Case No. 21-1068

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

FREDERICK W. HOPKINS, *et al.*

Plaintiffs-Appellees

v.

LARRY JEGLEY, *et al.*

Defendants-Appellants

On Appeal from the United States District Court
for the Eastern District of Arkansas
Case No. 4:17-cv-404 (Hon. Kristine G. Baker)

BRIEF OF THE STATES OF KENTUCKY, ALABAMA, ARIZONA, FLORIDA, GEORGIA, INDIANA, KANSAS, LOUISIANA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NORTH DAKOTA, OHIO, OKLAHOMA, SOUTH CAROLINA, TENNESSEE, TEXAS, UTAH, & WEST VIRGINIA AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLANTS

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INTERESTS OF *AMICI CURIAE*[1]

This case challenges Arkansas's law prohibiting abortion providers from dismembering unborn children while they are still alive.[2] Ark. Code Ann. §§ 20-16-1802(3), 20-16-1803. Arkansas's law does not prohibit abortions at any point during pregnancy. It merely provides that abortions cannot be performed in a particularly heinous way. In so doing, Arkansas's law extends a modicum of compassion and respect to unborn children.

The live-dismemberment procedure that Arkansas's law regulates, which is commonly known as a D&E abortion, is a singularly gruesome procedure. The district court described it as one in which "fetal tissue generally comes apart." *Hopkins v. Jegley*, --- F. Supp. 3d ---, 2021 WL 41927, at *54 (E.D. Ark. Jan. 5, 2021). That description reveals almost nothing about the procedure. Only by understanding what happens during a live-dismemberment abortion can the *amici* States' interests be fully appreciated.

During a live-dismemberment abortion, an abortion provider uses "grasping forceps" to "grab the fetus." *See Gonzales v. Carhart*, 550 U.S. 124, 135 (2007). Using the forceps, the abortion provider "pulls" on the child, and the "friction causes the fetus to

[1] The *amici* States file this brief without consent of the parties or leave of the Court. Fed. R. App. P. 29(a)(2).

[2] Although the *amici* States focus on Arkansas's law prohibiting live-dismemberment abortion, this should not suggest agreement with the district court's conclusions about the other issues raised in this appeal.

tear apart." *Id.* "For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman." *Id.* This is a repetitive process in which the abortion provider removes the unborn child piece by piece by piece. *Id.* at 135–36. All told, the abortion provider "may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes." *Id.* at 136. The abortion provider then "examines the different parts to ensure the entire fetal body has been removed." *Id.* Keep in mind that abortion providers do not use the live-dismemberment procedure early in a pregnancy. That is, "the more developed the child, the more likely an abortion will involve dismembering it." *Harris v. W. Ala. Women's Ctr.*, 139 S. Ct. 2606, 2607 (2019) (Mem.) (Thomas, J., concurring).

For these reasons, "[n]o one would dispute that, for many, D & E is a procedure itself laden with the power to devalue human life." *Gonzales*, 550 U.S. at 158. Count the *amici* States among the "many." Allowing such a procedure to occur within their borders undermines the *amici* States' interests in "show[ing] [their] profound respect for the life within the woman" and "in protecting the integrity and ethics of the medical profession." *Id.* at 157 (citations omitted). As a result, many *amici* States have chosen, like Arkansas, to prohibit the live dismemberment of unborn children.[3] The *amici* States

[3] Ky. Rev. Stat. Ann. § 311.787; Ala. Code §§ 26-23G-2(3), 26-23G-3; Ind. Code §§ 16-34-2-1(c), 16-34-2-9, 16-34-2-10; Kan. Stat. Ann. § 65-6743; La. Stat. Ann. § 40:1061.1.1; Miss. Code Ann. §§ 41-41-151–57; Neb. Rev. Stat. §§ 28-326(4), 28-347–28.347.06; N.D. Cent. Code § 14-02.1-04.2; Ohio Rev. Code Ann. § 2919.15; Okla. Stat. §§ 1-737.7–.16; Tex. Health & Safety Code Ann. § 171.151–.153; W. Va. Code § 16-2O-1.

therefore share an interest in ensuring that this Court correctly applies the Supreme Court's precedent to Arkansas's law, which the district court failed to do.

