No. 12-16670

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Paul A. Isaacson, M.D.; William Clewell, M.D.; Hugh Miller, M.D.,
Plaintiffs-Appellants,

v.

Tom Horne, Attorney General of Arizona, in his official capacity; William Montgomery, County Attorney for Maricopa County, in his official capacity; Barbara LaWall, County Attorney for Pima County, in her official capacity; Arizona Medical Board; and Lisa Wynn, Executive Director of the Arizona Medical Board, in her official capacity,
Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRCIT OF ARIZONA
Civil Action No. 2:12-cv-01501-JAT-PHX
The Honorable James A. Teilborg, Judge

EMERGENCY MOTION UNDER 9TH CIR. R. 27-3
RELIEF REQUESTED IMMEDIATELY

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(ii) The nature of the emergency is as follows:

This Court's emergency action is needed by **Wednesday, August 1, 2012.** Immediate preliminary injunctive relief is necessary in order to prevent the State of Arizona from impermissibly banning pre-viability abortions beginning at 20 weeks in pregnancy. A law prohibiting a woman from obtaining an abortion prior to viability is per se unconstitutional. Plaintiffs' motion for a preliminary injunction was denied by the District Court on July 30, 2012, in an order that also denied declaratory and permanent injunctive relief. Order at 1-15, ECF 50 (attached as relevant record). As set forth further below, if the ban is permitted to go into effect it will cause irreparable harm to Plaintiffs' patients and other Arizona women, by

violating their constitutional rights and endangering their health. Plaintiffs have demonstrated that they regularly provide pre-viability abortions to their patients at or after 20 weeks of pregnancy. Based on the fact that they provide more than 50 such procedures per year, they are very likely to have such a patient within the next several days and almost certain to have such a patient within the next 21 days.

(iii) Counsel for Defendants were notified of this emergency motion on July 30, 2012, by attempted telephone call, e-mail notification, and e-mail with copies of this motion and supporting documents attached. All the grounds stated in this motion were raised before the District Court in Plaintiffs‘ motion for a preliminary injunction.

CORPORATE DISCLOSURE STATEMENT

The Plaintiffs in this matter are individual physicians and therefore no corporate disclosure statement is necessary.

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INTRODUCTION

During its 2012 session, the Arizona legislature enacted House Bill 2036 (~~"~~HB 2036" or ~~"~~the Act") which, among other restrictions, makes it a criminal offense to provide an abortion beginning at 20 weeks of pregnancy. This provision is scheduled to take effect on August 2, 2012.

Plaintiffs in this case are board-certified obstetrician- gynecologists. Enforcement of the ban will bar them from providing pre-viability pregnancy terminations for their patients at or after 20 weeks, in contravention of their patients' rights and in some cases at the expense of their patients' health. They therefore challenged the ban as applied to abortions performed prior to viability on the grounds that it violates their patients' right under the Fourteenth Amendment, and sought preliminary and permanent injunctive and declaratory relief.

Plaintiffs moved for a preliminary injunction to preserve the status quo while the serious constitutional issues raised by the ban could be fully addressed. Before the District Court, Plaintiffs established that a preliminary injunction was warranted. Evidence presented by both sides demonstrates conclusively that the Act prohibits abortions beginning at a point when viability is not possible. Declaration of Paul A. Isaacson, M.D., in support of Plaintiffs' Motion for Preliminary Injunction, attached

hereto as Ex. 1 (~~I~~saacson Decl.") ¶ 15;[1] Declaration of William H. Clewell, M.D., in support of Plaintiff's Motion for Preliminary Injunction, attached hereto as Ex. 2 (~~C~~lewell Decl.") ¶ 10;[2] Declaration of Jean A. Wright, M.D., attached to Defendant Montgomery's Motion to Dismiss, attached hereto as Ex. 3 ¶ 17 (viability can occur at 23 or 24 weeks). Plaintiffs made an irrefutable showing that they are likely to succeed on the merits of their claim that the 20 week ban prohibits women from obtaining abortions prior to viability and is therefore unconstitutional as applied to such abortions. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846 (1992) (affirming ~~t~~the right of the woman to choose to have an abortion before viability"). They further demonstrated irreparable harm both through the deprivation of their patients' constitutional rights and by showing that the Act would subject some women to delay or denial of health care.

On July 30, the District Court entered an order denying the preliminary injunction, denying a permanent injunction, and ordering that judgment be entered in Defendants' favor as to declaratory judgment. Order at 15. That judgment was also issued on July 30, 2012. ECF No. 51. In sum, the District Court's opinion is based on the wholly erroneous characterization of the Act as a permissible regulation of abortion, Order at 9, in spite of the fact that the Act, on its face, creates an outright

[1] Plaintiff Dr. Paul Isaacson is a board certified obstetrician gynecologist who practices in the Phoenix area.
[2] Plaintiff Dr. William Clewell is a board certified obstetrician-gynecologist with a subspecialty in perinatology, who practices in the Phoenix area.

ban for women seeking pre-viability abortions after 20 weeks. Relying on this distortion, the District Court ignored binding Supreme Court precedent that forecloses bans on pre-viability abortions, regardless of what state interests are asserted or what exceptions are made. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 846, 879 (1992) (plurality opinion) (~~"b~~efore viability, the State's interests are not strong enough to support a prohibition of abortion"; ~~"R~~egardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability."). The next step in the District Court's faulty analysis was to conclude that even though the Act is an outright ban on abortion at 20 weeks, does not ~~"i~~mpose a substantial obstacle to previability abortions." Order at 9-10.

The District Court improperly relied on the decision in *Gonzales v. Carhart*, 550 U.S. 124 (2007), to support its conclusions. The District Court, as is this Court, is bound by the Supreme Court's decisions in *Roe v. Wade*, 410 U.S. 113 (1973) and *Casey*, 505 U.S. 833. Nothing in *Gonzales* provides a plausible basis for concluding that one of the essential components of *Roe*, reaffirmed in *Casey* -- that the states cannot ban abortions prior to viability -- has been called into question, much less overruled sub silentio. Those cases protect the right to end a pregnancy at any point at which the fetus is not viable, whether it be 5 weeks, 12 weeks, or 20 weeks.

Plaintiffs have appealed the denial of declaratory and permanent injunctive relief and now seek immediate emergency relief to prevent the ongoing violation of their patients' rights, resulting in undeniable irreparable harm, which will occur if the Act is allowed to take effect.

BACKGROUND

A. HB 2036 – Arizona's Ban on Pre-viability Abortions

The Act bans abortions beginning at 20 weeks of pregnancy and contains the narrowest possible exception for only immediate medical emergencies. It creates a new provision, to be codified as A.R.S. § 36-2159 B., which provides:

> Except in a medical emergency, a person shall not knowingly perform, induce or attempt to perform or induce an abortion on a pregnant woman if the probable gestational age of her unborn child has been determined to be at least twenty weeks.

"~~G~~estational age" is defined as "~~t~~he age of the unborn child as calculated from the first day of the last menstrual period of the pregnant woman." A.R.S. § 36-2151(4) (set forth as existing law in HB 2036, § 3).

A woman may obtain an abortion at or after 20 weeks only if she is experiencing a "~~m~~edical emergency," defined as:

> a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

A.R.S. § 36-2151(6) (set forth as existing law in HB 2036, § 3).

Violation of the Act is a Class 1 misdemeanor, punishable by up to six months imprisonment. HB 2036, § 7 (creating A.R.S. § 36-2159(C)); A.R.S. § 13-707(A)(1). A violation also constitutes unprofessional conduct, which is grounds for suspension or revocation of the physician's medical license. HB 2036, § 7 (creating A.R.S. § 36-2159(D)).

Existing Arizona law already prohibits post-viability abortions unless needed to preserve the woman's life or health. A.R.S. § 36-2301.01 (A)(1) (prohibiting ~~k~~knowingly perform[ing] an abortion of a viable fetus unless . . . the abortion is necessary to preserve the life or health of the woman.").[3]

B. Proceedings Below

On July 12, 2012, Plaintiffs filed this lawsuit against Tom Horne, Attorney General of Arizona; William Montgomery, County Attorney for Maricopa County; Barbara LaWall, County Attorney for Pima County; the Arizona Medical Board; and Lisa Wynn, Executive Director of the Arizona Medical Board. Plaintiffs challenged the Act on the single ground that it violates the substantive due process rights of women seeking previability abortions at or after 20 weeks, in violation of the Fourteenth Amendment and 42 U.S.C. § 1983, and sought declaratory and preliminary and permanent injunctive relief. ECF Nos. 1, 2, & 3. On July 19,

[3] ~~"~~Viable~~e~~fus' means the unborn offspring of human beings that has reached a stage of fetal development so that, in the judgment of the attending physician on the particular facts of the case, there is a reasonable probability of the fetus' sustained survival outside the uterus, with or without artificial support." A.R.S. § 36-2301.01(C)(3).

Defendant Montgomery filed his opposition to Plaintiffs' motion, ECF No. 27, which was joined by Defendants Horne, Wynn, and the Arizona Medical Board. That same day, Defendant Montgomery also filed a Motion to Dismiss. ECF No. 25. On July 19, Defendant LaWall filed her response, agreeing that a delay in enforcement of the law until final resolution on the merits would best serve the interests of justice, citing the ~~–c~~onsiderable risk that enforcement of H.B. 2036 may not only result in the deprivation of a constitutional right, for which there is no adequate remedy, but also cause the criminal prosecution of individuals who assist another in the exercise of that right." ECF No. 23 at 2.

On July 25, 2012, the District Court, the Honorable Judge Teilborg, heard oral argument on the motions for preliminary injunction and dismissal. On July 30, the District Court, as noted, issued its decision denying the preliminary injunction, denying a permanent injunction, and directing that declaratory judgment be entered in favor of Defendants. Order at 14-15.

STANDARD OF REVIEW

When deciding whether to issue a preliminary injunction pending appeal, this Court considers: (1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies. *See*

Humane Soc'y of U.S. v. Gutierrez, 527 F.3d 788, 789–90 (9th Cir.2008); *see generally Cal. Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849-50 (9th Cir. 2009), *vacated and remanded on other grounds sub nom. Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 182 L. Ed. 2d 101 (2012) (reversing the district court's denial of a preliminary injunction). This same standard applies where, as here, plaintiffs seek ~~a~~ stay of a state action that the district court has declined to enjoin." *Cal. Pharmacists Ass'n.* 563 F.3d at 849-50.

~~[~~T]he very purpose of a preliminary injunction . . . is to preserve the status quo and the rights of the parties until a final judgment issues in the cause." *U.S. Philips Corp. v. KBC Bank N.V.*, 590 F. 3d 1091, 1094 (9th Cir. 2010) (citations omitted). Here, Plaintiffs seek to preserve the status quo under current Arizona law, which, in conformance with constitutional standards, bans abortion only after viability. *See* A.R.S. § 36-2301.01; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 870 (1992).

Plaintiffs readily meet their burden here. Inasmuch as the Act violates decades of binding U.S. Supreme Court and Ninth Circuit precedent, the District Court's denial of the preliminary injunction is clearly erroneous. Thus, Plaintiffs are exceedingly likely to prevail on the merits of their claim. Moreover, as Plaintiffs have demonstrated, their patients and the women of Arizona will suffer irreparable harm if the Act is allowed to go into effect, whereas there is no injury

to Defendants, nor benefit to the public interest, in enforcing this unconstitutional law. This Court should therefore enjoin the ban as applied to abortions prior to viability – before the Act takes effect on August 2, 2012.

ARGUMENT

I. Plaintiffs Have Made a Strong Showing that they are Likely to Succeed on the Merits.

a. Supreme Court Precedent Establishes that the State of Arizona Cannot Ban Abortion When the Fetus is not Viable.

Based on straightforward, binding Supreme Court precedent, Plaintiffs have established that they are highly likely to succeed on the merits of their claim that the Act impermissibly bans abortions prior to viability. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. at 846, 870 (1992) (affirming a woman's right to terminate her pregnancy before viability); *Roe v. Wade*, 410 U.S. 113, 163-64 (1973) (a state may prohibit abortion only after viability); *see also Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 921 (9th Cir. 2004) ("Adult women have a Fourteenth Amendment right to terminate a pre-viability pregnancy."). In *Casey*, the Supreme Court ruled that "[i]t is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood," including the decision whether to terminate a pregnancy. 505 U.S. at 849, 852-53. Further to the point, the *Casey* Court specifically held that "[r]egardless of whether

exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Casey*, 505 US at 879. *See also Roe*, 410 U.S. at 163-65.

The constitutional protection for women seeking abortions prior to viability holds fast regardless of what interests the state asserts to justify the ban. *Casey's* statement that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion," could not be more clear.

Indeed, every Circuit court, including this one, since *Roe* to rule on a ban on abortion – at any point prior to viability – has invalidated that ban. *See Jane L. v. Bangerter*, 102 F.3d 1112, 1117-18 (10th Cir. 1996) (discussing a ban on abortions after 20 weeks from conception as an unconstitutional prohibition of previability abortions), *cert. denied sub nom. Leavitt v. Jane L.*, 520 U.S. 1274 (1997); *Sojourner T. v. Edwards*, 974 F.2d 27, 31 (5th Cir. 1992) (deeming a ban on abortions to be unconstitutional), *cert. denied sub nom. Connick v. Sojourner T.,* 507 U.S. 972 (1993), and *Edwards v. Sojourner T.*, 507 U.S. 972 (1993); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366, 1372 (9th Cir. 1992) (invalidating a ban on abortions throughout pregnancy with limited exceptions), *cert. denied*, 506 U.S. 1011 (1992).

In rejecting Plaintiffs' claim that the Act is an impermissible ban on abortions prior to viability, the District Court relied entirely on the Supreme Court's opinion in

Gonzales. The *Gonzales* decision, however, supports Plaintiffs position that the ban is unconstitutional. *See Gonzales v. Carhart*, 550 U.S. 124, 146 (2007) (quoting *Casey*, 505 U.S. at 878-79) (~~"a~~ssuming" the principle that, ~~"[b~~]efore viability, a State ~~"m~~ay not prohibit any woman from making the ultimate decision to terminate her pregnancy'"). *See also Stenberg v. Carhart*, 530 U.S. 914, 920-21 (2000) (quoting *Casey*, 505 U.S. at 870) (declining to ~~"re~~visit" the legal principles reaffirmed in *Casey* that ~~"b~~efore ~~"~~viability . . . the woman has a right to choose to terminate her pregnancy.'").

In *Gonzales* the Court considered the validity of a federal law banning so-called partial-birth abortions. *Gonzales*, 550 U.S. at 132. The case did not involve a prohibition on all abortions, but only a regulation limiting women's access to a single abortion procedure. That the Court did not intend its opinion to undermine its prior decisions distinguishing between outright bans on abortion and *regulations* of abortion is clear. As the Court explained, while the government may ~~"u~~se its voice and its regulatory authority to show its profound respect for the life within the woman," such actions must not be ~~"d~~esigned to strike at the right itself." *Id.* at 157-58.[4]

[4] *Gonzales* also makes clear that bans are not subject to the substantial obstacle standard. In upholding a prohibition on a single abortion method, the *Gonzales* Court distinguished its reasoning in *Danforth*, which had struck down an effective ban on abortion after twelve weeks. *Gonzales*, 550 U.S. at 164-65. Whereas *Gonzales* affirmed a ban on one method of abortion where other safe, common methods remained readily available, the

The District Court committed clear error in relying on *Gonzales* to characterize the Act as a regulation as compared to a ban. In support of its conclusion, the District court made three erroneous findings. First, it relies upon the existing definition of abortion set forth in A.R.S. § 36-2151(1), which does not include procedures used to "save the life or preserve the health of the unborn child, to preserve the life or health of the child after a live birth, to terminate an ectopic pregnancy or to remove a dead fetus," as evidence that the Act does not prohibit all abortions and therefore is a regulation, rather than a ban. This makes no sense. The language relied on by the District Court lists conduct that is not, by definition, an abortion. Order at 9. It is illogical to claim that because the Act – an abortion ban – does not ban that which under existing law is not considered to be an abortion somehow changes the Act from a ban to a regulation. The Act subjects only abortions to criminal prohibition; that conduct that was never subject to regulation as abortion remains legal is irrelevant.

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law struck down in *Danforth* banned the "then-dominant second-trimester abortion method," and was therefore "'an unreasonable . . . regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks.'" *Id*., quoting *Danforth,* 428 U.S. at 79. The Court thus remains firm in differentiating between abortion regulations, which are acceptable unless they impose a substantial obstacle to previability abortions, and measures that act to ban previability abortions outright, which are per se unconstitutional. *Gonzales* also left untouched the clear constitutional prohibition on a state setting a number of weeks as a proxy for viability. *Planned Parenthood of Central Mo. v. Danforth,* 428 U.S. 52, 64 (1976) ("[I]t is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period.").

