05-1382

IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF PLANNED PARENTHOOD RESPONDENTS

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QUESTIONS PRESENTED

Whether the Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) (the "Act"), is unconstitutional, even if construed as banning only intact dilation and evacuation ("D&E") abortions, because banning such abortions would deprive some women of a meaningfully safer pre-viability abortion option, and would thus endanger women's health.

Whether the Act is unconstitutional because it either will chill physicians from performing any D&E (the most commonly used pre-viability second-trimester abortion method), or will force physicians to alter their medical practices to avoid felony prosecution, even if it means acting against their best medical judgment, and therefore imposes an undue burden on a woman's right to end a pre-viability pregnancy.

Whether the Act is unconstitutionally vague because it fails to provide fair warning of the medical procedures it bans, and permits arbitrary and discriminatory enforcement.

PARTIES TO THE PROCEEDING

Petitioner is Alberto R. Gonzales, Attorney General of the United States.

Respondents are Planned Parenthood Federation of America, Inc.; Planned Parenthood Golden Gate; and the City and County of San Francisco.

Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate are not-for-profit corporations that do not have parent corporations and are not owned in any part by a publicly held company.

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STATEMENT OF THE CASE[1]

Congress enacted the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) (the "Act"), in an effort to nullify this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000).[2] Petitioner (the "Government") argues that the Act should be upheld because it differs from the Nebraska law invalidated in *Stenberg* in two respects: first, it is accompanied by congressional findings that are entitled to deference; and, second, it describes the criminalized medical procedures differently. Alternatively, the Government argues that *Stenberg* should be overruled.

Not only are the Government's distinctions meritless, but its argument obscures the real difference between this appeal and *Stenberg*. This appeal comes to this Court on a record developed during a three-week trial, including testimony from an array of distinguished physicians associated with major medical institutions nationwide. On the basis of that record, the District Court made extensive findings of fact regarding the significant medical benefits and safety of intact dilation and evacuation ("intact D&E") abortions,[3] and the indefensibility – under any standard of

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[1] References to PA are to the Appendix to the Petition for A Writ of Certiorari; references to JA are to the Joint Appendix; references to Gov't Br. are to the Brief for the Petitioner; references to ER are to the Ninth Circuit Excerpts of Record; references to Supp. ER are to the Ninth Circuit Supplemental Excerpts of Record; references to Carhart Gov't Br. are to the Brief for the Petitioner in *Gonzales v. Carhart*, No. 05-380.

[2] *See, e.g.*, 149 Cong. Rec. S3486 (daily ed. Mar. 11, 2003) (statement of Sen. Santorum) ("Why are we here? We are here because the Supreme Court defended the indefensible. . . . We have responded to the Supreme Court."); 149 Cong. Rec. S3606 (daily ed. March 12, 2003) (statement of Sen. Santorum) ("What the Supreme Court did . . . is fundamentally wrong.").

[3] While the Act does not mention intact D&E or D&X (or, indeed, use the word "intact"), the Government states that "partial-birth abortion" refers to intact D&E, or D&X, the term used in *Stenberg*. Gov't Br. 2. The Ninth Circuit correctly held that the terms intact D&E and D&X are interchangeable. PA 3a-4a n.3; *see also Stenberg*, 530 U.S. at 928.

review – of the congressional findings. The lengthy trial debunked numerous myths and misperceptions about intact D&Es that were propagated by Congress, codified in the Act's findings, and repeated by the Government throughout this litigation. The record here establishes that:

- The terms "*infant*icide," "partial-*birth*" abortion, and "late-term" abortion (*e.g.*, Gov't Br. 2, 9, 47) (emphasis added) are blatantly misleading. Intact D&E is used predominantly in the second trimester – or "mid-term" – of pregnancy. PA 83a, 84a; *see also* JA 1103. And only pre-viability abortions are at issue because Planned Parenthood's health centers perform no post-viability abortions. Trial Tr. 135:16-18, Mar. 29, 2004; *cf.* PA 83a.
- Although the Government and Congress claim the Act bans only one particular method of abortion, intact D&E (*e.g.*, Gov't Br. 2), the lower courts found that the Act also bans some non-intact (disarticulation) D&Es. PA 80a-84a, 32a; Gov't Br. 34 n.6. Collectively, D&Es account for 95% of pre-viability, second-trimester abortions. PA 58a.
- Claims that the health benefits of intact D&E are "marginal[]" and that intact D&E is "never medically indicated" (Gov't Br. 21, 24; Act § 2(14(O)), are refuted by the record. Leading obstetrician-gynecologists – including an expert panel assembled by the American College of Obstetricians & Gynecologists ("ACOG") – identified a range of specific medical circumstances in which intact D&E has meaningful safety advantages over other methods. *See* § I.B.1.b, *infra*; JA 855, 860-61, 1104.
- Contradicting Congress's finding that intact D&E is a "disfavored [medical] procedure" (Act § 2(2)), many major medical organizations believe that intact D&E carries meaningful safety advantages over other methods. Supp. ER 485-87 (ACOG), ER 553 (Cal. Med. Ass'n)

("CMA"), 562 (Am. Pub. Health Ass'n) ("APHA"); *see generally* PA 186a; *cf.* JA 670; PA 106a (Am. Med. Ass'n) ("AMA"). No comparable medical organizations supported the Act.

- Congress's finding that "no medical schools" teach intact D&E (Act § 2(14)(B)) is verifiably false. Intact D&E is taught at leading medical schools such as those at Columbia University, Cornell University, New York University, Northwestern University, University of Pittsburgh, University of California at San Francisco, and Albert Einstein College of Medicine, and will likely be taught at Yale University. PA 205a; *Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp. 2d 436, 479 (S.D.N.Y. 2004), *aff'd*, *Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278 (2d Cir. 2006) ("*NAF*"). Intact D&Es are also performed and taught at other leading medical schools that do not want to be publicly identified. *See* JA 1100, 1101, 1107-08.
- Contrary to Congress's and the Government's core rationale for the Act, there is no moral or ethical consensus about intact D&E. There are significant moral and ethical concerns on both sides, including the ethics of denying women access to the safest treatment and forcing doctors to use medical techniques they consider less safe. *See* JA 537 ("[T]he only reason why I want to be able to . . . perform a D&E with intact extraction . . . is because . . . that is the best way I can take care of my patients."); *see also* JA 187 ("I wouldn't even have any idea how to consent a patient if I am [doing something to avoid liability, and not] for her clinical benefit.").

Congressional History

The Government recounts that Congress held hearings leading to the Act's passage, but fails to note both the partisan and polemic nature of the hearings, and the fact

that they elicited no medical information that meaningfully differed from the evidence before this Court in *Stenberg*.

Between 1995 and 2003, Congress held six hearings about so-called "partial-birth abortion."[4] PA 173a. In all, only eight physicians testified – six supporting the ban.[5] The District Court concluded that the oral testimony before Congress was "not only unbalanced, but intentionally polemic," and was "heavily weighted in favor of the Act," with Congress hearing "disproportionately from physicians opposed to abortion generally." PA 183a, 182a; *see also Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 822 (D. Neb. 2004) (the congressional record "contains remarkably little substantive information from physicians on either side"); *id*. at 1011 ("Congress arbitrarily relied upon the opinions of doctors who claimed to have no (or very little) recent and relevant experience with surgical abortions.").

Following *Stenberg*, new "partial-birth abortion" legislation was introduced. The post-*Stenberg* bills were *designed* to serve as vehicles for overturning *Stenberg* by omitting the health exception that this Court held was required, and "finding" that one is not needed. *See* PA 42a n.26 (citing 149 Cong. Rec. H4933 (daily ed. June 4, 2003) (statement of Rep. Conyers) ("The 'findings,' in effect, are an attempt to overturn *Stenberg*.")); 149 Cong. Rec. H4933 (daily ed. June 4, 2003) (statement of Rep. Farr) ("[T]his legislation presumes that the authors' findings overrule those of the Supreme Court.").[6]

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[4] This Court is familiar with the four Congressional hearings held prior to *Stenberg*. *See*, *e.g.*, 530 U.S. at 929, 935.

[5] This excludes doctors who testified solely about the effect of maternal anaesthesia on a fetus. PA 177a.

[6] The findings that were enacted into law in 2003 were identical to the 2002 bill findings. The findings did not take into account post-*Stenberg* evidence. Rather, they were prepared and made part of the first

Congress held two cursory post-*Stenberg* hearings. It heard from only two doctors who had not previously testified, and both supported the ban. *See* PA 173a-82a. As the lower courts noted, and belying Congress's claim that much of Congress's evidence was compiled post-*Stenberg* (Act § 2(5)), none of the post-*Stenberg* testimony provided new information. *See* PA 193a ("Congress did not have before it any *new* medical evidence or studies not available to both the district court and Supreme Court in *Stenberg*.") (emphasis in original); *NAF v. Gonzales*, 437 F.2d at 292 n.9 (Walker, C.J., concurring) ("[T]he evidence has not changed since the Supreme Court decided *Stenberg* – only the conclusions that Congress decided to draw from that evidence"); *accord* PA 192a.

In 2003, during the 108th Congress which enacted the Act, highly-credentialed physicians and nationally recognized major medical groups, including ACOG, submitted statements to Congress opposing the Act. 149 Cong. Rec. S3479 (daily ed. Mar. 11, 2003) (statement of Sen. Boxer) (ACOG); Supp. ER 521 (Am. Med. Women's Ass'n) ("AMWA"), 554-55 (Ass'n of Reprod. Health Professionals) ("ARHP"), 562 (APHA); *see generally* PA 186a.[7] No comparable medical groups supported the ban. Supp. ER 670-76 (medical submissions in Congress post-*Stenberg*).

Congressional proponents, however, ignored the substantial medical opposition to the bill, ignored the evidence of the medical benefits of intact D&E, and ignored Congressional colleagues who repeatedly advised that the

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post-*Stenberg* bill before Congress held a single post-*Stenberg* hearing. *See NAF*, 437 F.3d at 292 n. 9 (Walker, J., concurring) (citations omitted).

[7] The AMA, which had supported earlier bans, opposed the Act because of its criminal penalties. Supp. ER 556. A consulting firm hired by the AMA to review its decision-making processes concluded that its support for pre-*Stenberg* versions came out of the "least democratic, least researched, and least systematic decision-making process." ER 1123.

bill was unconstitutional. Congress rejected amendments that would have added a health exception, stricken the inaccurate congressional findings, and limited the Act's applicability to post-viability abortions. PA 80a-81a, 87a, 189a-90a, 193a-94a n.50, 207a-08a.

