No. 17-935

In The Supreme Court of the United States

PLANNED PARENTHOOD OF ARKANSAS & EASTERN OKLAHOMA, et al.,

Petitioners,

v.

LARRY JEGLEY & MATT DURRETT,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Arkansas law requires medication abortion providers to maintain a working arrangement with a physician who agrees to ensure that patients needing follow-up treatment receive it. On a pre-enforcement facial challenge, is a district court entitled to preliminarily enjoin that commonsense requirement without determining whether a medication abortion provider's decision to stop performing abortions – rather than offer compensation to recruit a physician to fulfill that role – would impose an undue burden on a large fraction of relevant patients?

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The opinion of the United States Court of Appeals for the Eighth Circuit (App. 1a-16a) is reported at 864 F.3d 953. The opinion of the district court (App. 17a-108a) is unreported but is available at 2016 WL 6211310 (E.D. Ark. Mar. 14, 2016).

JURISDICTION

The judgment of the Eighth Circuit was entered on July 28, 2017. A petition for rehearing *en banc* was denied without dissent on September 27, 2017. App. 111a-112a. The petition for a writ of certiorari was filed on December 21, 2017. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

INTRODUCTION

Petitioners Planned Parenthood and Stephanie Ho seek review of a unanimous Eighth Circuit decision vacating and remanding a preliminary injunction against a requirement that medication abortion providers ensure that patients who experience complications have access to follow-up treatment. The remand was with instruction for the district court to determine whether that requirement likely imposes an undue burden on a large fraction of relevant patients.

Petitioners do not dispute that decision was correct. Rather, they concede that to preliminarily enjoin

Arkansas's contract-physician requirement on their facial challenge, the district court was required to determine that requirement at a minimum likely imposes an undue burden on a large (or they say significant) fraction of relevant patients. And while Petitioners contend that the district court *should* have made that determination, they do not dispute that the district court *did not* make that finding. Instead, the district court merely suggested that Arkansas's requirement might unduly burden "some women" in a portion of Arkansas. App. 14a.

Not a single member of the Eighth Circuit believed this decision warranted *en banc* review. Yet Petitioners argue that this Court should – not just grant review but – summarily reverse and declare the challenged requirement facially unconstitutional. That extraordinary request rests on their erroneous assertion that Arkansas's contract-physician requirement mirrors the 30-mile admitting privileges requirement for all abortion providers in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). *See* Pet. 3. But Arkansas law does not require that abortion providers themselves have admitting privileges anywhere. Arkansas law merely requires medication abortion providers to have a contractual relationship (to ensure follow-up treatment if needed) with a physician that has admitting privileges.

To the extent Arkansas's contract-physician requirement is comparable to any law discussed in *Hellerstedt*, it is like the pre-existing Texas working arrangement provision which that case impliedly blessed and

affirmatively relied on. *See* 136 S. Ct. at 2311-12 (explaining the lack of additional benefits of the new Texas law compared to working arrangement provision). Thus, it is not at all clear how Petitioners can argue that the Eighth Circuit was required to invalidate Arkansas's requirement.

Nor is it clear how Planned Parenthood – which *never* objected to that Texas working arrangement requirement – can plausibly claim that it cannot comply with Arkansas's similar (actually, less strict) requirement. Indeed, that Petitioners' professed inability to comply with Arkansas law is a facade is aptly illustrated by their concession that their purported "efforts to recruit a contract physician did not include any offer of financial compensation" (App. 6a n.4) and consisted of a mass mailing denouncing the contract-physician requirement as "medically unnecessary." Supp. App. 1a, JA 446.[1] This Court's review is not warranted.

STATEMENT

A. Background

1. *Medication Abortion's Unique Risk Profile*. Medication abortions are less common than surgical abortions. The record here, for instance, establishes that

[1] "JA" refers to the joint appendix below. "Supp. App." refers to Respondents' attached supplemental appendix.

just 14% of Arkansas abortion patients opted to undergo medication abortion. *See* App. 25a.[2]

Medication abortion also presents a different risk profile than surgical abortion. In particular, medication patients are more likely to suffer complications that require follow-up treatment "than those who have surgical abortions." Ark. Code Ann. 20-16-1502(a)(18); *see* JA 440 (Petitioners' expert's testimony that medication patients are more likely to require follow-up treatment). Additionally, because the most common drug regime requires patients to take a second dose of medication days after leaving an abortion provider, "by the time any complications arise," the patient may also be "hundreds of miles away" and unable to return to the abortion provider. Brief of American College of Obstetricians and Gynecologists et al. as Amicus Curiae 11; *see* App. 24a (describing protocol); *cf.* App. 29a ("given the patient population and distances patients

[2] Petitioners belatedly attempt to show that medication is more common than medical data indicates. *See* Pet. 5. Eschewing record data demonstrating that less than a quarter of abortions through nine weeks are medication abortions (JA 364-65 (Arkansas abortion data)), Petitioners cite outside the record projections derived from survey responses discussed in an advocacy piece to argue that medication abortion – while still rarer than surgical abortion – is more common nationally. Pet. 5. This Court, however, should decline Petitioners' belated invitation to disregard record data in favor of survey projections that the authors of the cited advocacy piece concede have "several shortcomings." Rachel K. Jones & Jenna Jerman, *Abortion Incidence & Serv. Availability in the U.S., 2014*, 49 Persp. on Sexual & Reprod. Health 17, 22, 25 (2017).

travel as described by [Petitioners]," complications are unlikely to occur near hospital close to provider).

Further, while Petitioners argue that many patients experiencing complications could return to a medication abortion provider or turn to their local emergency rooms for follow-up treatment, Petitioners concede that *some* women will experience complications requiring treatment that neither medication abortion providers nor emergency room physicians provide. *See* Pet. 7 ("[A]lmost all" patients experiencing complications can receive treatment at an emergency room or "can return to [Petitioners'] [abortion] center for treatment."); App. 58a-59a ("There is record evidence that, for *most* of the small number of patients who experience complications or need follow-up care, *many* can be, and are, treated at the clinic or health center, not a hospital." (emphasis added)); App. 66a ("emergency room physicians are well qualified to evaluate and treat *most* complications that can arise after a medication abortion" (emphasis added)).