Second, the District Court relies on the fact that the ban contains a medical emergency exception to support its finding that it is a regulation, rather than a ban. *Id*. This finding completely contradicts the statement in *Casey* that "[r]egardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." 505 US at 879. The District Court offers no explanation for its departure from this straightforward precedent.[5]

Finally, the District Court suggests that because the Act does not ban abortions in some medical emergencies and women can still obtain abortions prior to 20 weeks, the Act is fairly characterized as a "limit on some pre-viability

[5] Although the District Court does not explain the relevance of this aspect of its opinion, it held that, because the ban's exception for a "medical emergency" is identical to the one discussed in *Casey*, it must therefore also be construed identically, to "encompass conditions that could lead to 'an illness with substantial and irreversible consequences.'" Order at 7 (quoting *Casey*, 505 U.S. at 880). *Casey* explicitly affirmed the holding of *Roe* that a postviability ban on abortion is permissible only "if the law contains exceptions for pregnancies which endanger the woman's life or health." 505 U.S. at 846; *accord id.* at 872, 879. *Casey* also held that otherwise-permissible *regulations* of abortion, which imposed short delays (such as a 24-hour waiting period), were constitutional as long as they provided an exception that would permit an abortion without delay in a "medical emergency." *Id.* at 879-880 (quoting 18 Pa. Cons. Stat. § 3203 (1990)). Thus, a "medical emergency" exception, by design, applies only to prevent catastrophic health consequences due to the delay from complying with an abortion *regulation*. In contrast, the Act applies the language of a "medical emergency" exception to the very different context of a previability abortion *ban*. Under the Act, a woman not facing a "medical emergency" will not be delayed in obtaining an abortion, she will be completely denied her right to previability abortion completely. *Casey* never considered, let alone approved of, the use of "medical emergency" language as the basis for rendering a previability abortion ban constitutional. The District Court thus implausibly quotes *Casey* in support of a proposition directly contrary to its actual holding.

abortions", Order at 9, rather than an impermissible ban. Again, the District Court's reasoning is flawed on its face. The Supreme Court has made clear that "before viability, the State's interests are not strong enough to support a prohibition of abortion." *Casey,* 505 U.S. at 846, and neither the District Court nor this Court are free to ignore that holding.

In sum, laws banning previability abortions – whether they apply from the beginning of pregnancy, from 12 weeks, or from 20 weeks – are per se unconstitutional; they are not reviewed under the "substantial obstacle" standard. *Casey* makes this explicit by stating that such bans are impermissible, regardless of what exceptions are made or state interests asserted. *Id.*, 505 U.S. at 846 ("Before viability, the State's interests are not strong enough to support a prohibition of abortion"); *id.* at 879 ("regardless of whether exceptions are made for particular circumstances," a state may not ban abortion before viability). The Court has already balanced the applicable interests and drawn a bright line. The District court's conclusion that the Act should be assessed under the substantial obstacle test as a regulation, rather than a ban, is therefore foreclosed.[6]

[6] The district court also analyzed whether Plaintiffs' challenge was a facial challenge or an as-applied challenge. Plaintiffs' challenge is as applied. The Act bans abortions that occur both before viability and after viability; Plaintiffs only challenge the Act as it applies to pre-viability abortions. In any event, the label put on Plaintiffs' claim is irrelevant: Regardless of whether one characterizes the challenge as facial or as applied, Plaintiffs are entitled to injunctive relief. As the Supreme Court has explained, "[]egardless of whether exceptions are made for particular circumstances, a State may

b. The District Court's undue burden analysis is improper

Because a ban on previability abortions is unconstitutional, the District Court's assessment of whether or not the ban amounts to an impermissible undue burden is irrelevant. Here, though, the Act unquestionably places an insurmountable obstacle—an outright ban—in the path of women seeking abortion previability. Hence, even if the "undue burden" analysis had any application here, which it does not, it would not change the result. Even a cursory review of the District Court's reasoning demonstrates, that, even if such an analysis were appropriate here, its conclusion to the contrary is unsupportable.

In the first instance, the District erred by considering the impact of the ban on all women seeking abortions and not just those seeking pre-viability abortions at or after 20 weeks. This approach is squarely foreclosed by Supreme Court precedent. In *Casey*, the state argued that a requirement that married women seeking abortions notify their husbands was not a substantial obstacle because "the statute affects fewer than one percent of women seeking abortions." *Casey*, 505

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not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability." *Casey*, 505 U.S. at 879. There is no dispute that the Act bans abortions before viability, *see* Order at 10, and that is all Plaintiffs have asked the Court to enjoin. Thus, although such a showing is unnecessary, Plaintiffs have shown the Act operates unconstitutionally in all of the cases in which they seek to have it enjoined. There is absolutely no reason why Plaintiffs should have to prove more. *See Citizens United v. Fed. Election Comm'n*, 130 S. Ct 876, 893 (2010) (explaining that "the distinction between facial and as-applied challenges is not so well defined that is has some automatic effect or that it must always control the pleadings and disposition in every case involving a constitutional question," rather "it goes to the breadth of the remedy employed by the Court, not what must be pleaded in a complaint").

U.S. at 894. The Court rejected this argument, explaining that "[t]he analysis does not end with the one percent of women upon whom the statute operates; it begins there. . . . The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id*. The same is true here. The analysis begins with the group of women who are affected by the Act – those women who seek previability abortions at or after 20 weeks and who do not qualify for the medical emergency exception. For all these women, the Act operates as an absolute, and unconstitutional, ban on abortions.

The remaining reasons offered by the District Court, that women can obtain all information they need to decide whether or not to have an abortion prior to 20 weeks, and the state's asserted interests in fetal pain and maternal health, again simply ignore the unequivocal statements by the Supreme Court that "before viability, the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846.

As a result, notwithstanding the District Court's order, Plaintiffs' have established that they are likely to succeed on their claim that the Act is an unconstitutional ban on abortions prior to viability.

c. The District Court Cannot Ignore Supreme Court Precedent

It is axiomatic that a lower court may not overrule a decision of the Supreme Court of the United States. Rather, lower courts "should follow the case which

directly controls, leaving to [the Supreme] Court the prerogative of overruling its own decisions." *Rodriguez de Quijas v. Shearson/Am. Express, Inc.*, 490 U.S. 477, 484 (1989).[7]

This general rule is all the more true here given the circumstances under which *Roe* was initially decided and then reaffirmed. In *Casey*, the Court ruled that *Roe*'s core holding has a "dimension that the resolution of the normal case does not carry" because it "call[ed] the contending sides of a national controversy to end their national division by accepting a common mandate rooted in the Constitution." *Casey*, 505 U.S. at 866-67. As a result, to "overrule [*Roe*] under fire in the absence of the most compelling reason . . . would subvert the Court's legitimacy beyond any serious question." *Id.* at 867. Accordingly, given *Roe*'s extraordinarily "rare precedential force," *Casey*, 505 U.S. at 867, the precedential force of *Casey* must be all the greater given that it reflects the Court's resounding reaffirmation "under fire"

[7] The Supreme Court has repeatedly explained that lower courts have no authority to "conclude [the Supreme Court's] most recent cases have, by implication, overruled an earlier precedent." *Agostini v. Felton,* 521 U.S. 203, 237 (1997); *accord Musladin v. Lamarque*, 555 F.3d 830, 837 (9th Cir. 2009) (rejecting argument that the Ninth Circuit need no longer follow binding precedent based on subsequent rulings because "[t]he Supreme Court has made clear that the circuit courts must follow Supreme Court precedent until the Supreme Court itself declares it no longer binding."). This is true even where a party purports to base its claims on new legal theories or facts. *Rodriguez*, 490 U.S. at 484 ("If a precedent of th[e Supreme] Court has direct application in a case, yet appears to rest on reasons rejected in some other line of decisions, the Court of Appeals should follow the case which directly controls."); *cf. Casey,* 505 U.S. at 860 ("divergence from the factual premise of 1973, [regarding the safety of abortion and point of viability] have no bearing on the validity of *Roe's* central holding, that viability marks the earliest point at which the State interests in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions.")

(*id*.), intended to dispel any doubt once and for all, that the central holding of *Roe* was correct and that the Constitution protects women's right to abortion prior to viability.

II. IRREPARABLE HARM

Enforcement of the Act will cause irreparable harm to Plaintiffs, their patients and the women of Arizona.[8] First, Plaintiffs' patients will suffer irreparable harm due to deprivation of their constitutional rights – here the right to make the decision to end a pregnancy prior to viability. "[U]nlike monetary injuries, constitutional violations cannot be adequately remedied through damages." *Stormans, Inc. v. Selecky*, 586 F.3d 1109, 1138 (9th Cir. 2009) (citations omitted) (internal quotation marks omitted); *accord Elrod v. Burns*, 427 U.S. 347, 373 (1976) (holding that loss of constitutional "freedoms . . . unquestionably constitutes irreparable injury"); *Am. Trucking Assn's, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1058-59 (9th Cir. 2009) (holding that an injury is irreparable when it cannot be adequately compensated in damages); *Women's Med. Ctr. of Nw. Hous. v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001) (affirming district court's finding of irreparable harm based on threat to women's constitutional right to privacy).

[8] Defendants did not contest Plaintiffs' showing of irreparable harm, other than offering a single conclusory statement that the ban's stated purpose is to benefit "a pregnant woman and the her [*sic*] unborn child." Defs. Resp. 16, ECF No. 25.

In addition to the deprivation of their constitutional right to obtain an abortion prior to viability, Plaintiffs presented unrebutted evidence that enforcement of the Act would force some of Plaintiffs' patients to carry to term against their will, even when doing so presents significant risks to their lives and health, and even where there is no hope of giving birth to a child who will survive. Clewell Decl. ¶ 18. For some women, continuation of the pregnancy exacerbates a pre-existing medical condition; for others, the pregnancy itself generates medical risk. Isaacson Decl. ¶ 13. Plaintiffs regularly provide previability abortion care at and after 20 weeks for women suffering with many such conditions. *Id.* ¶¶ 13-14; Clewell Decl. ¶ 16. To give just a few examples, they end pregnancies for women with pulmonary hypertension and severe cardiac disease, whose cardiovascular status worsens as the pregnancy progresses, and who terminate their pregnancies to avoid exacerbating their conditions and risking irreversible heart damage; for women with breast cancer who need immediate cancer treatment that poses serious risks to the fetus; for women with or at risk of developing serious infections related to the pregnancy; and for women experiencing pregnancy loss such as advanced cervical dilation and placental abruption – many of whom have tried to carry the pregnancy at least until the fetus becomes viable, only to see their conditions worsen such that they ultimately decide that the diminishing prospects for a live birth no longer justify the risks to their own health. Isaacson Decl. ¶ 14; Clewell

Decl. ¶¶ 16-17.

However, if the Act is allowed to go into effect, a woman seeking to terminate a previability pregnancy at or after 20 weeks due to a medical condition that poses a significant risk to her health may either be prohibited from doing so altogether, or may have to delay the procedure until her condition worsens to the point where it fits within the Act's narrow definition of "medical emergency" and immediate action is necessary. Isaacson Decl. ¶ 20; Clewell Decl. ¶¶ 20-22. Conversely, a woman who would prefer to wait and see if her medical condition can be controlled so that she can continue the pregnancy may feel pressured into terminating the pregnancy while she still can – before 20 weeks – rather than risk the serious deterioration of her health that may occur after 20 weeks, when she can no longer terminate under the Act. *Id*. ¶¶ 23-26. The Act thus inhibits women from obtaining and Plaintiffs from providing medical treatment that would otherwise be available, and endangers women's health. *See* Isaacson Decl. ¶¶ 21-22; Clewell Decl. ¶ 27.

Other of Plaintiffs' patients seek abortions at or after 20 weeks because the fetus has been diagnosed with a serious problem. Isaacson Decl. ¶ 21; Clewell Decl. ¶¶ 14-15. These conditions may not be detected until the woman undergoes an obstetric ultrasound, including a detailed anatomical examination. Isaacson Decl. ¶ 12; Clewell Decl. ¶ 13. These procedures are typically performed after 18

weeks, but may be performed later if, for example, the woman is obese. Isaacson Decl. ¶ 12; Clewell Decl. ¶ 13.

Fetal conditions that Plaintiffs' patients have had diagnosed near or after 20 weeks, and that have led them to seek abortion care, include anencephaly, a significant malformation or absence of the brain, which results in death before or soon after birth; renal agenesis, the absence of kidneys which leads to death before or shortly after birth; severe structural anomalies such as limb-body wall complex, in which the organs are often outside the body cavity; severe heart defects; and neural tube defects such as encephalocele (the protrusion of brain tissue through an opening in the skull), and severe hydrocephaly (severe accumulation of excessive fluid within the brain that almost completely destroys the brain). *Id*. ¶¶ 14-15.

Often, after making an initial diagnosis of a serious fetal condition near or at 20 weeks, the woman's regular obstetrician refers her to a specialist for additional tests and consultation. Isaacson Decl. ¶¶ 11-12; Clewell Decl. ¶ 13. The Act leaves little or no time for women receiving these diagnoses to obtain additional information and consult with others before the ban prohibits them from obtaining an abortion. *Id*. ¶ 25. As a result, they may no longer have the option of terminating the pregnancy or may feel rushed to terminate a pregnancy that they might otherwise have decided to continue, in order to avoid the 20 week cutoff. *Id*.

In sum, if the Act is permitted to go into effect, not only will it violate the

constitutional rights of Plaintiffs' patients and women throughout Arizona, but patients who receive a diagnosis of fetal anomaly near 20 weeks will be rushed to make a decision regarding terminating the pregnancy without time to gather information and fully consult with those they trust; women for whom pregnancy may become dangerous will feel pressured to terminate the pregnancy before 20 weeks, rather than waiting to see if their doctors can manage their pregnancies and keep their risks in an acceptable range; and women who do not terminate before 20 weeks, will be forced to delay or forego desired previability care, because their condition does not come within the Act's narrow medical emergency definition. Isaacson Decl. ¶ 20; Clewell Decl. ¶¶ 20-25. *See also Harris v. Bd. of Supervisors, L.A. Cnty.*, 366 F.3d 754, 766 (9th Cir. 2004) (finding plaintiffs to have established a likelihood of irreparable harm where evidence showed they would experience complications and other adverse effects due to delayed medical treatment). In all these cases, the harm is severe and irreparable.

III. Equities and the Public Interest

If allowed to take effect, the Act will not only deny Plaintiffs' patients their constitutional rights (which itself constitutes irreparable harm, *see Stormans,* 586 F.3d at 1138), some of them also will lose their opportunity to obtain abortion care – a loss which cannot later be remedied. *See* Isaacson Decl. ¶¶ 19-22; Clewell Decl. ¶¶ 20-22, 26. Defendants, by contrast, have not alleged that they will suffer

any harm if a preliminary injunction is granted, nor could they do so. They would only be delayed in their ability to enforce the Act while the serious constitutional issues raised by the ban are resolved – simply a preservation of the status quo. *See e.g.*, *Am. Civil Liberties Union v. Johnson*, 194 F.3d 1149, 1163 (10th Cir. 1999) (~~"~~[T]hreatened injury to [constitutional rights] outweighs whatever damage the preliminary injunction may cause Defendants' inability to enforce what appears to be an unconstitutional statute."). Where a plaintiff is threatened with ~~"~~irreparabl[e] los[s]," the ~~"~~the balance of hardships between the parties tips sharply in favor of [the plaintiff]" and an injunction is warranted. *Alliance for the Wild Rockies v. Cottrell*, 632 F.3d 1127 at 1137.

Likewise, the public interest will be served by the issuance of an injunction, as the protection of constitutional rights is always in the public interest. *See Klein v. City of Laguna Beach*, 381 F. App'x 723, 727 (9th Cir. 2010) (~~"~~the public has a fundamental interest in the protection of all people's constitutional rights"); *Preminger v. Principi,* 422 F.3d 815, 826 (9th Cir. 2005) (~~"~~Generally, public interest concerns are implicated when a constitutional right has been violated, because all citizens have a stake in upholding the Constitution."). It is well-settled that ~~"~~it would not be equitable or in the public's interest to allow the state to continue to violate the requirements of federal law, especially when there are no adequate remedies available to compensate. . . Plaintiffs for the irreparable harm

that would be caused by the continuing violation." *Cal. Pharmacists Ass'n*, 563 F.3d at 852-53. As this Court has recognized, "society as a whole suffers" when members of the public are "deprive[d] . . .of their rights." *Lopez v. Heckler*, 713 F.2d 1432, 1437 (9th Cir. 1983); *see also id.* ("[T]he balance of hardships as between the litigants lies sharply in favor of the plaintiffs. When, the public interest is included, that balance is overwhelming"); Pima Cty. Atty's Resp. Pls.' Mot. Prelim. Inj. 2, ECF 23 (recognizing that the public trust placed in her office requires "that extreme care must be taken to ensure that individuals are not prosecuted for engaging in constitutionally protected conduct.") Therefore, the public interest is served in granting an injunction that, as in this case, prevents violations of constitutional rights.

CONCLUSION

For the foregoing reasons, this Court should grant Plaintiffs' Motion for Emergency Injunction Pending Appeal.

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CERTIFICATE OF SERVICE

I hereby certify that on July 30, 2012, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that some of the participants in the case are not registered CM/ECF users. I have sent the foregoing document by email to the following non-CM/ECF participants:

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/s/ Janet Crepps

Index of Copies of Affidavits and Other Sworn Statements Pursuant to Fed. R. App. P. 8(a)(2)(B)

Exhibit 1: Declaration of Paul A. Isaacson, M.D.

Exhibit 2: Declaration of William H. Clewell, M.D.

Exhibit 3: Declaration of Jean A. Wright, M.D., M.B.A., F.A.A.P., F.C.C.M.

