UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC.,	)	
Plaintiff,	)	
v.	)	Case No. 1:16-cv-1807-TWP-DML
COMMISSIONER, INDIANA STATE DEPARTMENT OF HEALTH, *et al.*,	)	
Defendants.	)	

DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

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INDEX OF EXHIBITS TO DEFENDANTS' MEMORANDUM IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

EXHIBIT	DESCRIPTION
Exhibit A	Declaration of Christina Francis, M.D., in Opposition to Plaintiff's Motion for Preliminary Injunction
Exhibit B	Declaration of Aaron Kheriaty, M.D., in Opposition to Plaintiff's Motion for Preliminary Injunction
Exhibit C	Declaration of Anne Hendershott, Ph.D., in Opposition to Plaintiff's Motion for Preliminary Injunction
Exhibit D	Transcript, Deposition of John H. Stutsman, M.D. (Sept. 27, 2016)
Exhibit E	Transcript, Deposition of Betty Cockrum (Sept. 22, 2016)
Exhibit F	Planned Parenthood of Indiana and Kentucky Job Description for Nurse Practitioner
Exhibit G	Exhibit 10 to the Deposition of John H. Stutsman (online listings for portable ultrasound machines)

INTRODUCTION

This case features the combination of two widely and constitutionally accepted steps in the abortion process: waiting periods (which yield two trips to medical facilities of some kind) and ultrasounds. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the Supreme Court upheld a 24-hour waiting period, and in *A Woman's Choice—East Side Women's Clinic v. Newman*, 305 F.3d 684 (7th Cir. 2002), the Seventh Circuit upheld Indiana's 18-hour waiting period, despite the implicit two-trip requirement. Indiana has required performance of pre-abortion ultrasounds since 2011, and has required that they at least be offered since 2005, with no legal challenge even calling the requirement into question.

Now, with the aim of feeding maternal reflection with compelling evidence of fetal humanity (the better to persuade the mother against abortion), the General Assembly has moved the ultrasound from "eleventh-hour" abortion prep to the 18-hour in-person consultation that *already* must occur. The only question is whether combining otherwise perfectly constitutional abortion prerequisites somehow imposes an unconstitutional undue burden on women seeking abortion. Common sense tells us no, and while Planned Parenthood seeks to override it via (1) Supreme Court pronouncements on women's health protections rather than fetal life protections and (2) its own freely chosen business practices, neither the law nor the record precludes the legislature from requiring that a woman have reasonable minimum time to consider a fetal ultrasound before choosing abortion.

FACTUAL BACKGROUND

I. Ultrasounds, Waiting Periods, and the Abortion Decision

Diagnostic ultrasound is an imaging method that utilizes high-frequency sound waves to produce images of structures within the body. Mayo Clinic, *Ultrasound*, http://www.mayoclinic.

org/tests-procedures/ultrasound/basics/definition/prc-20020341 (last visited Oct. 3, 2016). Ultrasound is used for a wide array of medical purposes, including to diagnose gallbladder disease, evaluate flow in blood vessels, guide a needle for biopsy or tumor treatment, evaluate a breast lump, check a thyroid gland, and diagnose some cancers. Mayo Clinic, *Ultrasound: Why It's Done*, http://www.mayoclinic.org/tests-procedures/ultrasound/basics/why-its-done/prc-20020341 (last visited Oct. 3, 2016). When a woman is pregnant, fetal ultrasound produces images of the baby in utero, which helps the physician monitor the baby's development, evaluate potential problems, and confirm diagnoses. Mayo Clinic, *Fetal Ultrasound: Definition*, http://www.mayoclinic.org/tests-procedures/fetal-ultrasound/basics/definition/prc-20014506 (last visited Oct. 3, 2016).

Ultrasound is also part of the standard of care for women who undergo abortions. Ex. A, Decl. of Christina Francis, M.D. ["Francis Decl."] ¶ 10. Among other things, the ultrasound documents a viable intrauterine pregnancy—rather than an ectopic pregnancy—and confirms the gestational age of the fetus. *Id.* Indeed, PPINK already performs ultrasounds before each abortion for these very reasons. ECF No. 1, Compl. at 5 ("PPINK uses ultrasound to confirm that there is an intrauterine pregnancy and to verify fetal age to insure that abortions are performed within PPINK's time limits[.]"); ECF No. 24-1, Decl. of Betty Cockrum [Cockrun Decl.] ¶ 27.

Equally important are the benefits of ultrasound for informing a woman's decision to have an abortion. An ultrasound is a crucial step in a woman's choice whether to terminate her pregnancy because it allows her to see her child perhaps for the first time and more fully consider its humanity, perhaps for the first time. Francis Decl. ¶¶ 12–13; Ex. B, Decl. of Aaron Kheriaty, M.D., ["Kheriaty Decl."] ¶ 9; Ex. C, Decl. of Anne Hendershott, Ph.D. ["Hendershott

Decl."] ¶ 12. An ultrasound image can be easily distinguished from other images of fetal development that a woman may view during the course of her pregnancy because the mother is allowed to view *her own child*, rather than a computer-generated image of a fetus. *See* Francis Decl. ¶ 12. For some women, viewing the live, moving image of their baby and being able to see the arms and legs and hear the heartbeat helps them bond with the child and view it as more than just a clump of cells. *Id.*

Some Indiana women have reported that viewing the ultrasound image of their baby led them to decide not to terminate their pregnancies. *Id.* What is more, the State's expert, Dr. Christina Francis, testified before the legislature that one of her patients who had an abortion felt that an ultrasound waiting period would have given her more time to consider her decision and change her mind. *Id.* ¶ 13. The patient had a medication abortion at a PPINK clinic in Indianapolis. *Id.* She underwent an ultrasound on the day of her abortion but chose not to view the image because she felt it might cause her to change her mind. *Id.* She did not want to be persuaded to abort because she was already at the clinic, had paid for the abortion, and felt pressured by those circumstances to go through with the procedure. *Id.* The patient told Dr. Francis that had she undergone the ultrasound the day before her abortion appointment, she likely would have viewed the ultrasound image and does not think she would have come back the next day to proceed with the medication abortion. *Id.*

According to one study, for women with medium or low decision certainty about abortion, viewing an ultrasound image was associated with deciding to continue the pregnancy in a significant number of cases. Mary Gatter et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81 (2014). Women with medium or low decision certainty who viewed the ultrasound image had a 95.2% rate of proceeding to abortion

compared with a 97.5% rate for women with high decision certainty who viewed the ultrasound. *Id.*

Waiting periods, like ultrasounds, also have an effect on the abortion decision, although they are not unique to abortion procedures. On the contrary, "it would be unusual for a significant treatment procedure to occur immediately after a diagnostic or preliminary procedure" because "[s]uch a timeline often would not afford the patient adequate time to consider the different treatment options, ask questions, or seek additional medical advice." Kheriaty Decl. ¶ 11; *see also* Francis Decl. ¶ 8 (discussing informed consent appointments one to four weeks prior to a hysterectomy or other permanent sterilization procedure and noting that some patients have backed out of these procedures after having time to consider the risks and benefits); Ex. D, Transcript of Deposition of John Stutsman, M.D. ["Stutsman Dep."] at 14 (discussing preoperative appointments the day before a hysterectomy), 17 (noting that some patients decide not to have a hysterectomy after hearing the informed consent information). In the abortion context, one study has even shown that abortion waiting periods were associated with a ten percent drop in the post-abortion suicide rate. Jonathan Click, *Mandatory Waiting Periods for Abortions and Female Mental Health*, 16 Health Matrix 183, 193 (2006).