2. *The Abortion-Inducing Drugs Safety Act*. The Abortion-Inducing Drugs Safety Act addresses the greater likelihood that medication abortion patients will need follow-up treatment far from an abortion provider by ensuring that all medication abortion patients receive "the name and phone number" of a physician who has contracted with the provider "to handle complications" and "emergencies associated with the use or ingestion of . . . abortion-inducing drug[s]." Ark. Code Ann. 20-16-1504(d). That contract physician – but not the provider – must have admitting and

surgical privileges at an Arkansas hospital, and he or she will be legally obligated to arrange necessary follow-up treatment regardless of a patient's location. *See id.*

To give medication abortion providers time to comply with that requirement, it was not scheduled to take effect until *nine* months after enactment. Ark. Code Ann. 20-16-1510.

3. *Arkansas Abortion Providers*. Arkansas has three large abortion facilities subject to special regulatory requirements. *See* Ark. Code Ann. 20-9-302(a)(1); Ark. Admin. Code 007.05.2-1-13. Two of those facilities are located in the center of the state in Little Rock. App. 5a. One is operated by Planned Parenthood and performs only medication abortions. *Id.*

The other, Little Rock Family Planning Services (LRFP), performs surgical and medication abortions. *Id.* Petitioners do not dispute that if they choose to stop performing abortions, most Arkansas abortion patients will be unaffected because they can travel to LRFP and that provider can accommodate any corresponding patient increase. *See* App. 93a-94a (Petitioners offered no evidence LRFP cannot accommodate increase); *see also* App. 11a-12a.[3]

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[3] Petitioners concede that LRFP will continue performing surgical abortions, but they *allege* LRFP will stop administering medication abortions. *See* Pet. 8-9. Petitioners never provided *any* evidence to support that bare allegation, and LRFP did not seek to enjoin the contract-physician requirement. Rather, Petitioners improbably suggest that because they would rather stop

Planned Parenthood also operates a medication-only abortion facility in the northwest corner of the state in Fayetteville. App. 5a. Two other abortion facilities – including one operated by Planned Parenthood – in nearby Tulsa, Oklahoma, also serve that region. *See* JA 375. Those facilities are roughly 80 miles from the county where Fayetteville is located, and unlike in Arkansas, patients may obtain abortions at those facilities in a single trip. *See id.*; Okla. Stat. Ann. tit. 63, sec. 1-738.2 (initial consultation may be by telephone). Indeed, despite the district court's inexplicable assumption that women in the Fayetteville area cannot obtain abortions in Tulsa, Arkansas residents account for 3.5% of *all* Oklahoma abortions.[4]

Additionally, patients throughout Arkansas may obtain an abortion from any number of private practitioners who do not work for an abortion facility. *See* Ark. Code Ann. 5-61-101(a).[5]

4. *The Contract-Physician Requirement's Benefits*. Petitioners acknowledge that the contract-physician

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performing medication abortions than offer compensation to recruit a contract physician, it is likely LRFP will make the same decision. *See infra* at p. 11 (discussing Petitioners' refusal to offer financial compensation). Petitioners do not point to any evidence LRFP will make that same decision, and this Court should disregard Petitioners' claim.

[4] *See* Abortion Surveillance in Oklahoma, Oklahoma State Department of Health 20 (June 2017), https://www.ok.gov/health2/documents/2016AbortionReportFinal.pdf.

[5] Petitioners ignore these providers and wrongly assert (Pet. 8) without any evidentiary basis that Arkansas has three abortion providers.

requirement mandates "good medical practice" and will benefit patients. Pet. 7 n.3; *see also* App. 68a (benefits merely "not compelling").

For instance, Petitioners concede that the contract-physician requirement mandates the "good medical practice" of giving patients a number (other than emergency services) to call if they experience worrying symptoms or complications. Pet. 7 n.3. Indeed, while Petitioners focus on the fact that large abortion facilities were previously required to give patients access to a consultation hotline that can be staffed by a nurse, they do not dispute that no similar requirement previously applied to private practitioners performing abortions. *See id.* (citing Ark. Admin. Code 007.05.2-7(E)'s requirement that facilities performing ten or more abortions per month – but not other providers – must have consultation hotline staffed by nurse or physician); *see also* Ark. Code Ann. 20-16-1504(d) (*every* medication abortion provider must give patients contract physician's number). They also do not dispute that while the contract-physician requirement mandates that medication abortion providers give patients access to a *physician*, they could meet the prior requirement by providing access to a *nurse* charged with scheduling appointments and directing patients to emergency services. *Compare id. with* Ark. Admin. Code 007.05.2-7(E).

Petitioners also do not dispute that *some* of their patients, who currently only have access to a nurse-staffed hotline, will benefit from having another place to turn for reassurance and advice. *See* App. 60a

(Petitioners argue that "[i]n *most* cases . . . patients can be reassured over the phone or, if need be, arrangements are made for the patient to return to the [abortion] center for care." (emphasis added)); *see also* JA 52 (Petitioners' expert's testimony that "many of those women who visit ERs after an abortion do so because of concerns they are having about their symptoms in cases where the ER visit is not actually medically necessary. In those cases, the ER physician can evaluate, counsel, and release those patients.").

In addition to that benefit, the contract-physician requirement further mandates that medication abortion providers ensure patients who are more likely than other abortion patients to need follow-up treatment get that care. Indeed, by imposing a requirement that medication abortion providers identify a physician who is obligated to "handle" patient complications by providing follow-up treatment (in a hospital setting or elsewhere) or, if the patient is far away or unable to travel, arranging for that care, that requirement prevents providers from abandoning patients. Ark. Code Ann. 20-16-1504(d); *see also* THE AMERICAN HERITAGE DICTIONARY 796 (5th ed. 2011) (defining "handle" to include "deal[ing] with or hav[ing] responsibility for" or "manag[ing]"); NEW OXFORD AMERICAN DICTIONARY 788 (3d ed. 2010) ("handle" means to "manage (a situation or problem)"). It likewise ensures that patients requiring follow-up that neither local emergency rooms nor medication abortion providers perform receive that care. *See* Pet. 7 (conceding *some* patients require treatment that neither provides); *see also* JA 402

(discussing difficulties emergency room physicians encounter trying to arrange follow-up treatment).

