemedicine ban does not constitute an undue burden.**

Not only do Plaintiffs ignore that *Roe*, *Akron*, *Casey*, and *Gonzales* affirmed physician-only laws, they also never contemplate that the logic of these decisions extends to whether a physician can be required to be *physically* present for an abortion. Given Plaintiffs’ repeated reliance on supposedly authoritative scientific studies, *Casey* is particularly instructive. There, again, the Court held that a state could require the physician—and not a “qualified assistant”—to personally provide information to a patient: “[T]he Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others.*”<sup>142</sup>

Plaintiffs again fail to claim that a large fraction of Oklahoma women are substantially burdened by the in-person law. In any event, like the physician-only law the in-person law “ensure[s] the safety of the abortion procedure.”<sup>143</sup> Plaintiffs point to various affidavits and citations, but Defendants have countered with affidavits from medication abortion expert Dr. Donna Harrison, former longtime Planned Parenthood clinic manager Sue Thayer, and the Telehealth Alliance of Oklahoma, all of which oppose telemedicine abortions for safety reasons.<sup>144</sup> When an issue is disputed like this, Plaintiffs should not be allowed to unilaterally overthrow the will of the People’s representatives in the Oklahoma Legislature.<sup>145</sup>

## **3. Oklahoma’s telemedicine law is not a special law.**

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<sup>141</sup> Exhibit 11, Sandra Harrison Aff. ¶¶ 8-9.

<sup>142</sup> *Casey*, 505 U.S. at 885 (emphasis added in *Mazurek*, 520 U.S. at 974-75).

<sup>143</sup> *Mazurek*, 520 U.S. at 974-75.

<sup>144</sup> Ex. 4, Dr. Harrison Aff. ¶¶ 28-48; Ex. 5, Thayer Aff. ¶¶ 5-13; Ex. 11, S. Harrison Aff. ¶¶ 8-9.

<sup>145</sup> *Gonzales*, 550 U.S. at 166.

Laws regulating abortion differently from other procedures are not special laws, due in large part to the presence of the unborn child. Plaintiffs' telemedicine abortion claim also fails because it is built around a fiction—that “[a]ll other forms of healthcare other than medication abortion may be provided via telemedicine.”<sup>146</sup> This is not true. Statutorily, opioids are restricted for telemedicine,<sup>147</sup> and the Medical Board and Osteopathic Board have robust authority to regulate telemedicine; indeed, the Osteopathic Board seemingly exercised that authority in a case involving a doctor seeking to utilize telemedicine for OBGYN care.<sup>148</sup> Abortion has not been “singled out,” and it is *not* the “only healthcare service for which the Oklahoma legislature has seen fit to override the deference given to physicians in all other areas of medicine.”<sup>149</sup>

If the in-person requirement is a special law, it is reasonable. As the Arizona Court of Appeals observed, courts have long held “‘eye-to-eye, face-to-face’ interaction is superior to even videoconferencing,” and a “legislature could reasonably conclude that telephonic consultation was inferior to in-person consultation during which the interviewer could perceive the condition and comportment of the patient, in furtherance of the state’s interest in the woman’s health.”<sup>150</sup>

Plaintiffs cite several studies supposedly proving that telemedicine abortions are safe as in-person abortions. But Plaintiffs make no effort to show that the nature and objective of the law in 2012 was impermissible. Telemedicine abortion was not widely practiced in 2012<sup>151</sup> (nor is it now<sup>152</sup>) and only one cited study had been published in 2012, concerning Iowa. It cannot be the case that the 2012 Legislature acted irrationally by not embracing a single new study from one

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<sup>146</sup> Pls’ Memo at 14.

<sup>147</sup> Plaintiffs briefly acknowledge the opioid restriction, in a belated footnote. Pls’ Br. at 14 n.4.

<sup>148</sup> See Exhibit 12, Kelsey Aff. ¶¶ 2-5 (Medical Board); Exhibit 13, Stratton Aff. ¶¶ 2-5 (Osteopathic Board). See also Exhibit 11, S. Harrison Aff. ¶ 6.

<sup>149</sup> Pls’ Memo at 14-15.

<sup>150</sup> *AAPLOG*, 257 P.3d at 194.

<sup>151</sup> Pls’ Exhibit E, Grossman Aff. ¶ 35 (only 2 states allowed telemedicine abortions before 2012).