II. The 18-Hour Ultrasound Requirement

Since 1995, Indiana has prescribed the manner of obtaining a woman's informed consent before performing an abortion. Ind. Code § 16-34-2-1.1. Of particular relevance here, the informed-consent law requires abortion providers to give pregnant women certain state-mandated information in person, 18 hours prior to the abortion procedure. Ind. Code § 16-34-2-1.1(a)(1). This effectively requires women to make two trips to a health facility of some sort.

The Seventh Circuit upheld these informed consent procedures against a constitutional challenge in *A Woman's Choice—East Side Women's Clinic v. Newman*, 305 F.3d 684 (7th Cir. 2002).

In 2005, Indiana amended the informed consent statute to require abortion providers to notify their abortion patients of "[t]he availability of fetal ultrasound imaging and auscultation of fetal heart tone services to enable the woman to view the image and hear the heartbeat of the fetus and how to obtain access to these services." Ind. Code §§ 16-34-2-1.1(a)(1)(F), (b) (2005). Six years later, the legislature made it mandatory for the woman to undergo a pre-abortion ultrasound. *See* Ind. Code § 16-34-2-1.1(b) (2011). In addition, the woman must "view the fetal ultrasound imaging and hear the auscultation of the fetal heart tone . . . *unless* the pregnant woman certifies in writing, before the abortion is performed, that the pregnant woman does not want to view the fetal ultrasound imaging." *Id.* Because the statute did not specify at what point the ultrasound must take place, providers could—and did—administer the ultrasound on the same day as the abortion procedure. *See* ECF No. 24, Mem. in Supp. of Mot. for Prelim. Inj. ["Pl.'s PI Mem."] at 8; Cockrum Decl. ¶ 27.

In 2016, the legislature, having heard from Dr. Francis about her patient who regretted her abortion, amended the law once again, adding no new substantive requirements but simply combining the existing ultrasound and waiting period requirements. As of July 1, 2016, the ultrasound must take place 18 hours prior to the abortion at the same appointment wherein the provider administers the informed consent information. Specifically, Indiana Code section 16-34-2-1.1(a)(5) (the "Ultrasound Law") now provides:

> *At least eighteen (18) hours* before an abortion is performed *and at the same time that the pregnant woman receives the information required by subdivision (1)*, the provider shall perform, and the pregnant woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible unless the pregnant woman certifies in writing, on a form developed by the state department, before the abortion is performed, that the pregnant woman:

> (A) does not want to view the fetal ultrasound imaging; and (B) does not want to listen to the auscultation of the fetal heart tone if the fetal heart tone is audible.

Ind. Code § 16-34-2-1.1(a)(5) (emphasis added). By moving the ultrasound to the informed consent stage of the process, the legislature acknowledged that imaging serves a purpose beyond simply providing medical information about the fetus. It also gives the woman an opportunity to see a live, moving image of her baby and consider the full weight of her decision with all the relevant information before her.

III. PPINK's Health Centers, Current Ultrasound Capabilities, and Ultrasound Policy

PPINK operates three health centers in Indiana that offer both surgical and medication abortions (Bloomington, Merrillville, and Indianapolis), and one health center that offers only medication abortions (Lafayette). Cockrum Decl. ¶¶ 7–9. Additionally, PPINK operates thirteen other health centers in Indiana that do not provide abortion services of any kind, but that facilitate the abortion process. *Id.* ¶¶ 4, 7, 9. Prior to July 1, 2016 (the date the Ultrasound Law took effect), PPINK provided the state-mandated informed consent information at all 17 of its health centers regardless whether the center provided abortion services. *Id.* ¶¶ 21–22. PPINK offered informed-consent services in all of its health centers "in order to minimize the travel distances and other inconveniences for women obtaining abortions" such that "only one lengthy and disruptive trip was necessary." *Id.* ¶ 22. Having given their informed consent the previous day, women "would generally obtain an ultrasound on the day of the planned abortion[.]" Pl.'s PI Mem. at 8; Cockrum Decl. ¶ 27.

With the Ultrasound Law now in effect, women must now have their ultrasound at least 18 hours before the abortion procedure. Currently, six PPINK clinics are equipped with ultrasound machines: the four clinics that offer abortion services (Bloomington, Merrillville, Indianapolis, and Lafayette) and two additional clinics (Mishawaka and Evansville). Cockrum

Decl. ¶ 41–43. PPINK will not accept the results of ultrasounds performed by other providers. *Id.* ¶ 45. And while the ultrasound machines PPINK uses at its facilities "cost at least $25,000 for the machine itself" and "must be operated by specially trained technicians," *id.* ¶ 28, PPINK's medical director and CEO both testified that they were not aware whether PPINK investigated alternative options such as purchasing a portable ultrasound machine (some of which have price points as low as $4,250, *see* Francis Decl. ¶ 16), purchasing a refurbished machine, or leasing or financing a machine. Stutsman Dep. at 117–21; Ex. E, Transcript of Deposition of Betty Cockrum ["Cockrum Dep."] at 70–72.

ARGUMENT

PLAINTIFF CANNOT DEMONSTRATE A LIKELIHOOD OF SUCCESS ON THE MERITS

I. Because the Ultrasound Law Is Justified Principally By the State's Interest in Protecting Fetal Life Rather Than Maternal Health, *Hellerstedt* Does Not Provide the Correct Standard

This case requires the Court to interpret the meaning of the Supreme Court's recent decision in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). PPINK's arguments presuppose application of *Hellerstedt*'s balancing test to *all* abortion regulations. But the Texas regulations invalidated in *Hellerstedt* were designed to protect maternal health, while, much like Indiana's extant and undeniably constitutional 18-hour informed consent requirement, the Ultrasound Law is designed to protect fetal life. The distinction is critical, because it is one thing for a court to choose between competing views of what is better for the woman's health where the principal regulatory objective—advancing the woman's health—is agreed. It is quite another for a court to choose between the outright conflicting interests of a fetus and a mother seeking abortion, where there is fundamental disagreement over the legitimacy of the principal regulatory objective. "Balancing" the interests in this case would merely put the Court in a position of

second-guessing the legitimacy of the State's interest in protecting fetal life. But since the Supreme Court has said that states retain a compelling interest in protecting fetal life, and there can be little question but that ultrasounds and waiting periods advance that interest, such balancing is inappropriate. Accordingly, the appropriate standard remains that of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), under which Indiana's Ultrasound Law must survive.