EXHIBIT 1

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Additional Co-Counsel listed in Complaint

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Paul A. Isaacson, M.D., et. al.,

Plaintiffs,

vs.

Tom Horne, Attorney General of Arizona, et. al.,

Defendants.

Case No.

DECLARATION OF PAUL A. ISAACSON, M.D.

1. I am a Plaintiff in this lawsuit.

2. I have reviewed Arizona House Bill 2036.

3. I submit this declaration in support of Plaintiffs' Motion for Preliminary Injunction or Temporary Restraining Order sought to prevent enforcement of the ban on abortions beginning at 20 weeks gestational age, contained in Arizona House Bill 2036 (Section 7), to be codified as Ariz. Rev. Stat. § 36-2159.

4. I am a physician licensed to practice medicine in Arizona and Nevada. I graduated from Tufts University School of Medicine in 1991. I am board-certified in obstetrics and gynecology. I hold privileges at Banner Good Samaritan Medical Center in Phoenix.

5. I offer this declaration as an expert in obstetrics and gynecology. My statements herein are based on my training, years of practice, and my ongoing review of literature and other sources of information generally relied on by those in my field. A copy of my *curriculum vitae* is attached as Exhibit A.

6. I co-own a private reproductive healthcare facility in Phoenix called Family Planning Associates Medical Group ("FPA"). At FPA, I provide a variety of services, including gynecological services, family planning, well-woman exams, STD testing, and abortions.

7. I provide abortions to women seeking previability abortions at or after 20 weeks on a regular basis, and see such patients approximately 50 times per year. Previability refers to that point in pregnancy before "there is a reasonable probability of the fetus' sustained survival outside the uterus, with or without artificial support." Ariz. Rev. Stat. § 36-2301.01 C. 3. Gestational age, as defined in HB 2036, means the duration of the pregnancy as dated from the woman's last menstrual period,

8. Abortions as I perform them, including those performed at or after 20 weeks gestational age, are safe procedures that pose no greater risks to my patients than carrying to term.

9. There are well documented and significant risks associated with carrying any pregnancy to term. For individual women, these risks may be much higher due to a preexisting condition or a condition that arises during pregnancy.

10. In my experience, while women sometimes consider the comparative medical risks of abortion and carrying a pregnancy to term, that is only one factor among many other important factors that go into their decision whether or not to continue with a pregnancy.

11. Approximately 70% of my patients seeking abortions at or after 20 weeks do so due to a serious or lethal fetal abnormality. These patients have received this diagnosis from their obstetrician or a specialist who deals with high risk pregnancies, and the vast majority of these patients have been referred to me from another physician. Among my patients, the most common types of fetal anomalies are neural tube defects, including anencephaly, meinigomyeloceles and holoprosencephaly; trisomy 18 and 13; Potters syndrome; diaphragmatic hernia; Down's syndrome; cystic hygromas, and fetal cardiac anomalies.

12. Many of the patients I see for an abortion due to fetal anomalies come to me following detection of the problem through a full obstetric ultrasound, which usually occurs after 18 weeks. When the obstetric ultrasound indicates a problem, it is routine practice to conduct an additional ultrasound or other tests. Thus, it may be several days or a few weeks before the woman has all of the information she needs and desires in order to make an informed decision as to whether to continue or terminate the pregnancy.

Typically, these patients have reached the decision to terminate the pregnancy after multiple consultations with specialists and/or loved ones.

13. Many of my remaining patients seeking abortions at or after 20 weeks do so because they are experiencing a medical condition that is either caused by or exacerbated by the pregnancy or because they wish to obtain treatment for a condition but cannot do so while pregnant. Women in these circumstances have presented with, among other conditions, diabetes, kidney disease, cardiac disease, history of severe pre-eclampsia or eclampsia and maternal hematologic diseases that cause abnormal blood clotting.

14. For example, I have treated patients with preexisting conditions that have made the pregnancy high-risk. In one such circumstance I performed a procedure for a patient at high risk of stroke during pregnancy due to a cardiac abnormality. The pregnancy prevented her cardiologist from providing the recommended treatment.

15. Based on my training and experience, at 20 weeks, no fetus is viable. It is commonly accepted in the field of obstetrics and gynecology that a normally developing fetus will attain viability at approximately 24 weeks.

16. Not all fetuses will attain viability at 24 weeks, however, due to a variety of factors such as maternal nutrition, health, and lifestyle or problems with fetal development or fetal anomalies. Some fetuses never attain viability due to anomalies.

17. The 20 week ban therefore prohibits previability abortions that I perform for my patients beginning at 20 weeks gestational age.

18. Due to the criminal penalties and provisions allowing for suspension or revocation of my license if I violate the ban, I will have no choice, absent an injunction, but to stop providing previability abortions beginning at 20 weeks gestational age.

19. Enforcement of the 20 week ban will harm my patients by preventing them from obtaining previability abortions. Some of my patients may, as a result, be forced to carry a pregnancy they wish to terminate to term.

20. Among these patients, some will be seeking to terminate in order to preserve their health. These patients will be precluded from doing so altogether or will be forced to delay the procedure until their conditions worsen to the point where they clearly come within the narrow definition of "medical emergency" in HB 2036. In the absence of HB 2036, and consistent with the standard of care, I would otherwise perform the abortion without delay.

21. Other patients will be seeking an abortion because the fetus has been diagnosed with a lethal or serious anomaly. It is cruel to deny women access to abortion in these circumstances. What purpose is served by forcing a woman to carry a pregnancy for months when the unavoidable outcome is that the baby will die during birth or shortly thereafter?

22. This delay or denial of care is contrary to the good practice of medicine and imposes unconscionable burdens on women seeking abortions.

I declare under penalty of perjury that the foregoing is true and correct.

Dated this 9th day of July, 2012.

Paul A. Isaacson, M.D.

Exhibit A

CURRICULUM VITAE FOR PAUL A. ISAACSON, M.D.

1331 N. 7th Street, #225
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Professional History

2007 to present	Birth Control Care Center Las Vegas, NV
2004 to 2009	Summit Family Planning Las Vegas, NV
1997 to Present	Family Planning Associates Phoenix, AZ
1998 to 2004	Private Practice - Ob/Gyn East Valley Ob/Gyn, P.L.C. Chandler, AZ
1997 to 1998	Planned Parenthood of Southern Arizona - Staff Physician
1995 to 1997	Private Practice - OB/GYN Women's Health Care Associates Chandler, Arizona
1994 - 1995	Planned Parenthood of Greater Boston Brookline, Massachusetts
1994 - 1995	Women's Health Service Chestnut Hill, Massachusetts
1991 - 1995	Resident, OB/GYN Brigham and Women's Hospital Boston, Massachusetts and Massachusetts General Hospital Boston, Massachusetts
1988 - 1989	Chemistry Lab Technician, St. Elizabeth's Hospital Boston, Massachusetts [Part-time during Medical School]

Education

1991 - 1995	Brigham and Women's Hospital Boston, Massachusetts Intern and Resident, Obstetrics and Gynecology and Massachusetts General Hospital Boston, Massachusetts Intern and Resident, Gynecology

1987 - 1991	Tufts University School of Medicine Boston, Massachusetts Medical Doctorate
1983 - 1987	Boston College Chestnut Hill, Massachusetts B.S., Biochemistry [summa cum laude]

Appointments and Hospital Affiliation

1994 - 1995	Administrative Chief Resident, Obstetrics and Gynecology Brigham and Women's Hospital, Boston, Massachusetts Massachusetts General Hospital, Boston, Massachusetts
1991 - 1995	Clinical Fellow in Obstetrics, Gynecology, and Reproductive Biology, Harvard Medical School, Boston, Massachusetts
2003 – present	Banner Good Samaritan Medical Center, Phoenix, AZ – Active Staff

Awards

Phi Beta Kappa
Alpha Sigma Nu National Jesuit Honor Society
Alpha Omega Alpha Medical Honor Society
Society of Laproendoscopic Surgeons,
Outstanding Laproendoscopic Resident Surgeon - 1995

Licensure and Certification

State of Arizona Board of Medical Examiners	License #23227
State of Nevada Board of Medical Examiners	License #10490

National Board of Medical Examiners - Diplomate
American Board of Obstetrics and Gynecology - Diplomate

Professional Associations

Massachusetts Medical Society
National Abortion Federation

Exhibit 2

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Additional Co-Counsel listed in Complaint

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Paul A. Isaacson, M.D., et. al.,

Plaintiffs,

vs.

Tom Horne, Attorney General of Arizona, et. al.,

Defendants.

Case No.

DECLARATION OF WILLIAM H. CLEWELL, M.D.

WILLIAM H. CLEWELL, M.D., declares and states the following:

1. I am a perinatologist licensed to practice medicine in the state of Arizona, where I am engaged in the practice of obstetrics and gynecology and maternal-fetal medicine. I am a Plaintiff in this lawsuit, and I submit this declaration in support of Plaintiffs' Motion for a Preliminary Injunction and/or Temporary Restraining Order against enforcement of that part of Section 7 of House Bill 2036, to be codified as Ariz. Rev. Stat. § 36-2159 ("the ban"), that bans pregnancy termination care starting at 20 weeks as measured from the first day of the woman's last menstrual period ("LMP"). I offer this declaration as an expert in obstetrics and gynecology and in maternal-fetal medicine, which is the sub-specialty of perinatologists, the doctors who care for women with high-risk pregnancies.

2. I am Director of Fetal Medicine and Surgery and Director of Obstetrical Ultrasound at Banner Good Samaritan Medical Center in Phoenix; a faculty member in the Division of Maternal-Fetal Medicine at Good Samaritan Regional Medical Center; a partner in a perinatology practice group; and Clinical Professor of Obstetrics and Gynecology at the University of Arizona College of Medicine in Tucson. I was previously Director of the Obstetrics Section at the University of Colorado School of Medicine and Visiting Professor of Obstetrics and Gynecology at Kings College Hospital School of Medicine and Dentistry in London.

3. I received my medical degree from Stanford University School of Medicine in 1970; did an internship in Pediatrics at Strong Memorial Hospital in Rochester, New

York, from 1970-1971; did my residency in Obstetrics and Gynecology at Stanford from 1971-1974; and did my fellowship in Perinatal Medicine at the University of Colorado School of Medicine from 1974-1976. I am board-certified both in Obstetrics & Gynecology and in Maternal-Fetal Medicine.

4. My medical association memberships include the American College of Obstetrics and Gynecology, the Phoenix Obstetrical and Gynecological Society, and the Society of Maternal-Fetal Medicine, and I am a founding member of the International Fetal Medicine and Surgery Society. I have authored numerous articles in peer-reviewed journals and book chapters. The topics on which I have published include gynecological emergencies, premature labor, fetal diagnosis, fetal therapy, fetal surgery, hypertensive emergencies and neurological disorders in pregnancy.

5. The facts I state here are based on my many years of medical practice, my personal knowledge, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession. A copy of my *curriculum vitae* is attached as Exhibit A.

My Patients and My Practice Subject to the Ban

6. I provide my patients with comprehensive care for high-risk pregnancies. This care includes pre-conception counseling; prenatal care; prenatal diagnosis of fetal anomalies; fetal assessment; and fetal treatment including fetal transfusion, shunt placement and other therapeutic procedures that I undertake before birth to allow medically compromised fetuses to survive and / or to improve their outcomes after birth. I have pioneered several such in utero therapies. I also provide labor and delivery care, as

well as induced pregnancy terminations in cases of maternal medical indications, cases of lethal or severe fetal anomalies, and/or cases of pregnancy failure. That care includes pregnancy terminations at and after 20 weeks LMP.

7. In my role as Director of Fetal Medicine and Surgery at Banner Good Samaritan Hospital, I perform Maternal-Fetal Medicine consultations on other physicians' patients with high-risk pregnancies who are either hospitalized or are out-patients in the Banner Maternal Fetal Center. I also regularly provide in-hospital care for the antepartum patients, meaning those admitted for complications of pregnancy before birth. This includes patients with preterm labor, antepartum bleeding, uncontrolled diabetes and other conditions requiring close monitoring of fetal and maternal wellbeing. This entails making teaching rounds with medical students and OB GYN residents on the service at the hospital, as well as personal rounds on all the antepartum patients. As Director of Obstetric Ultrasound at Banner Good Samaritan Hospital, I spend a good deal of time interpreting ultrasound images, and I also occasionally consult on other physicians' patients in a private perinatology office setting.

8. I have provided a limited number of pregnancy terminations as part of my practice since 1971, when I started my residency. Each year, I perform, teach, or supervise a small number of induced pregnancy terminations, approximately half of which are for women experiencing pregnancy failure. Although these procedures comprise a very small part of my practice, they are an important part of the comprehensive care I offer my patients.

9. My colleagues and I perform pregnancy terminations only in cases of serious or lethal fetal anomaly and/or maternal medical complications; for pregnancy

terminatons in other instances, we refer our patients to other respected physicians in the community. Approximately 90% of induced pregnancy terminations in the U.S. take place during the first trimester of pregnancy, through approximately the 13th week. Given the nature of my practice, however, most of those that I perform or supervise occur after that point: first, diagnoses of fetal anomaly are almost never possible earlier in pregnancy; second, the maternal health conditions that prompt the pregnancy terminations I perform or supervise often emerge or are exacerbated after that point.

10. No fetus is viable at 20 weeks; a healthy singleton fetus becomes viable by about the 24th week; some medically compromised fetuses become viable only later in pregnancy; and others can never become viable because of a lethal anomaly. I am not aware of any physician in Arizona who performs induced abortions where the fetus is viable, that is, when it has a reasonable probability of sustained survival outside the uterus.

11. Legal induced pregnancy termination is extremely safe, and presents far lower risks for a woman than does carrying a pregnancy to term. (Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Ob. & Gyn. 215-19 (Feb. 2012)) (legal induced pregnancy termination is 14 times safer than carrying to term in terms of the woman's risk of death, and also carries a lower risk of complications short of death). As pregnancy progresses, the risks of induced pregnancy termination increase, so that starting at 21 weeks LMP, legal induced termination and carrying to term entail comparable risks of death for the woman. (Linda A. Bartlett *et al.*, *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Ob. & Gyn. 729-37 (Apr. 2004)). However, for

certain of my patients with medical conditions or carrying fetuses with anomalies that increase the risks to the woman, pregnancy termination past 21 weeks clearly remains far safer for the woman than carrying to term.

12. Several times each year, my colleagues and I provide termination care to a patient at or after 20 weeks LMP. This happens in cases of fetal anomaly, maternal medical complication, and pregnancy failure.

13. In some patients, we cannot diagnose a fetal anomaly until very close to, or after, 20 weeks. Amniocentesis – a procedure to detect and diagnose chromosomal anomalies – is usually performed at about 16 weeks, but may occur later, and requires 10 - 12 days for the results to be available. Detailed anatomic ultrasound exams are generally done after 18 weeks (and among obese women, whose numbers are increasing, these exams may not be reliable until later). In other words, even if a patient starts out receiving prenatal care from a perinatologist, she will not get a diagnosis of many fetal anomalies until close to or at 20 weeks. A definitive diagnosis will generally occur later still if the patient began her prenatal care with an obstetrician who is not a perinatologist. After doing an initial exam, such an obstetrician who suspects a fetal anomaly will often refer the patient to my practice for a more detailed assessment. This entails at least some delay, and the final consultation often does not occur until after 20 weeks. Even if the patient has the final consultation and receives the diagnosis in the 19th week, she and her family need time to make the extremely difficult decision whether to continue the pregnancy, which means that termination, if that is their decision, will occur after 20 weeks.

14. I have performed pregnancy terminations at and after 20 weeks for women

who have received the devastating diagnosis that the fetuses they were carrying had lethal anomalies: anencephaly, a significant malformation of the brain which results in death before birth or very soon thereafter; renal agenesis, in which the fetus lacks kidneys and where the child, if born, usually dies of respiratory failure within twenty-four hours of birth; severe structural anomalies such as limb-body wall complex, in which the organs are often outside the body cavity; certain congenital heart defects; body stalk anomaly, in which the anterior body wall of the fetus fails to develop and the fetus is attached directly to the placenta; ectopia cordis, in which the fetal heart is outside the chest; certain combinations of malformations that individually would not be lethal but that in combination cannot be overcome; chromosomal anomalies such as trisomy 13 and 18 (three copies of chromosomes 13 and 18); and many other, less common lethal chromosomal, single gene defects or lethal structural anomalies.

15. Others of my patients decide to end their pregnancies at or after 20 weeks after learning the potentially equally devastating news that their fetuses have severe but not necessarily lethal anomalies. These include severe cardiac anomalies, such as hypoplastic left heart syndrome, critical aortic stenosis, and various complex cardiac malformations, and neural tube defects such as encephalocele (the protrusion of brain tissue through an opening in the skull) and severe hydrocephaly (severe accumulation of excessive fluid within the brain that almost completely destroys the brain). There are numerous other lethal and severe anomalies which individually are very rare, but when referrals come from a large population (i.e., the state of Arizona and beyond), in aggregate amount to a significant number of pregnancies affected.