Lower Court Proceedings

During the three-week bench trial, twelve expert obstetrician-gynecologists ("ob-gyns") appeared in person to testify for both sides. The District Court also accepted into evidence deposition testimony from an additional five expert ob-gyns, an expert pathologist, designated representatives of ACOG and three other medical groups, and two Department of Justice officials. The District Court concluded that it "was presented with much more extensive medical and scientific evidence on both sides of the issue concerning the safety and necessity of intact D&Es" than Congress, which "heard significantly more policy-based arguments." PA 172a; *cf*. *NAF*, 330 F. Supp. 2d at 482 (New York district court heard "more evidence during its trial than Congress heard over the span of eight years").

Eight of Planned Parenthood's eleven expert ob-gyns testified in person. Each of the eight is board-certified in ob-gyn, three were also qualified as experts in maternal-fetal medicine, and two as experts in epidemiology. These eight are experts in second-trimester surgical abortion care; all are affiliated with major teaching hospitals; and all have taught and performed intact D&Es, as well as other safe abortion procedures. PA 97a-99a & n.16 (describing qualifications). In contrast, none of the Government's witnesses has expertise in second-trimester surgical abortion care; and none has taught, performed or even personally observed

intact D&E. PA 100a-04a.[8]

Critical to the District Court's ruling were its determinations about expertise and credibility. The District Court qualified Planned Parenthood's eight in-person ob-gyn witnesses as experts in intact D&E, as well as in ob-gyn generally, and found their testimony credible. PA 139a, 144a ("These doctors are all well-respected in their practices, and their expertise in recommending and performing D&E and intact D&Es is unassailable.").

The Government's four in-person ob-gyn witnesses were qualified as experts in ob-gyn generally. However, the District Court found they "lacked the background, experience, and instruction to qualify as experts regarding" intact D&E because none had ever been instructed regarding, or had ever performed, supervised, taught, been taught, or even observed an intact D&E procedure.[9] PA 104a. Indeed, the Government's in-person ob-gyn witnesses had minimal experience performing *any* D&E procedures. PA 101a-04a.

In addition, the District Court had "credibility concerns" about two Government witnesses, Drs. Sprang and Cook. PA 185a; *see also* PA 140a-41a; *Carhart*, 330 F. Supp. 2d at 1024. These witnesses were connected to the proceedings in Congress. Dr. Sprang co-authored "an opinion piece," M. Leroy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Am.

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[8] Government expert Charles Lockwood was the Chair of the Ob-Gyn Department at NYU when intact D&Es were taught and performed there by physicians he hired. JA 995-96.

[9] The District Court allowed the Government's ob-gyn witnesses "to testify only regarding their opinions on the safety of [intact D&E], based upon their review of the literature" because they "did not 'appear to have any personal experience with'" relevant abortion procedures. PA 104a.

Med. Ass'n 744 (1998) ("Sprang article"), ER 896-99, "upon which Congress very obviously relied" in preparing its findings. PA 184a.[10] The District Court found that "a number of the conclusions" in the Sprang article are "troublesome and contrary to the medical evidence presented by both sides to this court," and that given the "contradictory testimony that Dr. Sprang gave at trial, the article and many of its conclusions become even more questionable." PA 184a-85a. Dr. Cook appeared twice before Congress and testified that there was no need for intact D&E in the cases of particular women who had testified about the intact D&E abortions they had, but he "did not explain the medical reasons for his conclusions." PA 179a. At trial, Dr. Cook acknowledged that he did not review the actual medical records associated with the cases about which he testified before Congress. JA 769-70.

On the basis of its detailed fact-finding, the District Court struck down the Act on the grounds that:

(a) the Act is unconstitutional for lack of a health exception because "the record before this court . . . demonstrates that 'significant medical authority supports the proposition that in some circumstances, [intact D&E] is the safest procedure'" (PA 214a (citation omitted)), and the congressional findings do not trump the need for a health exception because they are "unreasonable and . . . not supported by substantial evidence" (PA 212a);

(b) the Act imposes an undue burden on a woman's right to abortion because the Act's definition of "partial-birth abortion" encompasses all variants of D&E, the

[10] Dr. Sprang did not testify before Congress, but his co-author, Dr. Neerhof, testified for the ban during the 108th Congress. ER 862-66.

method used in 95% of all pre-viability, second-trimester abortions (PA 85a-89a); and

(c) the Act violates physicians' due process rights by failing to give them adequate notice of which abortions are banned and which are permitted, and placing them at risk of arbitrary and discriminatory enforcement (PA 92a-96a).

The Ninth Circuit affirmed on these same grounds and permanently enjoined the Act in its entirety after analyzing the remedy question under the framework this Court set forth in *Ayotte v. Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006).

SUMMARY OF ARGUMENT

This appeal reaches this Court with a factual record compiled after a lengthy trial including testimony from numerous highly-credentialed and respected medical experts with expertise in second-trimester surgical abortions, and a District Court ruling containing detailed findings of fact that are overwhelmingly supported by the evidence. Those facts demonstrate, as even some Government witnesses agreed, that any D&E abortion when performed in the safest manner can proceed so as to meet each of the statutory elements of a "partial-birth abortion." Thus, the Act is unconstitutional because physicians will either be chilled from continuing to provide these procedures, or they will be forced sometimes to alter their practices to avoid criminal prosecution – even if it means proceeding against their best medical judgment. In either event, women's liberty will be infringed and their right to choose abortion unduly burdened.

Alternatively, if the terms of the Act do not put physicians at risk each time they perform a D&E (in other words, if the Act does not mean what it says), then it fails to

provide physicians with fair warning as to which abortions are permitted, and which are federal felonies; and is, thus, unconstitutionally vague.

The Government has offered various interpretations of the Act in an effort to escape these failings. These interpretations are inconsistent with each other, unsupported by any fair reading of the Act, and draw insupportable distinctions among medical procedures. Thus, the Government's efforts highlight, rather than solve, the Act's constitutional defects.

The record also demonstrates beyond cavil that there are numerous circumstances where women suffering from serious medical conditions or carrying fetuses with severe anomalies would derive meaningful medical benefits from intact D&E, and that even for women whose health condition is not compromised, intact D&E is a significantly safer method of abortion. The record lays to rest the Government's assertion that the medical benefits of intact D&E are marginal, hypothetical, or affect only a few women. Therefore, the Act is also unconstitutional because it purposefully lacks an exception to allow the banned procedures whenever necessary to protect a woman from a significant health risk.

The congressional findings do not alter this conclusion. The findings are an effort to circumvent this Court's authority to determine the scope of individual rights, relating to the longstanding constitutional protection for women's health in the context of abortion regulations, and thus are due little deference. In any event, as the lower courts concluded, under *any* standard of review, the congressional findings are entitled to no deference because they are patently unreasonable.

The Government urges that *Stenberg v. Carhart* be

overruled. Not only does this Court's jurisprudence not recognize any reason for doing so, but overturning *Stenberg* would implicate the consistent line of precedent that pregnant women cannot be forced to sacrifice or compromise their health by an abortion regulation. The Court has never recognized a state interest strong enough to trump the paramount concern that pregnant women's health be safeguarded, and it should not do so here.

The Government addresses these issues in the reverse order. Although Planned Parenthood believes the Court need not reach the health exception claim because the Act could ban any D&E, we have presented our arguments below in the same order as in the Government's Brief.

ARGUMENT

I. THE ACT UNCONSTITUTIONALLY IMPERILS THE HEALTH OF SOME PREGNANT WOMEN

In an unbroken line of cases beginning with *Roe v. Wade*, 410 U.S. 113 (1973), and reconfirmed unanimously in *Ayotte*, this Court has ruled that the government cannot regulate abortion in a manner that imperils women's health. The Government now asks the Court to reject its precedents and rule that – even before fetal viability, when the state interest in regulating abortion is less compelling (*Stenberg*, 530 U.S. at 930) – a governmental preference for how fetal demise occurs justifies forcing some women to end their pregnancies by abortion procedures that leading ob-gyns and ACOG believe are significantly less safe. This Court should decline this request, reaffirm *Stenberg* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and affirm the lower court.

A. The Court Should Apply the "Substantial Medical Authority" Test

This Court has repeatedly made clear that abortion

regulations that do not protect women's health are unconstitutional. Thus, in *Roe v. Wade*, the Court recognized the state's authority to ban post-viability abortions, but only if abortions to protect women's health are excepted. 410 U.S. at 164-65. In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), this Court struck down a ban on saline amniocentesis abortions because it "force[d] a woman . . . to terminate her pregnancy by methods more dangerous to her health." *Id*. at 79. In *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), the Court struck down a requirement that a second physician be present for post-viability abortions because it lacked an exception for when delay in arrival of the second physician would endanger the woman. Thus, even in the context of post-viability abortions where governmental interests are most compelling, abortion regulations cannot "fail[] to require that maternal health be the physician's paramount consideration." *Id*. at 768-69. Citing *Roe*, *Danforth* and *Thornburgh*, the Court unanimously reaffirmed the ongoing vitality of this principle last term in *Ayotte*. 126 S. Ct. at 967.

In applying this principle in *Casey*, the Court considered it crucial that the medical emergency exception was broad enough "'to assure that compliance with [the challenged restrictions] would not in any way pose a significant threat to the life or health of a woman.'" 505 U.S. at 880 (citation omitted). Otherwise, the Court "would be required to invalidate the restrictive operation of the provision." *Id*. *Stenberg* applied this aspect of *Casey*. It ruled that to prevent a "significant threat to the life or health of a woman," *id.*, a method-specific ban must have a health exception if "substantial medical authority supports the proposition that banning [that method] could endanger women's health." *Stenberg*, 530 U.S. at 938; *see also id*. at 947 (O'Connor, J., concurring) ("[T]he Nebraska statute is inconsistent with *Casey* because it lacks an exception for

those instances when the banned procedure is necessary to preserve the health of the mother.").

Requiring "substantial medical authority" as the quantum of proof for whether a health exception is constitutionally required to prevent a "significant threat to the life or health of a woman," *Casey*, 505 U.S. at 880, ensures both that individual physicians cannot act with "unfettered discretion," *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting), and that "responsible differences of medical opinion" are "tolerate[d]." *Id.* at 937. Moreover, the substantial medical authority test strikes the correct balance because it incorporates the principle – integral to safeguarding a constitutionally protected liberty interest – that if an error is to be made, it should be on the side of protecting pregnant women's health and liberty, especially pre-viability, when the governmental interests on the other side are simply insufficient to place women at "risk of tragic health consequences." *Id.* at 937.