Furthermore, while Petitioners focus on their current voluntary protocols for treating complications (including their referral practices), they do *not* suggest that existing law imposes a similar requirement. *See* Pet. 7-8. Nor do Petitioners deny – as the Eighth Circuit correctly recognized – that they "could unilaterally decide to discontinue" those current practices. App. 15a n.9.[6]

Past conduct by the Planned Parenthood affiliate that originally brought this lawsuit – Planned Parenthood of the Heartland – also uniquely underscores that risk and the value of setting legally enforceable standards. *See* Order, *Planned Parenthood et al. v. Jegley et al.*, No. 16-2234 (8th Cir. Oct. 21, 2016). For instance, sworn congressional testimony from a former affiliate manager demonstrates that entity's established practice for addressing complications was to "tell women who experienced complications at home to report to their local ER" and "say they were experiencing a miscarriage, not that they had undergone a chemical abortion." Planned Parenthood Exposed: Hearing of H. Comm. on the Judiciary, 114th Cong. 18 (2015) (testimony of Susan Thayer). That deceptive policy, as the manager explained, enabled Planned Parenthood to

[6] Petitioners erroneously contend that the Eighth Circuit suggested that Planned Parenthood could also discontinue its nursing hotline. Pet. 7 n.3. But the Eighth Circuit correctly observed that Petitioners could discontinue the current hotline *procedures* that the district court cited. *See* App. 15a n.9.

continue "outsourcing complications to others." *Id.* at 20.

5. *Petitioners' Decision Not to Recruit a Contract Physician*. Petitioners concede that their "efforts to recruit a contract physician" and comply with Arkansas law have never "include[d] any offer of financial compensation." App. 6a n.4. Instead, according to Petitioners, their failure to recruit a physician willing to contract with them *for free* demonstrates that neither they – nor anyone else – can comply with the contract-physician requirement. *See* Pet. 8-9.

Further, while Petitioners claim that they "contacted every ob-gyn [they] could identify" (Pet. 9) looking for a contract physician, they fail to mention that contact – which occurred more than *nine* months after the contract-physician requirement's enactment – consisted of a bulk mailing criticizing the Arkansas General Assembly and denouncing the contract-physician requirement as "medically unnecessary." Supp. App. 1a, JA 446.[7]

B. Procedural History

1. *District court proceedings*. The contract-physician requirement never took effect because just a few days before its effective date, Petitioners obtained a temporary restraining order. *See* App. 19a-20a.

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[7] Petitioners do not now contend that anything prior to their mailing denouncing the contract-physician requirement demonstrates an inability to comply. *See* Pet. 9.

The district court later issued a preliminary injunction because it believed that requirement's benefits likely did not outweigh the burdens that "some" patients in "the Fayetteville area" might face if Petitioners choose to stop performing abortions. *See* App. 25a, 34a-35a, 90a-94a.

To reach that conclusion, the district court began by reciting Petitioners' current protocols and referral practices. *See* App. 26a-29a. It did not consider whether other medication abortion providers have similar practices or Arkansas's interest in setting mandatory standards. *See* App. 15a-16a n.9. Instead, having concluded that Petitioners' current practices would likely meet *most* of Petitioners' patients' needs, the district court found, "the state's overall interest" was "not compelling." App. 66a-68a.

With respect to burdens, the district court declared that Petitioners' failure to recruit a contract physician through their mailing denouncing the contract-physician requirement demonstrated that they could not comply with Arkansas law. *See* App. 99a-100a. It declined to consider whether Petitioners could recruit a paid contract physician. *See id.* (declining to address efforts' validity); *see also* App. 6a n.4. Rather, fully embracing Petitioners' representations, the district court concluded that Petitioners' mailing denouncing the contract-physician requirement as "medically unnecessary" (Supp. App. 1a, JA 446) demonstrated that no medication abortion provider could comply and that, as a result, medication abortion would likely no longer be available. *See* App. 99a-100a; Pet. 8-9.

Yet the district court acknowledged that even if Petitioners choose to stop performing abortions and medication abortion was no longer available, that would not unduly burden most patients. Instead, noting that Petitioners had failed to introduce any evidence that their patients could not safely be accommodated elsewhere, the district court concluded that the vast majority of patients could continue – as before – obtaining abortions in Little Rock. *See* App. 93a-94a (finding record does not indicate that LRFP cannot accommodate increase); *see also* App. 11a-12a (noting district court's acknowledgement "that most women residing in Arkansas and seeking medication abortions would be unaffected by the contract-physician requirement"). And while the district court (erroneously) believed those abortions would be exclusively surgical, it acknowledged any unavailability of medication abortion would not pose a substantial obstacle for the vast majority of patients who can safely access surgical abortion. *See* App. 93a-94a (unavailability would only "result in negative consequences for those women" with unique conditions).

Thus, in its search for burdens, the district court ultimately turned to "women in the Fayetteville area." App. 25a. It concluded that group could never obtain an abortion in Tulsa (just 80 miles from the county where Fayetteville is located) and instead would have to travel 190 miles to Little Rock. App. 25a, 103a-104a. That distance, it then reasoned, could cause "some women" in that group to forgo or delay an abortion, and

on that basis, it held that facial relief was warranted. App. 34a-35a, 90a-94a.[8]

2. *The Eighth Circuit's Decision*. The Eighth Circuit unanimously vacated the district court's decision and remanded with instructions for the district court to determine whether the contract-physician requirement would – as required for facial relief – likely impose an undue burden on a large fraction of relevant patients. App. 15a. Interpreting this Court's precedents, the court found that, at a minimum, "to sustain a facial challenge and grant a preliminary injunction" here, "the district court was required to make a finding that the Act's contract-physician requirement is an undue burden for a large fraction of women seeking medication abortions in Arkansas." App. 10a-11a.

As the Eighth Circuit observed, "[t]he district court did not make this finding." App. 11a. In fact, "the [district] court [had] noted that most women residing in Arkansas and seeking medication abortions would be unaffected by the contract-physician requirement, as they could travel to LRFP for an abortion." App. 11a-12a.[9] Instead, as the Eighth Circuit detailed, the

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[8] The only statewide burden that the district court pointed to was its speculation that the contract-physician requirement might somehow prevent abortion providers from advising patients with "troubling" or emergency complications from "proceed[ing] to the nearest emergency room." App. 57a. Petitioners do not defend that speculation.

