In the
United States Court of Appeals
For the Seventh Circuit

No. 17-1883

PLANNED PARENTHOOD OF INDIANA
AND KENTUCKY, INC.,

Plaintiff-Appellee,

v.

COMMISSIONER OF THE INDIANA STATE
DEPARTMENT OF HEALTH, *et al.,*

Defendants-Appellants.

Appeal from the United States District Court for the
Southern District of Indiana, Indianapolis Division.
No. 1:16-cv-01807 – **Tanya Walton Pratt**, *Judge*.

ARGUED NOVEMBER 6, 2017
DECIDED JULY 25, 2018

Before BAUER, KANNE, and ROVNER, *Circuit Judges*.

ROVNER, *Circuit Judge*. Since 1995, the State of Indiana has required that, at least eighteen hours before a woman has an abortion, she must be given information provided by the State about, among other things, the procedure, facts about the fetus and its de-

velopment, and alternatives to abortion. That information is meant to advance the State's asserted interest in promoting fetal life. In other words, the State hopes that women who read that information and consider it will opt not to have an abortion, and will, instead, choose to carry the pregnancy to term. After she has received the mandated information, a woman must wait at least eighteen hours before having an abortion, thus, the State hopes, she will use the time to reflect upon her choice and choose to continue her pregnancy. The State also requires that a woman have an ultrasound and hear the fetal heartbeat prior to an abortion although she may decline the opportunity to do one or both, as 75% of women generally do.[1]

Prior to July 1, 2016, women could, and generally did, have the ultrasound on the same day of the procedure. This was, in large part, because almost all abortions in Indiana occur at one of four Planned Parenthood of Indiana and Kentucky (PPINK) health centers, and only those few PPINK facilities that offer abortion services (most do not) had the ultrasound equipment on site. The Indiana House Enrolled Act 1337 (HEA 1337), however, amended Indiana law and now requires women to undergo an ultrasound procedure at least eighteen hours prior to the abortion. Because of the structure and location of abortion services in Indiana and the population of women seeking

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[1] Prior to 2011, the law required that prior to an abortion the woman be shown an ultrasound "upon the woman's request." P.L. 193-2011, Sec. 9. In 2011 the legislature amended the statute to require that the woman be shown the ultrasound unless she certified in writing that she did not want to.

abortions, this change — moving the ultrasound from the day of the abortion procedure to at least eighteen hours before—as we will explore, is significant.

PPINK filed suit against the Commissioner of the Indiana State Department of Health and the prosecutors of Marion County, Lake County, Monroe County, and Tippecanoe County (collectively, "the State"), all in their official capacities.[2] PPINK claimed that HEA 1337 unconstitutionally burdens a woman's right to choose to have an abortion, and it sought preliminary relief enjoining the provision during the pendency of the litigation. The district court granted the preliminary injunction. We agree with the well-reasoned conclusions of the district court opinion, from which we borrow heavily.

A. Background information

1. The new law

Indiana Code § 16-34-2-1.1 mandates that at least eighteen hours prior to the abortion procedure, the

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[2] Courts have long declared that abortion providers have standing to sue to enjoin laws that restrict abortion. *Planned Parenthood of Wisc., Inc. v. Schimel*, 806 F.3d 908, 910 (7th Cir. 2015). "These cases emphasize not the harm to the abortion clinic of making abortions very difficult to obtain legally, though that might be an alternative ground for recognizing a clinic's standing, but rather the confidential nature of the physician-patient relationship and the difficulty for patients of directly vindicating their rights without compromising their privacy." *Id.* (internal citations omitted).

patient must be provided with the following information (among others) both orally and in writing: "that human physical life begins when a human ovum is fertilized by a human sperm;" the probable gestational age of the fetus at the time the abortion is to be performed, including a picture of the fetus at certain gestational ages, and other information about the fetus at its current stage of development; notice that the fetus can feel pain at or before twenty weeks; information about the risks of abortion and of carrying the fetus to term, and information regarding alternatives to abortion and other support services available. Ind. Code § 16-34-2-1.1(a)(1)-(2). A woman seeking an abortion must also receive a color copy of a brochure, authored and distributed by the Indiana State Department of Health, that contains all of this same information. The State controls every aspect of the information conveyed to patients via this brochure—from the drawings, to the color, information about development, and wording of the risks of the procedures. Neither the brochure nor the informed-consent information has been challenged in this litigation.