ARGUMENT

The district court determined that Arkansas is powerless to regulate how live-dismemberment abortions are performed within its borders no matter how inhumane the procedure is. This holding should be reversed for at least three reasons.

First, the district court failed to respect Arkansas's judgment—supported by medical and scientific evidence—that safe and effective alternatives to live-dismemberment abortion exist. Although the Court remanded this matter so that the district court could apply the Chief Justice's concurring opinion in *June Medical Services L.L.C. v. Russo*, 140 S. Ct. 2103 (2020), the district court failed to follow the rule that "state and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Id.* at 2136 (Roberts, C.J., concurring in the judgment) (quoting *Gonzales*, 550 U.S. at 163).

Second, the district court mistakenly held that the Plaintiffs' refusal to comply with Arkansas's law creates an undue burden, even though the Plaintiffs already perform a fetal-death procedure in some cases that complies with the law. The Plaintiffs' intransigence cannot suffice to invalidate Arkansas's duly enacted law.

Third, the district court wrongly gave the Plaintiffs a pass on their burden to establish entitlement to facial relief. The district court effectively invalidated Arkansas's

law in all circumstances because of the Plaintiffs' concerns that the alternatives to live-dismemberment abortion may not work in some circumstances.

I. Any medical uncertainty cuts in Arkansas's favor.

Despite this Court's remand for the district court to apply the Chief Justice's concurring opinion in *June Medical*, the district court gave no deference to Arkansas on matters about which there may be medical or scientific uncertainty. This error alone warrants vacating the district court's preliminary injunction.

Chief Justice Roberts's concurring opinion reaffirmed the "traditional rule," which is "consistent with *Casey*," that "state and federal legislatures [have] *wide discretion* to pass legislation in areas where there is medical and scientific uncertainty." *Id.* at 2136 (Roberts, C.J., concurring in the judgment) (emphasis added) (quoting *Gonzales*, 550 U.S. at 163). By refusing to apply this "traditional rule," the district court not only neglected *June Medical*, but it assumed for itself Arkansas's sovereign prerogative to make policy decisions in areas where there may be medical and scientific uncertainty.

Gonzales best illustrates the role that medical and scientific uncertainty plays in the undue-burden inquiry. At issue in *Gonzales* was whether a law banning partial-birth abortions amounted to an undue burden. *Gonzales*, 550 U.S. at 147. In considering whether the law "subjected women to significant health risks" and thus constituted an undue burden, the Court determined that this was a "contested factual question" in which "both sides have medical support for their position." *Id.* at 161 (cleaned up). Because of this factual dispute, the Court asked "whether the Act can stand when this

medical uncertainty persists." *Id.* at 163. *Gonzales*'s next step was key: The Court did *not* resolve this "contested factual question" by reviewing the lower courts' factual findings for clear error. Instead, *Gonzales* recognized that "[t]he Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Id.* at 163. For this proposition, the Court mainly cited cases from outside the abortion context. *Id.* (collecting cases). And the Court explained why: "Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." *Id.* at 164. The Court's bottom line was that the "medical uncertainty over whether the Act's prohibition creates significant health risks provides *a sufficient basis* to conclude in this facial attack that the Act does not impose an undue burden."[4] *Id.* (emphasis added).

Gonzales's medical-uncertainty holding resolves this case because Arkansas marshalled significant medical and scientific evidence to establish the safety and efficacy of the alternatives to live-dismemberment abortion.[5] The district court, however, rejected that evidence (and thus Arkansas's policy judgment) as simply unpersuasive. Rather than recognize Arkansas's "wide discretion" to act in the face of medical and

[4] The *Gonzales* dissent acknowledged this holding. *See id.* at 180 (Ginsburg, J., dissenting) ("The Court acknowledges some of this evidence, but insists that, because some witnesses disagreed with ACOG and other experts' assessment of risk, the Act can stand." (internal citation omitted)).