A. *Hellerstedt* balancing applies only to abortion restrictions designed to protect maternal health

Hellerstedt struck down two Texas abortion regulations that (1) required physicians performing abortions to have admitting privileges at a hospital within 30 miles of the abortion facility, and (2) required abortion facilities to meet minimum standards for ambulatory surgical centers under Texas law. *Hellerstedt*, 136 S. Ct. at 2300 (citing Tex. Health & Safety Code Ann. §§ 171.0031(a), 245.010(a)). Texas argued that both regulations were intended to "ensure patient safety and raise standards of care." Br. of Respondents at 16, *Whole Woman's Health v. Hellerstedt*, No. 15-274 (U.S.). The Court acknowledged the constitutional legitimacy of this state interest, *Hellerstedt*, 136 S. Ct. at 2310, but held that "neither of these provisions confers medical benefits sufficient to justify the burdens upon access that each imposes." *Id.* at 2300.

Thus, the Court in *Hellerstedt* re-weighed the state's interest in protecting maternal health against the burdens the Texas law placed on access to abortion. *Id.* at 2300, 2310. On the maternal-health side of the scale, the Court found no evidence demonstrating medical benefits of the challenged regulations. It observed that Texas could not identify "a single instance" in which the admitting-privileges requirement would help a woman obtain better treatment, *id.* at 2311, and agreed with the district court's conclusion that the surgical-center requirement had "such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary." *Id.* at

2316 (internal quotation omitted). On the burden side of the scale, the Court found substantial evidence supporting the conclusion that the requirements would dramatically reduce the number of abortion clinics in Texas, thus limiting access to abortion. *Id.* at 2313 (observing that the admitting-privileges requirement "led to the closure of half of Texas' clinics, or thereabouts"), 2316 (noting the parties' stipulation that the surgical-center requirement would further reduce the number of clinics to seven or eight).

Here, by contrast, the challenged regulation is concerned with the protection of unborn life. The main purpose is to give a woman seeking an abortion the opportunity to view an image of her baby before making her decision, with hope that she will reflect on that image (and other information provided) and decide against abortion. PPINK argues that Indiana's informed consent law already requires abortion providers to show women the brochure prepared by the Indiana State Department of Health, which contains computer-generated images of a fetus at various stages of development. Pl.'s PI Mem. at 8, 24; *see also* Ex. 1 to Cockrum Decl. These images, says PPINK, "are much clearer than those produced by ultrasound." Pl.'s PI Mem. at 8. But there is a significant difference between viewing an image of *a* baby and viewing an image of *your* baby. Women who have considered terminating their pregnancies have reported that they decided not to abort after viewing an ultrasound image of their fetus. Francis Decl. ¶ 12. These women have told their physician that "seeing the live, moving image of their babies, with arms and legs and a heartbeat, helped them bond with the child and view it as more than just a clump of cells." *Id.* Indeed, from a psychological standpoint, allowing a patient to see a visual image of what is going on inside her body "can have a much clearer psychological impact on a patient than simply hearing a description of the medical issue and treatment." Kheriaty Decl. ¶ 9.

When the ultrasound occurs immediately prior to the abortion procedure, the woman may feel pressured by the circumstances to go through with the abortion no matter how moved she is by the image. By that point she is at the clinic, the physician and clinic staff have cleared time in their schedules to treat her, she has already paid for the procedure, and she has already emotionally prepared herself for the procedure. *See* Francis Decl. ¶ 13. But when the ultrasound occurs 18 hours prior to the procedure at the time of the informed consent appointment, she will have time to consider the ultrasound image alongside all the other information she receives and weigh the risks, benefits, and consequences of her decision.

Thus, the Ultrasound Law is "designed to persuade [the woman] to choose childbirth over abortion[.]" *Casey*, 505 U.S. at 878. The *Hellerstedt* balancing test is a poor fit for this type of regulation. Balancing was appropriate in *Hellerstedt* because both sides—the state and the clinics—were concerned with the same thing: protecting the health of the mother. With this type of regulation, courts must merely evaluate, in essence, the extent to which state efforts to protect maternal health will actually do so. There is no call upon courts to sort out whose view of fundamentally conflicting interests "weighs" more. Here, the two sides' interests are fundamentally at odds with one another. PPINK's goal is to help the woman carry out her decision to terminate her pregnancy and the State's goal is to persuade the woman to reconsider that decision. This is a maternal-fetal conflict and cannot be redressed by *Hellerstedt* balancing.[1]

[1] In support of its interpretation of *Hellerstedt*, PPINK cites *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786 (7th Cir. 2013), where the Seventh Circuit said that "[t]he feebler the *medical* grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." *Id.* at 798 (emphasis added). However, PPINK omits the word "medical" in its summary of *Van Hollen*. *See* Pl.'s PI Mem. at 20 ("The Seventh Circuit has noted that the weaker the grounds demonstrated by the State . . . ."). But plainly that word underscores how the standard employed there and in *Hellerstedt* is directed at another type of regulation. *See Van Hollen*, 738 F.3d at 798 ("The cases that deal with abortion-related statutes sought to be justified on *medical* grounds . . . ." (emphasis added)). *Cf. Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 539 (9th Cir. 2004) ("*Casey* largely dealt with a law

B. Under *Casey*, the Ultrasound Law withstands constitutional scrutiny

Because this case is about the protection of fetal life, not maternal health, it requires only a straightforward application of *Casey*, which at bottom requires PPINK at the very least to prove the challenged law is "bound to" lead to a decline in abortions for a "large fraction" of women seeking abortion for reasons unrelated to persuasive effect. PPINK has not even attempted such a feat in this case.

1. Under *Casey*, the key question is burden, not government interest. It is not a "heightened scrutiny" test in the sense that it requires a "compelling" or even "important" government interest. Rather, the Court need only conclude that the Ultrasound Law serves a *legitimate* interest. *Casey*, 505 U.S. at 876; *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 800 (7th Cir. 2013) (Manion, J., concurring) (noting the "first step" under a *Casey* analysis is to determine if the challenged regulation is rationally related to a *legitimate* purpose).

Regardless, the State's promotion of fetal life is not only legitimate, but compelling. Dating back to *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court has recognized that in enacting and defending abortion regulations, "the State may assert interests beyond the protection of the pregnant woman alone." *Id.* at 150. The Court has consistently said that states have "a legitimate interest in promoting the life or potential life of the unborn." *Casey*, 505 U.S. at 870; *see also Gonzales v. Carhart*, 550 U.S. 124, 163 (2007) (recognizing "the State's interest in promoting respect for human life at all stages in the pregnancy.").