Prior to the enactment of the challenged law, Indiana required that "[b]efore an abortion is performed, the provider shall perform, and the pregnant woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible," unless the pregnant woman certified in writing, on a form drafted by the Indiana State Department of Health, that she declined to view the ultrasound or hear the fetal heart tone. Ind. Code § 16-34-2-1.1(b) (2011). In other words, the provider must offer the ultrasound, but a woman may affirmatively

decline. Prior to 2011 the provider did not have to offer the ultrasound, but only had to provide one if specifically requested by the woman. P.L. 193-2011, Sec. 9. In fiscal year 2016, only approximately 25% of women seeking abortion services chose to view their ultrasound images and only approximately 7% chose to listen to the fetal heart tone. Most importantly for this litigation, before 2016, the statute did not mandate when the ultrasound must occur, other than prior to the abortion. As a practical matter, however, the ultrasound procedures were performed just before the abortion. Ultrasound equipment is expensive and scarce. Not all PPINK locations have it, but, at the time the new law was enacted, the four locations that perform abortions had the equipment. Although patients can receive their informed-consent consultations at any one of the seventeen PPINK health centers throughout Indiana, abortions are performed only at four locations throughout Indiana (surgical abortions are available only at three locations). Therefore, to prevent women from having to travel far distances eighteen hours apart, providers performed the ultrasound on the day of the abortion procedure at one of the four facilities that had ultrasound and performed abortions.

The new statute, however, prevents this practice. It requires the following:

> At least eighteen (18) hours before an abortion is performed and at the same time that the pregnant woman receives the information required by subdivision (1), the provider shall perform, and the pregnant

> woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible unless the pregnant woman certifies in writing, on a form developed by the state department, before the abortion is performed, that the pregnant woman:
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> (A) does not want to view the fetal ultrasound imaging; and
>
> (B) does not want to listen to the auscultation of the fetal heart tone if the fetal heart tone is audible.

Ind. Code Ann. § 16-34-2-1.1(a)(5). PPINK argues that this requirement unduly burdens a woman's right to an abortion. Because PPINK's argument is based on the factual context, it is critical first to understand how PPINK health centers operate and where they are located.

2. PPINK facilities

At the time the law suit began, PPINK operated twenty-three health centers in Indiana. Due to financial constraints, that number has since dwindled to seventeen. Only four of the centers offer abortion services—Bloomington, Indianapolis, Merrillville and Lafayette—the latter of which offers only non-surgical abortions using medication. Of the centers that offer abortion services, the times these services are available are exceptionally limited. In Indianapolis, abortion services are only available three days per week; in Merrillville, a day and a half per week; and

in Bloomington and Lafayette, only one day a week. R. 24-1 at 6. PPINK will perform a surgical abortion only until thirteen weeks and six days after the first day of a woman's last menstrual period. It will provide medication abortions only until sixty-three days after the first day of a woman's last menstrual period. Women who are pushing up against the time deadline may not be able to wait until a provider is available at the facility closest to them, but may need to travel to a more distant facility where a timely appointment can be made. The thirteen PPINK health centers that do not provide abortion services provide well-women examinations, screening for cancer and sexually transmitted diseases, treatment for sexually transmitted diseases and other preventative health care.

There are no clinics in Indiana that perform abortions past these dates. The only providers of abortion services after these dates are hospitals and surgical centers (all of which happen to be located in Indianapolis) and those facilities generally only provide abortions that are medically indicated because of a fetal anomaly or a threat to a woman's health, and these are quite rare. Out of the 7,957 abortions performed in Indiana in 2015 (the year before enactment of the new law), only 27 occurred in a hospital or surgical center. Only eighteen occurred after thirteen weeks. Indiana State Department, Terminated Pregnancy Report—2015, at pp. 7, 17, 18 (released June 30, 2016). Available at https://www.in.gov/isdh /files/2015% 20TP% 20Report.pdf [Last visited June 19, 2018].

PPINK has attempted to expand its health services throughout Indiana, but it operates only seventeen centers spread across a large state and only four that provide abortions. This means that some women must travel great distances to obtain an abortion. For example, Indiana's second largest city, Fort Wayne, had a PPINK health center until July 9, 2018, but it did not provide abortion services. Now it has none.[3] The closest center providing such services is 115 miles away in Lafayette (a more than two hour drive).[4] There are also no out-of-state abortion clinics that are close to Fort Wayne.