The Government does not address the "substantial medical authority" standard. Rather, it argues that the lack of a health exception is facially constitutional so long as "significant health risks" are not imposed on "a large fraction" of women.[11] *E.g.*, Gov't Br. 13, 18. Under this chillingly callous view, *some* fraction of pregnant women – so long as it is not a "large fraction" – could be forced to endure "significant health risks" before a pre-viability abortion restriction could be found unconstitutional. This is

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[11] The Government places great emphasis on the risks being "significant," Gov't Br. 14, but there can be no dispute that the health risks at issue here rise to that level: the District Court found and the evidence demonstrates that intact D&E is "significantly" safer for some women than other methods, *see* § I.B.1, *infra*; *cf. Thornburgh*, 476 U.S. at 807 (White, J., dissenting) (the term "significant" in this context means that the comparative safety benefits are meaningful, cognizable, appreciable, and non-negligible).

neither the law nor constitutionally tolerable. Allowing a measurable but not "large fraction" of pregnant women to suffer significant harm before an abortion restriction is invalidated – *at least* as to the affected women – would contravene *Roe*'s "essential holding" that the health of pregnant women must remain paramount when regulating abortion. *Casey*, 505 U.S. at 880;[12] *accord Stenberg*, 530 U.S. at 934 ("relative rarity" of intact D&Es "not highly relevant" because "question is whether protecting women's health requires an exception for those infrequent occasions"); *Ayotte*, 121 S. Ct. at 267 (medical emergency exception needed in only a "very small percentage of cases").[13]

For these reasons, the abortion ban here must contain a health exception if "substantial medical authority supports the proposition that banning [intact D&E] could endanger women's health." *Stenberg*, 530 U.S. at 938.

B. "Substantial Medical Authority" Supports the Need for a Health Exception Here

The record overwhelmingly shows that intact D&E reduces the risks of potentially catastrophic complications, and thus its health benefits are not, as the Government cavalierly argues, "marginal." *E.g.*, Gov't Br. 10, 27-29. Because the quantum of evidence rises to the level of "substantial medical authority," the Act must have a health exception. 530 U.S. at 938.

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[12] In *Casey*, no party contended that, nor did the Court inquire whether, preeclampsia (or the other conditions at issue) affects a "large fraction" of pregnant women. Yet, if the medical emergency exception did not encompass those conditions, it would have been unconstitutionally narrow. 505 U.S. at 880.

[13] The "large fraction" inquiry relates to remedy; it does not relate to constitutional adequacy. *See generally* Br. for Am. Civil Liberties Union, N.Y. Civil Liberties Union, & Nat'l Abortion Fed'n as *Amici Curiae* Supporting Respondents.

1. Intact D&E is Significantly Safer

The District Court found that "intact D&E is in fact the safest medical option for some women in some circumstances and is significantly safer than induction, hysterotomy, or hysterectomy for terminating a second-trimester pregnancy, and under certain circumstances, also significantly safer than D&E by disarticulation."[14] PA 147a; *see also* PA 144a, 215a. It further found that there "appears to be little risk from the various elements of an intact D & E procedure." PA 145a. These factual findings are subject to a "clearly erroneous" standard of review. Fed. R. Civ. P. 52(a). Indeed, because they are based in part on the "credibility concerns" regarding two of the Government's four in-person ob-gyn witnesses (PA 185a; *see also* PA 140a-41a), they are entitled to especially great deference. *Anderson v. City of Bessemer City*, 470 U.S. 564, 574-75 (1985) (fact-finding based on credibility "can virtually never be clear error").[15]

The District Court, which is charged with resolving factual disputes, heard the testimony of twelve ob-gyns who testified in person, and chose to "accept[] the[] testimony [of the Planned Parenthood experts] over that of the government witnesses, who, while also well-respected and qualified to provide testimony in general on ob-gyn practice

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[14] These methods are discussed in § II.A.2.a, *infra*.

[15] Even if the findings that intact D&E is "significantly safer" and poses "little risk" were mixed questions of law and fact, or constitutional facts, they still must be reviewed deferentially because they are based on witness credibility. *See Salve Regina College v. Russell*, 499 U.S. 225, 233 (1991), citing *Miller v. Fenton*, 474 U.S. 104, 114 (1985) (even where unclear if a conclusion is "law" or "fact," there are "compelling and familiar justifications" for giving presumptive weight to trial court credibility determinations); *cf. Harte-Hanks Communications, Inc. v. Connaughton*, 491 U.S. 657, 688-89 & n.35 (1989) (even where appellate court engages in independent review of facts to determine if constitutional standard has been satisfied, credibility determinations are reviewed under clearly erroneous standard).

and safety, do not perform intact D&Es and who were not qualified to testify as experts on the practice." PA 144a.

The Government criticizes this decision (Gov't Br. 26), but given the broad discretion of a district court to choose which witnesses to qualify as expert and which to credit, and the reasonableness of the District Court's decision, their arguments fall flat. *See, e.g.*, *United States v. Allegheny Ludlum Corp.*, 366 F.3d 164, 186 (3d Cir. 2004) (citing *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 142 (1997)). Because the Government witnesses were inexperienced in *any* method of second-trimester surgical abortion, it was appropriate for the District Court to conclude that they could not meaningfully compare the risks and benefits of those techniques based on personal experience. Likewise, it was appropriate for the District Court to conclude that because the Government witnesses' only basis for understanding how an intact D&E is performed was based on hearsay, their assessment of the risks of the procedure could not be fully reliable.[16] For example, because they had no experience with the intact D&E technique, the Government witnesses were concerned about maternal harm due to "blind instrumentation" to reduce the fetal skull. But Planned Parenthood's experts explained, based on their clinical experience, that this concern was unfounded because this part of the procedure is performed under direct or ultrasonic visualization.[17] PA 68a.

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[16] *See, e.g.*, PA 101a n.18 (Dr. Sprang testified that his understanding was based in part on "significant" or "memorable" conversations with physicians, but he could not remember their names, or the dates or locations of those conversations), 102a n.19 (videotape that Dr. Cook reviewed of intact D&E was of "extremely poor" quality).

[17] It was also appropriate for the District Court to discount the testimony of at least some of the Government's witnesses because they were biased against all abortions, or – at a minimum – against all forms of D&E. PA 139a, 195a n.51, 199a; *cf.* PA 140a. That such physicians oppose

As shown below, the District Court's fact-finding is well-supported by the trial and congressional records, especially in light of its expertise and credibility findings, and is certainly not "clear error." Given the overwhelming evidentiary support, as found at trial and affirmed by the appellate court, the District Court's factual findings should not be disturbed. *Easley v. Cromartie*, 532 U.S. 234, 242 (2001) ("Where an intermediate court reviews, and affirms, a trial court's factual findings, this Court will not 'lightly overturn' the concurrent findings of the two lower courts.").

a. The Record Proves That Intact D&E is "Significantly Safer" Than Other Methods and Poses Little Risk

i. Planned Parenthood's experts testified that in their clinical judgment, based on substantial experience performing D&Es by all variants, D&Es in which the fetus is evacuated intact or relatively intact reduce the risk of serious complications and thus are significantly safer. The reduction in risk occurs because in intact D&Es: (1) Fewer passes are made through the woman's cervix and into her uterus with forceps and other instruments, resulting in reduced risk of lacerations to the cervix and uterus, reduced risk of uterine perforation, and reduced risk of infection.[18] (2) There is a reduced risk of leaving fetal parts in the uterus, which can cause infection. (3) There is a reduced risk of lacerations to the woman caused by the removal of sharp, bony fetal fragments. (4) There may be a reduced operating time, which likewise decreases the risks associated with blood loss and infection. It may also reduce the need for anesthesia, which in turn reduces the risks of the woman

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intact D&E does not prove that it is unsafe or inappropriate.

[18] Several Planned Parenthood experts have inadvertently injured a woman's uterus or cervix during a disarticulation D&E, but have never done so during an intact D&E. JA 77, 133, 283-84, 500, 966-67.

vomiting and aspirating her stomach contents. PA 144a; *see also* JA 116-19, 221, 424-27, 499-501, 923-24.

The substantial experience and expertise of the physicians who testified to the meaningful safety benefits of intact D&E cannot be denied. *See* PA 98a n.16; JA 14-21, 102-15, 154-69, 92-202, 244-56, 339-49, 416-23, 464-76.[19]

ii. Several Government experts acknowledged the benefits of intact extraction versus disarticulation, primarily because reduced instrumentation in the woman's uterus lowers the risks of cervical and uterine trauma, including perforation, and lowers the infection risk. JA 570-71, 720, 727, 780-81, 999-1000.

iii. Many medical organizations agree that intact D&E reduces the risks for some patients. For example, an AMA task force on which Defendant's expert Dr. Sprang served ("AMA Task Force"), concluded that: "[Intact D&E]

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[19] Although ignored in the congressional findings, many highly qualified physicians submitted letters to Congress describing medical benefits of intact D&E similar to the benefits described at trial. These submissions were from: (a) ob-gyns who regularly perform intact D&E (*see, e.g.*, Supp. ER 572 (letter from William K. Rashbaum, M.D., Professor of Obstetrics & Gynecology, the Albert Einstein Coll. of Med. and the Cornell Sch. of Med.)); (b) ob-gyns who refer patients to other physicians for intact D&Es because of the special advantages of this procedure (*see, e.g.*, 142 Cong. Rec. S11352 (daily ed. Sept. 26, 1996) (statement of Sen. Boxer) (letter from Dru Elaine Carlson, M.D., Dir., Reprod. Genetics, Dep't of Obstetrics & Gynecology, Cedars-Sinai Med. Ctr., and Assistant Professor, UCLA Sch. of Med.); Supp. ER 567-69 (letter from Laurence Burd, M.D., Assoc. Professor of Clinical Obstetrics & Gynecology, Univ. of Ill.) submitted to the Cong. Rec., Dec. 4, 1995 (141 Cong. Rec. S17891)); and (c) ob-gyns who perform and/or are familiar with the performance of abortions (*see, e.g.*, Supp ER 573-76 (letter from Natalie Roche, M.D., Assistant Professor of Obstetrics & Gynecology, N.J. Med. Coll., & Gerson Weiss, M.D., Professor & Chair, Dep't of Obstetrics, Gynecology & Women's Health, N.J. Med. Coll.) submitted to the Cong. Rec., Mar. 10, 2003 (149 Cong. Rec. S3385)).

may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&[E] may be preferred by some physicians, [p]articularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb." JA 670; *accord* PA 106a; *see also* Supp. ER 485-87 (ACOG), 552-53 (CMA), 554-55 (ARHP), 562 (APHA); ER 1057 (AMWA),; *see generally* PA 186a.