[9] Like the district court, the Eighth Circuit correctly noted that "parties generally treated LRFP's surgical-abortion services as a viable alternative to medication abortions." App. 6a-7a & n.5. Consequently, the Eighth Circuit did not address the district

district court had *only* suggested that "some" patients "in the Fayetteville area" might face an undue burden and it had never explained what "women in the Fayetteville area" meant or "define[d] or estimate[d] the number of women who would" face those increased distances. App. 11a-12a. The Eighth Circuit also observed that while the district court had cited testimony purportedly demonstrating that an increased distance of 100 miles could cause, as a general matter, 20-25% of the affected population to forgo an abortion, the district court did not apply that testimony to "women in the Fayetteville area" to determine whether a large fraction of relevant patients would face that burden. App. 13a.[10] Nor did the district court provide any indication what fraction of "women in the Fayetteville area" likely would, in its opinion, postpone abortions and face increased risks. App. 13a-14a.

The district court's failure to make any more concrete determinations, as the Eighth Circuit further explained, apparently rested on its assumption that the distance between Fayetteville and Little Rock

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court's erroneous announcement that every Arkansas medication abortion provider would – like Petitioners – choose to stop administering medication abortions rather than pay a contract physician.

[10] The Eighth Circuit noted that the district court's failure to apply that testimony appeared troubling since it would suggest that just 4.8-6% of those seeking medication abortions would face a substantial obstacle and other circuits have concluded percentages double that are insufficient for facial relief. App. 13a & n.8 (citing *Cincinnati Women's Servs., Inc. v. Taft*, 468 F.3d 361, 374 (6th Cir. 2006)).

standing alone required facial invalidation. App. 12a, 14a. But contrary to that assumption, "increased travel distances" standing alone do not constitute a substantial obstacle. App. 12a. Instead, the relevant question is the impact of those distances, including whether they resulted in "'fewer doctors, longer wait times, and increased crowding.'" *Id.* (quoting *Hellerstedt*, 136 S. Ct. at 2313). And as the Eighth Circuit recognized, the district court had expressly declined to find that was true here. App. 12a-13a.

"As a result" of those failures, the Eighth Circuit was "left with no concrete district court findings estimating the number of women who would be unduly burdened by the contract-physician requirement – either because they would forgo the procedure or postpone it – and whether they constitute a 'large fraction' of women seeking medication abortions in Arkansas such that Planned Parenthood could" likely prevail on a facial challenge. App. 14a. Yet rather than make those findings itself, the Eighth Circuit recognized that the better course was "to afford the district court an opportunity to make appropriate findings of fact and conclusions of law." *Id.* It, therefore, remanded the case with instruction – *not* to make "comprehensive and concrete statistical" determinations as Petitioners speciously claim (Pet. 24) but – to *undertake* additional fact-finding to *determine* whether a large fraction of relevant patients would face an undue burden. App. 14a-15a. In so doing, the Eighth Circuit "acknowledge[d] that the 'large fraction' standard is in some ways 'more conceptual than mathematical'" and that,

as a result, it was "not requir[ing] the district court to calculate the exact number of women unduly burdened by the contract-physician requirement." App. 15a (quoting *Cincinnati Women's Servs.*, 468 F.3d at 374).

Finally, having determined that the district court failed to find that a large fraction of patients would face an undue burden, the Eighth Circuit recognized that it was both impossible to review the district court's overall assessment and, at this stage, "unnecessary to reach the issue of the contract-physician requirement's benefits." App. 15a & n.9. But far from – as Petitioners inaccurately claim (Pet. 13, 18) – failing to disagree with the district court's assessment, the Eighth Circuit added that it had grave concerns about the district court's approach. App. 15a-16a & n.9. For instance, it noted that the district court had puzzlingly failed to consider whether Petitioners' unwillingness to offer financial compensation as part of their purported "efforts to recruit a contract physician" influenced their ability to comply. App. 6a n.4. It likewise noted the district court's failure to consider whether establishing baseline continuity of care standards for medication abortion patients would benefit patients. App. 15a-16a & n.9.

3. *Rehearing Petition*. Rather than allow the district court to determine whether a large fraction of patients would face an undue burden (and give the Eighth Circuit the opportunity to review a complete balancing analysis), Petitioners sought *en banc* review. *See* App. 111a-112a. Their *en banc* petition argued – as

Petitioners do now – that *Hellerstedt* required the Eighth Circuit to affirm the district court's preliminary injunction *sans* analysis. The court denied that request without dissent. *Id.* A divided panel later granted Petitioners' application for a stay of the mandate pending a petition for certiorari. App. 109a-110a.

REASONS FOR DENYING THE PETITION

I. The Eighth Circuit's decision is correct.

A. This case is not *Whole Woman's Health v. Hellerstedt.*

To justify review, Petitioners erroneously claim that this case is "virtually identical" to *Hellerstedt*. Pet. 16. That case involved a Texas law requiring all abortion providers to have admitting privileges within a narrow geographic radius that would not "help[] even one woman obtain better treatment" than a preexisting requirement that providers have a "'working arrangement' with a doctor with admitting privileges." 136 S. Ct. at 2311.

This Court concluded that Texas's provider admitting privileges provision imposed an undue burden because while it would not benefit patients, it had caused so many abortion providers to close that a significant (or large) fraction of women would be denied abortion access. *See id.* at 2316 (closures due to admitting privileges and companion requirement meant few remaining facilities would face impossible task of accommodating a five-fold patient increase); *see also*

id. at 2313. Indeed, because the remaining providers could not possibly accommodate the ensuing patient increase, requiring providers to have admitting privileges "would operate for a significant number of women . . . just as drastically as a complete ban on abortion." *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 683 (W.D. Tex. 2014); *see Hellerstedt*, 136 S. Ct. at 2316 (district court's conclusion that remaining providers "could not 'meet' that 'demand'" was well supported by estimates showing providers would have to go from providing 14,000 abortions to 60,000 to 70,000 abortions, "an increase by a factor of about five").

This case involves neither a comparable requirement nor one that *anyone* has ever suggested would "establish[] a *de facto* barrier to obtaining an abortion for a large number of [patients]." *Lakey*, 46 F. Supp. 3d at 683. Critically, Arkansas law does *not* require providers to have admitting privileges. Nor does Arkansas's contract-physician requirement resemble the nine or so admitting privileges requirements that the parties in *Hellerstedt* agreed were at issue in that case. *See* Brief of Respondent Texas at App. 1a-3a, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (No. 15-274) (Jan. 27, 2016) (listing "Admitting-Privileges Laws Enacted in 2011 or Later" and not referencing Arkansas's contract-physician requirement); Reply Brief of Petitioners Whole Woman's Health et al. at 8 n.2, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (No. 15-274) (Feb. 24, 2016) (listing decisions involving "similar requirement[s]," but not including decision

temporarily restraining the contract-physician requirement).