Again, the Ultrasound Law fits squarely within the tradition of such laws. The State's interest here is undeniable, as even PPINK seems to acknowledge. *See* Pl.'s PI Mem. at 21 ("[A]ny justification offered by the State must be either be supported by facts demonstrating that

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aimed at promoting fetal life, its application of the 'undue burden' standard is often not extendable in obvious ways to the context of a law purporting to promote maternal health").

the new regulation is required because of women's health *or* because of the State's interest in encouraging childbirth over abortion." (emphasis added)). The Ultrasound Law encourages women to carry children to term by giving them additional time to consider the fetus's life before making the decision to abort. Women have 18 more hours to view an ultrasound image that may show their fetus's arms, legs, and heartbeat. Francis Decl. ¶ 12.

Having 18 more hours would have changed the mind of at least one of PPINK's patients. *Id.* ¶ 13. That patient received an abortion at PPINK's Indianapolis clinic, where immediately before the abortion, a physician conducted an ultrasound. *Id.* Although she wishes she had not undergone the procedure, the pressures of the situation were overwhelming. *Id.* She had already paid for the abortion and was at the clinic. *Id.* As a result, she could not bring herself to view the ultrasound image and, instead, went through with the procedure. *Id.* She admits now that had she had an additional 18 hours, these pressures would not have been so pervasive. *Id.* She likely would have viewed the ultrasound and carried the child. *Id.*

2. That leaves only a consideration of whether the Ultrasound Law imposes a "substantial obstacle in the path of a woman seeking an abortion." *Casey*, 505 U.S. at 877. This inquiry is demanding of the challenger, as a regulation creates a substantial obstacle only where it "will have the likely effect of preventing a significant number of women for whom the regulation is relevant from obtaining abortions." *Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999); *A Woman's Choice—East Side Women's Clinic v. Newman*, 305 F.3d 684, 693 (7th Cir. 2002) (recognizing it is not enough to "imply that the effects [of an abortion regulation] in Indiana are *bound to be* unconstitutional" when the effects "are open to debate"). Therefore, a plaintiff must show not only that the regulation creates a substantial obstacle, but that it does so

"in a *large fraction* of the cases in which the law is relevant." *A Woman's Choice*, 305 F.3d at 698 (Coffey, J., concurring) (emphasis in original) (*quoting Casey*, 505 U.S. at 895).

PPINK cannot demonstrate any such burden. Indeed, the burdens PPINK alleges here closely resemble the alleged burdens of other abortion regulations that have already withstood constitutional scrutiny. In *Casey*, for example, the plaintiffs argued that the challenged 24-hour informed consent waiting period would force women to make two separate trips to the clinic, cause delays in excess of 24 hours for most women, and significantly increase the cost of obtaining an abortion (including costs of transportation, overnight lodging, and lost wages) thus particularly burdening low-income women. *Casey*, 505 U.S. at 885–86. Similarly, PPINK contends that the Ultrasound Law will cause delays in abortion services, require women to "travel a significant distance," and sometimes require women to make two trips to the clinic. Pl.'s PI Mem. at 10, 25. PPINK also alleges the Law will impose costs including "travel expenses, loss of income from work, [and] childcare expenses" that will be most burdensome for low-income women. *Id.* at 2.

The Court acknowledged these burdens in *Casey*, 505 U.S. at 885–86. It assumed that the waiting period could "increase[e] the cost and risk of delay of abortions" and that some women would be forced to travel long distances." *Id.* at 886 (internal citations omitted). But all these burdens together did not "demonstrate that the waiting period constitute[d] an undue burden." *Id.* None of these burdens imposed a "real health risk" on women nor did they interfere with women's abortion right. *Id.* at 886–87. Instead, the waiting period facilitated the "wise exercise" of that right. *Id.* at 887. Although some women may be delayed in getting an abortion, "[e]ven the broadest reading of *Roe* . . . has not suggested that there is a constitutional right to abortion on demand." *Id.*

Similarly, in *A Woman's Choice*, the plaintiff clinics argued that Indiana's "in-the-presence" consultation requirement for informed consent would require women to make "two tips to the clinic or hospital" and raise the cost of abortions. *A Woman's Choice*, 305 F.3d at 685. There, as here, the clinic plaintiffs (which included PPINK's corporate predecessor) contended the challenged law would cause some woman to "forgo an abortion" altogether and delay the procedure for other women. *Id.* Like the Court in *Casey*, the Seventh Circuit held that these costs, even taken together, did not constitute an undue burden. *Id.* at 692. The record only showed that the costs associated with the waiting period were "positive and have *some* effect—something that the plurality in *Casey* assumed." *Id.* at 692. Nothing suggested these costs would create the type of substantial obstacle that the spousal notification requirement created in *Casey*. *Id.* (noting the spousal notification requirement could "facilitat[e] domestic violence or even invit[e] domestic intimidation"). The record in *A Woman's Choice* did not have "the sort of evidence that permits an inferior federal court to depart from the holding of *Casey* that an informed-consent law is valid even when compliance entails two visits to the medical provider." *Id.*

PPINK's only real complaint is that the 18-hour ultrasound requirement will "mak[e] abortions more difficult to obtain," but even if so, that is insufficient to demonstrate undue burden. *Karlin*, 188 F.3d at 482 (holding that clinics must instead show an abortion regulation has "a strong likelihood of *preventing* women from obtaining abortions"). Indeed, "inconvenience, even severe inconvenience, is not an undue burden." *Id.* at 481.

Here, PPINK demonstrates at most that it has not yet adapted to the new requirement, and that as a consequence, a few women may encounter additional inconveniences when seeking abortions—although the evidence for that is both meager and unreliable. *See* Part II.B.1., *infra*.

PPINK posits only its own recent economic misfortunes and supposed lack of operational agility to substantiate the law's supposed burden on women. *See, e.g.*, Pl.'s PI Mem. at 5 (noting that unspecified "financial considerations are requiring PPINK to close and consolidate a number of its health centers"), 25 ("[D]ifficulty with scheduling . . . may mean that women must travel to geographically remote centers because ones that are close to them are too busy to accommodate them."), 28 (lamenting "[t]he press of scheduling"). It worries that increased burdens on staff will lead to high turnover. *Id.* at 17 ("Staff turnover will simply add to the general problems of congestion[.]").

In this regard, it is particularly telling that, despite predictions in earlier litigation that the "in-the-presence" requirement would require women seeking abortion to make two trips to "an abortion clinic or hospital," *A Woman's Choice*, 305 F.3d at 685, PPINK has managed to provide the 18-hour informed consent consultation at 17 health centers around the State, not merely at its four abortion clinics. *See* Cockrum Dep. at 96; Cockrum Decl. ¶¶ 2–3. Later, when the legislature added new information to be provided during the 18-hour informed consent consultation, PPINK adjusted staffing to meet the accompanying increased time commitment. Cockrum Dep. at 98. And, when another abortion clinic closed in Lake County in 2015, PPINK adjusted to meet the resulting increased demand for its abortion services by adjusting personnel hours and requiring employees to work longer shifts. Cockrum Dep. at 86–88. The higher volume of abortions has remained, and PPINK has not experienced high staff turnover as a result. *Id.* In short, PPINK has in the past proven itself able to adapt to new regulatory and market conditions, so its claim of inability to do so now is not credible.