Prior to the enactment of the challenged law, women seeking abortions could have their state-mandated informed-consent session at any one of the seventeen centers across the state. At this appointment, which usually only lasted about fifteen minutes, health care providers also calculated the gestational age of the fetus based on the length of time from the first day of the last menstrual period. To make it more convenient for patients, PPINK allowed parents to

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[3] PPINK anticipates reopening another clinic in Fort Wayne although it does not have a timeframe for doing so. See Appellate Record at 51, PPINK Citation of Additional Authority, 7/12/18.

[4] According to Google Maps, the distance from Fort Wayne to the address of the PPINK clinics is as follows:

Merrillville: 124 miles
Lafayette: 115 miles
Indianapolis: 122 miles
Bloomington: 203 miles

R. 24-1 at 3.

bring children to these appointments. Women could then have an ultrasound, as required by then-existing state law, on the day of the procedure at the health center providing the abortion. PPINK would use that ultrasound information to verify that the pregnancy was intrauterine (and not ectopic) and to verify the gestational age to insure that the abortions are being performed within the required limits. An ultrasound is not medically necessary prior to an abortion, but the state requirement to perform an ultrasound is not challenged in this case, just the timing of it. Allowing the informed consent to be performed at any of the PPINK centers made it practical for women who live a long distance from the few centers that offer abortion services, by eliminating the need for multiple visits.

Once the new law was enacted, requiring that the ultrasound take place at least eighteen hours prior to the abortion, the barriers for many women increased significantly. Because ultrasound machines were only available at the four PPINK centers that provide abortion services, women who lived a significant distance from one of those centers were faced with two lengthy trips to one of those facilities or an overnight stay nearby. PPINK attempted to ease that burden by purchasing one additional ultrasound machine for one health center that does not offer abortion services, and trained a staff member to use ultrasound equipment at another. Those expenditures exacted a heavy toll on the finances of the organization, and still did not ease much of the burden. The ultrasound machines PPINK uses cost approximately $25,000 and must be operated by trained technicians. National

Planned Parenthood policies, which are designed to align with generally accepted medical standards, require that an ultrasound image be interpreted by a physician or an advanced practice nurse. The nurse-practitioners at PPINK do not have the requisite training and PPINK asserts that it can afford neither the cost nor time to enroll nurses in the four-week training program.

3. Population served

The majority of women who seek abortion services at PPINK (and for that matter, the rest of the nation) are poor. The table below demonstrates the income level of patients relative to the federal poverty line (FPL).[5]

Income	% of pa-
Unknown	22%
0-100%	37%
101-150%	11%
151-200%	8%
201-250%	5%
251+%	16%

R. 24-1 at 14. These women often have precarious employment situations and generally are not paid for days they do not work. Many of them already have one or more children. In 2016, 33.73 percent of PPINK patients reported that they had children living with

[5] Poverty experts generally use 200% of the federal poverty line as an approximation of the income necessary to survive on one's own. R. 24-2 at 4. Many experts describe those at or below 100% of the federal poverty line as "poor" and those between 100% and 200% as "low income." *Id.*

them. R. 24-1 at 4–5.

4. The district court's decision

The district court carefully weighed the burdens identified by PPINK against the benefits the State hoped would accrue to its citizens—the protection of both fetal life and the mental health of women. It concluded that:

> The new ultrasound law creates significant financial and other burdens on PPINK and its patients, particularly on low-income women in Indiana who face lengthy travel to one of PPINK's now only six health centers that can offer an informed-consent appointment. These burdens are clearly undue when weighed against the almost complete lack of evidence that the law furthers the State's asserted justifications of promoting fetal life and women's mental health outcomes. The evidence presented by the State shows that viewing an ultrasound image has only a "very small" impact on an incrementally small number of women. And there is almost no evidence that this impact is increased if the ultrasound is viewed the day before the abortion rather than the day of the abortion. Moreover, the law does not require women to view the ultrasound imagine [sic] at all, and seventy-five percent of PPINK's patients choose not to. For these women, the new ultrasound [law] has no impact whatsoever. Given the lack of evidence that the new ultrasound law has the benefits asserted by the State, the law likely

> creates an undue burden on women's constitutional rights.

Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. State Dep't of Health, 273 F. Supp. 3d 1013, 1043 (S.D. Ind. 2017).

B. The legal standard

We review the district court's grant of a preliminary injunction in this case for an abuse of discretion, reviewing legal issues de novo, factual findings for clear error, and giving deference to the district court's weighing of the evidence and balancing of the equities. *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034, 1044 (7th Cir. 2017).