[5] By arguing that Arkansas's evidence establishes, at a minimum, the existence of medical and scientific uncertainty, the *amici* States do not suggest that Arkansas failed to independently establish the safety and efficacy of the alternatives to live-dismemberment abortion.

scientific uncertainty, the district court purported to resolve—as a factual matter—whether digoxin injections, potassium-chloride injections, and umbilical-cord transection subject women to significant health risks. *See Hopkins*, 2021 WL 41927, at *61–68. In so doing, the district court asked the wrong question. The issue before the district court was not which side's evidence was most persuasive, but whether there is "medical uncertainty over whether the Act's prohibition creates significant health risks." *See Gonzales*, 550 U.S. at 164. *Gonzales*, as reaffirmed by the Chief Justice's *June Medical* opinion, instructs that any such uncertainty "provides a sufficient basis" to uphold Arkansas's law against a facial attack. *See id.*

Under this standard, Arkansas's law readily survives the Plaintiffs' facial challenge. Although the district court believed that digoxin injections are "experimental" in some cases and that potassium-chloride injections are "potentially harmful," *Hopkins*, 2021 WL 41927, at *61, *66, these injections have long been used to cause fetal death before an abortion.[6] Two decades ago, the Supreme Court found that "[s]ome physicians use[] intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D & E (after 20 weeks), to facilitate evacuation." *Stenberg v. Carhart*, 530 U.S. 914, 925 (2000) (citation omitted). In *Gonzales*, the Court again acknowledged that "[s]ome doctors, especially later in the second trimester, may kill the fetus a day or

[6] The only professional study about umbilical-court transection found that, when performed "immediately prior to D&E," it is "a feasible, efficacious and safe way" to cause fetal death. [Doc. 23-13 at 4]; *see also Hopkins*, 2021 WL 41927, at *67 (discussing this study)

two before performing" a D&E by using a digoxin or potassium-chloride injection. *Gonzales*, 550 U.S. at 136; *see also id.* at 164 ("[I]t appears likely an injection that kills the fetus is an alternative under the Act that allows the doctor to perform the procedure."). The *Gonzales* dissent disputed the majority's reliance on these injections as an alternative to partial-birth abortion, arguing (unsuccessfully) that causing fetal death by injection "poses tangible risk and provides no benefit to the woman" and "[i]n some circumstances, injections are 'absolutely medically contraindicated.'" *Id.* at 180 n.6 (Ginsburg, J., dissenting) (cleaned up). Those arguments, however, did not carry the day. In fact, Justice Ginsburg's dissent in *Gonzales* reads very much like parts of the district court's decision. *E.g.*, *Hopkins*, 2021 WL 41927, at *58 ("Additional procedures expose patients to additional risks and burdens; no party argues that these procedures are necessary or provide any medical benefit to the patient.").

Aside from the Supreme Court's decades-long acknowledgement that digoxin and potassium chloride can be used to cause fetal death before an abortion, other evidence supports Arkansas's judgment that the alternatives to live-dismemberment abortion do not create significant health risks. Perhaps the most persuasive evidence on this issue comes from Plaintiff Frederick Hopkins, who *himself uses* digoxin to cause fetal death for an abortion after 18 weeks. [*See* Doc. 5 at 6; *see also* Doc. 73-2 at 9 (discussing Plaintiff Little Rock Family Planning Services' "typical protocol" of using digoxin)]. Dr. Hopkins is far from alone. "After *Gonzales*, abortion providers consistently used fetal-demise techniques to comply with the ban on partial-birth abortion." *Whole Woman's*

Health v. Paxton, 978 F.3d 896, 924 (5th Cir. 2020) (Willett, J., dissenting), *reh'g en banc granted & op. vacated*, 978 F.3d 974 (5th Cir. 2020) (Mem.).[7] In fact, "Planned Parenthood Federation of America even mandated that its affiliates use digoxin to cause fetal demise before D&E at or after 18 weeks' gestation." *Id.* "And the National Abortion Federation's 2018 Clinical Policy Guidelines for Abortion Care discuss both digoxin and potassium chloride (as well as lidocaine)—stating that each 'may be used to cause fetal demise' in second-trimester abortions.'" *Id.* at 925.