PPINK also says that women seeking abortion will be stymied by its lack of premium-quality ultrasound machines. First, such machines are already in place not only at PPINK's four

abortion clinics in Merrillville, Lafayette, Indianapolis, and Bloomington, but also at its health centers in Evansville and Mishawaka. Pl.'s PI Mem. at 10. Second, while PPINK bemoans the abortion prospects for women in Fort Wayne because it lacks an ultrasound machine there, it already has a health clinic in that city where women receive 18-hour counseling. *Id.* at 6; Cockrum Decl. ¶ 23. Given this focus on Fort Wayne, it seems that adaptation to this new requirement would require one additional machine and personnel training, yet PPINK has chosen not to purse that option.

PPINK emphasizes the high cost of its preferred machines, but far less costly (and portable) machines are available, even if only as a short-term solution. Francis Decl. ¶ 16. And while PPINK would prefer not to bother with having to train its nurse practitioners to perform and interpret ultrasounds, its CEO, Betty Cockrum, admits that the decision whether to do so is ultimately a business decision—a "choice" it makes in the deployment of resources to provide various services. Cockrum Dep. at 106. The Fourteenth Amendment does not protect abortion providers from having to make difficult business decisions in order to comply with legitimate (nay, compelling) government regulations.

II. Even if *Hellerstedt* Applies, the Benefits of the Ultrasound Law Outweigh Any Burden on Access to Abortion

As recounted above, the maternal-health balancing test of *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), which requires the court to consider the "burdens a law imposes on abortion access *together* with the benefits those laws confer," *id.* at 2309, is ill-suited to evaluate the validity of abortion regulations principally designed to protect fetal life. But even if it did apply to Indiana's 18-hour ultrasound requirement (either because *Hellerstedt* applies to all abortion regulations or because a secondary justification for the law is to protect the psychological health of women seeking abortions) PPINK has shown only *de minimis* burdens,

while the State has shown substantial benefits. Thus, even under the *Hellerstedt* standard, PPINK's challenge must fail.

A. The 18-hour ultrasound requirement is beneficial because it effectively advances the State's weighty interests in protecting fetal life and maternal psychological health

1. One particularly effective way for a state to advance its interest in protecting fetal life is to ensure that women have access to as much information as possible before they decide whether to have an abortion. The abortion choice is often a "difficult and painful moral decision," *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007), that may have "profound and lasting meaning." *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 873 (1992). It is no surprise, therefore, that the Supreme Court has recognized states have "an interest in ensuring so grave a choice is well informed." *Carhart*, 550 U.S. at 159. And courts have found no constitutional infirmity in laws that give women time and resources to make such a weighty choice, even if it requires them to make two visits to the abortion-providing facility. *See, e.g.*, *Eubanks v. Schmidt*, 126 F. Supp. 2d 451 (W.D. Ky. 2000) (upholding Kentucky's 24-hour waiting period, assuming a two-trip requirement); *Utah Women's Clinic, Inc. v. Leavitt*, 844 F. Supp. 1482 (D. Utah 1994), *rev'd on other grounds*, 75 F.3d 564 (10th Cir. 1995) (upholding Utah's 24-hour waiting period even assuming it required two trips).

In short, waiting periods give women the opportunity to consider all the information, weigh their options, and ask questions. They help "ensure that the woman's choice regarding the life or death of her child has been both knowingly and voluntarily made, after extended debate and careful reflection." *A Woman's Choice*, 305 F.3d at 701–02 (Coffey, J., concurring); *see also Casey*, 505 U.S. at 885 ("The idea that important decisions will be more informed and deliberate if they follow some period of reflection does not strike us as unreasonable, particularly

where the statute directs that important information become part of the background of the decision.").

2. PPINK acknowledges the State's compelling interest, but argues ultrasounds 18 hours before the abortion are unnecessary to advance that interest because abortion providers in Indiana are already required to provide patients with brochures that show "vivid representations of fetuses at various gestational ages." Pl.'s PI Mem. at 22. But an ultrasound image is materially different from a picture in a brochure. *Cf.* Mary Gatter, et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81, 85 (2014) (concluding that "voluntary viewing [of an ultrasound] was associated with some women's decisions to continue the pregnancy."). When a woman views an ultrasound image, she is not simply looking at a generic diagram of a typical fetus at a certain stage of gestation; she is, instead, viewing a real-time moving picture of *her* baby. *See* Francis Decl. ¶ 12. For this reason, ultrasounds can be very powerful.

And when a patient receives particularly powerful information, principles of informed consent suggest that the patient should be given extra time to consider the information and make a thoughtful choice. Decisions resulting from even short delays may be more "informed and deliberate if they follow some period of reflection." *Casey*, 505 U.S. at 885. Providing the ultrasound images and information at least 18 hours before the abortion improves the chances the woman will welcome and consider it when making the abortion decision. In addition to having extra time, the woman will be confronted with fewer pressures when provided the information. On the day of the abortion, she will be more likely to feel pressure from having made the appointment, having travelled to the clinic, having to go through the required lab tests, and having already paid for not only the ultrasound but also the abortion itself, before she actually

gets the ultrasound. *See* Francis Decl. ¶ 13. Particularly given PPINK's apparent lack of refund policy, *see* Cockrum Dep. at 135–36, a woman in that circumstance may feel more financially and emotionally committed to the procedure than she would 18 hours before. When provided in a context where the procedure is less imminent and the woman feels less committed, the ultrasound is more likely to have informative and persuasive impact.

Informed consent delays are common throughout the medical field. *See*, *e.g.*, Francis Decl. ¶ 5–7; Hendershott Decl. ¶ 10; Kheriaty Decl. ¶¶ 10–11. They give patients the opportunity to weigh the costs and benefits of any procedure as well as time to think of additional questions and concerns. Francis Decl. ¶ 7 ("In my experience, patients often think of additional questions several hours—and sometimes even days—after receiving the informed consent information."). Rarely are patients given only a few hours to digest vital information about their health and treatment choices. *Id.* ¶ 6; Kheriaty Decl. ¶ 11 ("[I]t would be unusual for a significant treatment procedure to occur immediately after a diagnostic or preliminary procedure."). Instead, they usually have at least 24 hours—and often several weeks—to consider all their options. Francis Decl. ¶ 6. Such time for reflection is especially important with respect to life-altering procedures where there is a high risk that the patient may regret the procedure—such as abortion or permanent sterilization. *See id.* ¶ 8; Kheriaty Decl. ¶¶ 12–13; Hendershott Decl. ¶ 12; *Carhart*, 550 U.S. at 159 ("[I]t seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.").