Instead, Arkansas law only requires medication abortion providers to have a contractual relationship (to ensure follow-up treatment if needed) with a physician that has admitting privileges. Thus, to the extent it resembles any requirement mentioned in *Hellerstedt*, the contract-physician requirement resembles Texas's pre-existing requirement that providers have a " 'working arrangement' with a doctor with admitting privileges." 136 S. Ct. at 2311. And far from suggesting that working arrangement provision was unbeneficial, this Court (and the parties in *Hellerstedt*) explicitly relied on that provision to conclude that Texas's requirement that providers have such privileges was unnecessary. *See id.* at 2311-12 ("compar[ing]" pre-existing working arrangement provision and provider admitting privileges provisions and stressing Texas's concession that it did not know "of a single instance in which the new requirement would have helped even one woman obtain better treatment" than a working arrangement); Reply Brief of Petitioners Whole Woman's Health et al., *supra*, at 9-10 (arguing provider privileges requirement was unnecessary because Texas could accomplish same continuity-of-care goals by requiring – as it long had – providers to have "an agreement with another physician who has admitting-privileges"); *see also* Brief of Planned Parenthood et al. at 30, *Planned Parenthood et al. v. Jegley et al.*, 864 F.3d 953 (No. 16-2234) (8th Cir. Nov. 2, 2016) (arguing *Hellerstedt* "left in place a pre-existing requirement that

providers have an 'arrangement' with a physician with privileges").

Moreover, if Petitioners belatedly mean to suggest that such arrangements are never beneficial, that claim clashes with Stephanie Ho's own practice – *except* when she is providing abortions – of maintaining "an arrangement with a [hospital] group" to ensure her patients enjoy continuity-of-care. JA 193. It is likewise inconsistent with Planned Parenthood's long compliance with Texas's working arrangement provision. *See* Complaint at ¶ 36, *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673 (No. 1:14-CV-00284) (W.D. Tex. Apr. 2, 2014) (working arrangement requirement "had been in effect since 2009 and had never been challenged in litigation").

But more importantly, Petitioners' focus on admitting privileges is little more than an attempt to distract from the fact that the contract-physician requirement is a carefully targeted response to medication abortion's unique risk profile and the failure of *some* abortion providers – including the entity that brought this suit – to ensure that patients have adequate access to reliable follow-up treatment. For instance, only the contract-physician requirement mandates that every medication abortion provider follow "good medical practice" (Pet. 7 n.3) and give patients the name and number of a physician to call if they experience complications or troubling symptoms.

Additionally, only the contract-physician requirement mandates that medication abortion providers

take legal responsibility for ensuring patients receive follow-up treatment. Indeed, unlike anyone under pre-existing requirements, a contract physician is legally obligated to handle complications by either providing follow-up treatment or arranging that treatment for patients who find it difficult to return to the abortion provider or need care that neither the abortion provider nor emergency room physicians can provide. Hence, as the Eighth Circuit correctly noted, unlike the provider admitting privileges requirement in *Hellerstedt* and similar cases, the contract-physician requirement sets a regulatory floor to address the unique (and undisputedly greater) risks associated with medication abortion. *See* App. 15a & n.9. And despite Petitioners' focus on their current, voluntary protocols, they do not deny that *some* patients will benefit from that regulatory floor. *See id.*[11]

Petitioners likewise cannot plausibly claim – especially on this record – that the contract-physician requirement poses a substantial obstacle for a large fraction of patients, let alone the kind that Texas's provider admitting privileges requirement did. It is not at all clear, for example, that the contract-physician requirement will pose *any* obstacle since Petitioners have *never* attempted to recruit a *paid* contract physician. Indeed, while it is unsurprising that abortion providers would

[11] States are not required to adopt or "revise [their] standards every time the American College of Obstetricians and Gynecologists (ACOG) or similar group revises its views about what is and what is not appropriate medical procedure in this area." *Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 456 (1983) (O'Connor, J., dissenting).

struggle to gain admitting privileges within a small radius (because that area contains few hospitals or the need to practice primarily in a small area) and providers would close, it is far from apparent that a much less demanding *statewide* requirement presents similar challenges. *See Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 915 (7th Cir. 2015) (under Wisconsin's 30-mile admitting privileges requirement, "several abortion doctors" maintained privileges "at more distant hospitals"); *see also Hellerstedt*, 136 S. Ct. at 2312 (noting inability to find qualifying doctors in small Texas cities).

And while Petitioners contend the failure to impose a narrow geographic requirement somehow undermines Arkansas's interest (*see* Pet. 7 n.4), in reality, allowing Petitioners to contract with any qualified Arkansas physician is consistent with the commonsense proposition that States should not exclude physicians who "have admitting privileges at a prestigious institution" just because that institution happens to be beyond a narrow radius. Brief of the United States as Amicus Curiae at 20, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (No. 15-274) (Jan. 2016).

Yet even exempting Petitioners' refusal to compensate a contract physician, Petitioners do not allege – and the district court did not find – that Petitioners' choice to stop performing abortions would burden a large (or significant) fraction of patients across Arkansas. To the contrary, far from finding women would face a substantial obstacle, the district court here "noted that *most* women residing in Arkansas and seeking

medication abortions would be unaffected by the contract-physician requirement, as they could travel to LRFP for an abortion." App. 11a-12a (emphasis added); *see also* App. 93a-94a (declining to find that providers could not accommodate increase).[12] In fact, to the extent it found *any* burden, the district court focused *entirely* on "women in the Fayetteville area" who it (wrongly) believed would encounter materially relevant distance increases and only suggested that "some women" in that group would encounter a substantial obstacle. *See* App. 7a-8a.[13]

In sum, especially on this record, Petitioners' bald assertions that the district court made findings that "closely track" (Pet. 21) those in *Hellerstedt* amount to little more than puffery, and puffery does not warrant review.[14]

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[12] Petitioners baldly contend that "many" or "a significant number of women" would face an undue burden if required to travel to Little Rock. Pet. 12-14, 21-22. But *neither* the district court nor the Eighth Circuit made such a finding. *See* App. 11a-12a. Nor did either court – like Petitioners claim (Pet. 18) – suggest women in the Fort Smith area would face materially relevant distance increases.