Even so, the district court determined that digoxin injections are not an alternative to the live-dismemberment procedure because they allegedly are "insufficiently studied when administered before 18 weeks LMP." *Hopkins*, 2021 WL 41927, at *61. But Arkansas established that there is no medical or scientific reason that doctors cannot use digoxin to cause fetal death prior to 18 weeks. [*See* Doc. 32-3 at 13–14]. In fact, a professional study about digoxin that included pregnancies at 17 weeks concluded that its "results are particularly reassuring with regard to patient safety." [Doc. 23-10 at 3]; *see also Hopkins*, 2021 WL 41927, at *61 (acknowledging that "only a few studies have included cases at 17.0 weeks LMP"). All of this establishes that, at a minimum, medical and scientific uncertainty exists on the subject.

[7] Although the Fifth Circuit panel affirmed an injunction against Texas's analogous law by a divided vote, the Fifth Circuit sua sponte granted en banc rehearing. The case was reargued in January 2021 and is ripe for decision.

Rather than give Arkansas the "wide discretion" it is due, the district court refused to apply *Gonzales* (and thus *June Medical*) "for reasons specific to this case." *Id.* at *59. According to the district court, it must defer to Arkansas's judgment only in narrow circumstances: when, as the district court put it, "the most common abortion procedure—standard D&E—would remain an available and viable option for all women." *Id.* In other words, the district court read *Gonzales*'s medical-uncertainty holding to be inapplicable whenever a state regulates "the most common abortion procedure." *See id.*

But neither *Gonzales* nor the Chief Justice's opinion in *June Medical* admit of such a rule-swallowing exception. The same goes for this Court's decision remanding this matter. In fact, this Court specifically directed the district court to apply the medical-uncertainty rule from *June Medical*. As this Court told the district court, "Chief Justice Roberts also addressed the discretion courts *must afford to legislatures*." *Hopkins v. Jegley*, 968 F.3d 912, 915 (8th Cir. 2020) (per curiam) (emphasis added). No equivocation. No qualifications. No suggestion that this rule does not apply if "the most common abortion procedure" is at issue.

It would be odd to discover the district court's abortion-specific exception to the medical-uncertainty rule hidden in *June Medical* and *Gonzales* given that the Supreme Court did not draw the rule from its abortion jurisprudence. It instead came from case law about other issues—for example, civil-commitment laws, *Kansas v. Hendricks*, 521 U.S. 346, 360 n.3 (1997), and alcohol regulation, *Lambert v. Yellowley*, 272 U.S. 581, 597

(1926); *see also Gonzales*, 550 U.S. at 163 (citing these and other cases). What's more, *Gonzales* rejected an attempt to impose an abortion-specific limitation to its holding. *See id.* at 164 ("Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts."). The district court's discovery of an abortion-specific exception in *Gonzales*'s medical-uncertainty holding therefore contradicts *Gonzales* (and thus *June Medical*).

In distinguishing *Gonzales*'s medical-uncertainty holding, the district court also emphasized *Gonzales*'s conclusion that courts "retain[] an independent constitutional duty to review factual findings where constitutional rights are at stake." *Hopkins*, 2021 WL 41927, at *59 (quoting *Gonzales*, 550 U.S. at 165). But this part of *Gonzales* addressed an argument that the Court should uphold the challenged law "on the basis of the congressional findings alone." *Gonzales*, 550 U.S. at 165. And here, as the district court found, Arkansas's law contains "no legislative findings of fact to which this Court could defer." *Hopkins*, 2021 WL 41927, at *59. At any rate, *Gonzales* determined that courts should review legislative factfinding "under a deferential standard," *Gonzales*, 550 U.S. at 165, which pairs well with the "wide discretion" that *Gonzales* gives the States to act in areas of medical and scientific uncertainty. *Id.* at 163.

The district court also distinguished *Gonzales* and *June Medical* by concluding that digoxin and potassium-chloride injections are not "alternative[s]" to a D&E abortion, but are "additional procedures." *Hopkins*, 2021 WL 41927, at *58. This distinction cannot be squared with *Gonzales*, which found that some abortion providers inject

digoxin or potassium chloride to cause fetal death before an abortion. *Gonzales*, 550 U.S. at 136. More to the point, *Gonzales* held that "alternatives are available" to partial-birth abortion and that "it appears likely an injection that kills the fetus is an alternative under the Act . . . ." *Id.* at 164. If digoxin and potassium-chloride injections are alternatives to partial-birth abortion, they also are alternatives to live-dismemberment abortion. After all, "[w]hy would such an injection be a constitutionally viable 'alternative' for one type of D&E procedure but not another?" *Paxton*, 978 F.3d at 928 (Willett, J., dissenting). This case, then, simply requires the Court to apply *Gonzales*'s rule that where a State "has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures *and substitute others*, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn." *Gonzales*, 550 U.S. at 158 (emphasis added).