What is more, antecedent counseling often requires consideration of bodily images, such as ultrasounds, x-rays, MRIs, and others. *See* Kheriaty Decl. ¶ 9; Francis Decl. ¶ 11. These images "are not simply tools for physicians to make diagnoses. They are also tools by which physicians can educate patients as to what is going on inside their bodies." Kheriaty Decl. ¶ 9.

Only by having such plainly relevant information as that provided by such images, with enough time to reflect on them, is a person in a position to render "informed consent." *Id.* ¶ 13.

3. Some women may feel so certain about their decision to undergo the procedure that the ultrasound requirement and other informed consent provisions will have no effect on their decision. But for other women, the decision may not be so clear. *See* Gatter, *supra*, at 82 (noting three categories of patients: "high decision certainty," medium decision certainty," and "low decision certainty"). These women "may need more time and support in reaching a decision about whether abortion is the correct decision for them." *Id.* at 86. The waiting period provides that critical time.

Indeed, for at least one Indiana woman, the waiting period and ultrasound image could have changed her mind. Francis Decl. ¶ 13. Although she received the state-mandated ultrasound immediately before having a medication abortion, she chose not to view the ultrasound, feeling pressured to continue with the abortion. *Id.* She convinced herself it was too late to change her mind. *Id.* Yet, looking back, she admits that had she had an additional 18 hours to decide whether to view the ultrasound, she would have viewed it and chosen not to have an abortion. *Id.* Dr. Francis testified about this patient to the legislature when it considered whether to enact this requirement. *Id.*

4. Even if women are not persuaded by the ultrasound image to carry their child to term, viewing the image has important psychological benefits that weigh in favor of the Ultrasound Law. The State's expert, Dr. Aaron Kheriaty, states that "[m]any abortion patients are morally and emotionally conflicted about the abortion decision, and those who choose to go through with the procedure often report conflicted feelings of ambivalence, regret, or distress afterwards." Kheriaty Decl. ¶ 7. Medical studies demonstrate "quite consistently that abortion is

associated with moderate to highly increased risks of psychological problems subsequent to the procedure." Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009*, British Journal of Psychiatry (2011), 199, 180–86. Indeed, one study examining the mental health claims of low-income California women over a four-year period after abortion and childbirth found that the overall rate of such claims was 17 percent higher for the women who aborted than for those who gave birth. Hendershott Decl. ¶ 11 (citing Priscilla K. Coleman, et al., *State-Funded Abortion Versus Deliveries: A Comparison of Outpatient Mental Health Claims Over 4 Years*, Am. J. of Orthopsychiatry, Vol. 72(1), Jan. 2002, 141–52). Within 90 days of the end of the pregnancy, mental health claims were 63 percent higher among the abortion group than the birth group. *Id.*

There is also a more objective physiological component to this benefit. While PPINK relies on a woman's report of the timing of her last menstrual period for purposes of initial scheduling decisions, its officials concede that women are sometimes wrong and that ultrasound is the most reliable way to confirm gestational age. Cockrum Dep. at 92–93; Stutsman Dep. at 71–73. Occasionally, when a woman has an ultrasound on the day of the abortion, she learns she is farther along than expected and that, as a result, she cannot have the abortion that day. Cockrum Dep. at 93. The Ultrasound Law will ensure women are provided that information before the day of the abortion, *i.e.*, before she has made the final psychological, intellectual, emotional and moral commitment to the abortion. Having that information earlier will give the woman more time to deal with the implications and be less distressing than if she expected termination that very day.

Given the potential for psychological impact and regret—especially among patients who were already conflicted and uncertain about their decision—it is critical that women have

sufficient time to consider all the medical information and make an informed decision about whether to have an abortion. Kheriaty Decl. ¶ 8; Hendershott Decl. ¶ 12. "Combining the preexisting ultrasound and waiting period requirements gives women time to weigh the information they have received alongside the image of their baby, and to give full consideration to what is a very weighty and fraught decision." Hendershott Decl. ¶ 12.

B. The alleged burdens of the Ultrasound Law are relatively light and not qualitatively different from other, unquestionably constitutional, abortion regulations

Even if the new law creates *some* burden on women's access to abortion, PPINK has provided no evidence that it is particularly heavy. In *Hellerstedt*, 136 S. Ct. at 2312, the weight of the burden caused by the admitting-privileges requirement was demonstrated by closure of half the abortion-providing facilities in the state. Eight of these clinics closed even before the admitting-privilege requirement went into effect, while another eleven closed on the law's effective date. *Id.* Only seven to eight of those facilities would have remained if the surgical-center requirement had also gone into effect. *Id.* at 2316. PPINK has alleged nothing similar here, only that purchasing additional ultrasound machines and training staff will be costly, and that in the meantime some women may encounter new inconveniences.

1. PPINK's evidence of negative operational impact is meager and unreliable

PPINK's CEO, Betty Cockrum, stated that due to increased traffic at facilities with ultrasound machines, PPINK would have to send women to more distant facilities to receive care, Cockrum Decl. ¶ 60, but she later admitted, "I can't give you any specifics" and said she had "no idea" how often patients were actually sent elsewhere. Cockrum Dep. at 117. Nor did she know whether the travel distance would deter patients from obtaining treatment, how patients traveled to the facility, or how many patients lacked access to transportation. *Id.* at 119.

PPINK has provided no evidence that any woman has been unable to obtain an abortion as a result of the Ultrasound Law. The only evidence that anyone may have been delayed by the 18-hour ultrasound requirement is provided by anecdotes from Cockrum, who knew of only six women affected by Indiana's ultrasound waiting period. Cockrum Decl. ¶ 73; Cockrum Dep. at 112. First, those stories are undocumented and have been passed along by unknown numbers of staffers before reaching Cockrum, who has never taken any steps to verify their accuracy. Cockrum Dep. at 121–26. Anyone who has played the childhood game of telephone knows the capacity for well-meaning human beings to misunderstand, miscommunicate, and distort even a seemingly straightforward account of events as they hear it from one person and pass it along to the next.

Second, there is insufficient detail about those cases to draw any conclusions from them. One of these women claimed she did not schedule an abortion at PPINK because she could not make two trips from Fort Wayne to a PPINK facility. Cockrum Decl. ¶ 73(b). Another stated she could not miss work to drive to PPINK's facilities because she had just started a new job. Cockrum Decl. ¶ 73(e). But PPINK never followed up with these patients to see whether they chose not to get abortions or instead found different providers. Cockrum Dep. at 126. PPINK also does not know whether one of the other women ultimately got an abortion. Cockrum Dep. at 126.