iv. "[P]reliminary results" of the only peer-reviewed study of intact D&E "indicate the relative safety of intact D&E, and provide valuable information for doctors in exercising their clinical judgment." PA 143a; *see* JA 1055 (Stephen T. Chasen, *et al.*, *Dilation and evacuation at ≥ 20 weeks: comparison of operative techniques,* 190 Am. J. Obstetrics & Gynecology 1180 (2004) ("Chasen study")). The Chasen study compared complications of intact D&Es at a median gestational age of twenty-three weeks with complications of disarticulation D&Es at a median gestational age of twenty-one weeks, and found the two techniques to be equally safe at those respective gestational ages. However, because the risks of abortion increase with gestational age, one would have expected more complications in the intact D&E group. JA 430-32. This suggests that intact D&Es are safer than disarticulation D&Es when performed at the same gestational age. JA 430-32, 492-93, 497-99. Notably, the only serious complications in the Chasen study were experienced by women who had disarticulation D&Es. JA 432, 491-92.

v. Experts on both sides agreed that the hypothesized risks of intact D&E are overstated or speculative. Government witness Dr. Bowes testified that intact D&E does not pose long-term maternal health risks, and does not pose risks on a more serious or frequent basis than other abortion methods. JA 587-88. Government witness Dr. Clark does not believe that intact D&E carries "increase[d] . . . risks compared to D&E or any other method

of termination." JA 901. Government witness Dr. Lockwood testified that the congressional findings "exaggerate the risk of the procedure," and that there is no greater risk of amniotic fluid embolism as between disarticulation and intact D&Es. JA 990, 1034. Government witness Dr. Sprang agreed with the AMA Task Force that "there is little research on whether [cervical incompetence is] more likely to result from D&E (or intact D&X) or from labor induction techniques." JA 671-72; *see also* PA 145a (Government failed to prove that intact D&E increases likelihood of cervical incompetence).

b. The Safety Benefits of Intact D&E are Particularly Important for Some Women

The record also amply supports the District Court's finding that intact D&E has particular benefits for "some women in some circumstances." PA 147a. ACOG's select panel of experts considered "at a minimum, 25 to 30 different types of cases" where intact D&E was used, and concluded that there were individual patient circumstances when it was a better choice for the patient. JA 1108-09; *see also* JA 1104-05. Intact D&E offers particular benefits where: (i) it is especially important to minimize instrumentation in the uterus; (ii) it is especially important to minimize blood loss; (iii) the pregnancy involves an abnormal placenta; (iv) the fetus suffers from a severe anomaly resulting in an enlarged body part; and (v) it is especially important to minimize any complication.[20]

i. ACOG's select panel identified several circumstances where intact D&E was significantly safer due to reduced uterine instrumentation, including:

[20] Intact D&E is sometimes sought to facilitate pathological testing or the grieving process. *See* JA 296-97, 427-28, 501-02, 924-25.

- where the abortion is to treat sepsis (a severe systemic infection) because "any increase in instrumentation might increase the ability of bacteria to enter the bloodstream." JA 860-61, 1110; *see also* Supp. ER 565-66.
- where the woman suffers from trophoblastic disease (potentially malignant uterine tumors developing from abnormal proliferation of placental cells) because "increased instrumentation is likely to transport [the] disease . . . to other areas such as the lung." JA 861, 1110.

ii. Several physicians testified that intact D&E minimizes the risk of particularly dangerous complications for women prone to hemorrhage, *see, e.g.*, JA 506-07, 919-20 (anemic women; women on chemotherapy; women with acute fatty liver of pregnancy), or women who need to reduce the risk of bleeding. *See* JA 374-76 (women taking anti-coagulants; women with liver failure or who recently had liver transplants); 143 Cong. Rec. S4521 (daily ed. May 15, 1997) (letter from Dr. David Grimes, Clinical Professor of Obstetrics & Gynecology, Univ. of N.C., describing intact D&E for patient with HELLP syndrome involving liver failure).

iii. Several physicians reported the special benefits of intact D&E in the case of placental abnormalities. 149 Cong. Rec. S3600 (daily ed. Mar. 12, 2003) (statement of Sen. Feinstein) (letter from Dr. Philip D. Darney, Chief of Obstetrics & Gynecology, San Francisco Gen. Hosp., describing cases of placental abnormalities where intact D&E was "critical to providing optimal care"); JA 513-14 (intact D&E reduces risk of uterine rupture where the placenta is abnormally adherent to the uterine wall).

iv. Several physicians testified that intact D&E has special benefits where an anomaly greatly enlarges fetal parts. If the head or abdomen is very large, to perform

a disarticulation D&E, the physician must open the forceps to the full dimension of the enlarged part – a "very wide degree" – and the wider the forceps are opened, the more likely "to traumatize or perforate the uterus." JA 503-04; *see also* JA 297-99.

v. Reduced risk of complications during an intact D&E is "particularly important" for women with serious medical problems because "if that woman experiences a complication, [it] may be catastrophic compared to a woman . . . . without preexisting medical problems." JA 461. A woman with serious medical problems "doesn't have the physiological reserve to cope with a complication like uterine perforation, or laceration, or heavy bleeding." JA 461-62; *see, e.g.*, JA 294-96 (attempted intact D&E for patient with scleroderma who was in an unstable medical condition).

In sum, the District Court's findings that intact D&E is significantly safer than alternative methods, especially for some women, and poses no special risks, are overwhelmingly supported by the trial and congressional records, and should not be disturbed.

2. Because the Overwhelming Evidence of Significant Safety Benefits Constitutes "Substantial Medical Authority," a Health Exception is Required

The overwhelming support for the finding that intact D&E is "significantly safer than [other methods]" (PA 147a) – and the absence of well-informed contrary testimony – compels finding that the "substantial medical authority" quantum of proof has been met. PA 215a (since *Stenberg*, "the majority of highly-qualified experts . . . believe intact D&E to be the safest . . . procedure under certain circumstances"); *see also NAF*, 437 F.3d at 278

("[u]nquestionably such 'substantial medical authority' exists").

Compared with *Stenberg*, many more experts testified here in support of the medical need for intact D&E. These experts have direct personal experience actually performing and teaching intact D&E. *Cf. Stenberg*, 530 U.S. at 966-67 (Kennedy, J., dissenting) (none of Dr. Carhart's experts had performed intact D&E). Also, while the *Stenberg* Court accepted Nebraska's argument that intact D&E is used only by "a 'handful' of doctors," 530 U.S. at 933 (citation omitted), the record here shows that it is used at preeminent medical institutions in major cities nationwide that are leaders in the medical field. PA 205a. Moreover, while no peer-reviewed studies of intact D&E existed when *Stenberg* was decided, the recent Chasen study supports the safety benefits of intact D&E. PA 143a. In sum, there is more and better evidence of "substantial medical authority" here than in *Stenberg*. *See NAF*, 437 F.3d at 287 (record here is "even more compelling" than in *Stenberg*).

The Government failed to adduce "substantial and objective medical evidence to demonstrate [that it] had considerable support for its conclusion that the ban create[s] a substantial risk to no woman's health." *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting). Thus, the Government is left only with the congressional findings and its own rhetoric. But characterizing the health benefits as "marginal" (*e.g.*, Gov't Br. 29), or likewise characterizing the women who need intact D&E as a "tiny category of hypothetical cases" (*id.*), does not make it true. To the contrary, the record overwhelmingly demonstrates that the risk of significant harm is real (PA 147a) and that the women subjected to this risk are not "hypothetical." The District Court correctly ruled that "substantial medical authority"

supports the need for a health exception to prevent "tragic health consequences." 530 U.S. at 937-38.

C. The Congressional Findings Cannot Trump the Need for a Health Exception

The Government rests its case on the hope that this Court will simply defer to the congressional findings. However, whether independently reviewed or reviewed deferentially, the findings cannot trump the need for a health exception because – as the lower courts held – they are patently unreasonable.

1. Deferential Review is Not Appropriate Here

The Court should decline to review the congressional findings with "a high degree of deference" (Gov't Br. 19) (sometimes referred to as "substantial evidence" review (*id*. at 21)), for three reasons.

First, Congress intentionally passed the Act to circumvent the constitutional rule established in *Stenberg* that a health exception is needed if "substantial medical authority supports the proposition that banning [intact D&E] could endanger women's health." *Stenberg*, 530 U.S. at 938; *see* Statement of Case, *supra*. Because the findings are simply a bald-faced attempt to end-run *Stenberg*'s constitutional rule, they are entitled to no deference. *Dickerson v. United States*, 530 U.S. 428, 437 (2000) ("Congress may not legislatively supersede our [constitutional] decisions"); *City of Boerne v. Flores*, 521 U.S. 507, 536 (1997).

Second, "substantial evidence" review is inapplicable because it is fundamentally at odds with *Stenberg* and prior cases guaranteeing the primacy of maternal health. If substantial evidence review were all that were required to override the need for a health exception, a legislative majority could invite witnesses to give testimony against an abortion method in support of pre-determined findings, and

this Court would have to defer to those findings. This would be so even if the "substantial medical authority" quantum of proof was met by the legislative minority's witnesses, or was proven at a trial challenging the law.

Substantial evidence review would thus set the stage for dismantling one of the core principles of this Court's abortion jurisprudence: majority will, not pregnant women's health, would be the "paramount" concern when the government regulates abortion. *Thornburgh*, 476 U.S. at 769. Indeed, under the Government's legislative deference theory, the quantum of proof needed to omit a health exception would be *less protective* of women's health than the standard proposed by the *Stenberg* dissenters. *Cf. Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting) (health exception *not* needed only if "substantial and objective medical evidence . . . demonstrates [that the legislature] had considerable support for its conclusion that the ban created a substantial risk to no woman's health").

Third, the Act burdens the right to choose abortion. When reviewing legislation that – like the Act – is subject to heightened scrutiny, this Court has always engaged in a searching, independent review of any constitutionally relevant facts. *See*, *e.g.*, *Sable Commc'ns of Cal., Inc. v. FCC*, 492 U.S. 115, 129 (1989) (standard of review cannot "foreclose our independent judgment of the facts bearing on an issue of constitutional law"); *Landmark Commc'ns, Inc. v. Virginia*, 435 U.S. 829, 843 (1978) (legislative deference "cannot limit judicial inquiry when First Amendment rights are at stake."); *accord Casey*, 505 U.S. at 851 ("where reasonable people disagree the government can adopt one position or the other," but not where "the choice . . . intrude[s] upon a protected liberty").[21] Independent review

[21] None of the cases the Government cites for the proposition that the Court defers to congressional findings on complex medical and

is particularly important here because the findings are likely to be dispositive of a constitutional right. If the Court were required to defer blindly to them, Congress could – under the guise of making "factual findings" – do an end run around this Court's constitutional rulings.