II. The Plaintiffs' refusal to follow the law is not a basis to invalidate it.

In many respects, this appeal reduces to the Plaintiffs' refusal to follow Arkansas's law even though they already follow it for some patients. Nowhere is this internal inconsistency more apparent than with Dr. Hopkins. He readily admits to injecting digoxin before abortions after 18 weeks. [Doc. 5 at 6; *see also* Doc. 73-2 at 9 (describing LRFP's "typical protocol" of injecting digoxin)]. As Dr. Hopkins tells it, "practical concerns justify using" digoxin after 18 weeks, with the "main benefit" being "establish[ing] compliance with the federal so-called 'partial-birth abortion' ban, or similar state laws." [Doc. 5 at 6]. Although Dr. Hopkins currently uses digoxin after 18

weeks, he now objects to following Arkansas's law *in its entirety*, including for abortions after 18 weeks. [*Id.* at 7–10]. Thus, Dr. Hopkins objects to doing what he is already doing—a confounding position that the district court nevertheless relied on in preliminarily enjoining Arkansas's law. *See Hopkins*, 2021 WL 41927, at *73 ("There is record evidence to support that Dr. Hopkins and LRFP will no longer continue to provide this abortion care if [Arkansas's law] takes effect.").

It is well-established that an abortion provider's refusal to follow the law cannot be wielded to invalidate the law. As *Gonzales* put it, "[t]he law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Gonzales*, 550 U.S. at 163. Put another way, the undue-burden standard is not violated merely if "some part of the medical community were disinclined to follow the proscription." *See id.* at 166. Thus, the fact that the Plaintiffs are "disinclined" to follow Arkansas's law—even though they already inject digoxin for abortions after 18 weeks—does not amount to an undue burden. "[T]he point is that Plaintiffs have used—and continue to use—digoxin to cause fetal demise. Yet in this litigation they claim that digoxin is unsafe and experimental." *See Paxton*, 978 F.3d at 925 (Willett, J., dissenting). Abortion providers cannot veto state law simply by refusing to follow it.

This commonsense principle also finds support in the Chief Justice's concurring opinion in *June Medical*. In a key passage from *June Medical* that the district court failed to mention in its 253-page opinion, the Chief Justice explained that it is "necessary" for

a court to find that an alleged undue burden is "attributable to the new law rather than a halfhearted attempt" by an abortion provider to comply with the law. *See June Med.*, 140 S. Ct. at 2141 (Roberts, C.J., concurring in the judgment). Only by considering this issue, the Chief Justice reasoned, can a court "accurately identify" whether a law constitutes an undue burden. *See id.*

The Plaintiffs have not made any attempt—not even a "halfhearted" one—to comply with Arkansas's law. Worse, the Plaintiffs tie themselves in knots to explain why they will not follow Arkansas's law even though they already follow it for some of their patients. Any burden on abortion access therefore is not attributable to Arkansas's law, but to the Plaintiffs' refusal to do what the law requires and what they already do in some cases.

III. The Plaintiffs' evidence does not justify facial relief.

The district court determined that Arkansas's law amounts to an undue burden for the requisite large fraction of women because "there is record evidence to support that Dr. Hopkins and LRFP will no longer continue to provide this abortion care if the D&E Mandate takes effect." *See Hopkins*, 2021 WL 41927, at *73. This conclusion is a sleight of hand; it substitutes the Plaintiffs' unwillingness to follow Arkansas's law for concrete evidence about how the law will affect women. A careful look at why the Plaintiffs refuse to follow Arkansas's law reveals that their alleged concerns relate to—at most—a very small group of women, not to a large fraction of women. The Plaintiffs' argument therefore boils down to the contention that Arkansas's law is unconstitutional

all the time because the alternatives to live-dismemberment abortion may not work *some of the time*. That's not how facial invalidation works.