To obtain a preliminary injunction, PPINK must establish that it has some likelihood of success on the merits; that it has no adequate remedy at law; that without relief it will suffer irreparable harm. *City of Chicago v. Sessions*, 888 F.3d 272, 282 (7th Cir. 2018). If that burden is met, the court must weigh the harm that the plaintiff will suffer absent an injunction against the harm to the defendant from an injunction, and consider whether an injunction is in the public interest. *Id.* Our court employs a sliding scale approach, "The more likely the plaintiff is to win, the less heavily need the balance of harms weigh in his favor; the less likely he is to win, the more need it weigh in his favor." *Valencia v. City of Springfield*, 883 F.3d 959, 966 (7th Cir. 2018) (internal citations omitted).

The district court correctly noted that the need for and propriety of a preliminary injunction of this law would depend mostly on the likelihood of success on the merits. It therefore focused most of its attention, as do we, on that factor.

II.

A. The test articulated in *Casey* and *Whole Women's Health*

The basic premise from which we must begin our review of the district court opinion is that the Supreme Court has recognized and affirmed "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State ... [without] the imposition of a substantial obstacle to the woman's effective right to elect the procedure." *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 846 (1992). But yet, "[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id.* at 874. How then, do we determine whether a law's effects are incidental or unconstitutionally limiting? The *Casey* court set forth an undue burden test which declared that a state may not establish a regulation that "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus." *Id.* at 877. As the Casey court explained,

> A statute with [an improper] purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.

Id. Recently, the Supreme Court reiterated this test noting that *Casey* held that a law is unconstitutional if it imposes an "undue burden" on a woman's ability to choose to have an abortion, meaning that it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Whole Woman's Health v. Hellerstedt*, – 136 S.Ct. 2292, 2324 (2016), (citing *Casey*, 505 U.S. at 877).

Importantly, both *Whole Woman's Health* and *Casey* stress that the undue burden test is context specific. *Id.* at 2306; *Casey*, 505 U.S. at 885. An abortion statute valid as to one set of facts and external circumstances can be invalid as to another. *Whole Woman's Health*, 136 S.Ct. at 2306.

The State argues that the test for weighing abortion regulations differs depending on the purpose of the statute and that *Casey* and *Whole Women's Health* establish different tests depending on the nature of the regulation. The State claims that under *Casey*, an informed-consent and waiting period law will only be

invalidated if the regulations "impose a 'substantial obstacle in the path of a woman seeking an abortion.'" Appellant's Brief at 26 (citing *Casey*, 505 U.S. at 877). This standard, it argues, is somehow different than the undue burden test of *Whole Women's Health* which, the State says, is only appropriately applied to regulations that ostensibly promote women's physical health. Appellant's Brief at 17. The State claims that the balancing test is not appropriate here because, unlike in *Whole Women's Health*, the parties' stated interests are fundamentally opposed—the plaintiffs' goal is to help women carry out their decisions to terminate a pregnancy and the State's goal is to persuade a woman to reconsider that decision. Regulations that address informed-consent and waiting periods, the State argues, are subject only to "demonstration that they will cause a significant decline in abortions unrelated to the persuasive impact." Appellant's Brief at 22.

The State is incorrect that the standard for evaluating abortion regulations differs depending on the State's asserted interest or that there are even two different tests—the undue burden test of *Whole Women's Health* and a less-exacting "substantial obstacle" test (as the State argues) derived from *Casey*. To the contrary, *Casey* described the undue burden test as "a standard one of general application," and equated the "substantial obstacle" with "undue burden" noting that "[a] finding of an *undue burden is shorthand for* the conclusion that a state regulation has the purpose or effect of placing a *substantial obstacle* in the path of a woman seeking an abortion of a

non-viable fetus." *Casey*, 505 U.S. at 876–77 (emphasis ours). In fact, in *Casey's* seminal iteration of the undue burden test, the Court applied it to all of the regulations at issue in that case, including those that the state claimed affected women's health (record keeping and reporting), but also to spousal notification and parental involvement, which the state asserted were related to its interest in potential life. *Id.* at 887–99. In other words, the *Casey* Court applied the same undue burden test to all of the regulations at issue in that case without regard to the state's asserted interest. In fact, *Casey* made clear that "a statute which, while furthering the interest in potential life, *or some other valid state interest*, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Id.* at 877 (emphasis added).