The Government is wrong that this Court applies a "single standard" in reviewing congressional findings. Gov't Br. 19, 20. Rather, this Court often undertakes an independent and searching review to ensure that congressional fact-finding is not used to unduly burden individual liberties. *See, e.g.*, *Ashcroft v. Free Speech Coal.*, 535 U.S. 234, 240, 253-54 (2002) (invalidating ban on virtual child pornography despite congressional findings that such pornography increases sexual exploitation of children); *cf. United States v. Morrison,* 529 U.S. 598, 614 (2000) (invalidating part of Violence Against Women Act despite extensive congressional findings on economic impact of gender-motivated violence).[22] It should do so here.

2. No Deference is Due Because the Findings are Not "Reasonable"

In any event, the Court need not decide the appropriate degree of deference because the Government cannot prevail even under the "substantial evidence" standard of *Turner Broadcasting System, Inc. v. Federal Communications Commission*, 512 U.S. 622 (1994) ("*Turner I*"). The three district courts that reviewed the Act did what *Turner I* instructed: they followed their "obligation to exercise independent judgment" and used the evidence to

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scientific issues (Gov't Br. 19) involved a fundamental right. *See generally* Br. of Constitutional Law Professors David L. Faigman & Ashutosh A. Bhagwat, *et al.*, as *Amici Curiae* in Support of Respondents, at 26-27.

[22] Similarly, in *Bd. of Trustees of the Univ. of Ala. v. Garrett*, 531 U.S. 356 (2001), Gov't Br. 19-20, Congress made findings that it had authority to enact the legislation at issue, and the Court rejected those findings.

assess whether Congress had "drawn reasonable inferences based on substantial evidence." *Turner I*, 512 U.S. at 666; *see also Turner Broad. Sys. v. Fed. Commc'n Comm'n*, 520 U.S. 180, 211 (1997) ("*Turner II*"). Notably, all three district courts concluded that the findings are *not* reasonable and merit no deference. PA 172a ("Congress has not drawn reasonable inferences based on substantial evidence"); *accord* PA 194a; *Carhart*, 331 F. Supp. 2d at 1008 (same); *NAF*, 330 F. Supp. 2d at 487 (same). Indeed, the District Court found "that all of the government's own witnesses disagreed with many of the specific congressional findings." PA 195a; *see also NAF*, 330 F. Supp. 2d at 482 (Government experts "disagreed with almost all of Congress's factual findings").

Unlike in *Turner I*, the bulk of the congressional findings here consist of either legal argument or Congress's value judgments. The findings that at least appear to be factual can be broken down into four categories. The findings in each category are false, and therefore "unreasonable" and not entitled to deference.[23]

i. The first category of findings asserts that there is a "consensus" of opinion against "partial-birth abortion," including that it is disfavored in the medical community, absent from medical school curricula, and unrecognized by mainstream medicine. Act §§ 2(1), (2), (14)(B), (C), (O). As the Ninth Circuit correctly ruled: "Even the most cursory review of the Act and the congressional record . . . reveals that no such medical consensus exists, a fact that the government essentially concedes in its brief . . . and that is fully confirmed by the evidence introduced [at trial]." PA 22a; *see also* PA 196a ("the evidence available to

[23] This excludes legal arguments couched as "findings," such as those arguing for deference, summarizing and criticizing *Stenberg*, and self-servingly reporting that Congress has "substantial evidence" for its findings. *See, e.g.*, Act §§ 2(3)-(4), (6)-(13), (14)(D), (G), (H).

Congress . . . very clearly demonstrates . . . that there is no medical or ethical consensus regarding either the humanity, necessity, or safety of [intact D&E]"). The lack of consensus was confirmed at trial. *See* § I.B.1, *supra* (evidence of safety of intact D&E confirms that there is no consensus against its use, it is not "disfavored," and it is part of leading medical schools' curricula); JA 673 (Dr. Sprang, agreeing that the AMA could reach no ethical consensus), 861.

ii. The finding in the second category asserts that there is no "credible medical evidence" supporting the safety of "partial-birth abortion." Act § 2(14)(B). This finding is unreasonable and cannot be accepted because Congress very definitely had before it, and there clearly is, "credible medical evidence" supporting the safety of "partial-birth abortion." Numerous physicians and medical organizations submitted statements to Congress attesting to the safety of intact D&E. *See* § I.B.1, *supra*. In addition, the amicus brief submitted by ACOG to this Court in *Stenberg* was entered into the congressional record. ER 1233-47. Moreover, that "credible medical evidence" was overwhelmingly confirmed by the evidence presented at trial. PA 143a-44a; *see* § I.B.1, *supra*.

iii. The findings in the third category assert that "partial-birth abortion" carries health risks and a ban will advance women's health. Act §§ 2 (14)(A), (F), (O). These findings are also unreasonable because – as even the Government's witnesses agreed – intact D&E is no riskier than disarticulation D&E, and may well be safer. PA 145a, 200a-02a (rejecting congressional findings related to alleged intact D&E complications).

iv. Apparently recognizing the outright falsity of the findings in categories (i)-(iii), the Government now ignores them and asks the Court to uphold the Act based exclusively on the findings in the fourth category –

Congress's assertion that "partial-birth abortion" "is never medically indicated" (Act §§ 2(14)(E), (O)) to preserve the health of pregnant women. Gov't Br. 21. As the courts below found, "substantial medical authority" believes that intact D&E is significantly safer than other methods and is medically indicated in some circumstances. *See* § I.B, *supra*. Given the weight of this evidence, this Court should not defer to a finding based on testimony from physicians without second-trimester abortion expertise.[24]

Moreover, any assessment of these findings must be informed by the serious flaws in Congress's politicized, pre-determined fact-finding process.[25] *See* Statement of Case, *supra*. Seen through that lens, and given the objective falsity of so many of them, it is apparent that none of the congressional findings are entitled to deference.

D. *Stenberg* Should Not Be Overruled

Because the "substantial medical authority" standard is met and the unreasonable congressional findings are entitled to no deference, this Court cannot uphold the Act without overruling *Stenberg*. Regardless of whether a

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[24] The Government cites congressional testimony of Drs. Kathi Aultman, Curtis Cook, Mark Neerhof, Nancy Romer, and Pamela Smith. Carhart Gov't Br. 31-33. None of these physicians are experts in second-trimester surgical abortion, and several, if not all, oppose abortion by any method. Statement of the Case, *supra* (Cook and Neerhof); *Richmond Med. Ctr. For Women v. Gilmore*, 55 F. Supp. 2d 441, 449 (E.D. Va. 1999) ("Dr. Kathi Aultman . . . was not current on the medical aspects of abortion"); *Planned Parenthood of Greater Iowa, Inc., v. Miller*, 30 F. Supp. 2d 1157, 1165 n. 9 (S.D. Iowa 1998) (same); ER 53 (Dr. Smith was president-elect of the American Association of Pro-Life Obstetricians and Gynecologists; presumably, she opposes all abortions); ER 161-63 (Dr. Romer did not report any experience performing abortions).

[25] There is no basis for the Government's claim that the Court should defer to Congress's so-called credibility determinations. Gov't Br. 25-26. *Akins v. Texas*, 325 U.S. 398 (1945), the only case it cites for that assertion, did not involve congressional findings.

majority of this Court agreed with the *Stenberg* majority, "the principles of *stare decisis* weigh heavily against overruling it now." *Dickerson*, 530 U.S. at 443. The considerations identified in *Casey* to test whether "overruling a prior decision [is consistent] with the ideal of the rule of law," 505 U.S. at 854, do not support overturning *Stenberg*. Its holding has not proven unworkable in practice; doctors at leading medical institutions nationwide have been trained to use this technique; pregnant women have benefited from access to safer procedures; *Stenberg* has been applied consistently by the lower courts; and there have been no legal or factual developments that would undermine *Stenberg*'s underpinnings. Indeed, not only do the legal foundations of *Stenberg* remain strong, the principle that women's health must remain paramount when the government regulates abortion was unanimously reaffirmed last term in *Ayotte*.

Under these circumstances, overruling *Stenberg* would lack the "special justification" needed to overrule a precedent recognizing a constitutional liberty interest. *Harris v. United States*, 536 U.S. 545, 557 (2002); *cf. Lawrence v. Texas*, 539 U.S. 558 (2003). Rather, there would be no "justification beyond a present doctrinal disposition to come out differently from the Court" of 2000. *Casey*, 505 U.S. at 864. That result would "invite[] the popular misconception that [the Court] is little different from the two political branches of the Government. No misconception could do more lasting injury to this Court and to the system of law which it is [its] abiding mission to serve." *Mitchell v. W.T. Grant Co.*, 416 U.S. 600, 636 (1974) (Stewart, J., dissenting); *see also Casey*, 505 U.S. at 864 (same); *cf. Bush v. Vera*, 517 U.S. 952, 985 (1996) ("Our legitimacy requires, above all, that we adhere to *stare decisis*, especially in such sensitive political contexts . . . where partisan controversy abounds.").

Reaffirming *Stenberg* is also imperative because its reasoning applies, rather than departs from, the careful balance established in *Casey*. There, the Court held: "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." 505 U.S. at 880. The core principle that pregnant women must be able to protect their health despite abortion restrictions would surely be hollow if doctors were forbidden to treat patients by performing the "significantly safer" intact D&E method where appropriate.

Casey departed from *City of Akron v. Akron Center for Reproductive Health, Inc.*, 463 U.S. 416 (1983), and *Thornburgh* only in recognizing that the interest in potential life is "substantial" throughout pregnancy. 505 U.S. at 876-78. *Casey* nowhere suggests that the state interest in potential life justifies a restriction that puts women's health at risk by banning the safest pre-viability abortion method – without a health exception.[26]

The Government argues that two interests justify the ban – the interest in potential life and in prohibiting infanticide. Gov't Br. 10, 14, 28. Neither applies here. An intact D&E ban does not save fetal life, *Stenberg*, 530 U.S. at 951 (Ginsburg, J., concurring); it merely pushes women to a less safe method. *Cf. Harris v. McRae*, 448 U.S. 297, 345 (1980) (Marshall, dissenting) (the "interest in protecting fetal life is not a legitimate one when it is in conflict with 'the preservation of the life or health of the mother.'") (quoting *Roe*, 410 U.S. at 165). As to "infanticide," prior to viability

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[26] Because intact D&E is significantly, not marginally, safer than disarticulation D&Es (PA 147a), requiring a health exception will not deny government a "meaningful constitutional role in regulating abortion" (Gov't Br. 11); it merely ensures that the government's role is to protect citizens rather than harm them.

when the fetus cannot survive regardless of how it is removed from the uterus, "it is difficult to rest the Act's constitutionality upon an interest in maintaining a distinction between infanticide and abortion." *NAF*, 437 F.3d at 292 n.9 (Walker, C.J., concurring); *cf*. *NAF*, 437 F.3d at 288 (noting that another federal law, 1 U.S.C. § 8(a), explicitly draws the line against "infanticide" – in a manner that clarifies that intact D&E is not infanticide – by defining "child" as an infant "born alive" and defining "born alive" as the "*complete* expulsion or extraction" of a living fetus from its mother) (emphasis added).