The large-fraction standard requires a plaintiff to prove, and the district court to find, that the challenged law "will operate as a substantial obstacle to a woman's choice to undergo an abortion" in a "large fraction of the cases in which the law is relevant." *Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953, 958 (8th Cir. 2017) (cleaned up) (quoting *Planned Parenthood of S.E. Penn. v. Casey*, 505 U.S. 833, 895 (1991) (joint op.)). This standard is not met if the district court fails to "define or estimate the number of women who would be unduly burdened" by the law. *Id.* at 959. Nor is it met by focusing only on "amorphous groups of women." *Id.* The district court must "conduct fact finding concerning the number of women unduly burdened by the [challenged law] and determine whether that number constitutes a 'large fraction.'" *Id.* at 960.

Rather than apply the large-fraction standard, the district court created an always-available short cut to facial invalidation. Instead of focusing on the number of women who will face a substantial obstacle, the district court mistakenly relied on the Plaintiffs' unwillingness to perform abortions after 14 weeks and the lack of "other providers in Arkansas that could fill this gap in care." *Hopkins*, 2021 WL 41927, at *73. From the Plaintiffs' refusal to perform abortions after 14 weeks, the district court inferred that Arkansas's law constitutes an undue burden for "100%" of applicable women because "D&E abortions will no longer be performed in Arkansas." *Id.* at *74. By fixating on the Plaintiffs' reaction to the law, however, the district court tied the constitutionality

of Arkansas's law to the choices made by the Plaintiffs *who are challenging the law*. And in so doing, the district court bypassed its duty "to conduct fact finding concerning the number of women unduly burdened by the [challenged law]." *See Jegley*, 864 F.3d at 960.

Had the district court undertaken that endeavor, it would have had no option but to find that the Plaintiffs failed to make the large-fraction showing. As noted above, Dr. Hopkins and LRFP already perform digoxin injections for abortions after 18 weeks. [Doc. 5 at 6; Doc. 72-3 at 9]. So, at least for those women, Arkansas's law does not pose a substantial obstacle. But the district court still found that Arkansas's law is an undue burden for "100%" of these women. *See Hopkins*, 2021 WL 41927, at *74. Its reason? The Plaintiffs allegedly will stop performing all abortions after 14 weeks because of "ethical and legal concerns." *Id.* Dr. Hopkins explained his concerns this way: "There are patients for whom it is simply not safe to do such injections, because of particular aspects of their anatomy and/or the pregnancy."[8] [Doc. 5 at 8]. He continued: "For other women, we can do the [digoxin] injection, but it does not work." [*Id.*]. On this latter point, the district court found that digoxin causes fetal death in the overwhelming majority of cases—its success rate is between 90 and 95 percent.[9] *Hopkins*, 2021 WL

[8] Tellingly, Dr. Hopkins made no effort to quantify how often this will occur. At most, he has identified "amorphous groups of women" for whom a digoxin injection may not cause fetal death. *See Jegley*, 964 F.3d at 959.

[9] Even if digoxin is only 90–95 percent effective, that does not mean that Arkansas's law is facially invalid. [*But see* Arkansas Br. at 36 (citing peer-reviewed literature showing that digoxin succeeds 99.4 percent of the time)]. In the few instances in which a first injection of digoxin does not work, an abortion provider can give a second injection. [Doc. 23-14 at 2 ("[D]igoxin injection was repeated at the physician's discretion before

41927, at *14. Thus, reduced to its core, the district court deduced that "100%" of women will face a substantial obstacle because the Plaintiffs have no assurance that digoxin will work all the time and thus cannot perform abortions any of the time.

This tortured logic "turns facial validity on its head." *Paxton*, 978 F.3d at 932 (Willett, J., dissenting). It cannot be the case that "[f]etal demise is unconstitutional all of the time because the techniques don't work some of the time." *See id.* To survive a facial challenge to its law, Arkansas "need not prove that every alternative works every time for every woman. As the Supreme Court put it in *Gonzales*, a state need only show 'the availability of safe alternatives' to live dismemberment." *Id.* (cleaned up).