[13] As noted, even that determination rested on an erroneous determination that *none* of those patients could (or would) obtain an abortion in nearby Tulsa. *See* App. 102a-104a.

[14] Petitioners' other suggestion that in requiring a large fraction for facial relief, "the Fifth Circuit in [*Hellerstedt*] imposed the very same requirement as the Eighth Circuit" (Pet. 21) here is inconsistent with the fact that this case – unlike *Hellerstedt* – does not involve *any* finding that a significant number of women likely face an undue burden.

B. Petitioners concede that the district court failed to make required findings.

No one disputes the Eighth Circuit's conclusion that the district court did not make findings necessary to justify facial relief. Petitioners do not dispute, for instance, that pre-enforcement, facial relief is not appropriate unless, at a minimum, a plaintiff "demonstrat[es] that 'in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion.'" App. 10a (quoting *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 895 (1992)); *accord Gonzales v. Carhart*, 550 U.S. 124, 167-68 (2007) (plaintiffs must "demonstrate[ ] that the Act would be unconstitutional in a large fraction of relevant cases").[15]

Petitioners likewise do not directly dispute that a plaintiff cannot meet that standard by – as the district court incorrectly held – merely showing that a law might prevent (or make it more difficult for) "some women" to obtain an abortion. Indeed, that argument is squarely foreclosed by *Casey*. *See* 505 U.S. at 885-87 (waiting period not invalid simply because it would require women in 62 of 67 counties to make two trips of at least an hour and sometimes longer than three

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[15] Because Petitioners do not dispute that the district court did not determine the contract-physician requirement would impose an undue burden on a large fraction of relevant patients, Respondents assume that test – and not the traditional facial challenge standard set forth in *United States v. Salerno*, 481 U.S. 739, 745 (1987) – applies. If this Court grants review, however, it should apply the *Salerno* standard.

hours to obtain an abortion and would "particularly" burden "*some* women"); *id.* at 899 (parental consent provision not facially unconstitutional even though it was likely to prevent some women from obtaining an abortion); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 744 F. Supp. 1323, 1356-57 (E.D. Pa. 1990); *see also Cincinnati Women's Servs.*, 468 F.3d at 374 ("The *Casey* Court itself was not persuaded to invalidate Pennsylvania's parental-consent requirement by record evidence showing that the requirement would altogether prevent *some women* from obtaining an abortion." (emphasis added)); *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 700 (7th Cir. 2002) (Coffey, J., concurring) ("*Casey* upheld a parental notification law despite the district judge's undisputed finding that, in some of the 46 percent of cases where a minor can neither obtain the requisite consent of a parent nor avail herself of the judicial bypass provisions, the law may act in such a way as to deprive [the minor] of her right to have an abortion." (internal quotation marks omitted)).

Instead, under *Casey*, a plaintiff must make the more demanding showing that a law is "likely to prevent a significant" or large "number of women from obtaining an abortion." 505 U.S. at 893. Petitioners do not point to any such finding here. Rather, they proclaim *ipse dixit* "that a significant number of women here would . . . be burdened" and that commonsense shows that the district court's conclusions "closely track" previous findings that a "significant but ultimately unknowable" fraction of women will be burdened. Pet. 21

(internal quotation marks omitted). But as their failure to cite anything to support that declaration highlights, the district court reached no such conclusion. To the contrary, that "court noted that most women residing in Arkansas and seeking medication abortions would be unaffected by the contract-physician requirement, as they could travel to LRFP for an abortion" and that only "some" patients "in the Fayetteville area" would be burdened. App. 11a-14a. Moreover, contrary to Petitioners' assertion, commonsense (like this Court's case law) does not suggest that *significant* and *some* are equivalent terms.[16]

Faced with those facts, Petitioners attempt to justify review by rewriting the undue burden standard and the Eighth Circuit's opinion. They contend, for instance, that review is warranted because the Eighth Circuit was required to balance benefits and burdens *without* any indication whether the contract-physician requirement would likely burden a large or small fraction of patients. *See* Pet. 19-20. But this Court has never suggested that courts *could* – let alone must – weigh benefits and burdens without determining whether it is likely the challenged provision will pose a substantial obstacle to a large or small fraction. *See Hellerstedt*, 136 S. Ct. at 2313 (assessing benefits and burdens and finding "burden 'undue' when requirement places 'substantial obstacle to a woman's choice' in 'a large fraction of the cases in which' it 'is relevant' "

[16] Petitioners' suggestion would mean that there is no difference between a person who has *significant* moral failings and a person who has *some* moral failings.

(quoting *Casey*, 505 U.S. at 895)); *Casey*, 505 U.S. at 893 (spousal notification provision would "likely . . . prevent a significant number of women from obtaining an abortion"). Indeed, given that "even a law that confers little or no benefit may still be warranted if it imposes little or no burden," it is nonsensical to suggest that inquiry can be conducted in the abstract. Brief of the United States Amicus Curiae, *supra*, at 24.[17]

Equally meritless is Petitioners' contention that the Eighth Circuit required the district court to make "comprehensive and concrete statistical" determinations about the number of women burdened. Pet. 24. Contrary to that claim, the Eighth Circuit explained that the large fraction test is "more conceptual than mathematical" and that it was "not requir[ing] the district court to calculate the exact number of women unduly burdened." App. 14a-15a (internal quotation

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[17] Petitioners' corresponding contention (Pet. 19-20 n.9) that an undue burden exists where burdens even slightly outweigh benefits conflicts with the discretion afforded legislatures to address problems "even when fundamental liberty interests are at stake and even when leading members of the profession disagree with the conclusions drawn by the legislature." *Stenberg v. Carhart*, 530 U.S. 914, 970 (2000) (Kennedy, J., dissenting); *see also Akron*, 462 U.S. at 456 (O'Connor, J., dissenting) (this Court should not "function[ ] as the nation's *ex officio* medical board with powers to approve or disapprove medical and operative practices and standards" (internal quotation marks omitted)). Applying that principle, like the Eighth Circuit, other circuits have concluded that regulations impose an undue burden where the burdens they impose "*significantly* exceed[ ] what is necessary to advance the state's interests." *Schimel*, 806 F.3d at 919 (emphasis added); *see also Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 913 (9th Cir. 2014).

marks omitted). Instead, as that court explained, the problem with the district court's approach was that it had failed to provide *any* concrete indication what fraction of women it believed would face an undue burden. App. 13a-14a. Thus, review is not warranted.