PPINK also provides an expert declaration from sociologist Dr. Jane Collins arguing that low-income women seeking abortions will find it particularly hard to cope with the new Ultrasound Law. While there is little doubt that the poor have a more difficult time than the affluent when it comes to surmounting many barriers in life, Dr. Collins provides no concrete evidence of how the Ultrasound Law actually affects low-income women. Instead, she provides

unsupported, hyperbolic, worst-case-scenario speculation, including about how a woman who wants an abortion but has limited resources and an inflexible, tenuously held job could suddenly find herself homeless simply because she must have an ultrasound 18 hours before the abortion. ECF No. 24-2, Decl. of Jane Collins, Ph.D. ¶ 40. But anybody can speculate about a series of seemingly plausible negative events that lead to a tragic outcome, no matter the context. Being a sociologist doesn't make such speculation any more factual. And as fellow sociologist Dr. Anne Hendershott testifies, Dr. Collins "provides no concrete sociological evidence demonstrating that low-income women will be deterred from getting abortions due to the Ultrasound Law." Hendershott Decl. ¶ 8.

Moreover, Dr. Hendershott says "[i]t is clear that the difficulties low-income women may face in accessing abortion services have not deterred women who are intent on terminating their pregnancies." *Id.* ¶ 9. "In fact," she says, "as the incidence of abortion has declined throughout the United States, the number of low-income women obtaining abortions continues to climb—demonstrating that low-income women are not deterred from accessing these services. In 2014, three-fourths of abortion patients were low income: 49% lived at less than the federal poverty level (a 7% increase from 2008) and 26% lived at 100-199% of the federal poverty level." *Id.* (citing Janna Jerman, et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute (May 2016), *available at* https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014).

Part of the reason may be that low-income women must contend with similar "two-trip" burdens in any number of medical contexts, such as "diagnostic testing, discussion of test results, pre-operative consultation, screening, blood work, and follow-up visits. Some of these may also require trips to more than one location and a waiting period in between visits." Hendershott Dec.

¶ 10. Accordingly, even for low-income women, "[t]he logistical challenges of arranging transportation, child care, and time off work are not unique to the abortion context." *Id.*

Meager even on its own terms, PPINK's account of the operational impact of this new law is simply not supported by reliable evidence.

2. The burdens alleged by PPINK are not imposed by the Ultrasound Law so much as PPINK's own business practices and an infinite variety of other daily challenges unrelated to government regulation

What is more, the burdens PPINK alleges are the result of its own policies and business practices, rather than the enactment of the Ultrasound Law. First, PPINK does not accept ultrasounds from other medical providers. Cockrum Decl. ¶ 45. Cockrum, who is not a physician, justifies this policy based on a supposed need for the most current and certain images to determine gestational age. *Id.* ¶ 45; Cockrum Dep. at 106–07. But PPINK's medical director testified that, if it were up to him, PPINK would accept ultrasounds from other providers. Stutsman Dep. at 101. Doing so, of course, could minimize the travel burden on women who do not live near one of PPINK's multiple ultrasound machines. For example, a woman in Fort Wayne could surely get an ultrasound at any number of providers in her community.

Second, PPINK alleges the requirement creates an additional burden on women receiving an ultrasound because those women must now coordinate childcare for their other children. Pl.'s PI Mem. at 13. Cockrum has stated that 33.73% of women receiving abortion services at a PPINK facility have children living with them. Cockrum Decl. ¶ 24. But this statistic does not mean that all of those women would have trouble arranging child care. Cockrum later admitted that she did not know how many of these women have a spouse also living with them or how many of those children are too young to go to school. Cockrum Dep. at 100. In any event, there is no medical requirement that children be absent from the examination room during even a

transvaginal ultrasound. It is common for children to attend these procedures and easy to safeguard the mother's privacy by draping her lower body with a sheet. Francis Decl. ¶ 15. Although PPINK alleges children may be a distraction during the examination, Cockrum Dep. at 100, is unclear why it would not on that basis exclude children from *all* meetings and examinations involving patients.

Third, PPINK alleges the ultrasound requirement creates an additional burden due to the impracticality of training PPINK's nurse practitioners to interpret ultrasound results. Pl.'s PI Mem. at 11. Notably, PPINK nurse practitioners are already expected to perform similar interpretive duties in other areas of practice. *See* Ex. F, Job Description for PPINK Nurse Practitioner. It is an "[e]ssential function" of a PPINK nurse practitioner to "review and interpret[] the medical and social history of contraceptive patients," and to "[i]nterpret laboratory data." *Id.* Cockrum protests that training nurse practitioners to interpret ultrasound results would "typically" require four weeks of "expensive" training that would take employees away from the clinics. Cockrum Dep. at 105. Even if true, once again this is about allocation of resources, which is at bottom a business decision involving choices—a point on which even Cockrum agrees. *Id.* at 106. The right to abortion does not insulate abortion clinics from making difficult decisions about allocations of resources.

Fourth, PPINK claims that it cannot afford to purchase additional ultrasound machines for its other health centers, but provides no evidence that it has fully explored its options in this regard. PPINK makes a blanket statement that "[ultrasound machines are expensive, costing more than $25,000 for equipment alone." Pl.'s PI Mem. at 10. But PPINK's medical director and Cockrum both state that they are unaware whether PPINK investigated less expensive alternatives such as portable machines, refurbished machines, or leasing or financing

arrangements. Stutsman Dep. at 117–22; Cockrum Dep. at 70–72. Notably, Cockrum stated that she "do[es] not know" what alternatives PPINK considered before making such a "significant purchase." Cockrum Dep. at 71–72.

The evidence in the record suggests that portable ultrasound machines are available at much lower price points. A simple Google search yields numerous options far less costly than the ultrasound machines normally used by PPINK, with many falling in the $1,500 range. Ex. G, Stutsman Dep. Exhibit 10. Dr. Francis also notes that "new, high-quality, portable ultrasound machines" are available at prices "ranging . . . from $4,250 to $8,500." Francis Decl. ¶ 16. PPINK's medical director has used a portable machine in his private practice group and testified that it was a reliable machine. Stutsman Dep. at 118–19. PPINK offers no explanation as to why it did not explore these and other potentially lower-cost options.

Nor did PPINK include money for purchase of even one ultrasound machine in its FY 2017 capital budget. Cockrum Dep. at 73–75. Instead, the only budgeting measures it took in preparing to comply with the new Ultrasound Law was to add a position for a floating nurse practitioner who might help address crowded appointment calendars from day-to-day across the state. *Id.* Unfortunately, PPINK's other business commitments and challenges have prevented it from using the new floating nurse practitioner in this way. *Id.*

3. Other unquestionably constitutional abortion regulations have operational impact similar to what PPINK alleges here

Again, the sum and substance of PPINK's assertion that the Ultrasound Law will impose unconstitutional burdens is that it may be one factor in a lengthy chain of causation leading to an outcome where a woman who wants a non-surgical abortion or a first-trimester abortion will have to settle for a second-trimester abortion or surgical abortion. It also posits—without concrete evidence of any such consequences—that in some particularly extreme circumstances,

requiring the ultrasound 18 hours before the abortion rather than day of will prevent some women from having an abortion at all. Pl.' PI Mem. at 18. Even if these speculations prove accurate, they do not amount to the sort of burden that can render an otherwise permissible abortion regulation unconstitutional. Otherwise, long-accepted regulations of abortion procedures, services, and counseling could be newly vulnerable to attack.