While the Act serves an interest in promoting a moral judgment against intact D&E, this Court has repeatedly held that its "obligation is to define the liberty of all, not to mandate our own moral code." *Casey*, 505 U.S. at 850; *Lawrence*, 539 U.S. at 571 (citations omitted). Thus, in *Casey*, this Court acknowledged that some view abortion as "nothing short of an act of violence against innocent human life," yet ruled that this view cannot trump the woman's liberty interest. 505 U.S. at 851-53. So here, intact D&E cannot be banned, especially given its significant safety benefits, on the grounds that some view it as immoral.[27] In sum, using morality as justification for forcing women to have significantly less safe pre-viability abortions would undermine *Casey*, as well as *Stenberg*. The Court should not go down this path.

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[27] Notably, many of the Government witnesses expressly testified that they did not find intact D&E more objectionable than disarticulation D&Es (PA 199a) – undermining the very premise of the congressional findings and the Government's defense of the Act, namely that intact D&E is particularly unacceptable.

II. THE ACT IMPOSES AN UNDUE BURDEN ON WOMEN'S RIGHT TO PRE-VIABILITY SECOND-TRIMESTER ABORTIONS AND IS UNCONSTITUTIONALLY VAGUE

The Act is an undue burden because physicians will be chilled from performing any D&E for fear of running afoul of its terms. It also fails to give fair notice of the prohibited conduct, rendering it unconstitutionally vague.

A. The Act Bans D&E Abortions and Therefore Imposes an Undue Burden

The lower courts found that any D&E when performed in the safest manner can violate the Act, and that physicians can neither predict nor control when this will occur. *See* PA 80a-89a, 26a-33a. As a result, the Act will chill doctors from performing any D&E, or force them to take steps to avoid prosecution, despite their best clinical judgment. *Id.* The Government's argument that there is no undue burden because "standard D&Es" remain available (Gov't Br. 30-35), fails because it does not meaningfully distinguish between permitted and banned D&Es.

1. A Law That Bans D&E Abortions Imposes an Undue Burden

Women have a "right . . . to choose to have an abortion before viability . . . without undue interference from the State." *Casey*, 505 U.S. at 846. Thus, before viability, an abortion regulation may not "impose[] an undue burden on a woman's ability to make this decision." *Id.* at 874, 878. In *Stenberg*, the parties and the Court all agreed that a statute that bans D&Es as a general category imposes an undue burden. 530 U.S. at 938. This is because the vast majority of pre-viability, second-trimester abortions are D&Es, including approximately 95% of abortions between 16 and 20 weeks of pregnancy and 85% after 20

weeks of pregnancy. PA 58a.[28] Because the Nebraska statute caused "those who perform [D&E procedures to] fear prosecution, conviction and imprisonment," it would have chilled doctors from performing D&Es, imposing an "undue burden upon a woman's right to make an abortion decision." *Stenberg*, 530 U.S. at 945-46; *see also Danforth*, 428 U.S. at 75-79 (invalidating ban on "the most commonly used" second-trimester method). The same is so here.

2. The Record Proves That the Act Bans D&Es

a. The District Court Finding That Any D&E May Violate the Act Should Not Be Disturbed

The District Court found that "any abortion using the D&E . . . method could proceed so as to violate the Act when performed in the safest manner." PA 83a. This conclusion is based on detailed factual findings explaining how D&Es are performed.[29] In particular, the District Court found that D&Es by any variant are performed in two steps: first the

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[28] Virtually all post-first-trimester abortions are by D&E or induction. *See* PA at 57a. For some women, inductions are contraindicated. *See* PA 125a-28a. Other women strongly prefer D&E, which is performed on an outpatient basis, to induction, which requires hospitalization and labor of up to two days. *See* PA 58a n.5, 61a-63a, 129a. A tiny number of post-first-trimester abortions are performed by abdominal surgery in which either the fetus is extracted through the woman's abdomen (hysterotomy) or the uterus is removed with the fetus in it (hysterectomy). PA 63a. These procedures are "major surgery and are not recommended except in the case of extreme emergency" because of their relatively high rate of morbidity and mortality. *Id.*

[29] The Government cannot argue that the District Court's findings are "clearly erroneous" as they are based on the testimony of highly-qualified ob-gyn experts with experience and expertise in second-trimester surgical abortions, and on admissions from the Government's witnesses. *See* § I.B, *supra*. The Government adduced no evidence regarding the scope of the Act. S*ee* PA 75a (Government "devoted very little attention to the undue burden issue," and "mistakenly conflate[d]" it with the issue of vagueness).

cervix is dilated, and then the uterus is surgically evacuated by drawing the fetus out through the cervix and vagina. PA 58a, 60a. Most commonly, the fetus is extracted in parts, with disarticulation "occur[ing] only when the fetus meets resistance that restricts the motion of the fetus." *Stenberg*, 530 U.S. at 939; *see* PA 67a n.11 (completely intact extraction occurs only rarely). The disarticulation occurs when "traction is created between the instrument and the counter-traction of the internal os of the cervix" due to a fetal part being too big to pass through and lodging in the cervical opening. *Stenberg*, 530 U.S. at 939 (quotation and citation omitted); *see also* JA 73, 359, 960.

When performing any D&E, sometimes the dilation permits the fetus to be extracted intact or relatively intact to the torso or skull before a larger part lodges in the cervix. PA 81a-82a; JA 219-20, 279-80, 367-69, 438, 962; *cf.* JA 504. The Government witnesses agreed. *See* JA 718-19 (Dr. Shadigian agrees that in any D&E the fetus may be removed to the torso), 571 (Dr. Bowes agrees that in any D&E the fetus may be extracted to the skull with one pass of instruments). While the frequency of intact or relatively intact removal varies, for the testifying physicians, the occurrences "ranged from between 5% to 33% of all D&Es performed, with most doctors reporting occurrences of around 5-15% of the time." PA 67a.[30]

Physicians cannot assess how likely an intact or relatively intact extraction will be until they remove the

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[30] Abortions in which the fetus is extracted intact or relatively intact are referred to by a variety of terms, including "intact D&E," "intact variant of D&E," and "dilation and extraction" or "D&X." "Most significantly," as the District Court found, "all of the testifying physicians who have performed intact extractions refer to this procedure as a variant of D&E, and not as an entirely separate procedure. . . . The only physicians who referred to it as a separate procedure were witnesses who had never performed the procedure." PA 68a; *see also* JA 51, 52, 129, 220, 280-81, 961.

dilators and assess the amount of dilation, the lie of the fetus, and the depth of the vagina, among other considerations. *See* JA 479-83; *see also* JA 220-21, 281, 435. Again, the Government's witnesses agree. *See* JA 1003 (Dr. Lockwood testified that "the decision was made most often . . . during the performance of the procedure to reflect . . . the extent of cervical dilation"). For these reasons, the District Court found: "[t]he potential for a largely intact removal cannot be ascertained until the surgical procedure has already begun." PA 66a; *see also* JA 143-44, 220-21, 371, 939.[31]

Regardless of how dilation is achieved, once an intact or relatively intact fetus is extracted to where a larger part lodges at the cervix with insufficient dilation to continue the extraction, the physician must take steps to complete the procedure. Among the options are "disarticulation . . . , or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation." PA 83a; *see also* JA 73, 132, 142-43, 282-83, 368-70, 439, 963-65. The Government's witnesses agree. *See* JA 719.[32] If the fetus is still living when it is extracted past the navel or to the head and lodges there, the physician knows that any of the steps taken to complete the procedure will cause fetal demise. PA 83a; *see also* JA 77, 82, 965.

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[31] While most physicians use a uniform dilation protocol for all D&Es at any point in pregnancy (*see*, *e.g.*, JA 440, 480, 481), a few testified that if intact extraction would have particular benefits for a patient, they would take steps to dilate the cervix more than usual to increase the likelihood of intact removal. *See* PA 67a; JA 294-97; *cf.* JA 374-76.

[32] When this happens, Government witness Dr. Cook prefers to make multiple incisions in the woman's cervix, rather than to injure the fetus – *even pre-viability* when the fetus cannot survive. *See* JA 784-88. Planned Parenthood's witnesses testified that this technique is highly inappropriate prior to viability because, *inter alia*, it poses serious risks to the woman's future fertility. JA 291-92, 522.

Two underlying facts are particularly critical. First, "the amount of cervical dilation that can be achieved is individual to each woman and cannot necessarily be controlled." PA 59a; *see also* JA 216, 436, 982. Second, in any D&E, the physician tries to reduce the number of times instruments are inserted through the cervix and into the uterus by extracting as much of the fetus as possible with each instrumental pass. JA 72, 214, 241, 438, 909-10, 960, 962. Once again, the Government's witnesses agree. *See* JA 570, 718, 999-1000.

When intact, or relatively intact, extraction is possible, it would increase the risks of perforation, hemorrhage and infection to unnecessarily place instruments in the uterus to cause disarticulation. JA 214, 221, 279, 281-82, 962-63; *see also* JA 1000 (Government witness Dr. Lockwood agrees). Thus, in any D&E, when the dilation and other factors suggest that the fetus can be extracted intact, the physician attempts to do so in order to reduce the instrumentation in the woman's uterus, and thereby reduce the risk of serious complication.

Based on these findings, the District Court concluded that any D&E may be banned by the Act "when performed in the safest manner." PA 83a. Referencing the Act's definitional language, the District Court explained:

> In performing all D&E's . . . physicians "deliberately and intentionally" extract the fetus from the woman's uterus and through her vagina . . . . [which] is called a "vaginal delivery." . . . *Plaintiffs' and the government's experts agree that in any D&E . . . a living fetus may be extracted in a breech presentation until some "part of the fetal trunk past the navel is outside the body of the mother."* . . . In any D&E . . . if the fetus has been brought to th[is] point . . . , a physician may then, in order to complete the

> abortion in the safest manner, need to perform an "overt act," short of completing delivery, that the physician knows the fetus cannot survive, if it still living, and that "kills" the fetus.