C. There is no right to choose medication abortion.

Abandoning the district court's burdens analysis, Petitioners belatedly contend that court was required to conclude that the contract-physician requirement imposes a substantial obstacle because patients who *prefer* medication abortion have a constitutional right to their preferred abortion methodology. *See* Pet. 21-22 & n.10. As a preliminary matter, Petitioners' argument is premised on their peculiar (and erroneous) representation that every Arkansas medication abortion provider will choose – like Petitioners apparently have chosen – to stop administering medication abortions rather than recruit a paid contract physician and lacks merit for that reason. *See* Pet. 8-9.

Petitioners' argument likewise does not warrant review because this "Court has not articulated any rule that would suggest that the right to choose abortion" articulated in *Casey* also "encompasses the right to choose a particular abortion method." *Planned Parenthood of Southwest Ohio Region v. DeWine*, 696 F.3d 490, 514-15 (6th Cir. 2012); *see also Gonzales*, 550 U.S. at 158 ("*Casey*'s requirement of a health exception" cannot be interpreted so broadly that "it becomes tantamount to

allowing a doctor to choose the abortion method he or she might prefer"); *Stenberg*, 530 U.S. at 965 (Kennedy, J., dissenting) ("*Casey* made it quite evident, however, that the State has substantial concerns for childbirth and the life of the unborn and may enact laws 'which in no real sense depriv[e] women of the ultimate decision.'" (quoting *Casey*, 505 U.S. at 875)); *cf. Benton v. Kessler*, 505 U.S. 1084, 1085 (1992) (Stevens, J., dissenting) (arguing the Court should extend *Casey* to encompass that right).

To the contrary, where – as is true here – a regulation leaves patients free to access a "commonly used and generally accepted [abortion] method," simple "convenience" or preference does not prevent States "from imposing reasonable regulations." *Gonzales*, 550 U.S. at 165-66; *see also Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 78-79 (1976) ("[T]he outright legislative proscription of [a particular methodology] fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks."). A contrary holding, moreover, would undermine *Gonzales*' central premise that "[t]he law need not give abortion doctors" – whose ability to challenge abortion regulations is derivative of their patients' rights – "unfettered choice" to use particular abortion methodologies. 550 U.S. at 163.

Further, applying that framework, at least one court of appeals has rejected Petitioners' suggestion

that effectively barring medication abortion is a substantial obstacle merely because "some women" – or even most – "prefer a [medication] abortion over a surgical abortion." *DeWine*, 696 F.3d at 515-16. As that court explained, even a strong preference does not establish "a *substantial obstacle* for a large fraction of women in deciding whether to have an abortion" but merely that they have been denied the heretofore unknown "right to choose *a particular method* of abortion." *Id.* (emphasis in original); *see also id.* at 516 (the right articulated in *Casey* "protects the 'freedom to decide whether to terminate a pregnancy'" and does not incorporate a right to select a "preferred method" (quoting *Casey*, 505 U.S. at 874)).

Lastly, to the extent Petitioners claim that the Ninth Circuit has reached a different conclusion, that circuit's approach represents an outlier that is inconsistent with this Court's precedent. Pet. 25 (citing *Humble*, 753 F.3d 905). The case that Petitioners rely on for that proposition also involved a *very* different factual record where – unlike here – the district court had (incorrectly) determined that medication abortion was safer than surgical abortion and that the unavailability of medication abortion would likely close a facility that "would *significantly* reduce the number of Arizona women who receive abortions." *Humble*, 753 F.3d at 916-17 (emphasis added). Because Petitioners concede that medication abortions involve a greater risk of complications and need for follow-up treatment than surgical abortions, Petitioners are foreclosed from making the first argument. Similarly, as noted, the

district court here did *not* find that Petitioners' choice to stop performing abortions would significantly impact access. *E.g.*, App. 6a n.5, 94a. Review is not warranted.

D. Petitioners' novel preliminary injunction standard is inconsistent with precedent.

Petitioners further erroneously contend that review is warranted because the Eighth Circuit did not consider "the procedural posture of this case." Pet. 23. Specifically, Petitioners argue that because they only needed to demonstrate that they were "*likely* to prevail on the merits" to obtain a preliminary injunction, the district court was not required to determine whether the contract-physician requirement would unduly burden a large fraction of patients. *Id.* (internal quotation marks omitted) (emphasis in original). That argument ignores the fact that Petitioners still had to show that it is likely that a large fraction of relevant patients would be unduly burdened, and the district court did not make that finding.

Additionally, to the extent that Petitioners suggest that the showing required to obtain a preliminary injunction against a democratically enacted statute is not demanding, that claim ignores the fact that "a preliminary injunction is an extraordinary remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (per curiam) (internal quotation marks omitted) (emphasis in

original); *see also Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008) ("Issuing a preliminary injunction based only on a possibility of irreparable harm is inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief."). Far from being undemanding, the likelihood of success standard "reflects the idea that governmental policies implemented through legislation or regulations developed through presumptively reasoned democratic processes are entitled to a higher degree of deference and should not be enjoined lightly." *Able v. United States*, 44 F.3d 128, 131 (2d Cir. 1995); *accord Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 530 F.3d 724, 733 (8th Cir. 2008) (en banc) ("By re-emphasizing this more rigorous standard for demonstrating a likelihood of success on the merits in these cases, we hope to ensure that preliminary injunctions that thwart a state's presumptively reasonable democratic processes are pronounced only after an appropriately deferential analysis.").

That is even more true where, like here, the underlying claim rests on a facial challenge that "threaten[s] to short circuit the democratic process by preventing laws embodying the will of the people from being implemented in a manner consistent with the Constitution" and questions about implementation remain unanswered. *Richmond Medical Ctr. for Women v. Herring*, 570 F.3d 165, 173 (4th Cir. 2009) (*en banc*) (quoting *Wash. State Grange v. Wash. State Republican*

Party, 552 U.S. 442, 451 (2008)); *see also Stenberg*, 530 U.S. at 978-79 (Kennedy, J., dissenting). Review is not warranted.