Nor is there anything in the Court's decision in *Whole Women's Health* to suggest that it applied a different standard than the undue burden test articulated in *Casey*. Rather, the *Whole Women's Health* Court clearly states to the contrary. When discussing "undue burden" it starts with the sentence, "We begin with the standard, as described in *Casey*" and then goes on to note how it will apply that standard: "The rule announced in *Casey* [ ] requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S.Ct. at 2309. And in fact, in announcing this rule, the Court cited specifically to the balancing the *Casey* court did for provisions not justified by a concern for women's health—those related to

spousal notification and parental consent. *Id.* (citing *Casey*, 505 U.S. at 887–98, 899–901).

Not only does *Whole Woman's Health* confirm that courts must apply the undue burden balancing test of *Casey* to all abortion regulations, it also dictates how that test ought to be applied. Citing *Casey*, the *Whole Woman's Health* Court emphasized that the undue burden test requires courts to "retain[ ] an independent constitutional duty to review factual findings where constitutional rights are at stake." *Whole Woman's Health,* 136 S.Ct. at 2310. In other words, a court cannot merely depend on legislative statements and findings in evaluating the constitutionality of laws regulating abortion. *Id.* The proper standard is for courts to consider the evidence in the record—including, expert evidence. *Id.* And, as we discuss next, this is precisely what the district court did below.

B. The evidence of burdens and benefits

1. Burdens

Noting the Supreme Court's mandate to consider the evidence in the record and then weigh the asserted benefits against the burdens, the district court did just that; it made findings and evaluated the persuasiveness of the evidence regarding the burdens and benefits created by the new ultrasound law. 273 F. Supp. 3d at 1021 (citing *Whole Woman's Health,* 136 S.Ct. at 2310). Beginning with the burdens, the district court considered the burdens as presented by PPINK, focusing first on the proper population to consider, and then considering how the new regulations

impact finances, employment, child care, and the safety of women in abusive relationships.

As the district court noted, "[t]he proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* at 1021 (citing *Casey*, 505 U.S. at 894). In this case, as the district court correctly determined, the new ultrasound law is a restriction primarily for women for whom an additional lengthy trip to a PPINK health center for their informed-consent appointment acts as an impediment to their access to abortion services. The district court found specifically that this group consisted of low income women who do not live near one of PPINK's six health centers where ultrasounds are available. We agree with the district court on this point, but also note that the concerns about confidentiality in employment situations and abusive spouses that we address further below, can create impediments that span income levels. Nevertheless, our analysis, like the district court's, does not rely upon this larger group.

All of the burden in this case originates from the lengthy travel that is required of some women who have to travel far distances for an ultrasound appointment at least eighteen hours prior to an abortion. Recall that before the enactment of the new ultrasound regulation, all women seeking an abortion had to travel some distance to the nearest PPINK facility at least eighteen hours prior to an abortion in order to participate in an informed-consent information session. Because the law did not require that women

have an ultrasound until just before the abortion procedure, however, they could participate in that informed-consent meeting at any of the twenty-three PPINK facilities spread throughout Indiana.[6] Now, however, they must travel on the day prior to the abortion, to one of six PPINK facilities that has ultrasound equipment. As we noted above, this means that some women must travel great distances twice in order to receive an abortion. For example, women in the second largest city in Indiana, Fort Wayne, must now travel approximately 400 miles over two days to obtain an abortion, as the closest ultrasound machine is 87 miles away in Mishawaka (174 miles round trip) and the nearest abortion-providing health center is 115 miles away in Lafayette (230 miles round trip). R. 24-1 at 3, 13–14. Previously, when Fort Wayne still had its non-abortion-providing health clinic, women in Fort Wayne could have their fifteen-minute-long informed-consent appointment right at the PPINK health center in Fort Wayne.

Although the travel distance is the origin of the burden, the district court found that the strain of the law extends into the realm of finances, employment, child care, and domestic safety. The district court considered the testimony of PPINK's expert in gender studies, poverty, and low-wage labor markets, Dr. Jane Collins, who explained the impact of the new law on these interconnected stressors and on the already precarious financial lives of poor women seeking an abortion. R. 24-2. She analyzed the family budgets of

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[6] Due to budget problems there are now only seventeen PPINK facilities in Indiana.

low-income women and assessed how the additional costs associated with the new ultrasound law would impact these women and their families. Her testimony confirmed what common sense suggests. Many low-income women do not have employment that pays them when they miss a day of work or they may have precarious job situations in which they could be fired for excessive absences. A second lengthy trip for an ultrasound appointment likely requires a second missed day of work. And women with young children who could previously bring them along to an informed-consent session must leave them behind for the ultrasound, as PPINK's policies prohibit children from being present during an ultrasound. (And as we discuss below, both safety and common sense support such a policy). The new ultrasound law therefore requires women to arrange child care for an additional day.