PA 81a-83a (citations to witnesses on both sides omitted) (emphasis added). Accordingly, "any abortion performed using the D&E . . . method could proceed so as to violate the Act." PA 83a; *see also* PA 84a ("When beginning a D&E . . . , a physician cannot predict if [it] . . . will . . . violate[] the Act, but the physician knows that [it] is a possibility."). The Act thus unconstitutionally burdens women's pre-viability, second-trimester abortion right. *Stenberg*, 530 U.S. at 945-46.

b. The Government's "Standard D&E" Theory Cannot Save the Act

The Government argues that the Act does not impose an undue burden because it permits so-called "standard D&Es." Gov't Br. 31-35. The problem for the Government is that the distinctions it proposes between banned and protected D&Es depend on factual premises that are contradicted by the District Court's fact-finding and the record, and on semantic distinctions that do not withstand scrutiny. There remains no clear demarcation between banned and permitted D&Es. As a result, the Act will chill the provision of all D&Es.

i. First, the Government suggests that the Act's "anatomical 'landmark[]'" language excludes "standard D&Es." Gov't Br. 31-33. It bases this on its assertions that "[i]n a standard D&E," the physician: "dismembers the fetus while the remainder . . . is still inside the womb"; "use[s] the cervix to restrain the body of the fetus to enable dismemberment"; and "deliver[s]" through the cervix a "smaller portion of the fetus," which is then disarticulated. According to the Government, these

assertions show that the fetus is not delivered past the Act's "anatomical 'landmarks'" in a "standard D&E." *Id*.

This description, however, contradicts the District Court's findings and the record. Perhaps that is why the Government cites no evidence for its theory; nor could it.[33] There is no "standard" degree to which a fetus is extracted before it lodges in the woman's cervix. Experts on both sides testified that the number of times the physician needs to insert instruments into the uterus to extract the fetus varies, and thus, there is no standard degree to which the fetus is extracted before an obstructing part must be disarticulated or reduced in size. *See supra.* Physicians do nothing to "restrain" the extraction in any D&E; rather they extract as much of the fetus as possible with each pass of the instruments, and do not disarticulate, compress or decompress until necessary to complete the procedure. *See supra*; *see also Stenberg*, 530 U.S. at 939.

It is, therefore, misleading to argue that the "anatomical landmark" language protects "standard D&Es." This language simply legislates a particular theory – divorced from the facts – of what constitutes a "standard" degree of extraction before demise in a "standard D&E," *i.e.*, less than "past the navel," leaving some "standard D&Es" legal, while making others a federal crime. The Government recognizes this when it argues that the overt act requirement protects physicians who perform a "standard D&E abortion *not already excluded* by the anatomical 'landmark' requirement." Gov't Br. 32 (emphasis added).

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[33] The testimony cited for the Government's claim that in "standard D&Es" the "physician dismembers the fetus while the remainder of the fetus is still inside the womb" (Gov't Br. 31, 32), merely describes how some physicians grasp a fetus with instruments. JA 144-47, 452. It does not conflict with the District Court's findings that during a D&E, a part of a fetus past the navel may be delivered before the physician must disarticulate to complete the procedure.

ii. Second, the Government asserts that the Act's "overt act" requirement excludes the remaining "standard D&Es" because in a "standard D&E" the "'delivery' of a portion of the fetus is incidental and integral to . . . the performance of the lethal act," and is not a separate "overt act, other than completion of delivery." Act, § 3(b)(1)(B). Gov't Br. 32. Even accepting this premise, *arguendo*, the problem is: how is a physician to know what steps that cause demise are legal because they are "incidental and integral" to the delivery, and what steps are not? As the District Court found: in any D&E the physician may "extract[] the fetus intact until 'part of the fetal trunk past the navel is outside the woman's body,' but . . . is not extracted so far that the calvarium lodges at the cervical opening," and may then, "in order to complete the abortion in the safest manner, need to perform an . . . act," such as "disarticulation, . . . or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation." PA 82a-83a. Any of these steps will cause fetal demise; yet all of these steps would be undertaken to complete the delivery, and thus could be understood as "incidental and integral" to it.

The Government's position is difficult to follow even as among disarticulation D&Es. Sometimes the Government states that disarticulation is permitted as "incidental and integral" to delivery; other times, it states that it is a banned "overt act." *Compare* Gov't Br. 32 (permitting post-landmark "standard D&Es" where disarticulation is "incidental and integral" to delivery) *with* Gov't Br. 33 ("delivery-followed-by-dismemberment" abortions are not "standard D&Es"). If there is a meaningful distinction between permitted and banned instances of completing the abortion in these circumstances, the Government has not identified it.

iii. Third, the Government argues that the Act's "for the purpose of" requirement excludes "standard D&Es." It posits two scenarios as illustrative of abortions that would meet the "for the purpose of" language, violating the ban. In the first, the physician extracts the fetus "beyond a specified anatomical 'landmark' for the purpose of subsequently killing the living fetus by crushing the fetal skull," in a separate overt act. Gov't Br. 33. However, the Government cites nothing suggesting this scenario happens. Nor could it. Planned Parenthood's experts testified that in *no* D&E do they extract the fetus to any anatomical point "for the purpose of" doing anything other than completing the abortion as safely as possible. *See* JA 309-10; *see also* JA 72, 82-83, 128, 214, 277, 476; *cf.* JA 568-69 (Bowes) (physician's intent is always to end the pregnancy in the way safest for the woman).

The Government's second banned scenario references the Ninth Circuit's opinion, describing an abortion where the physician delivers the fetus "for the purpose of subsequently killing the living fetus *by dismemberment*." Gov't Br. 33 (emphasis in original).[34] However, the Ninth Circuit opinion reveals that it was discussing abortions where the physician delivers the fetus past the Act's "anatomical landmarks" (Gov't Br. 32) and then "disarticulat[es] . . .or compress[es] the abdomen or other fetal part that is obstructing the completion of the

[34] The Government argues that there is no record evidence that doctors ever extract the fetus past the specified points "for the purpose of subsequently killing the living fetus *by dismemberment*." Gov't Br. 33 (emphasis in original). Planned Parenthood agrees. But as noted above, there is also no record evidence that physicians extract the fetus to the specified points "for the purpose of" performing *any* lethal act other than completing the delivery. It is thus hard to discern the difference that the Government is positing between disarticulation or dismemberment, on the one hand, and any other action that a physician takes when a fetal part obstructs the completion of the abortion.

uterine evacuation." PA 30a. It is unclear why such an abortion is banned, given that (as described), the lethal act is necessary to removing an obstructing part, and thus is "incidental and integral" to the delivery. Gov't Br. 32.

The Government thus fails to explain how the "for the purpose of" language narrows the Act.

c. Any "Specific Intent" Requirement Does Not Save the Act

The Government claims that the Act is limited because it "applies only where the person performing the abortion has the specific intent, at the outset of the procedure, to deliver the requisite portion of the fetus for the purpose of performing the ultimate lethal act," which must be an act that is not "incidental and integral" to the delivery. Gov't Br. 32. This argument fails based on the Act's plain language. While Congress included several explicit scienter provisions in the Act, "specific intent" is not one of them.[35] The Act is thus not "readily susceptible" to the Government's "specific intent" construction. *Reno v. Am. Civil Liberties Union*, 521 U.S. 844, 884 (1997).

However, even if the Act were construed to require "specific intent," physicians could not be assured of its scope. As this Court has noted, specific intent is a "difficult legal concept" (*Liparota v. United States*, 471 U.S. 419, 433 n.16 (1985)) that "has been the source of a good deal of confusion," which "has led to a movement away from its use," including its abandonment by the Model Penal Code. *United States v. Bailey*, 444 U.S. 394, 403-04 (1980); *cf. Liparota*, at 433 n.16 (jury instructions regarding specific intent have

[35] In the lower courts, the Government argued that the Act's text-based *mens rea* requirements cure the overbreadth and vagueness. Here, it has abandoned that argument, which was properly rejected by the lower courts. PA 94a-95a, 39a-40a.

been "criticized as too general and potentially misleading").

It is unclear, for example, whether a physician would be found to have the "specific intent" to perform an intact D&E based on the fact that he always attempts to reduce uterine instrumentation by extracting the fetus as intact as possible, and thus, as the District Court found, he "cannot predict if the procedure . . . will . . . violate[] the Act, but . . . knows that [it] is a possibility." PA 84a. Does the intent to reduce uterine instrumentation by removing the fetus as intact as possible bring a physician within the reach of the Act? Does the knowledge that, in most cases, the physician will have to perform an act (disarticulation, compression or decompression) in order to complete the delivery, and which will cause the demise of the fetus, constitute specific intent to perform a "partial-birth abortion," especially given the success rate in extracting the fetus intact to the head ranging from 5-33%?

Engrafting an additional *mens rea* element onto the Act neither answers these questions nor clarifies the parameters of the criminal *actus reus*. Thus, it does not alleviate the chill on physicians. Rather, the specific intent construction rests on the Government's "standard D&E" theory that fails to meaningfully distinguish between permitted and banned overt acts. A heightened *mens rea* requirement is no limitation if physicians do not know what actions are criminal if performed with that mental state.

In sum, the scienter provisions do not limit the Act in a manner on which physicians can rely. As a result, those who perform any D&E must "fear prosecution, conviction, and imprisonment[; t]he result is an undue burden upon a woman's right to make an abortion decision." *Stenberg*, 530 U.S. at 945-46.[36] *See* PA 84a-85a (describing the "significantly

[36] Two ob-gyns who were not covered by an injunction testified

negative impact" enforcing the Act would have on Planned Parenthood and its patients); *see also* JA 162-63.

B. The Act is Impermissibly Vague and Should Not Be Narrowly Construed

The lower courts correctly ruled that the Act is unconstitutionally vague because it "fails to define clearly the medical procedures it prohibits."[37] PA 33a; *accord* PA 92a-95a. The Act thus forces physicians to "guess at its meaning and differ as to its application." *Smith v. Goguen*, 415 U.S. 566, 572 n.8 (1974). It therefore "trap[s] the innocent by not providing fair warning" and encourages "arbitrary and discriminatory enforcement." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). The Act's failure to provide adequate notice raises particular concern because it "implicates a constitutionally protected right" and "imposes criminal penalties." PA 33a-34a; *accord* PA 91a; *see also Kolender v. Lawson*, 461 U.S. 352, 358 n.8 (1983) (when "a statute imposes criminal penalties, the standard of certainty is higher"); *Colautti v. Franklin*, 439 U.S. 379, 391 (1979) (review is more stringent where uncertainty "threatens to inhibit the exercise of constitutionally protected rights") (citations omitted).