16. Likewise, some of my patients with medical conditions that make

pregnancy particularly dangerous for them may not be referred to me until almost 20 weeks or even after that point. To preserve their health, some of these patients end their pregnancies after getting a definitive diagnosis; others try to continue the pregnancy at least until the fetus becomes viable, and of those, some succeed, while others ultimately decide to end their pregnancies. These conditions include maternal heart disease, pulmonary hypertension, and Eisenmenger's syndrome – in all of which the increase in cardiac output that occurs in pregnancy dramatically increases maternal mortality, that is, the woman's risk of death. Hence, some of my patients with severe cardiac disease and worsening cardiovascular status – or rheumatic heart disease with worsening cardiac function – terminate their pregnancies because continued pregnancy is likely to exacerbate their conditions, with serious consequences, including the risk of irreversible heart damage or death. Other patients have had end stage renal (kidney) disease; mechanical heart valve; and Marfan's Syndrome with dilatation of the aorta, which dramatically increases the woman's risk of sudden death due to aortic rupture. Some cancers, including some breast cancers, require radiation therapy or chemotherapy, which are extremely toxic to the fetus. Most patients, if they are to undergo such treatment, choose to terminate rather than have the fetus die in utero as a consequence of treatment.

17. Finally, some of my patients experience pregnancy failure close to or after 20 weeks. These scenarios include advanced cervical dilation with "hour glassing" of membranes into the vagina, premature rupture of membranes, and placental abruption (premature separation of the placenta) with serious bleeding. Some such patients opt to terminate fairly quickly, to minimize the risks to their health. Others try to carry the pregnancy until the fetus becomes viable. We do everything we can to help them;

sometimes we succeed and the woman has a baby. Other times, the risks to the woman become so high, and the chances for a live birth so remote, that she and her family ultimately decide to end the pregnancy some period of time after the condition first arises.

The Effect of the Ban

18. I have read the ban and I am gravely concerned for my practice and most of all for my patients and their families. This law would force some of my patients to carry to term against their will, even when doing so presents shocking risks to their lives and health, and even where there is no hope of giving birth to a child who will survive. This is medically brutal and emotionally cruel.

19. Because this care is critical to my patients' health, I fear enforcement of the ban for my patients' sake as well as for my own. Because my patients include women with grave medical indications for terminating pregnancy, I fear prosecution under the ban all the more because instead of a straightforward exception for procedures necessary to preserve my patient's life or health, it has only an extremely narrow medical emergency exception.

20. The ban's medical emergency exception is an affirmative danger to my patients. Starting at 20 weeks LMP, it allows me to terminate a pregnancy only if an "immediate" termination or a termination with no "delay" is necessary to avert death or serious medical harm. As I outlined above, the instances in which pregnancy clearly jeopardizes a woman's life and health are many, but the instances in which a patient will die or suffer such harm absent an "immediate" termination or a termination with no delay

are far less frequent. Only when a patient is, for example, hemorrhaging or extremely severely infected could I feel comfortable that I would not face prosecution for ending the pregnancy.

21. For example, I saw a patient this year at 22 weeks with an ongoing placental abruption, which means that the placenta had prematurely detached from the uterine wall. Because of the abruption, she had been bleeding for weeks; to replace lost blood, we had transfused her – with 7 units of blood in 3 days; and we ultimately advised the family to consider termination. The woman was initially unsure of her decision, which was an excruciating one. Several days into the process, when she ultimately decided to terminate, she was clearly at risk from the pregnancy and the chance of a viable outcome was remote, but she just as clearly did not need an "immediate" pregnancy termination to avert death or preserve her health: I could have continued transfusing her for days or weeks, and indeed, some women in those circumstances choose that route, hoping for the slight chance that they will be able to continue the pregnancy until the fetus becomes viable.

22. This illustrates one of several awful perversions this ban would impose on women and their doctors. My duty is to offer my patients care before they face "immediate" death or damage; I cannot let them get to that point without at least offering them care to save their lives and preserve their health. But under the ban, that is exactly what I would have to do: wait and let my patient deteriorate until an "immediate" termination – or a termination without delay – was necessary. That's the worst medicine imaginable and contrary to well established obstetric principles.

23. In an equally ugly distortion, the ban would force women to make a

decision before they would otherwise have to, and some of those women may well feel compelled to terminate. For example, the patient with the bleeding abruption may have felt compelled to terminate sooner, knowing that she wouldn't be able to do so to preserve her health if she waited until after 20 weeks. Some patients in that situation might otherwise try to continue the pregnancy, and of those, some might succeed. The ban will thus rush some women to terminate who would otherwise try to continue their pregnancies, and of those, some would have ended up having babies.

24. The same is true of women with medical conditions such as heart disease: a woman at 19 weeks may decide to try to carry the pregnancy as long as possible, but only if she knows that if the risks grow too large in her view, she can terminate the pregnancy. But if she knows that that option will not be available to her at 20 weeks, she may well terminate at 19 weeks, to save her heart and possibly her life. That is because with maternal heart disease, just as with bleeding from placental abruption, the cases in which a pregnancy termination with no delay is necessary to preserve the woman's life or health are rare. Far more frequent are cases of maternal heart disease in which continued pregnancy poses a clear and significant threat to the woman's life or health, but she could decide either to bear the risk by continuing the pregnancy or to protect herself against the risk by ending it. The ban would deny her the latter option at 20 weeks, when no fetus is viable.

25. The same is true of the woman grappling with the shocking news that her fetus has a severe or lethal anomaly. That patient needs time to resolve her feelings, to consult with those she loves and trusts, and to come to her decision. Under the ban, a family that gets the diagnosis at 19 weeks and 5 days would not have time to consider,

discuss, pray – whatever process they deem necessary to make this terribly hard decision. The upshot might be that the woman requests a termination within a few hours simply to avoid being denied the option at 20 weeks. It is inappropriate to rush a patient in making this decision. Usually the diagnosis has come like a "bolt from the blue," in that the family had no suspicion of the problem prior to the ultrasound or other test. The woman and her family are in a moment of crisis and grief, and deserve the time they need to make their decision. A "right" decision is more important than a quick one.

26. Some women facing such grave circumstances decide to continue their pregnancies. That is the right decision for them, and I provide them with the best medical care possible. But under the ban, my patients who did not terminate before 20 weeks would have no option. Some would carry to term – against their will – notwithstanding the risk to their lives; some would do so notwithstanding the risk to their health; and still others would unwillingly remain pregnant notwithstanding the impossibility of giving birth to a child who would survive, either because of a lethal anomaly or because of pregnancy failure. Some other women may attempt a self induced termination or seek a non-medical one: I began my medical training in the era when illegal pregnancy terminations were a major cause of maternal mortality and morbidity.

27. This ban would be devastating for my patients and for me as a physician. I am honored to provide care for women and families through some of the most joyous times in their lives, but also through what may be the hardest time in their lives. My job is to give them information and options, and then to respect and support their decision. That way, as I tell them, no matter what they decide, when they look back years later on this very difficult time, they can feel comfortable with the decision they made. That is

my ethical obligation, and under the ban, I would fear prosecution for fulfilling it. This outrageous intrusion into medical care would thus impose terrible, irreparable harm on my patients and on me.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on July 11, 2012

William H. Clewell, M.D.

Exhibit A

CURRICULUM VITAE

WILLIAM H. CLEWELL, MD

CURRENT POSITIONS

Director, Obstetrical Ultrasound
Banner Good Samaritan Medical Center
Phoenix, AZ

Director, Fetal Medicine and Surgery
Banner Good Samaritan Medical Center
Phoenix, AZ

Faculty, Department of Obstetrics and Gynecology
Division of Maternal Fetal Medicine
Good Samaritan Regional Medical Center

Phoenix Perinatal Associates
Phoenix, AZ

ACADEMIC APPOINTMENT

Clinical Professor
Department of Obstetrics and Gynecology
University of Arizona, College of Medicine
Tucson, AZ
1990 - present

EDUCATION

University of Colorado School of Medicine
Denver, Colorado
Fellow, Perinatal Medicine
1974-1976

Academic Training Fellow
American College of Obstetrics and Gynecology-Ortho
1974-1975

Stanford University School of Medicine
Stanford, California
Resident in Obstetrics and Gynecology
1971-1974

Strong Memorial Hospital
Rochester, New York
Intern, Pediatrics
1970-1971

Stanford University School of Medicine
Stanford, California
Doctor of Medicine
1970

University of California, Berkeley
Honors in Biochemistry
1965

MEDICAL LICENSURE

Arizona	1987
Colorado	1976
California	1971

BOARD CERTIFICATION

Board Certified in Obstetrics and Gynecology
American Board of Obstetrics and Gynecology, 1977

Board Certified in Maternal-Fetal Medicine, Subspecialty Board, 1981

PAST POSITIONS

Visiting Professor, Obstetrics and Gynecology
Kings College Hospital School of Medicine and Dentistry
London, United Kingdom
July 7, 1985-July 6, 1986

Director, Obstetrics Section, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1982 – 1987

Associate Professor, Division of Perinatal Medicine
University of Colorado School of Medicine
1982 – 1987

Associate Professor, Division of Perinatal Medicine
University of Colorado School of Medicine
1981 – 1987

Associate Professor, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1981

Assistant Professor, Department of Obstetrics and Gynecology
University of Colorado School of Medicine
1976 – 1981

MAJOR SCIENTIFIC INTEREST:

Role of estrogen in the control of uterine circulation.
Antepartum management of fetal diseases.

PROFESSIONAL MEMBERSHIPS

Phi Beta Kappa
Alpha Omega Alpha
Fellow, American College of Obstetrics and Gynecology, 1980
Phoenix Obstetrical and Gynecological Society
International Fetal Medicine and Surgery Society
Society of Maternal-Fetal Medicine

ABSTRACTS

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2. **Clewell WH**. "Control of uterine circulation", in Uterine Physiology, Proceedings of a Brook Lodge Workshop, eds. Greeman EA, Noah ML, Work BA. PGS Publishing Co., Littleton, Massachusetts.

3. **Clewell WH**, Stys SJ, Battaglia FC. "Fetal pathophysiology", in Fetal and Maternal Medicine, eds. Quilligan EJ, Krechmer N. John Wiley and Sons, New York.

4. Stys SJ, Clark KE, **Clewell WH**, Meschia G. "Hormonal effects on cervical compliance in sheep", in Biology of Cervical Dilatation, eds. Naftolin N, Stubblefield PG. Raven Press, New York.

5. **Clewell WH**, Meschia G. "Effects of estrogen on uterine blood flow", In Uterine and Placental Blood Flow. New York.

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7. Johnson ML, **Clewell WH**, Pretorius D, Meier P, Manchester D. "Fetal Therapy", in The Principles and Practice of Ultrasonography in Obstetrics and Gynecology, eds. Sanders RC, James AE. Appleton-Century-Crofts, East Norwalk, Connecticut.

8. **Clewell WH**. "The fetus with ventriculomegaly: Selection and treatment", in The Unborn Patient—Prenatal Diagnosis and Treatment, eds. Harrison MR, Golbus MS, Filly RA., W.B. Saunders Company, Philadelphia, Pennsylvania.

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Exhibit 3

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Paul A. Issacson, M.D., et al., Plaintiffs, v. Thomas C. Horne, et al., Defendants.	Case No.: 2:12-cv-01501-JAT **DECLARATION OF JEAN A. WRIGHT, M.D., M.B.A., F.A.A.P., F.C.C.M.; EXHIBIT "A"**

DECLARATION OF JEAN A. WRIGHT, M.D., M.B.A., F.A.A.P., F.C.C.M.

Pursuant to 28 U.S.C. § 1746, I, Jean A. Wright, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law. I declare and state as follows:

1. I have personal knowledge of the matters set forth herein, and am competent to make this declaration. I submit this declaration in support of the Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction in the above-captioned proceeding. The opinions I render today are my own, and do not represent any group.

2. I have reviewed the challenged provisions of Arizona House Bill 2036 (herein "HB 2036").

3. I am aware that HB 2036's restriction of abortions past twenty weeks of gestation, except in cases of "medical emergency," is based, in part, upon the following findings set forth in Section 9 of the Act:

> [(A)](7) There is substantial well-documented medical evidence that an unborn child by at least twenty weeks of gestation has the capacity to feel pain during an abortion.
>
> [(B)] …the legislature's purposes in promulgating this act include to: (1) Prohibit abortions at or after twenty weeks of gestation…based on…the strong medical evidence that unborn children feel pain during an abortion at that gestational age.

4. It is my expert opinion that these statements relating to fetal pain and the findings upon which the Arizona legislature based them, are substantially based in scientific fact.

5. I am licensed to practice medicine by the States of North Carolina and Georgia. I am board certified in Pediatrics, Anesthesia, and in both sub-boards of Critical Care Medicine.

6. I am a Fellow in both the American College of Critical Care Medicine and the American Academy of Pediatrics.

7. I have served as a member of the Academy of Pediatrics Committee on Child Health Finance, and am active in national and statewide initiatives and policy statements regarding the financing of pediatric healthcare. I have been a member of the Federal Advisory Committee for the CDC's Task Force on Fetal Alcohol Effects, and I have served on the Advisory Board of the Fogarty International Center of the National Institutes of Health. In 2007, Governor Perdue of Georgia appointed me to the Advisory Board for Women's Health Initiatives. In 2000, I was recognized by the American College of Physician Executives with the Physician of Excellence Award.

8. I currently serve as the Vice President and Chief Medical Officer for two of the hospitals in the Carolinas Healthcare System, which is the third largest public healthcare system in the United States.

9. Previously, I was the Executive Director for the Backus Children's Hospital and The Women's Institute at Memorial Health in Savannah, GA. I also served as the Chairman of the Department of Pediatrics for Mercer School of Medicine (Savannah Campus). I have served as an executive officer for several other hospitals and health systems.

10. After graduating in three years from the University of Michigan in 1974, I attended Wayne State University School of Medicine in Detroit. Upon graduation in 1978, I began residency training in Pediatrics at Emory University in Atlanta. I was Chief Resident in 1981 in pediatrics, and then began a residency in anesthesia at Emory. I joined the faculty of Emory in 1983 as a pediatric anesthesiologist and intensivist. I earned an MBA degree in 1994 from the executive degree program of Emory's Goizuetta School of Business. In 1998, I was awarded an honorary Doctorate of Divinity from Westminster College in Pennsylvania.

11. I held the positions of Assistant Professor of Pediatrics and Anesthesia at the Emory University School of Medicine from 1983 through 1991, and Associate Professor of Pediatrics & Anesthesia and Director of the Division of Critical Care Medicine from 1991 to 1997, where Dr. K.S. Anand conducted research. From 1994 through 1997, I served as Associate Professor and Program Director for Pediatric Health Services at the Emory Center for Clinical Evaluation Sciences.

12. I was Clinical Associate Professor of Pediatrics at Emory from 1997 through 2002. I was Professor and Chairman of Pediatrics at Mercer University School of Medicine from 2002 through 2009.

13. I have briefed Congressional staff and testified before both Houses of Congress on fetal and pediatric pain, particularly with regard to the federal Partial Birth Abortion Ban, and have testified on the same subject in several state legislative bodies.

14. Attached hereto as Exhibit "A" is a true and correct copy of my current *curriculum vitae*.

15. In the last 30 years, the fields of developmental neurobiology, perinatology, neonatology, pediatric anesthesia and pediatric surgery have exploded with knowledge. That knowledge has radically impacted how we as clinicians care for the unborn infant, and the infant born prematurely. However this knowledge has lagged behind in permeating the clinical care involved in abortion, particularly in the abortion of the late-term fetus.

16. Improvements in neonatology push for a new definition of viability for the premature infant. In 1973, when Roe v. Wade was decided, neonatology was in its infancy as a science and as a practice. The understanding of the physiology of the pre-term infant, the equipment, medications, physicians, and specialized units available to care for them were present but limited. By contrast, today there are thousands of neonatologists, hundreds of Neonatal Intensive Care units, and breaking discoveries in the world and womb of the developing fetus and neonate. Artificial surfactant, liquid ventilation, ECMO, and other heroic technologies support the infants who would have not survived in 1973. Specific textbooks, journals, fellowship training programs, and scientific conferences abound focused solely on the care of the premature infant.

17. When the Supreme Court in Roe focused its discussion on the issue of fetal "viability," the common understanding was that infants born before 28 weeks could not survive. And there was no expectation that the date of viability would be pushed back earlier than 28 weeks. Today that age of viability has not only been pushed back beyond 28 weeks, but even to 23 and 24 weeks. The number of children that are born and survive at 23 - 28 weeks gestation is common enough now that the term "Micro-premie" has been coined to describe them and an additional body of neonatal science is focused upon them. As medical science pushes the frontier of fetal "viability" to 23 weeks and perhaps earlier with the advent of artificial wombs and placental support, there is a possibility that a definition of "viability" based upon gestational age will soon be irrelevant.

18. Pain is a subjective phenomenon for every one – adults, children, and the unborn alike. Therefore, evaluating the perception of pain is difficult in all human subjects. But identifying the structures, processes and measuring the response to noxious stimuli is increasingly done in all age groups.

19. Drs. Anand and Fitzgerald, as well as others, have demonstrated that very preterm neonates have the neuro-anatomic substrate and functional physiologic and chemical processes in the brain required for mediating pain or noxious stimuli, known as nociception. The pain receptors needed to feel pain on the skin are referred to as cutaneous nociceptive nerve endings. Recent anatomic studies have shown that the density of these cutaneous nociceptive nerve endings in the late fetus and newborn infant may equal or exceed that of adult skin.