<sup>152</sup> See *id.* (listing 13 states as currently permitting telemedicine abortions).

state on a new procedure. Moreover, until 2019 all of the studies involved data from Iowa.<sup>153</sup> But Thayer testifies that Iowa Planned Parenthood leaders encouraged employees to dissuade patients from revealing the real reason for complications, and that she was fired for voicing safety concerns about medication abortion.<sup>154</sup> This does not inspire confidence in Iowa studies. These studies also show that follow-up rates are lower for telemedicine abortion than in-person abortion.<sup>155</sup> This is a concern, as consistent follow-up is critical to patient health and well-being.<sup>156</sup> Plaintiffs disparage the telemedicine ban as pointless because “[i]n the rare instances when complications do arise” they “occur after the patient has already left the clinic.”<sup>157</sup> Plaintiffs apparently have little intention to have their own patients follow up with them, which is disturbing.<sup>158</sup>

A smattering of limited-at-best studies is not the end-all be-all of legislating.<sup>159</sup> Legislatures can consider evidence like that from national expert Dr. Harrison, who testifies that telemedicine abortion trivializes the seriousness and risks of medication abortion, that an in-person examination by a physician is necessary to rule out dangerous contraindications, and that an in-person meeting encourages better follow-up and complications management.<sup>160</sup> The Legislature can also listen to the view of influential coalitions like the Telehealth Alliance of Oklahoma, which vigorously supports the expansion of telemedicine but nevertheless opposes telemedicine abortion as “completely contrary” to its principles and medically inappropriate.<sup>161</sup>

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<sup>153</sup> See Exhibit 4, Dr. Harrison Decl. Attachment N, Kohn, *supra* n.35, at 2.

<sup>154</sup> Exhibit 5, Thayer Aff. ¶¶ 5-13.

<sup>155</sup> Exhibit 4, Dr. Harrison Aff. Attachment N, Kohn, *supra* n.35 (“follow-up within 45 days of abortion was lower among telemedicine patients (60.3%) than standard patients (76.9%)”).

<sup>156</sup> *Id.* ¶¶ 39-43 & Attachment L, ACOG Practice Bulletin No. 143, at 9.

<sup>157</sup> Pls’ Memo at 18 n.8 (citing Pls’ Exhibit E, Grossman Aff. ¶ 30).

<sup>158</sup> Exhibit 4, Dr. Harrison Aff. ¶¶ 39-48.

<sup>159</sup> See *Casey*, 505 U.S. at 884-85.

<sup>160</sup> Exhibit 4, Dr. Harrison Aff. ¶¶ 28-43. Dr. Harrison also testifies at length about her concerns with Plaintiffs’ proposed telemedicine policies. *Id.* ¶¶ 32-38. Sue Thayer testifies about similar concerns she voiced in Iowa about the medical adequacy of telemedicine abortion—concerns that led to her being fired. Exhibit 5, Thayer Aff. at ¶¶ 6-10.

<sup>161</sup> Exhibit 1, Sandra Harrison Aff. ¶ 8.

**B. Plaintiffs’ “harms” are not cognizable, significant, or traceable to Defendants.**

Again, even if the telemedicine ban was enjoined, Plaintiffs would not automatically be able to practice telemedicine abortions. The Medical Board and Osteopathic Board would still have to determine if the practice was permissible, meaning the harm here is attenuated at best.

Plaintiffs’ primary harm argument that relates more uniquely to telemedicine is that the telemedicine ban hurts rural women, in particular. The Telehealth Alliance of Oklahoma doesn’t believe so, however. Nor does Dr. Harrison, who testifies that medication abortion may be particularly poorly suited for rural women (as opposed to less risky surgical abortion) because of the lack of access to emergency care or follow-up.<sup>162</sup> Plaintiffs point to the burdens faced by women in rural areas, but Plaintiffs’ own telemedicine plan doesn’t appear to address the “significant” travel issues facing Oklahoma women, given that women would still have to travel to Plaintiffs’ Oklahoma City clinic for care.<sup>163</sup> That travel “harm” stays the same for Plaintiffs’ patients; it is merely the convenience of physicians’ travel schedules Plaintiffs are promoting.

**C. Equity and the public interest disfavor enjoining an eight-year-old law.**

The telemedicine law is still the status quo, and it has stood for nearly a decade without challenge. Moreover, at least 15 other states maintain the same ban. Equity disfavors an injunction.

**CONCLUSION**

In the end, this Court should dismiss Plaintiffs’ far-fetched theories. To do otherwise would potentially endanger Oklahoma women, it would threaten the separation of powers by undermining the State’s broad authority to regulate medicine and the scope of practice, and it would require defying or ignoring several explicit U.S. Supreme Court precedents.

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<sup>162</sup> Exhibit 4, Dr. Harrison Aff. ¶ 43.

<sup>163</sup> Pls’ Exhibit B, Burkhart Aff. ¶ 4.

Respectfully submitted,



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**CERTIFICATE OF SERVICE**

Counsel certifies that on this 14th day of January 2020, a true and correct copy of the foregoing RESPONSE IN OPPOSITION TO MOTION FOR A TEMPORARY INJUNCTION was served, postage prepaid to the following:

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