II. There is no circuit split warranting review.

Like the Eighth Circuit, every court of appeals to have considered the issue has held that merely preventing (or making it more difficult) for some women to obtain an abortion does not constitute a substantial obstacle warranting facial relief. *See Herring*, 570 F.3d at 175 ("[T]o hold [ban on particular abortion methodology] unconstitutional for all circumstances based on . . . possible rare circumstances . . . is not appropriate under any standard for facial challenges."); *Cincinnati Women's Services*, 468 F.3d at 373 ("Other circuits that have applied the large fraction test to facial challenges to abortion regulations have, likewise, only found a large fraction when *practically all* of the affected women would face a substantial obstacle in obtaining an abortion." (emphasis in original)); *see also Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 541 (9th Cir. 2004) ("A significant increase in the cost of abortion or the supply of abortion providers and clinics can, at some point, constitute a substantial obstacle to *a significant number* of women choosing to have an abortion." (emphasis added)).

Particularly relevant here, as noted, the Sixth Circuit rejected a challenge to a law that effectively banned medication abortion for certain patients on the grounds that it would not constitute a substantial

obstacle for the vast majority of patients. *See DeWine*, 696 F.3d at 515-16. Moreover, equally relevant, that court also upheld a regulation that would require women to travel 400 miles further roundtrip to obtain an abortion where "the record [did] not provide any evidence regarding what percentage of patients . . . could not travel" that distance and correspondingly whether a " 'large fraction' of women seeking" an abortion "could not still have one by traveling to another clinic." *Women's Professional Corp. v. Baird*, 438 F.3d 595, 606 (6th Cir. 2006). And like the Eighth Circuit, that court has held that "some women" do not constitute a large fraction sufficient to justify facial relief. *Cincinnati Women's Services*, 468 F.3d at 373 (in-person consultation requirement preventing approximately 12.5% of women seeking an abortion from obtaining one was not facially invalid). As that court stressed, "no circuit has found an abortion restriction to be unconstitutional under *Casey*'s large-fraction test simply because some small percentage of the women actually affected by the restriction were unable to obtain an abortion." *Id.* at 374.

Similarly, the Seventh Circuit has held that laws that merely burden or prevent some women from obtaining an abortion are not facially invalid. *See Karlin v. Foust*, 188 F.3d 446, 486 (7th Cir. 1999) ("While the evidence proffered by plaintiffs . . . show that [Wisconsin's] mandatory waiting period would likely make abortions more expensive and more difficult for *some* Wisconsin women to obtain, we nevertheless must conclude, as did the Court in *Casey*, that plaintiffs have

failed to show that the effect of the waiting period would be to prevent a significant number of women from obtaining abortions." (emphasis added)); *see also Newman*, 305 F.3d at 699-700 (Coffey, J., concurring) ("[E]ven assuming in the case before us that some number of women will be burdened by the law, it is clear that a law which incidentally prevents 'some' women from obtaining abortions passes constitutional muster."); *cf. Schimel*, 806 F.3d at 918 (closures prompted by provider admitting privileges requirement would increase distances and "impose hardship on some women" but finding a substantial obstacle based on "uncontradicted testimony" establishing that the remaining providers "could not absorb the additional [quadruple] demand for abortions").

Against that backdrop, Petitioners attempt to manufacture a split based on their erroneous assertion that the Eighth Circuit required the district court to make "comprehensive and concrete statistical" determinations. Pet. 24-25. As explained above, however, the Eighth Circuit required no such determination. *See supra* at pp. 28-29. Instead, like other circuits (and this Court), the Eighth Circuit correctly concluded that a finding that "some women" in part of Arkansas might be unable to obtain an abortion does not justify facial relief.

Likewise, Petitioners' contention that the Eighth Circuit's application of the undue burden test differs from the Seventh and Ninth Circuits' approach because the Eighth Circuit did not engage in a full balancing analysis *at this stage* is just a variation on their

unconvincing claim that courts can balance benefits against burdens *without* determining what burdens exist. *See* Pet. 25. Additionally, to the extent that Petitioners suggest that courts may apply variations on the same general approach to determine benefits, they do not suggest the kind of deep split that could possibly warrant review at this stage. *See* Pet. 24. Petitioners' attempt to conjure a circuit split does not warrant review.

III. This case presents significant vehicle problems.

Even if the question presented otherwise warranted review, this case would provide a poor vehicle to address it. As framed by Petitioners, the question assumes that the contract-physician requirement will "ban medication abortion." Pet. i. That factual premise, however, is not supported by the record. To the contrary, on this record, Petitioners have only shown that they – and they alone – failed to recruit a contract physician through efforts that "did not include any offer of financial compensation." App. 6a n.4. It is unknown whether Petitioners can recruit a compensated contract physician.[18] Indeed, despite the district court's failure to consider that issue (as it must on remand), it is far easier to fill a paid role than an unpaid one. *See* Adam Smith, THE WEALTH OF NATIONS (Modern Library

[18] Nor is it clear that Petitioners would have been unsuccessful had their efforts not consisted largely of a mass mailing denouncing the contract-physician requirement as "medically unnecessary." Supp. App. 1a, JA 446.

ed. 1994) (1776) Ch. X, Pt. 1, p. 114 ("Every man's interest [will] prompt him to seek the advantageous, and to shun the disadvantageous employment."); *id.* ("The wages of labour vary with the ease or hardship, the cleanliness or dirtiness, the honourableness or dishonourableness of the employment.").

Petitioners' question further wrongly assumes that if Petitioners choose to stop performing medication abortions that decision will leave one abortion provider "hundreds of miles away from significant population centers." Pet. i. Yet the record establishes that the county where Fayetteville is located is just 80 miles from two abortion facilities, including a Planned Parenthood facility. Similarly, women in the Fort Smith area would likewise not find themselves "hundreds of miles" from an abortion provider, but just over one hundred miles to those same facilities and approximately 150 miles from Little Rock.[19]

Finally, review at this stage, where the court of appeals only remanded with instructions, would be particularly unsuitable. As the record stands, this Court would not have the benefit of the Eighth Circuit's review of a complete balancing analysis. Petitioners' repeated bald assertions that the contract-physician requirement would unduly burden "a significant number of women" (Pet. 21-22), moreover, highlight the value of a remand that will allow the district court to

[19] Given the proximity of those Tulsa providers, if this Court grants review it should consider whether the mere act of crossing a state border (as the district court assumed here) is an undue burden.

test those claims. Thus, even if this Court believed review might eventually be warranted on a record that demonstrated that Arkansas's contract-physician requirement likely imposed an undue burden on a large (or significant) fraction of patients, review is unwarranted at this stage.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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