20. Early studies by Hooker showed that cutaneous sensory perception appears in the perioral area of the human fetus in the seventh week of gestation and gradually spreads to all cutaneous and mucous surfaces by 20 weeks in the same or greater density than adults.

21. Several types of observations speak for the functional maturity of the cerebral cortex in the fetus and neonate. First, fetal and neonatal EEG patterns (which include cortical components of visual and auditory evoked potentials) have been recorded in preterm babies of less than 28 weeks gestation. Second, cortical evoked potentials from somatosensory stimuli (touch, pain, heat, and cold) were also recently documented in preterm neonates from 26 weeks gestation.

22. A study of intrauterine blood sampling and blood transfusions in fetuses between 20 and 34 weeks of gestation showed that hormonal responses to the needle sticks were consistent with the fetal perception of pain and were correlated with the duration of the painful stimulus.

23. Ultrasonographic findings report specific fetal movements in response to needle punctures in utero. When neonates are born prematurely at 23 weeks gestation, they demonstrate highly specific and well-coordinated physiologic and behavioral responses to pain—similar to those seen in full-term neonates, older infants, and small children. The responses of these prematurely born infants give us a window in the world of the pre-born, validating outside the uterus what they were capable of manifesting inside the uterus.

24. There is substantial evidence that an unborn child is even more sensitive to pain than newborn. It takes less of a noxious stimulus to create pain in the unborn child. Neurotransmitter development in the dorsal horn of the spinal cord involves the early and abundant expression of the neurotransmitters mediating nociception (substance P, L-glutamate, VIP, CGRP) and increased somatosensory excitability in the premature spinal cord. In contrast, the neurotransmitters contained in descending inhibitory fibers from supraspinal centers (5-HT, Norepinephrine, Dopamine) were expressed after birth, implying poorly developed gate control mechanisms for pain in preterm infants.

25. Opioid receptor labeling in the brain stem of fetuses at 19-21 weeks gestation demonstrate very high densities in supraspinal centers associated with sensory perception. These inhibitory opioid receptors may be the only protection for the developing neuronal systems from constant over stimulation, given the overall underdeveloped gate control mechanism in the dorsal horn of the spinal cord.

26. The practice of Pediatric Surgery and Pediatric Anesthesia has shown us how pre-born and pre-term infants respond to pain. The magnitude of hormonal and physiologic responses to invasive procedures or surgical operations is much greater in neonates as compared to adults. Pain in the fetus and neonate can be measured in two dimensions. Pain and surgical stress are demonstrated by a coordinated outpouring of pituitary, adrenal, and pancreatic hormones. Secondly, cardiovascular responses, such as increases in blood pressure, heart rate, dysrhythmias, or poor cardiac output may signal pain. Anand demonstrated that newborns generate a catacholamine and metabolic responses up to 3 - 5 times those of adult patients undergoing similar types of surgery.

27. Partsch, et al. in 1991 provided preliminary evidence for a therapeutic response in Opioid (pain) receptors of fetuses at 16-21 weeks on the administration of intravenous sedation/anesthesia in the maternal patient as compared with those that did not receive anesthesia; the infants of mothers who received anesthesia were less stressed by the procedure.

28. The science of fetal pain continues to develop, and as it does it is reasonable to believe that we may learn that fetal pain can occur even earlier.

29. In a randomized controlled trial, preterm babies undergoing ligation of the patent ductus arteriosus were given nitrous oxide, with or without the addition of an intravenous pain medication (fentanyl). The hormonal responses of neonates receiving nitrous oxide alone were associated with significant increases in blood glucose, lactate, and pyruvate. These biochemical changes were prevented in neonates given the therapeutic doses of the pain medication. This study went on to show that aggressive anesthesia not only decreased the stress responses of neonates undergoing surgery but also improved their postoperative clinical outcome.

30. Surgical advances at places like the Fetal Surgery Center at the University of California allow for the surgeon to partially remove the fetus through an incision in the womb, repair the congenital defect and slip the pre-viable infant back into the womb. Anesthesia for the pre-born child is a planned part of these surgical procedures, and every effort is made to prevent the pre-born child from experiencing noxious stimuli with the hormonal and physiologic changes that accompany the surgery.

31. Anand and Hickey concluded in "Pain and Its Effects in the Human Neonate and Fetus" (New Engl. J. Med. 317:1321-1329) that "[C]urrent knowledge suggest that human considerations should apply as forcefully to the care of neonates and young, nonverbal infants as they do to children and adults in similar painful and stressful situations." I concur with this estimation.

32. Based on the foregoing, it is my expert opinion that the Arizona's legislature's conclusion in HB 2036 that "an unborn child by at least twenty weeks of gestation has the capacity to feel pain during an abortion" is well grounded in scientific and medical fact. While it is not known at this date precisely when a fetus become capable of experiencing pain, it is reasonable to conclude based on the studies discussed herein and others that the perception of pain begins at some point before twenty weeks gestation.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Further, Declarant sayeth naught.

DATED: This 18th day of July, 2012.

Jean A. Wright, M.D., M.B.A., F.A.A.P., F.C.C.M.

Jean A. Wright, M.D., M.B.A.
FAAP, FCCM

Curriculum Vitae

Executive Summary

Jean Wright is the Vice President and CMO for two of the hospitals in the Carolinas Healthcare System. Carolinas Healthcare is the 3rd largest public healthcare system in the United States, and has 32 owned or managed hospitals, and 48,000 employees. CMC-Northeast is a 435 bed tertiary care referral hospital and CMC-University is 133 bed hospital next to the campus of UNC-Charlotte.

Before coming to North Carolina, she was the Executive Director for the Backus Children's Hospital and The Women's Institute at Memorial Health in Savannah, GA. She served as the Chairman of the Department of Pediatrics for Mercer School of Medicine (Savannah Campus). Memorial Health is a two-state healthcare organization serving a 35-county area in southeast Georgia and southern South Carolina. Memorial Health was been named 2 years in a row by Fortune Magazine as one of the One Hundred Best Places to work in America, and has received the J.D. Power award as well for the past two years.

After graduating in 3 years from the University of Michigan in 1974, Jean attended Wayne State University School of Medicine in Detroit. Upon graduation in 1978 began her residency training in Pediatrics at Emory University in Atlanta. She was Chief Resident in 1981 in pediatrics, and then began a residency in anesthesia at Emory. She joined the faculty in 1983 as a pediatric anesthesiologist and intensivist. Subsequently she became board certified in Pediatrics, Pediatric Critical Care, Anesthesia, and Anesthesia-Critical Care. In 1994, she received her MBA from the executive degree program at Emory's Goizuetta School of Business. In 1998 she was awarded an honorary Doctorate of Divinity from Westminster College.

Prior to coming to Savannah, Jean was VP of Medical Management for Children's Healthcare of Atlanta, with responsibility for Quality, Credentialing, Medical Staff, Infection Control, Disease Management and Performance Improvement. She was involved in many aspects of developing the Children's Health Care System into an autonomous pediatric integrated health care delivery system. Children's is now one of the largest Pediatric systems in the country, with 400 beds, 1200 physicians, and over 200,000 outpatient visits and nearly a half a million nurse telephone advice calls.

Her research activities are outcomes related projects, with special interests in the economic consequences of medical and social illnesses. Dr. Wright headed the Pediatric Program in Health Services for the Emory Center for Clinical Effectiveness for 5 years.

In 2000 - 2002, Jean served as the Executive Director of Faith-Based Healthcare. Faith-based Healthcare is a non-profit organization which brings physicians, non-profit organizations and churches together to develop alternatives to financing healthcare and health insurance.

She is a Fellow in both the American College of Critical Care Medicine, and the American Academy of Pediatrics. Dr. Wright is a member of the Academy of Pediatrics Committee on Child Health Finance, and is active in national and statewide initiatives and policy statements regarding the financing of pediatric healthcare. She is also active in NACHRI (National Association of Children's Hospitals and Related Institutions) and as a speaker and Trustee for CMDA (Christian Medical and Dental Association). She is a member of the Federal Advisory Committee for the CDC's Task Force on Fetal Alcohol Effects, and on the Advisory Board of the Fogarty International Center of the NIH. In 2007, Governor Perdue has appointed her to the Advisory Board for Women's Health Initiatives.

Dr. Wright has given testimony before the U.S. House and Senate, and has appeared on 20/20, the O'Reilly Factor, CNN, Prime Time America and Janet Parshall's America. In 1998 she was awarded an honorary doctorate of divinity from Westminster College, and in 2000 she was recognized by the American College of Physician Executive's with the *Physician of Excellence Award.*

J.A. Wright MD MBA

J.A.Wright MD MBA

JEAN A. WRIGHT, M.D., M.B.A.

BIOGRAPHICAL

Home Address:	8636 Carly Lane Mint Hill, NC 28227 704-545-9662 (Home) 704-918-3729 (mobile) Email: jeanwright@bellsouth.net	
Office Address:	920 Church Street, North, Concord, NC 28025	
Birth Date:	September 3, 1953	
Birth Place:	Detroit, Michigan	
Children:	Bethany Leigh Wright Emily Grace Wright Hudson Taylor Wright	August 29, 1999 August 23, 2005 July 20, 2005
Citizenship:	U.S.A.	

EDUCATION AND TRAINING

Undergraduate

1971-1973	Adrian College,	Adrian, MI
1973-1974	University of Michigan, Ann Arbor, MI	B.S. 1974
1974-1978	Wayne State University School of Medicine, Detroit, MI	M.D. 1978
1993 -1994	School of Business, Emory University Executive M. B. A. program	MBA, 1994
1998	Honorary Doctor of Divinity Westminster College, Pennsylvania	D Div, 1998

Post-Graduate

1978-1980	Emory University Affiliated Residency Program Pediatric Internship and Residency Atlanta, GA
1980-1981	Chief Resident, Pediatrics Egleston Children's Hospital at Emory Emory University School of Medicine
1981-1983	Emory University Affiliated Residency Program

ACADEMIC APPOINTMENTS

September 2002 – 2009	Professor and Chairman of Pediatrics Mercer University School of Medicine
February 1997 – Sept 2002	Clinical Associate Professor of Pediatrics Emory School of Medicine
Sept. 1991 – February 1997	Associate Professor of Pediatrics & Anesthesia Emory University School of Medicine Director, Division of Critical Care Medicine
Aug. 1994 -1997	Program Director, Pediatric Health Services Emory Center for Clinical Evaluation Sciences Assoc. Professor, Emory Center for Clinical Evaluation
Dec. 1992 - June 1996	Division Director, Pediatric Emergency Medicine Fellowship Director, Pediatric Emergency Medicine Chief, Emergent & Urgent Care Services, Egleston Children's Hospital
June 1994- September 1995	Vice Chairman, Clinical Services, Department of Pediatrics, Emory University
July 1983 – September 1991	Assistant Professor of Pediatrics and Anesthesia

HOSPITAL POSITIONS

May 2009 – Present	VP & CMO Carolinas Healthcare System CMC NorthEast and CMC University
June 2005 – May 2009	Vice President for the Children's Hospital & Women's Institute
September 2002 – 2005	Executive Director, Backus Children's Hospital 100 Bed Children's Hospital at Memorial Health
July, 1998 – November, 2001	Vice President, Medical Management, Children's Healthcare of Atlanta
Dec. 1994 – April, 2000	Medical Director, Egleston Children's Hospital
Sept. 1995 - Feb, 1996 Feb. 1998 – Nov. 1999	Two terms: CEO, Egleston Pediatric Group, Inc.
Dec. 1992 - June 1996	Chief, Emergency Medicine and Critical Care Medicine, Hughes Spalding Children's Hospital
Aug. 1994 - Dec 1994	Associate Medical Director, Egleston Children's Hospital

Sept. 1991 - Jan. 1994	Medical Director, Pediatric Intensive Care Unit Fellowship Director, Pediatric Critical Care
Dec. 1992 - July 1993	Medical Director, Egleston Emergency Center
May 1991- Aug 1992	Acting Director, Division of Critical Care Medicine Acting Medical Director, Pediatric Intensive Care Unit
May 1991 - April 1992	Medical Director, Respiratory Care Department
April 1985-1991	Assistant Professor of Pediatrics and Anesthesia Associate Director, Pediatric Intensive Care Unit
1983-1985	Assistant Professor of Anesthesia and Pediatrics Clinical Coordinator of Pediatric Intensive Care Unit Staff Anesthesiologist Egleston Children's Hospital at Emory Emory University School of Medicine
1981-1983	Emergency Room Physician Scottish Rite Hospital for Children, Atlanta, GA

CURRENT HOSPITAL MEDICAL STAFF APPOINTMENTS

- Memorial Health University Medical Center, Savannah

CERTIFICATION AND LICENSURE

American Board Certifications and Fellowship Status

1976, 78, 79 National Boards, Part I, II, & III
1984 Certified, American Board of Pediatrics
1984 Diplomat, Fellow, American Academy of Pediatrics
1998 Certified, American Board of Anesthesia
1989 Certified, Special Qualifications, Critical Care, American Board of Anesthesia
1992 Certified, Sub-Board of Pediatric Critical Care, American Board of Pediatrics
2001 Re-Certified in Pediatric Critical Care, American Board of Pediatrics (Current through 2007)
2007 Re-Certified in Pediatric Critical Care, ABP, Current through 2014

Other Certificates

1984 Fellow, American Academy of Pediatrics (FAAP)
1990 Certified, ECMO Physician
1998 Fellow, American College of Critical Care Medicine (FCCM)

Medical or Other Professional Licensure

1981- Present	Georgia Medical License #22669
2010 – Present	North Carolina License # 2010-00879

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

1983 Fellow, American Academy of Pediatrics
1983 International Anesthesia Research Society
1983 Society of Critical Care Medicine
1983 American Society of Anesthesia
1983 Georgia Society of Anesthesia
1983 Christian Medical and Dental Society
1983 Southern Medical Association
1987 Society of Pediatric Anesthesia
1991 Extracorporeal Life Support Organization
1994 American College of Physician Executives
1998 Fellow, College of Critical Care Medicine
2006 Member, ACHE
2007 AOA – Alpha Omega Alpha Honorary Medical Society

OTHER HOSPITAL AND PROFESSIONAL ACTIVITIES

Hospital Committees at Egleston Children's Hospital:

1983 - 2001	PICU Multidisciplinary Committee, Chair (1991-1994)
1990 - 2001	ECMO Supervisors Committee
1990 - 2001	ECMO Morbidity and Mortality Committee
1990 – 2001	US National Disaster Medical Assistance Team (DMAT)
1993 – 2001	Service Chiefs Meeting (Weekly)
1986 - 2000	Medical Executive Committee
1997 – 2000	Quality Improvement Committee (of the System Board)
	Resource Utilization Management Committee
	Clinical Monitoring Committee
	Quality Management Committee
	Performance Improvement Council
1986 - 1992	Resuscitation Committee (Code 99), Chairperson
1991 - 1995	Trauma Committee
1992 - 1996	Quality Assessment
1988 - 1991	Pharmacy and Therapeutics Committee
1993 - 1996	Emergent & Urgent Care Service Meeting (Chair)
1995 - 1998	Credentials committee

Department of Pediatrics Committees

1996 - 1997	Emory Egleston Children's Center Interim Board
	Contract Development Subcommittee
	COO, Search Committee
1993 - 1996	Department of Pediatrics Executive Committee
1991 - 1997	Division Directors Weekly meeting
1995- 1996	Emory Clinic & EEPCF task force
1994 - 1996	EEPCF Improvement task force (Chair)
1992 - 1994	Incentives Task Force
1993 - 1994	Patient Care Task Force (Strategic Planning)

Medical School Appointments/Committees

1993 - 1996	Emory University Medical School Admissions Committee

1995 – 1998	Emory - Egleston Joint Committee
1995 - 1998	Emory - Egleston Coordinating Committee (Chair)

Academy of Pediatric Committees

1995 – 1998	Georgia AAP Committee on Managed Care
1995 - 1997`	Pediatric Emergency Medicine Leadership Committee
1996 - present	Georgia AAP Committee on Child Health Finance
1997 - present	National Committee on Child Health Finance

Volunteer Work

1997 – 2001	Trustee, Christian Medical Dental Society National speaker, workshop leader, writer
1988 – 1990	Board member, Friends of China Foundation Three trips to People's Republic of China, 1986 - 1989. Cardiac Anesthesia and Intensive Care.
1985-present	Board of Reference, Human Resource Council
1988-1990	Founding Board Member, Good Samaritan Project, A ministry to patients with HIV disease
1994	Project Team Member: The World Bank project on hospital management for the People's Republic of China.
1997 -2002	Member, Egleston Auxillary

AMERICAN HEART ASSOCIATION ACTIVITIES

1987- 1996	Affiliate Faculty, ACLS, Georgia Affiliate
1988-1994	National Faculty, PALS, Georgia Affiliate
1981-1987	Director, Advanced Cardiac Life Support Courses for Egleston and Emory Hospitals.
1989-1996	Emergency Care Committee, Georgia Affiliate
1887-1996	ACLS Subcommittee of the ECC, Georgia Affiliate
1992	Georgia Affiliate Delegate to National Conference on Cardiopulmonary Resusciation and Emergency Cardiac Care, Dallas, Texas. February, 1992.
1992 – 1996	Co-Chair, State wide PALS Task Force, Georgia Affiliate
1992 - 1994	National Council on Critical Care

AWARDS

1975	Dean's Award for Student Research Wayne State University School of Medicine "Vitamin A Metabolism in the Retina"
1973	National Science Foundation Undergraduate Research Grant Oakland University, Rochester, MI "Viral Plaque Formation and Growth Analysis by Computerized Differential Equations"
1995	Wyeth™ Pediatric Miracle Maker Award Honoring exceptional patient, hospital & community service
1995	Best Doctors In America: Southern Region

1995 Positive Profiles; For promoting positive physician leadership
Top 50 Physicians in the country.

1998 Wayne Christy Award, and Honorary Doctorate of Divinity, Westminster College, New Wilmington, PA

1999 Best Doctors in America

2000 Award of Excellence from the American College of Physician Executives.

2007 Alpha Omega Alpha – Honorary Society – Elected Faculty Member

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GRANTS

1. Abbott Pharmaceutical Protocol #89883. Opticath^{tm} 5.5 F heparin-coated, flow-directed thermodilution catheter customer preference study. Total award: **$9,000.**

2. Physio-Control Corporation
   a) Field Trial of Pediatric Quik-Pace^{R} Disposable noninvasive pacing electrode. Approved, March, 1992. **Budget $1500**
   b) Field Trial of Pediatric Fast-Patch^{R} Disposable External Defibrillation Electrode. Approved, March, 1992. ***Budget $1500***

3. Children's Research Center, Emory University. High Frequency Oscillation Compared to Conventional Ventilation in the Management of Acute Respiratory Failure in Pediatric Patients. Award granted, May, 1992. ***Budget: $13,124.***

4. Pharmacodynamics of Famotidiene in Pediatric Intensive Care Patients. Merck, Sharpe and Dohme, Approved ***Budget: $14,000***. Awarded, June, 1992

5. *Co-Investigator*: Emergency Medical Services for Children. State of Georgia EMS (PI). Total Budget: ***$500,000*** over 2 years. Awarded, October, 1993.