If the Act does not place physicians at risk of running afoul of the ban during every D&E they perform, which is – as the District Court ruled – how it must be understood

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they had stopped performing D&Es. S*ee* JA 235-36 ("I am currently going to stop doing D&Es . . . [b]ecause I think it would be unpredictable for me to know whether I violate the act."), 935-36 ("I don't do [D&Es] anymore . . . [b]ecause of the law, because I heard that I might go to prison, and because I'm not clear on what I can and cannot do."); *cf.* JA 451.

[37] The Act is also unconstitutionally vague because it applies only to abortions performed "in or affecting interstate . . . commerce." *See generally* Br. of *Amicus Curiae* California Medical Association in Support of Respondents. This aspect of Planned Parenthood's vagueness claim was raised, but not reached by the lower courts. PA 89a n.15; JA 1082 ¶ 30.

based on the plain meaning of its terms and an understanding of D&E practice, then Planned Parenthood does not know what the Act bans and permits.

The Government argues that the Act is not vague because it "unambiguously excludes standard D&E abortions" (Gov't Br. 37), but it acknowledges that some "standard D&Es" will not be excluded by the Act's "anatomical landmark" language. However, the Government fails to meaningfully distinguish between "overt acts" that are permitted because they are "incidental and integral" to the delivery, and those that are banned. *See supra*. Because physicians will have to "guess at [the] meaning" of the Act's language and the Government's strained interpretations, it is unconstitutionally vague. *Smith*, 415 U.S. at 572 n.8.

The Government's second response is to admit that the law is "*broad*," but to argue that its breadth does not make it vague. Gov't Br. 38 (emphasis in original); *see, e.g.*, *id*. at 38 (breadth of phrase "overt act" is "necessary" to capture physicians who perform an "atypical lethal act"), 39 (breadth of phrase "living fetus" is purposefully broad enough to criminalize pre-viability abortions). Notably, the Government admits that the real problem with drafting a precise law is that Congress could not do so *and* "reach[] the full range of conduct" that Congress sought to prohibit, which – by the Government's own admission – includes some disarticulation D&Es. Gov't Br. 38. But, "'[i]t would certainly be dangerous if the legislature could set a net large enough to catch'" physicians performing any D&E, and "'leave it to the courts to step inside' to announce" which D&Es are banned. *Ayotte*, 126 S. Ct. at 968 (quoting *United States v. Reese*, 92 U.S. 214, 221 (1875)).

The Government urges the Court to avoid any constitutional problems resulting from the Act's overbreadth

and vagueness by adopting a narrowing construction that exempts "standard D&Es" from the Act's scope. Gov't Br. 35-36, 39-40. There are numerous problems with this suggestion, starting with the fact that the Government never states explicitly what narrowing construction it proposes, and its "standard D&E" theory is so at odds with the District Court findings and the record that it is certainly not clear on its face. The Government suggests that the limiting construction should be based on defining "standard D&Es" as those in which the lethal act consists of disarticulation that is "incidental and integral" to delivery (and thus is not an "overt act, other than the completion of delivery" within the meaning of the Act). Gov't Br. 32. Yet, in its Brief in *Carhart*, the Government seems to dismiss such an interpretation. Carhart Gov't Br. 47. The disconsonance between the Government's different approaches casts further doubt about what the Act bans, and certainly raises the specter of arbitrary and discriminatory enforcement.

Even if this were the construction the Government means to propose, it is unacceptable because it includes only abortions where the overt act consists of disarticulation, but not those involving other medically appropriate steps, such as compression, decompression, or cutting the umbilical cord (*see* PA 83a), that would cause fetal demise and are "incidental and integral" to completion of the delivery. The Act's language – "performs the overt act, other than completion of delivery, that kills the partially delivered living fetus" (Act § 3(b)(1)(B)) – does not distinguish between types of "overt act[s]." Moreover, there is no constitutional basis for distinguishing among them. Indeed, if the Court construed the Act as exempting "incidental and integral" overt acts consisting of disarticulation, but not consisting of the other methods of completing an abortion when a fetal part obstructs complete extraction, it would push physicians to perform D&Es in a manner that will be

riskier for some women. *Cf*. JA 427, 503-04. Accordingly, the Court should reject the Government's suggestion.

III. THE ACT MUST BE ENJOINED IN ITS ENTIRETY

If this Court finds that the Act fails to meet constitutional standards in any respect, it must decide the appropriate remedy. The Ninth Circuit was correct that a court cannot – consistent with the text of the Act, legislative intent, and the judiciary's limited role – devise a narrow injunction that adequately addresses the Act's constitutional infirmities. PA 40a-54a. Accordingly, the permanent injunction and declaratory judgment facially invalidating the Act must be affirmed.

i. If the Court concludes that the lack of a health exception is unconstitutional, it must – as the Ninth Circuit did – decline to engraft one onto the Act because to do so would "violate the intent of the legislature and usurp the policy-making authority of Congress." PA 41a. In *Ayotte*, this Court concluded that the "touchstone for any decision about remedy is legislative intent." 126 S. Ct. at 968. Here, the legislative history abundantly shows that Congress did not "inten[d]" (*id*.) the Act to have a health exception. PA 42a-45a.

As the Government concedes, Congress rejected several proposals to include a health exception (Gov't Br. 42; *see* PA 43a n. 28; Statement of Case, *supra*), even though they were repeatedly warned by their colleagues that without one, it would violate *Stenberg*. PA 42a n. 27. Indeed, the Act's co-sponsors did not hesitate to show their disdain for a health exception. *See* 149 Cong. Rec. S3486 (daily ed. Mar. 11, 2003) (statement of Sen. Santorum) ("I hope the Justices read this Record because I am talking to you . . . . [T]here is no reason for a health exception."); *see also* ER 1204 (H.R. Rep. No. 108-58 (2003), at 69 (statement of Rep. Chabot)

("[A] health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed."); *see generally* PA 42a n. 26, 44a n. 29. Moreover, the Act's findings explicitly state that "a ban on partial birth abortion is not required to contain a 'health' exception." Act § 2(13).

In response, the Government offers two arguments against facial invalidation. First, it argues that "the proponents of the Act would have preferred to prohibit partial-birth abortions in at least some circumstances, even if they could not have prohibited them altogether." Gov't Br. 43 (citing a 1997 statement of Senator Ashcroft, who was not in Congress when the Act was enacted). Yet the record shows that the Senate delayed passage of the Act (in response to a request from the National Right to Life Committee) in an attempt to time the enactment with a potential vacancy on this Court. JA 1052-54. This belies the claim that Congress was interested in preventing as many "partial-birth abortions" as possible. Rather, it suggests that Congress was primarily interested in trying to take advantage of a doctrinal shift on the Court to eliminate the constitutional principle that requires a health exception.

Second, the Government asserts that if the Court cannot determine whether Congress would have preferred no statute to a "modified" one, it should adopt partial invalidation as a default presumption. Gov't Br. 44. This result would conflict with *Ayotte*. While partial invalidation is *preferred*, *Ayotte* does not hold that it is appropriate when, as here, it would conflict with the second and third of the "three interrelated principles." 126 S. Ct. at 967-68.[38]

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[38] If there were to be a default presumption, it should be facial invalidation because Congress can always follow the Court's guidance and re-enact a law that conforms to the Constitution.

The second *Ayotte* principle prohibits courts from rewriting laws to conform to constitutional requirements. *Id*. at 968. Because Congress expressly rejected even a narrow health exception, this Court should not engage in the kind of "inherently complex" "line-drawing" that would be necessary to define the parameters of a health exception, and that *Ayotte* expressly counseled against. *Id.* at 968 (quoting *United States v. Nat'l Treasury Employees Union,* 513 U.S. 454, 479 n.26 (1995) (leaving to Congress the task of drafting a narrower statute "when Congress has sent inconsistent signals as to where the new line or lines should be drawn")).

The third *Ayotte* principle counsels against "circumvent[ing] the intent of the legislature," while being "wary of legislatures who would rely on [the Court's] intervention" to clarify laws that sweep within them constitutionally protected conduct. 126 S. Ct. at 968 (citations and quotation omitted). Even before *Ayotte*, this Court has instructed: "courts 'are not at liberty to create an exception where Congress has declined to do so.'" *Freytag v. Comm'r of Internal Revenue,* 501 U.S. 868, 873-74 (1991) (citation omitted).

Thus, while the Government is correct that the first *Ayotte* principle holds that partial invalidation is the "normal rule," partial invalidation is not proper where, as here, the second and third *Ayotte* principles counsel so strongly against writing in a health exception. Rather, because Congress did not intend the Act to have a health exception, the Act must be facially invalidated.

ii. If the Court concludes that the Act imposes an undue burden because it reaches or chills all D&Es, it should facially invalidate the Act under *Casey* and *Stenberg*. In *Casey*, the Court held that a law that imposes "a substantial obstacle to a woman's choice to undergo an abortion" must be facially invalidated if it so operates "in a

large fraction of the cases." 505 U.S. at 895 (facially invalidating spousal notice provision). In *Stenberg*, although this Court did not use the term "large fraction," it facially invalidated the overbroad Nebraska law because it would unduly burden the rights of women seeking any D&E.

The same is true here. Given that 95% of second-trimester abortions are D&Es, a D&E ban would certainly burden a "large fraction" of affected women. Thus, if the Act took effect, it would cause "[a]ll those who perform" D&Es to "fear prosecution, conviction, and imprisonment." *Stenberg*, 530 U.S. at 945; *cf. Casey*, 505 U.S. at 894.

The Government does not even attempt to explain why – if the Act impermissibly reaches all D&Es – *Stenberg*'s decision to facially invalidate the Nebraska law would not be controlling here. Rather, the Government's sole argument is that this Court should engraft a distinction between so-called "partial-birth abortions" and "standard D&E's" into the Act. Gov't Br. 45. But, as discussed in detail in § II.A.2.b, *supra*, this approach fails. Because the Act implicates all D&Es, it unduly burdens a "large fraction" of affected women and must be facially invalidated.

iii. Facial invalidation is also the appropriate remedy if the Court deems the Act impermissibly vague. *See*, *e.g.*, *Kolender*, 461 U.S. at 358 n.8, 361-62. As demonstrated in § II.A.2.b, *supra*, a narrowing construction that used the term "standard D&E" would merely propagate the substantive problems with the Act that lead to the need for a remedy in the first place. In other words, it would be no cure at all.

CONCLUSION

For the foregoing reasons, the judgment of the U.S. Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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