If it is true that fetal death cannot be accomplished in every circumstance, there is a tailor-made remedy for that: an as-applied challenge to Arkansas's law. "As-applied challenges are the basic building blocks of constitutional adjudication." *Gonzales*, 550 U.S. at 168 (citation omitted). They are "the proper manner to protect the health of the woman if it can be shown that in discrete and well-defined instances a particular condition has or is likely to occur in which the procedure prohibited by the Act must

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D&E for persistent fetal cardiac activity.")]; *Paxton*, 978 F.3d at 926 (Willett, J., dissenting) (noting that abortion provider's "own protocol documents say that '[i]f fetal demise has not been induced, a second injection of Digoxin can be administered at the physician's discretion'"). Even so, the low failure rate identified by the district court does not amount to a substantial obstacle for a large fraction of women for whom the law is relevant. *See Jegley*, 864 F.3d at 960 ("[T]he term 'large fraction,' which, in a way, is more conceptual than mathematical, envisions something more than the 12 out of 100 women identified here." (quoting *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 374 (6th Cir. 2006)).

be used." *Id.* at 167. In such a suit, "the nature of the medical risk can be better quantified and balanced than in a facial attack." *Id.* Thus, if there are "discrete and well-defined instances" when fetal death cannot be caused to avoid a live-dismemberment abortion (for example, a woman with a contraindication to digoxin), the courthouse doors are open to an as-applied challenge.

One final point: Although the district court determined that the Plaintiffs satisfied the large-fraction standard, the district court purported to exercise its discretion not to facially invalidate Arkansas's law. *Hopkins*, 2021 WL 41927, at *74–76. Relying on out-of-circuit case law, the district court preliminarily enjoined Arkansas's law only "as to Dr. Hopkins and LRFP," which it viewed as as-applied relief. *See id.* at *76. Granted, the line between facial and as-applied relief is not always clear. *See Doe v. Reed*, 561 U.S. 186, 194 (2010). But the relief here is facial. As-applied relief applies in "discrete and well-defined" circumstances. *See Gonzales*, 550 U.S. at 167; *see also Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006) ("It is axiomatic that a 'statute may be invalid as applied to one state of facts and yet valid as applied to another.'" (citation omitted)). That does not describe the broad relief granted by the district court. Under its preliminary injunction, Dr. Hopkins and LRFP can ignore Arkansas's law *no matter the circumstances* of a live-dismemberment abortion. Stated differently, the preliminary injunction does not "leav[e] other applications [of Arkansas's statute] in force." *See id.* There are no facts under which Dr. Hopkins and LRFP must follow Arkansas's law.

The fact that the district court only granted plaintiff-specific relief does not alter this conclusion. Consider, for example, what would happen if this Court simply affirmed the district court's preliminary injunction in its entirety. If a new plaintiff abortion provider then challenged Arkansas's law, Arkansas might not be prohibited by the preliminary injunction from enforcing the law against the plaintiff, but the legal holding that the statute is likely unconstitutional would bind the district court and make the challenge by the new plaintiff essentially a forgone conclusion. *See Ctr. for Comparative Politics v. Harris*, 784 F.3d 1307, 1315 (9th Cir. 2015) ("Even though [the plaintiff] only seeks to enjoin the Attorney General from enforcing the disclosure requirement against itself, the Attorney General would be hard-pressed to continue to enforce an unconstitutional requirement against any other member of the registry."); *see also Camreta v. Green*, 563 U.S. 692, 704 (2011) (stating that constitutional rulings "have a significant future effect on the conduct of public officials . . . and the polices of the government units to which they belong"). In this way, the Plaintiffs' "claim and the relief that would follow . . . reach beyond the particular circumstances of these [P]laintiffs." *See Reed*, 561 U.S. at 194.

CONCLUSION

The Court should vacate the district court's preliminary injunction against Arkansas's law prohibiting live-dismemberment abortion.

Respectfully submitted by,

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As required by Federal Rule of Appellate Procedure 32(g), I certify that this brief complies with the type-volume limitation in Fed. R. App. P. 29(a)(5) because it contains 4,951 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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