6. *Co-Principle Investigator*. Assoc. of Teachers of Preventive Medicine & CDC. Childhood Sexual Abuse as a Determinant of Chronic Disease Risk: Identification of Family Risk Factors and Long Term Consequences. **$1,638,488** budget for 5 Years. Awarded, October 1. 1994.

7. Principle Investigator. HRSA. "Better Babies" : Parental Perspectives on Neonatal Genetic Screening. **$1,100,000** for 3 years. *Application submitted*, January 2007.

PUBLICATIONS

(* denotes Mentored Postdoctoral Fellow)

1. Increased efficiency using a virtual procedural sedation room. Scott MA, Jozefczyk S, Marinsecu R, **Wright JA.** NACHRI, Annual meeting proceeds, Fall 2005.

2. Pediatric Gait Analysis: A Call For Standardization. Marinescu R. [1] MS, Ph.D. candidate; Mitchell S, PT; McCartney D. , MD; **Wright, JA** AACPDM, Fall 2005.

3. Novel use of Vapotherm for premature infants. O'Dey S., Beasley M., **Wright JA**. Submitted, October, 2005. Am Journal of Respiratory and Critical Care Medicine.

4. Fetal Alcohol Syndrome: Guidelines for Referral and Diagnosis. Department of Health and Human Services, National Center on Birth Defects an Developmental Disabilities, **National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect**. July 2004.

5. Children and Bioterrorism: Report to the Secretary of Health and Human Services. **National Advisory Committee on Children and Terrorism**. June, 2003.

6. Schools and Terrorism. A Supplement to the **National Advisory Committee on Children and Terrorism**. Journal of School Health 2004; 74 (2); 39 –51.

7. Creating a safe environment for pediatric MRI, **Wright JA, Scott M.** Submitted.

8. Pain in the Fetus and Newborn. Theology Matters, 2003. **Wright JA**

9. Extracorporeal Life Support in Pediatric Acute Respiratory Failure: We Can Afford It AND Need it. Critical Care Medicine, May, 2000, Vol 28. No. 5, 1690. Vats A, Culler, **Wright JA.**

10. Improving Substance Abuse Prevention, Assessment, and Treatment, Financing for Children and Adolescents. Pediatrics, Vol 105 No. **Committee on Child Health Finance**

11. Factors affecting Probability of Response to a Survey about Child Abuse. Edwards VJ, Anda RF, Nordenberg DF, Felitti VJ, Williamson DF, and **Wright JA.** Child Abuse and Neglect.

12. Quality and Accountability: Children's Emergency Services in a Managed Care Environment. Moody-Williams JD, Dawson D, Miller DR, Schafermeyer RW, **Wright JA**, Athey J. Annals of Emergency Medicine. December 1999 34:6 753 – 760.

13. Medicaid Policy Statement, Pediatrics, Vol. 104, No 2, August, 1999. Pp 344- 348. **Committee on Child Health Finance.**

14. Prediction of Postoperative Resource Utilization in Pediatric Surgical Patients, Anand KJS, Hopkins SE, Wall B, **Wright JA**, Ricketts RR, Flanders WD.

15. Principles of Child Health Care Financing, Pediatrics, Vol 102, No 4, October, 1998, pp 994-995. **Committee on Child Health Finance**

16. **Wright JA**, The Doctor Patient Relationship in the World of Managed Care. Today's Christian Physician. Winter, 1999.

17. Implementation of Title XXI: Child Health Insurance Program. **Committee on Child Health Finance**. Pediatrics, 1998, May, 944 ff.

18. Vats A*, Culler S, **Wright JA.** The Cost Effectiveness of ECMO for Pediatric Respiratory Failure. Critical Care Medicine, September, 1998

19. Simon HK, Nordenberg DF, **Wright, JA.** Changes in Academic Emergency Departments in Response to Market-driven Health Care Reform. *Academic Medicine*, Vol. 72, No.5/May 1997.

20. Bloom A*, **Wright, JA,** Krawiecki N, Morris R. Additive Impact of In-Hospital Cardiac Arrest On The Function of Children With Heart Disease. March *Pediatrics*, 1997.

21. **Wright JA**. Urgency and Readiness: The Drivers for Success in Academic Medicine. Invited Letter. *Submitted, Academic Medicine, Fall, 1996.*

22. **Wright JA,** Simon HK, Ledbetter DA, Stegelman M, Lanese CL. Utilization of a computerized model of Queing Theory to Optimize Emergency Department Staffing. Accepted, *Pediatric Emergency Care.*

23. Egleston Children's Hospital Executive Team (Gayer AJ, Bachmann M, Harrell T, **Wright JA).** The CHCA Academic Cost Analysis Model. Child Health Institute, July, 1996.
    1. Organization and Governance
    2. Case Studies
    3. The Urgency for Academic Cost Analysis
    4. Cost Analysis Model

24. Simon HK, Ledbetter D, **Wright JA**. "Fast Tracking" lower acuity patients in an Urban Pediatric emergency department., *Am J of Emer Med, Vol 15, No.6, October, 1997.*

25. Caballero R*, Clark RH, **Wright JA**: Pediatric Respiratory Failure: Predictors of Mortality. *Clinical Pediatrics*. June, 1996

26. Fortenberry JD, Bhardwaj V*, Niemer P, Cornish JD, **Wright JA** and Bland, L.:Neutrophil and cytokine activation with neonatal extracorporeal membrane oxygenation. *J Pediatr*, May, 1996, Vol 128, Number 5, Part I.

27. **Wright JA.** Career choices for Physician Executives. *The Atlanta Journal Of Medicine*, March, 1996.

28. Simon HK, Khan NS, Nordenberg DF, **Wright JA.** Pediatric Emergency Medicine Physician Interpretation of Plain Radiographs: Is Routine Review by a Radiologist Necessary and Cost Effective? *Ann Emerg Med*, March, 1996; 27:295-298.

29. Simon HK, Castillo JC, McLario D, Daley R, Lanese C, **Wright JA**: Fast tracking patients in an urban pediatric emergency department. *Am J Emerg Med*. Jan. 1996.

30. Recommended Guidelines for Uniform Reporting of Pediatric Advanced Life Support: The Pediatric Utstein Style. Writing Group: Zaritsky A, Nadkarni V, Hazinski MF, Foltin G, Quan L, **Wright JA,** Fiser D, Zideman D, O'Malley P, Chameides L, Cummins R, and the Pediatric Utstein Consensus Panel.

31. ***Accepted for simultaneous publication in:***
- ✓ Circulation, 1995
- ✓ Resuscitation, 1995
- ✓ Pediatrics, October, 1995, Vol. 96, No. 4 p 765 ff.
- ✓ Annals of Emergency Medicine, 1996

32. **Wright JA**, Bucciarelli RL, Pearson H. Clinton Health Care Reform Plan: Effect on Children. *Infectious Diseases in Children*, Academy of Pediatrics, October, 1993.

33. Cornish JD, Clark RH, Ricketts RR, Dykes FD, **Wright JA**, Boecler B, and Kesser K: Extracorporeal Membrane Oxygenation Service of Egleston Children's Hospital at Emory University: The First Year's Experience. *J of the Med Assoc of Georgia, 1993.*

34. **Wright, JA.** Submersion Injuries: Need for prevention and bystander CPR. *CPR Innovater*, Vol 2 (1), 1994

35. Burkett MW, **Wright JA,** Ho I, Yue Z, Hughes CF: Serpentine heart: Direct observation of the human heart during profound hyperkalemia. *Intnl J Cardiol.* 36 (1992) 109-1100.

36. Morris R, **Wright JA,** Walter W*, Krawiecki N: Neuropsychological, academic, and adaptive functioning in children who survive inhospital cardiac arrest and resuscitation. *J of Learning Disabilities, 26(1): 46-51,Jan, 1993.*

37. Caballero R*, Pirmohamed R, **Wright JA**: Use of alpha methyl-tyrosine for refractory hypertension in a child with neuroblastoma. *Crit Care Med*, 20(4):1060-1062,1992.

38. Watson CS, Davies CR, Ahmann PA, **Wright JA**: Neurologic outcome following pediatric resuscitation. *J Neurosci Nurs*, 19(4):205-210, 1986.

39. Phillips B, **Wright JA.** Cost Analysis of Pediatric Cardiac Arrest. *Medical Economics*. April 1985.

40. Forestner JE, **Wright JA:** Vancomycin-induced hypotension in a child with congenital heart disease. *Clin Pediatr*, July, 1984.

News Citations

1. TODAY, NACHRI Publication, Fall 1996
2. Pediatric News, June 1997 Managed Care & Subspecialists
3. OB-Gyn News, June 1997 Managed Care & Subspecialists
4. Gannett Press Release, Spring, 1997 Future of Children's Hospitals (Various metro city releases).
5. Atlanta Journal Constitution, August 9, 1997
6. Marietta Daily, August 10, 1997
7. Gwinnett Daily News, August 10, 1997
8. Pediatric News, January 1998, The Future of Medicaid
9. Goizuetta Business School Publication, Physician Executives, Spring, 1999
10. Life @ Work, Fall, 1999 Ethics: It's Your Choice
11. American Family Radio, October, 1999. Organ Transplantation and the Ethical Implications.
12. Orlando Evening News, May 2000, The integration of faith and health.
13. Today's Christian Doctors, August, 2000. Making Your Voice Heard
14. AAP News, Vol 20 Number 1, January 2002. With changes in healthcare, MBA can add options for MDs.
15. Ob-Gyn News, September, 2005. Fetal Pain.

Governmental Committees, Legislative Hearings and Congressional Testimony

1. 1996 U.S. House of Representatives, Committee on the Judiciary, March 21, 1996. HR 1833. Partial Birth Abortion Ban. Implications on fetal pain.
2. 1996 The American Academy of Pediatrics representative to Health Care Finance Administration Panel on RBRVS development. Baltimore, Maryland. June 11, 12, 1996.
3. 1997 Georgia Legislature. Special hearing on parental consent for minors undergoing abortion.
4. 1998 Advisor to the Georgia Attorney General regarding upcoming litigation in 1998 regarding fetal pain.

5. 1998 US. Senate, Judiciary Hearing, January 21, 1998. Implications on fetal and pediatric pain.
6. 2004 Congressional Staff Briefing, June 2004. Understanding Fetal Pain

2001	Advisor to U.S. House Committee on Commerce – Community Health Center Funding
2002	CDC's National Advisory Committee on Children and Terrorism
2003	NIH's Fogarty Center Advisory Board

BOOK CHAPTERS & BOOKS

Committee on Pediatric Emergency Medicine, American Academy of Pediatrics. Emergency Medical Services for Children: The Role of the Primary Care Provider. Chapter on Managed Care and EMSC. Winter, 1999.

Bland JB, **Wright JA:** Postoperative care of the pediatric cardiac patient. In Lake C (ed): 1988.

FELLOWS & GRADUATE STUDENTS

1. Teresa Lyle, BSN, MSN.
Woodruff School of Nursing, Masters Thesis,

2. Warren Walters, MA, PhD
Georgia State University, PhD Thesis

3. Audrey Bloom, MA, PhD
Georgia State University, PhD Thesis.

4. Bernard Connell, MD
Fellow, 1987-1989; Current Position, Faculty, Univ. Of Tenn - Chattanooga
Board Eligible, Pediatric Critical Care, and Pediatric Emergency Medicine

5. Robert Pettignano, MD
Fellow, 1987-1989; Current Position, Arnold Palmer Children's Hospital Critical Care Attending; Board Certified, Pediatric Critical Care

6. Roberto Caballero, MD
Fellow, 1989 – 1991; Current Position, Attending Physician
Cook - Fort Worth Children's Hospital, Fort Worth Texas.
Board Certified, Pediatric Critical Care

7. Vijay Bhardwaj, MD
Fellow, 1989 – 1991; Current Position, Medical Director, William Beaumont Hospital PICU
Board Certified, Pediatric Critical Care

8. Sharon Holloway, MD
Fellow, 1991 – 1994; Faculty, Medical College of Virginia, 1994 - 1995,
1993 American Academy of Pediatrics Award
Neonatology Section, Basic Science Research
Current Position, Asst. Professor, Emergency Medicine & Urgent Care
Children's Healthcare of Atlanta

9. Thomas Bruns, MD
Fellow, 993 – 1995; Current Position, Faculty, Univ of Tenn @ Chattanooga

10. Lisa Padgett, MD
Fellow, 1994 – 1995; Current Position, Faculty, Univ of Tenn @ Knoxville

11. David Weinkle, MD

Fellow, 1994-1996; Current Position, Pediatric Emergency Department
Children's Healthcare of Atlanta

12. Marty Belson, MD

Fellow, 1994-1996; Current Position, Faculty, Emory University, Pediatric Emergency Medicine

13. Amirah Daher, MD MPH

Fellow Critical Care Medicine, 1992 – 1996 & Joint Degree in MPH, Emory
Instructor, University of Jordan 1996 – 1999
Current position, PICU attending, Henry Ford Hospital, Detroit MI

14. Atul Vats, MD

Fellow, 1994- 1997; Faculty, Univ of Texas, Galveston, 1997 – 1999
Faculty, Emory University, 1999 - Current

15. Nandu Ranagumdum, MBBS

Fellow, 1995 – 1998; Current Position: J1 Visa Conversion, Amarillo, Texas

16. Mirna Farrah, MD

Fellow, 1995-1998; Current Position, Children's Hospital of Philadelphia, Univ of Penn.

17. Karl Serrao, MD

Fellow, 1996 – 1999; Current Position, Faculty, University of Texas, Corpus Christi, Texas

18. Toni Petrillo, MD

Fellow, 1998 – 2001, Currently, Asst Professor, Emory University, Atlanta, GA

19. Judith Heggen, DO

Fellow 1999 – 2002, Also received M.S. during fellowship.
Currently, Faculty University of Iowa.

Women in Leadership

Speaking engagements

1. Atlanta Women in Leadership	October, 1996
2. Cobb County Women's Chamber of Commerce	September, 1996
3. Atlanta Women's Chamber of Commerce	May, 1997, and May, 1998
4. Executive Women International	Sept 10, 1998
5. Focus on the Family / CMDS Annual Joint Conference	November, 11 - 14, 1998

Host Committee

1. Atlanta's Women Physicians for the Atlanta Women's Fund	Jan, 1998
2. Atlanta's Women In Medicine and Law	Jan, 2001, 2002

Motivational Speaking

Speaking engagements	**DATE**	**Type**	**Audience**
• The Ivan Allen Company	May, 1998	Annual Sales Meeting	125
• CMDS Annual Meeting	May, 1998	Annual National Meeting	85
• Executive Women International	Sept. 1998	Annual National Meeting	200
• CMDS Winter Ski Retreat	February, 1999	Annual Event	60
• Food for Thought	March, 1999 September, 2000	Monthly Lunch 'n Learn	100 150
• Lilburn Mother's Day Luncheon	May, 1999	Annual Event	50
• CMDS Pacific NW Winter Retreat	January, 2000	Annual Event	50
• CMDS Women's Retreat	March, 2000	Bi-Annual Event	50
• CMDS Annual Meeting	May, 2000	Annual Event	100
• CMDS Midwest Regional Meeting	May, 2000	Annual Event	100
• Oklahoma Family Practice Residency	March, 2001	Annual Event	100

• Focus on the Family Conference 400	November, 2001	Annual	Physician Meeting
• International CMDE Conference	February, 2002	Bi-annual	Physician 500
• CMDA Women's Retreat	March, 2002	Bi-annual	Physician 100
• Christian Management Association 1200	March, 2002	Annual	Conference
• Presbyterian General Assembly	June, 2002	Annual	Conference 1500

Management & Leadership Experience

1. Reorganized Pediatric Critical Care Medicine: Chief 1991 - 2000.

Restructured billing process: Net Income went from net loss to the department, the third most profitable division in three years. Recruited 5 new faculty members from nationally recognized programs. All 5 faculty board certified in Pediatrics & Critical Care. Restructured & resubmitted fellowship program for ACGME accreditation. Has been approved continuously. Two Fellows have won the Young Investigator Award at the American Academy of Pediatrics: one in 1993 for Basic Science, and one in 1998 for Basic Science. Increased coverage from one site (Egleston) to two (Hughes Spalding) in 1991.