For example, the law of Indiana and most other states requires either parental or judicial consent before a minor may have an abortion. *Parental Involvement in Minors' Abortions*, Guttmacher Institute (Oct. 1, 2016), https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions (explaining that 38 states require parental involvement in a minor's decision to have an abortion and, of those, 36 have a judicial bypass procedure). As the Supreme Court noted in *Casey* when upholding Pennsylvania's parental consent requirement, the Court has consistently approved such common-sense regulations as constitutional. *Casey*, 505 U.S. at 899 ("Our cases establish, and we reaffirm today, that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure.").

Yet there can be no doubt that such consent rules can cause delays in the abortion procedure such that some minors may be ineligible for an abortion even if the required consent (whether judicial or parental) is eventually forthcoming. Cockrum even acknowledged that she is aware of cases where minors have been unable to get abortions because the required consent, while eventually forthcoming, came too late. Cockrum Dep. at 81. Cockrum also acknowledged that state law requiring abortions to be performed by physicians contributes to the appointment crowding PPINK alleges. Cockrum Dep. at 63. Even state law requiring that second-trimester abortions occur in ambulatory surgical centers or hospitals may hinder abortion access—or at

least PPINK's ability to provide such abortions. Ind. Code § 16-34-2-1(a)(2)(B). But that does not make such regulations unconstitutional. *See Simopoulos v. Virginia*, 462 U.S. 506, 519 (1983) (upholding Virginia statute requiring second-trimester abortions to be performed only in licensed hospitals).

The point is that the mere possibility that an abortion restriction combines with any number of other uncontrollable circumstances (such as personal living situations, employment circumstances, transportation limits, and financial constraints) to make an abortion ultimately unreachable for some women is not enough to render it unconstitutional. Even under *Hellerstedt* balancing, at the very least there needs to be evidence of a dramatic impact, as the record in *Hellerstedt* provided, but as is missing here.

In this regard, it is important to bear in mind that PPINK, or at least its CEO, does not view accessibility to abortion *before* this ultrasound law to have been somehow optimal. Asked if there was a size of the universe of women who cannot get abortions that she finds acceptable, Cockrum said, "no." *Id.* In Cockrum's view, every woman "who finds herself with a pregnancy that . . . creates a challenge for her going forward in her life" would "ideally" have "access, without undue burden" to choose abortion. Cockrum Dep. at 83. Asked if, prior to the Ultrasound Law, that was the case "for every woman that that choice exists," Cockrum said "no," owing to both "the dearth of abortion providers" and regulatory burdens "that existed before 1337 went into place." *Id.* And the only difference between the regulatory burdens now and those in place before July 1, in Cockrum's view, is that "to the extent that you add burden to access, it necessarily means . . . if there's already a universe of women who cannot get abortions, for whatever reason, and you add additional burdens, it will make that universe grow." *Id.*

In other words, there is nothing about the Ultrasound Law that makes it intrinsically unconstitutional, in PPINK's view. Rather, its argument is that it is the accumulated burdens of multiple regulations, a lack of physicians, a lack of resources and personnel, and the personal circumstances of some patients that render it unconstitutional. But there is no doctrine—not even *Hellerstedt*—that permits an "accumulated burdens" analysis when determining whether a law is facially constitutional. Rather, the Court must focus on whether this law alone creates an unconstitutional burden.

* * *

PPINK has failed to carry its burden to prove the 18-hour ultrasound requirement is so overwhelming as to outweigh the State's compelling interest in persuading women not to have an abortion. *Hellerstedt* does not mandate that courts must accept a plaintiff's contention without any factual support, and PPINK's reliance on assumptions rather than facts, from the cost of ultrasound machines to the medical outcomes of patients whose stories it has not checked, cannot bear all the weight necessary for PPINK to prevail.

PLAINTIFFS HAVE NOT DEMONSTRATED IRREPARABLE HARM

In order to prevail on a motion for a preliminary injunction, Plaintiffs must establish that the denial of such an injunction will result in irreparable harm. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). "'Irreparable' in the injunction context means not rectifiable by the entry of a final judgment." *Walgreen Co. v. Sara Creek Prop. Co.*, 966 F.2d 273, 275 (7th Cir. 1992) (citations omitted).

In order to comply with the Ultrasound Law, PPINK must merely increase the availability of ultrasound equipment at its regional clinics. A marginal increase in the cost of regulatory compliance does not amount to the sort of irreparable harm that justifies a preliminary

injunction. Complying now would not preclude PPINK from reverting to its old ultrasound protocols later if it is ultimately successful with its claim.

PUBLIC POLICY AND THE BALANCE OF EQUITIES FAVOR THE STATE

To prevail on a motion for preliminary injunction, Plaintiffs "must show that the probability of success on the merits is sufficiently high—or the injury from the enforcement of the order sufficiently great—to warrant a conclusion that the balance of error costs tilts in favor of relief." *Ill. Bell Tel. Co. v. WorldCom Tech., Inc.*, 157 F.3d 500, 503 (7th Cir. 1998). When the party opposing the motion for preliminary injunction is a political branch of government, the restraint for issuing such an injunction is particularly high due to public policy considerations, as "the court must consider that all judicial interference with a public program has the cost of diminishing the scope of democratic governance." *Id.*

The citizens of Indiana have a strong interest in the implementation of the laws passed by their duly elected representatives. *United States v. Rural Elec. Convenience Coop. Co.*, 922 F.2d 429, 440 (7th Cir. 1991) (holding that "the government's interest is in large part presumed to be the public's interest"); *see also Fargo Women's Health Org. v. Schafer*, 819 F. Supp. 865, 867 (D.N.D. 1993) (denying motion for stay and injunction pending appeal of an abortion statute and reasoning that "the public interest lies in enforcement of statutes enacted by the people's legislature").

The Ultrasound Law serves the public interest by furthering the State's interest in promoting fetal life, an interest the Supreme Court has recognized as compelling as far back as *Roe v. Wade*. 410 U.S. 113, 163 (1973). The law also ensures that women are fully informed when they consent to abortion services, giving women additional time and resources to consider the weight of their decision. The harm to the State in preventing it from furthering these

important policy objectives significantly outweighs the administrative and equipment costs PPINK may incur in the near term, expenses PPINK does not allege will result in the closure of any of its facilities.

Accordingly, the State's interests in enforcement of the Ultrasound Law outweigh the harms that PPINK might suffer in the near term, pending a final decision on the merits. The law should not be preliminarily enjoined.

CONCLUSION

The Court should deny the Motion for Preliminary Injunction.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on October 5, 2016, a copy of the foregoing was electronically filed with the Clerk of the Court using the CM/ECF system, which sent notification of such filing to the following:

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