2. Reorganized Pediatric Emergency Medicine : Begun 1992

- Unified 4 sites of service into one academic division
- Increased staffing from 8 FTE's to 25 FTE's and 33 total members.
- Decreased turn around time and walk outs at all 4 sites
- Total 1993 patient visits of 140,000
- Recruited and hired 35 FTE since Jan, 1993
- Reorganized hospital run departments into Emory University Divisions
- Developed Fast Track Model to increase efficiency at 3 of 4 sites.
- Implemented common informatics systems and EMail for all CCM & PEM MDs.

3. Developed Model of Indigent Care Primary Care for Egleston Hospital

Five month project from inception to operation. Opening Date of first Clinic: April 5, 1994, Marietta, GA. Seven sites opened by the end of 1995, with a total of 20 full time physicians and providers.

4. Recruited Pediatricians for Emory Clinic, Center For Personal Physicians

Began first practice December 15, 1994, Two more physicians hired for July, 1994. Emory Clinic site staffing equals 3 FTEs by December, 1995.

5. Board Of Directors, Atlanta Children's Health Network

Developed product from initial stages through formal board developement. 150 primary care pediatricians in Metropolitan Atlanta Primary Care PHO with Egleston Children's Hospital.

6. Steering Committee, Pediatric Subspecialists Contracting Organization

Subspeciality Care PHO with alignment of the Emory Clinic pediatric subspecialists. This subsequently developed into the Emory Egleston Children's Center project; an attempt to bring all the pediatric subspecialists into a single practice plan (1995 - 1996).

7. Re-organized Pediatric Subspeciality Clinic for the Department of Pediatrics.

Improvement in organization structure, medical records, management reporting and resource utilization. Measurements of time to next appointment, patients/clinic session, and access to schedulers employed.

8. CEO and Founder, Egleston Pediatric Group, Inc.

A multidisciplinary group of over 84 pediatricians and pediatric subspecialists. Provides coverage for 9 satellite facilities with urgent care and 7 primary care. Also houses Critical Care, Medicare, Gastroenterology, Psychiatry and Endocrinology as of May, 1997.

9. Developed Child Protection Team

CDC Funded project to evaluate long term effects of child abuse. Bell South Celebrity Classic funded the development of a child protection team ($700,000). Rainbow Run designated to fund $30,000 operation costs. Local philanthopy pledged $50,000. Total awarded funding to date: **$3,280,000.**

10. Vice President, Medical Management

Reorganized Quality and Clinical Resource Management Department. Led preparation for JCAHO visit. Develop Critieria for clinical privileges. Built infrastructure for real-time case management and disease management programs. Developed Dashboard for Quality Monitoring. Co-facilitated the Board Quality Improvement Committee of the Board of Trustees. Integrated Process Thinking across the newly merged Children's System. Awarded Accreditation with Commendation back to back, and recognized in two JCAHO publications for Benchmark Programs (Performance Improvement and Physician Peer Review). Budget **$3,900,000** and 65 FTE's.

11. Backus Children's Hospital Turn-around.

After a decade of financial losses, the net income for Backus Children's Hospital has gone from – 1.5 million to + 8.8 million in 3 years. No layoffs or major restructuring occurred. Instead an intensive focus on managing the current business, physician integration, and increasing patient volume have created the improvement in a children's hospital with 75% Medicaid payor population. Now direct responsible for 133 inpatient beds, 500 employees, 3000 deliveries, and gross revenue of over $192 million (women's and children's combined).

INTERNATIONAL EXPERIENCE

1983:	General Medicine and Pediatrics Port-au-Prince, Haiti, Arranged through the Southern Baptist Church
1984:	General Medicine and Pediatrics, Papua New Guinea Guest of Summer Institutes of Linguistics, Taught physical diagnosis and first aid to 12 tribal men who function as physician assistants.
1985:	General Medicine and Pediatrics, Assisted Missionaries at outpost locations Guest of Summer Institutes of Linguistics
1986:	Guest of People's Republic of China, Friends of China Foundation Taught cardiovascular anesthesia and intensive care in medical schools in Guangzhou, Wuhan, Changsha and Beijing.
1987:	Guest of People's Republic of China, Friends of China Foundation Taught cardiovascular anesthesia and intensive care in medical schools in Guangzhou, Xinhua, Wuhan
1989:	Guest of People's Republic of China, Friends of China Foundation Taught cardiovascular anesthesia and intensive care in medical schools in Guangzhou and Changsha.
1994	Guest Lecturer: The World Bank & WHO project for Hubei Province. Physicians as Hospital Administrators, October, 1- 10, 1994. Tongi Medical School and Hubei Department of Public Health
1994	Two week seminar in Eastern Europe with the Emory Business School Privatization of previously socialized industries Budapest, Linz, Vienna, Prague
1999	Guest Professor, University of the Nations, Kona, Hawaii.
2000	International CMDE Conference, Kenya. Taught the mini-course on the Business of Medicine for Hospitals in Africa and the middle East.

2001 Shenyang, China. Mini-course on the Business of Medicine, and the development of Family practice residencies in China.

2002 Guest faculty, Beijing Children's Hospital, Beijing China. Leadership skills for hospital administrators.

Foreign Language Experience:
Varying proficiencies in Melanesian Pidgen (New Guinea language), and Mandarin Chinese .

Relevant Parts of the Record Pursuant to Fed. R. App. P. 8(a)(2)(B)

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF ARIZONA

Paul A. Isaacson, M.D.; William Clewell, M.D.; Hugh Miller, M.D.,

Plaintiffs,

vs.

Tom Horne, Attorney General of Arizona, in his official capacity; William (Bill) Montgomery, County Attorney for Maricopa County, in his official capacity; Barbara LaWall, County Attorney for Pima County, in her official capacity; Arizona Medical Board; and Lisa Wynn, Executive Director of the Arizona Medical Board, in her official capacity,

Defendants.

No. CV-12-01501-PHX-JAT

ORDER

Pending before the are: (1) Defendant Montgomery's Motion to Dismiss (Doc. 25), (2) Plaintiffs' Motion for Preliminary Injunction (Doc. 2), and (3) Defendant Montgomery's Motion to Dismiss Defendant LaWall (Doc. 42). The Court held a preliminary injunction hearing on July 25, 2012 and took these matters under advisement. The Court now rules on the Motions.

I. FACTUAL AND PROCEDURAL BACKGROUND

Arizona House Bill 2036 ("H.B. 2036") was approved by Governor Janice K. Brewer on April 12, 2012 and is set to take effect on August 2, 2012. On July 12, 2012, Plaintiffs filed a Complaint in this Court seeking a declaratory judgment that section 7 of H.B. 2036

is unconstitutional. Plaintiffs also request a preliminary and permanent injunction: (1) restraining Defendants, their employees, agents, and successors from enforcing section 7 as to previability abortions and (2) prohibiting Defendants, their employees, agents, and successors from bringing enforcement actions for previability abortions performed while any injunction is in effect restraining enforcement of section 7. Plaintiffs specifically object to the portion of section 7 that provides:

> Except in a Medical Emergency, a person shall not knowingly perform, induce or attempt to perform or induce an abortion on a pregnant woman if the probable gestational age of her unborn child has been determined to be at least twenty weeks.

H.B. 2036, 50th Leg., 2d Reg. Sess. § 7 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2159(B)) . "A person who knowingly violates this section commits a class 1 misdemeanor." H.B. 2036, 50th Leg., 2d Reg. Sess. § 7 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2159(C)). Further, "[a] physician who knowingly violates this section commits an act of unprofessional conduct and is subject to license suspension or revocation pursuant to title 32, chapter 13 or 17." H.B. 2036, 50th Leg., 2d Reg. Sess. § 7 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2159(D)). The statutory scheme also gives standing to certain individuals to bring civil actions for violations of section 36-2159. H.B. 2036, 50th Leg., 2d Reg. Sess. § 7 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2159(E)-(H)).

"Abortion" is defined as:

> the use of any means to terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will cause, with reasonable likelihood, the death of the unborn child. Abortion does not include birth control devices, oral contraceptives used to inhibit or prevent ovulation, conception or implantation of a fertilized ovum in the uterus or the use of any means to save the life or preserve the health of the unborn child, to preserve the life or health of the child after a live birth, to terminate an ectopic pregnancy or to remove a dead fetus.

H.B. 2036, 50th Leg., 2d Reg. Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(1)).

"Gestational age" is defined as "the age of the unborn child as calculated from the first day of the last menstrual period of the pregnant woman." H.B. 2036, 50th Leg., 2d Reg.

Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(4)).

"Medical emergency" is defined as "a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function." H.B. 2036, 50th Leg., 2d Reg. Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(6)).

"Viable fetus" is defined as "the unborn offspring of human beings that has reached a stage of fetal development so that, in the judgment of the attending physician on the particular facts of the case, there is a reasonable probability of the fetus' sustained survival outside the uterus, with or without artificial support." Ariz. Rev. Stat. Ann. § 36-2301.01; H.B. 2036, 50th Leg., 2d Reg. Sess. § 1 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-449.01(7)) ("'Viable fetus' has the same meaning prescribed in section 36-2301.01.").

In section 9 of H.B. 2036, the Arizona Legislature listed a number of findings and purposes it made in promulgating H.B. 2036. Findings in support of section 7 include: (1) that abortion "can cause serious both short-term and long-term physical and psychological complications for women;" (2) that abortion "has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at eight weeks of gestation or earlier, the relative risk increases exponentially at higher gestations;" (3) "[t]he incidence of major complications is highest after twenty weeks of gestation;"(4) "[t]he risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks gestation to one per 29,000 abortions at sixteen to twenty weeks and one per 11,000 abortions at twenty-one or more weeks . . . After the first trimester, the risk of hemorrhage from an abortion, in particular, is greater, and the resultant complications may require a hysterectomy, other reparative surgery or a blood transfusion;" (5) "[t]here is substantial and well-documented medical evidence that an unborn child by at least twenty weeks of gestation has the capacity to feel pain during an abortion;" and (6) that the State of Arizona has a legitimate concern in protecting the public's health and safety,

including the health of women who undergo abortions. H.B. 2036, 50th Leg., 2d Reg. Sess. § 9(A)(1-7) (Ariz. 2012).

As a result of these findings, the Arizona Legislature stated that it promulgated H.B. 2036 "based on the documented risks to women's health and the strong medical evidence that unborn children feel pain during an abortion at [20 weeks] gestational age." H.B. 2036, 50th Leg., 2d Reg. Sess. § 9(B)(1) (Ariz. 2012).

II. DEFENDANT MONTGOMERY'S MOTION TO DISMISS

Defendant Montgomery ("Defendant") filed a motion to dismiss, arguing that, under *Gonzales v. Carhart*, 550 U.S. 124 (2007), the Court cannot entertain a *facial* attack to H.B. 2036.[1] (Doc. 25). In response, Plaintiffs argue that this is not a facial attack because they are only challenging H.B. 2036 "as applied" to previability abortions. Plaintiffs further argue that, even if this is a facial attack, dismissal would nonetheless be inappropriate.

At the outset, the Court must resolve the debate as to whether this is a facial or as-applied challenge to section 7 of H.B. 2036. While Plaintiffs attempt to characterize their challenge to section 7 of H.B. 2036 as an "as-applied" challenge, in this action, Plaintiffs are challenging section 7 of H.B. 2036 on its face. Plaintiffs do not argue that the statute has been applied to Plaintiffs in this action (nor could they because H.B. 2036 has not yet gone into effect), nor do they argue that the *20 week* limitation is constitutional under some unspecified set of facts, but only unconstitutional as-applied to Plaintiffs.

Plaintiffs do argue that the provision of section 7 limiting abortions prior to 20 weeks

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[1] Defendant Montgomery also appears to argue that the case should be dismissed because the Complaint is not verified. However, there is no requirement that the Complaint be verified in order for the Court to consider a Motion for Preliminary Injunction. Rather, Federal Rule of Civil Procedure 65 provides that the court may issue a temporary restraining order without notice to the adverse party or its attorney only if "specific facts in an affidavit or a verified complaint clearly show that immediate and irreparable injury, loss, or damage will result to the movant before the adverse party can be heard in opposition." Fed.R.Civ.P. 65(b). However, this portion of Rule 65 is not implicated in this case because Plaintiffs are seeking a Preliminary Injunction rather than a temporary restraining order, Defendants have notice of Plaintiffs' Motion for Preliminary Injunction, and Plaintiffs submitted proper declarations to the Court in support of their Motion for Preliminary Injunction.

is unconstitutional. If the Court were to accept Plaintiffs' argument that it is unconstitutional to limit abortions prior to 20 weeks, there could be no possible reading of section 7 of H.B. 2036 that would render it constitutional "as applied" to certain factual situations. Because any ruling that the statute's 20 week limitation is unconstitutional would render section 7 of H.B. 2036 meaningless (as there is no other limitation in section 7), Plaintiffs are challenging H.B. 2036 on its face, and Plaintiffs' challenge is properly considered a facial challenge.

Defendant Montgomery argues that, because Plaintiffs challenge section 7 of H.B. 2036 on its face, this case should be dismissed because, in *Gonzalez v. Carhart*, 550 U.S. 124 (2007), the United States Supreme Court held that such an attack must be made "as-applied" to a particular factual situation.

In *Gonzales*, Plaintiffs argued that a statute unconstitutionally *lacked* a health exception. 550 U.S. at 167. The Supreme Court found that a facial attack could not be maintained because the respondents in that case had not "demonstrated that the Act would be unconstitutional in a large fraction of relevant cases." *Id.* at 167-168. Rather, the *Gonzales* Court found that an as-applied challenge would be the "proper manner to protect the health of the woman if it [could] 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 used." *Id.* at 167.

Unlike *Gonzales* in which the challenge was that the statute lacked certain language, H.B. 2036 contains the language to which Plaintiffs object *on its face*. That language is specifically that "a person shall not knowingly perform, induce or attempt to perform or induce an abortion on a pregnant woman if the probable gestational age of her unborn child has been determined to be at least twenty weeks." In their Complaint, Plaintiffs argue that this language is unconstitutional under Supreme Court jurisprudence. As such, in order to decide whether Plaintiffs are correct that, under clearly established law, section 7 of H.B. 2036 is unconstitutional, the Court must decide the merits of Plaintiff's facial challenge to the language of section 7 of H.B. 2036.

Of course, this does not foreclose the possibility that certain as-applied challenges

could or must be made under certain circumstances not present here, but, to decide the merits of Plaintiffs' arguments in this case, the Court must determine whether the language of the statute is valid on its face.

Accordingly, Defendant's Motion to Dismiss arguing that the case should be dismissed as an improper facial challenge (Doc. 25) is denied.

III. PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

A. Legal Standard for a Preliminary Injunction

To be entitled to a preliminary injunction, Plaintiffs must show: (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tip in their favor; and (4) an injunction is in the public interest. *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 24-25 (2008). Even if Plaintiffs have not demonstrated that they are likely to succeed on the merits, if Plaintiffs establish factors (3) and (4), a preliminary injunction is also appropriate when Plaintiffs have demonstrated "serious questions going to the merits" and the "hardship balance tips sharply toward plaintiff[s]." *Alliance for Wild Rockies v. Cottrell*, 632 F.3d 1127, 1134-35 (2011).

The Court notes that the parties do not materially dispute the facts in this case. Rather, the primary dispute between the parties is the state of the law following the United States Supreme Court's decision in *Gonzalez v. Carhart*, 550 U.S. 124 (2007).

B. Findings of Fact and Conclusions of Law

1. Likelihood of Success on the Merits

Broad facial challenges to an abortion statute "impose a 'heavy burden' upon the parties maintaining the suit." *Gonzales*, 550 U.S. at 167 (citing *Rust v. Sullivan*, 500 U.S. 173, 183 (1991)).

Plaintiffs argue that, if H.B. 2036 goes into effect, it will ban abortions prior to viability. Plaintiffs further argue that, at 20 weeks, no fetus has yet become viable, and thus, by banning abortions beginning at 20 weeks of age, H.B. 2036 bans abortions prior to viability. Plaintiffs argue that "[u]nder HB 2036, a woman seeking to terminate a previability pregnancy at or after 20 weeks due to a medical condition that poses a significant

risk to her health may either be prohibited from doing so altogether, or may have to delay the procedure until her condition worsens to the point where it fits within the Act's narrow definition of 'medical emergency' and immediate action is necessary." (Doc. 3 at 3-4).

At the outset, the Court notes that in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 879-80 (1992), the U.S. Supreme Court rejected such a narrow interpretation of the definition of "medical emergency," as set forth in Pennsylvania's abortion statute, which is identical to the definition of "medical emergency" in H.B. 2036. *Compare* H.B. 2036, 50th Leg., 2d Reg. Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(6)) (Arizona's definition of "medical emergency") *with Casey*, 505 U.S. at 902 (appendix to opinion of O'Connor, Kennedy, and Souter, JJ) (setting forth Pennsylvania's definition of "medical emergency.").

The *Casey* Court stated:

> Petitioners argue that the definition is too narrow, contending that it forecloses the possibility of an immediate abortion despite some significant health risks. If the contention were correct, we would be required to invalidate the restrictive operation of the provision, for the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health. 410 U.S., at 164, 93 S.Ct., at 732. See also *Harris v. McRae*, 448 U.S., at 316, 100 S.Ct., at 2687.
>
> The District Court found that there were three serious conditions which would not be covered by the statute: preeclampsia, inevitable abortion, and premature ruptured membrane. 744 F.Supp., at 1378. Yet, as the Court of Appeals observed, 947 F.2d, at 700–701, it is undisputed that under some circumstances each of these conditions could lead to an illness with substantial and irreversible consequences. While the definition could be interpreted in an unconstitutional manner, the Court of Appeals construed the phrase "serious risk" to include those circumstances. *Id.*, at 701. It stated: "[W]e read the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman." *Ibid.* As we said in *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 499–500, 105 S.Ct. 2794, 2799–2800, 86 L.Ed.2d 394 (1985): "Normally, . . . we defer to the construction of a state statute given it by the lower federal courts." Indeed, we have said that we will defer to lower court interpretations of state law unless they amount to "plain" error. *Palmer v. Hoffman*, 318 U.S. 109, 118, 63 S.Ct. 477, 482, 87

> L.Ed. 645 (1943). This "'reflect[s] our belief that district courts and courts of appeals are better schooled in and more able to interpret the laws of their respective States.' " *Frisby v. Schultz*, 487 U.S. 474, 482, 108 S.Ct. 2495, 2501, 101 L.Ed.2d 420 (1988) (citation omitted). We adhere to that course today, and conclude that, as construed by the Court of Appeals, the medical emergency definition imposes no undue burden on a woman's abortion right.

Id. at 880. In light of this analysis in *Casey*, the phrase "serious risk" in Arizona's statute must likewise encompass conditions that could lead to "an illness with substantial and irreversible consequences." *See id.*

Ever since *Roe v. Wade*, 410 U.S. 113 (1973), the United States Supreme Court has recognized that the Fourteenth Amendment of the United States Constitution guarantees the "constitutional liberty of the woman to have some freedom to terminate her pregnancy." *Casey*, 505 U.S. at 869. "The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted." *Id.*

In *Casey*, the Court stated the broad conclusion that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." 505 U.S. at 846. In *Gonzales*, the Supreme Court began defining the types of restrictions the government could impose in light of *Casey*.

More specifically, in *Gonzales*, the Supreme Court *assumed* to be true *Casey*'s premise that "a State 'may not prohibit any woman from making the ultimate decision to terminate her pregnancy'" and then set forth the standards and policy considerations that must be taken into account in determining whether a statute regulating previability abortions is constitutional. *Gonzales*, 550 U.S. at 146 (quoting *Casey*, 505 U.S. at 879). In *Gonzales*, the Court held that a statute prohibiting partial birth abortions both previability and postviability was constitutional. *See id.* at 124.

The parties in this case heavily dispute the effect of the *Gonzales* decision on *Casey*'s

statement that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion," and its applicability to H.B. 2036. Having considering H.B. 2036 in detail, the Court finds this statement from *Casey* inapposite because H.B. 2036 does not prohibit all abortions after 20 weeks gestational age. Rather, H.B. 2036 regulates abortions that take place after 20 weeks gestational age.

The portion of H.B. 2036 that defines "abortion" does not purport to include situations where means are used to "save the life or preserve the health of the unborn child, to preserve the life or health of the child after a live birth, to terminate an ectopic pregnancy or to remove a dead fetus." H.B. 2036, 50th Leg., 2d Reg. Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(1)). Further, the statute contains a medical emergency exception that allows for an abortion to avert a pregnant woman's death or to avoid a serious risk of substantial and irreversible impairment of a major bodily function. H.B. 2036, 50th Leg., 2d Reg. Sess. § 3 (Ariz. 2012) (to be codified as Ariz. Rev. Stat. § 36-2151(6)). Accordingly, H.B. 2036 does not purport to ban all abortions past 20 weeks gestational age. Further, the statute allows for abortions up to and including 20 weeks gestational age. As such, H.B. 2036 is not a ban on previability abortions, but is rather a limit on some previability abortions between 20 weeks gestational age and viability (which it is undisputed usually occurs between 23 and 24 weeks gestational age).

Accordingly, pursuant to *Gonzales*, H.B. 2036 would be "unconstitutional 'if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability,'" 550 U.S. at 156 (quoting *Casey*, 505 U.S. at 878) or, in other words, the issue in this case is whether H.B. 2036 "measured by its text in this facial attack imposes a substantial obstacle to late-term, but previability, abortions." *Id.* Further, where legislation does not impose a substantial obstacle to abortion and the legislation "furthers the legitimate interest" of the Government, abortion legislation will be upheld. *See id.* at 146.

a. Substantial Obstacle and the State's Interest

Based on the facts of this case, the Court finds that H.B. 2036 does not impose a

substantial obstacle to previability abortions. As referenced above, the effect of H.B. 2036 limits abortions between 20 weeks and the time of viability.

The Court recognizes that viability differs from woman to woman and 23 to 24 weeks gestational age is, on average, the attainment of viability. The parties appear to agree that the fetus most commonly attains viability at 23-24 weeks gestational age. *Compare* Doc. 2, Exhibit 1 at ¶ 15 ("It is commonly accepted . . . that a normally developing fetus will attain viability at approximately 24 weeks") *with* Doc. 25-1, Exhibit 2 at ¶ 17 ("The number of children that are born and survive at 23-28 weeks gestation is common enough now that the term 'Micro-premie' has been coined to describe them and an additional body of neonatal science is focused upon them. As medical science pushes the frontier of fetal 'viability' to 23 weeks and perhaps earlier with the advent of artificial wombs and placental support, there is a possibility that a definition of 'viability' based upon gestational age will soon be irrelevant."). As such, the Court focuses on this 3-4 week time frame (while recognizing that this time frame may be even shorter in the future as technology advances to make viability even earlier) and examines H.B. 2036 from that perspective.

Plaintiff Dr. Clewell avows that 90% of abortions take place during the first trimester of pregnancy, through approximately the thirteenth week. (Doc. 2, Exhibit 2 at ¶ 9). Further, Dr. Clewell avows that, in some patients, it is not possible to diagnose a fetal anomaly until close to 20 weeks. (*Id.* at ¶ 13). In support of this statement, Dr. Clewell avows that: (1) amniocentesis, a procedure to detect and diagnose chromosomal anomalies, is usually performed at about 16 weeks and requires 10-12 days for the results to be available; and (2) detailed anatomic ultrasounds are generally done after 18 weeks. (Doc. 2, Exhibit 2 at ¶ 13). Dr. Clewell stops short of claiming that there are any conditions that could only be diagnosed after 20 weeks that could not have been found before that time. And indeed, one of Defendant's experts, Dr. Sawyer avows "[w]ith antenatal screening being done with nuchal fold translucency testing and early genetic marker testing, the diagnosis of fetal anomalies should occur prior to 20 weeks gestation. It is truly rare [that a woman] loses the opportunity to abort because she is past 20 weeks gestation." Doc. 25-3, Exhibit 3 at ¶ 12. Accordingly,

the Court finds that it would be extremely rare to find a condition that could be diagnosed after 20 weeks that could not have been diagnosed earlier.

Based on the time frames set forth by Dr. Clewell, Plaintiffs argue that a pregnant woman needs time to make the extremely difficult decision as to whether to continue the pregnancy and, in such a situation, it will take longer than twenty weeks to make such a decision. Accepting these statements as true, while H.B. 2036 will make it necessary to make an immediate decision as to whether or not to have an abortion in some cases, such a time limitation cannot be construed to be a substantial obstacle to the right to make the abortion decision itself. *See Gonzales*, 550 U.S. at 157-58 ("the fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.") (quoting *Roe v. Wade*, 505 U.S. at 874).

In upholding a regulation in *Gonzales*, the Supreme Court noted that, despite the fact that the "necessary effect of the regulation" would "be to encourage some women to carry the infant to full term, thus reducing the absolute number of late-term abortions," the regulation was constitutional. See 550 U.S. at 160. Likewise, a corollary proposition in this case is that, while H.B. 2036 may prompt a few women, who are considering abortion as an option, to make the ultimate decision earlier than they might otherwise have made it, H.B. 2036 is nonetheless constitutional because it does not "prohibit any woman from making the ultimate decision to terminate her pregnancy." *Id.* at 146 (quoting *Casey*, 505 US. at 879). Therefore, Plaintiffs have not shown that H.B. 2036 imposes a substantial obstacle to previability abortions.

Further, to the extent that Plaintiffs argue that, in certain unique circumstances, a diagnosis of fetal anomalies will not occur until after 20 weeks and thus, the woman's decision as to whether to have an abortion will be completely taken away from her, such a situation cannot be the basis of the Court's decision in a facial challenge to a statute. *See Gonzales*, 550 U.S. at 153, 167 (noting that "[t]he elementary rule is that every reasonable construction must be resorted to, in order to save a statute from unconstitutionality," and

finding that an as-applied challenge is the proper manner to protect a woman if it can be shown that in specific, well-defined instances, a particular procedure must be used.). In this case, if the statute would be unconstitutional as applied to a particular woman because it deprives her of the right to make the abortion choice previability, such a challenge should be entertained at that time.

Accordingly, the Court must determine if the State has a legitimate interest in prohibiting abortions past 20 weeks gestational age. There is no question that the "government may use its voice and its regulatory authority to show its profound respect for the life within the woman." *Gonzales*, 550 U.S. at 157. In this case, the Legislature listed a number of findings it made in promulgating section 7 of H.B. 2036 and the purposes for the legislation. Chief among these purposes were: (1) to prevent abortions where the unborn child would feel the pain involved in an abortion, and (2) to protect the health of the pregnant woman, which resulted in part from a finding that the major complications of abortion are highest after 20 weeks of pregnancy.

It is undisputed in the Record before the Court that the two procedures described in *Gonzales* are the non-emergency procedures that would be used to perform an abortion past 20 weeks gestational age. The first, a D&E, is described in *Gonzales* as follows:

> Of the remaining abortions that take place each year, most occur in the second trimester. The surgical procedure referred to as 'dilation and evacuation' or 'D & E' is the usual abortion method in this trimester. *Planned Parenthood, supra*, at 960–961. Although individual techniques for performing D & E differ, the general steps are the same.
>
> A doctor must first dilate the cervix at least to the extent needed to insert surgical instruments into the uterus and to maneuver them to evacuate the fetus. *National Abortion Federation, supra*, at 465; App. in No. 05–1382, at 61. The steps taken to cause dilation differ by physician and gestational age of the fetus. See, *e.g., Carhart, supra*, at 852, 856, 859, 862–865, 868, 870, 873–874, 876–877, 880, 883, 886. A doctor often begins the dilation process by inserting osmotic dilators, such as laminaria (sticks of seaweed), into the cervix. The dilators can be used in combination with drugs, such as misoprostol, that increase dilation. The resulting amount of dilation is not uniform, and a doctor does not know in advance how an individual patient will respond. In general the longer dilators

> remain in the cervix, the more it will dilate. Yet the length of time doctors employ osmotic dilators varies. Some may keep dilators in the cervix for two days, while others use dilators for a day or less. *National Abortion Federation, supra,* at 464–465; *Planned Parenthood, supra,* at 961.
>
> After sufficient dilation the surgical operation can commence. The woman is placed under general anesthesia or conscious sedation. The doctor, often guided by ultrasound, inserts grasping forceps through the woman's cervix and into the uterus to grab the fetus. The doctor grips a fetal part with the forceps and pulls it back through the cervix and vagina, continuing to pull even after meeting resistance from the cervix. The friction causes the fetus to tear apart. For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman. The process of evacuating the fetus piece by piece continues until it has been completely removed. A doctor may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes. Once the fetus has been evacuated, the placenta and any remaining fetal material are suctioned or scraped out of the uterus. The doctor examines the different parts to ensure the entire fetal body has been removed. See, *e.g., National Abortion Federation, supra,* at 465; *Planned Parenthood,* 320 F.Supp.2d, at 962.
>
> Some doctors, especially later in the second trimester, may kill the fetus a day or two before performing the surgical evacuation. They inject digoxin or potassium chloride into the fetus, the umbilical cord, or the amniotic fluid. Fetal demise may cause contractions and make greater dilation possible. Once dead, moreover, the fetus' body will soften, and its removal will be easier. Other doctors refrain from injecting chemical agents, believing it adds risk with little or no medical benefit. *Carhart, supra,* at 907–912; *National Abortion Federation, supra,* at 474–475.

Id. at 135-36 (emphasis added). The second, less-commonly used, procedure is a medical induction, where "[t]he doctor medicates the woman to induce labor, and contractions occur to deliver the fetus." *Id.* at 140. In an induction procedure, the fetus is injected with a medication that induces a heart attack. *See Carhart v. Ashcroft,* 331 F.Supp.2d 805, 875 (D. Neb. 2004) (describing induction by intracardiac injection); *Planned Parenthood Federation of America v.* 320 F.Supp.2d 957, 960 (N.D. 2004) (explaining that induction is also known as a "medical abortion" where "drugs are administered to abort the pregnancy").

In choosing to put a limit on abortions past 20 weeks gestational age, the Arizona Legislature cited to the substantial and well-documented evidence that an unborn child has

the capacity to feel pain during an abortion by at least twenty weeks gestational age. Defendants presented uncontradicted and credible evidence to the Court that supports this determination. Namely, the Court finds that, by 7 weeks gestational age, pain sensors develop in the face of the unborn child and, by 20 weeks, sensory receptors develop all over the child's body and the children have a full complement of pain receptors. Doc. 25-1, Exhibit 1 at ¶ 4; Doc. 25-1, Exhibit 2 at ¶ 20.

That the unborn child can feel pain is further supported by the fact that when provoked by painful stimuli, such as a needle, the child reacts, as measured by increases in the child's stress hormones, heart rate, and blood pressure. Doc. 25-1, Exhibit 1 at ¶ 5. When the child is given anesthesia, these responses decrease, which is why doctors often give both the mother and the fetus anesthesia separately in the case of fetal surgery. *Id.*; Doc. 25-1, Exhibit 2 at ¶¶ 27, 29-30. Nowhere in the Record is it suggested that a fetus is given anesthesia before being subjected to a D&E or an induction abortion.

Given the nature of D&Es and induction abortions, as described above, and the finding that the unborn child has developed pain sensors all over its body by 20 weeks gestational age, this Court concludes that the State has shown a legitimate interest in limiting abortions past 20 weeks gestational age.

Further, in promulgating H.B. 2036, Arizona expressed concerns for the health of the pregnant woman, finding that the instance of complications is highest after twenty weeks of gestation. This additional legitimate interest further supports H.B. 2036's regulation on abortions after 20 weeks gestational age. *See* Doc. 25-3 at Exhibit 3.

Based on the foregoing, the Court finds that Plaintiffs cannot succeed on the merits of their claim that H.B. 2036 is unconstitutional and thus, Plaintiffs' requests for preliminary and permanent injunctions are denied.

IV. DECLARATORY JUDGMENT

Because the parties appear to agree that the facts at issue in this case are not materially in dispute, and agree that the Court needs no additional evidence or legal argument to reach its decision in this case, consistent with Federal Rule of Civil Procedure 65(a)(2), the Court

consolidates the preliminary injunction hearing with a trial on the merits.[2] Based on the analysis set forth above, Plaintiffs are not entitled to a declaratory judgment that section 7 of H.B. 2036 is unconstitutional.

V. CONCLUSION

Based on the foregoing findings and conclusions,

IT IS ORDERED that Defendants' Motion to Dismiss Case (Doc. 25) is denied.

IT IS FURTHER ORDERED that Plaintiffs' Motion for Preliminary Injunction (Doc. 2) is denied.

IT IS FURTHER ORDERED that Plaintiffs' request for a Permanent Injunction is denied.

IT IS FURTHER ORDERED that Plaintiffs' request for a declaratory judgment is denied. The Clerk of the Court shall enter judgment in favor of Defendants and against Plaintiffs on the declaratory judgment action.

IT IS FURTHER ORDERED that Defendant Montgomery's Motion to Dismiss Barbara LaWall (Doc. 42) is denied as moot.

DATED this 30th day of July, 2012.

James A. Teilborg
United States District Judge

[2] While the Court notes that Defendant Montgomery objected to the Court converting the preliminary injunction hearing to a trial on the merits, *see* Doc. 27 at 17, the Court finds that there is no reason that the Court should not proceed to the merits at this time.