Dr. Collins calculated that the additional cost posed by the new ultrasound law for a woman living in Fort Wayne, Indiana who has children, no car, and would lose a day's wages would be between $219 to $247. R. 24-2 at 18. Many low-income families have a discretionary monthly budget of approximately $40. *Id.* The additional expenses of over $200 constitute roughly 25% of their entire monthly budget. *Id.* These expenses are above and beyond the cost of the abortion itself which was, at the time of the hearing, $410 for the abortion and $100 for the ultrasound. R. 24-1 at 8; R. 35-5 at 35. Dr. Collins explained that to cover the costs associated with abortions, many women (about one third) will delay or stop paying basic bills in order to afford an abortion. R. 24-2 at 21. Up to 50%

of women borrow money from family and friends. R.24-1 at 20. The district court concluded that, "for many women faced with the already high costs of an abortion and a lack of means to afford them, the additional expenses of lengthy travel, lost wages, and child care created by the new ultrasound law create a significant burden." 273 F. Supp. 3d at 1028.

The cost of the ultrasound rule is measured not only in dollars but in time and access as well. Surgical abortions are available at PPINK health centers until thirteen weeks and six days after the last menstrual period. In fiscal year 2016, approximately 22% of all abortions and more than 34% of surgical abortions performed at PPINK took place in the three weeks before the deadline. R. 24-1 at 7–8. Women often push up against the deadline because they are gathering the necessary funds, making logistical arrangements or because they failed to promptly recognize the signs of pregnancy. R. 24-1 at 7–8. (Most women cannot know they are pregnant until at least 4 weeks following their last menstrual period, thus reducing the time they have to discover the pregnancy, explore their options and discuss them with a partner, family or doctor, arrange for missed work and child care, and secure two appointments—to only nine weeks, 6 days for a surgical abortion and thirty-five days, for a medical abortion).

Before the new ultrasound law, PPINK could usually accommodate women imminently facing the deadline by scheduling an informed-consent appointment at the nearest PPINK health center and then, the next day, she could travel the further distance, if

necessary, to a PPINK facility that offered abortion services. After the enactment of the new law (and before the district court issued a preliminary injunction), the PPINK health centers with ultrasound machines became so overwhelmed with appointments that PPINK could not adequately respond to women who contacted PPINK near the end of the allowable time period. As a result, PPINK had to double book appointments causing further delays for women and longer wait times for women who were already missing work time and needing to arrange child care. Even with overscheduling, appointment availability grew scarce and women had to wait longer to have an abortion. This precluded the option of medication abortions for some women and any abortion choices for others. Abortion appointments were already scarce in Indiana given that physicians are only available at the four health centers offering abortions at limited times: Indianapolis (3 days/week); Bloomington (1 day/week); Merrillville (1.5 days/week); and Lafayette (1 day per week). R. 24-1 at 6. With such limited availability, delays in getting an ultrasound appointment might mean having to wait an entire week longer before a physician is available at the closest PPINK center, or travelling to the health center where a physician is on duty. Moreover, the new law causes other problems related to delay. Although the informed-consent process only took approximately fifteen minutes before, after the enactment of the new law, the process took as long as seventy-five minutes. This added to the cost of child care, missed work time, and made it harder to hide visits from abusive partners.

The district court credited the evidence that the

demands on the PPINK staff trying to accommodate so many additional ultrasound appointments during the period of time the law was enforced were unsustainable. The additional quantity of appointments required staff to stay late and took away resources from the many non-abortion services that PPINK provides such as cancer screening, well-women health screening, family planning, and preventative services. According to PPINK's CEO, requiring staff to work at this pace and level of intensity is not workable over the long term, and ultimately leads to high staff turnover, exacerbating the problem further. R. 24-1 at 11.

Finally, the district court found that the new regulation has an impact on victims of domestic violence. The district court noted that one national study showed that 13.8% of women who had an abortion had been in an abusive relationship within a year before the abortion. 273 F. Supp. 3d at 1026. Instead of stealing away for a fifteen-minute informed-consent session at a nearby PPINK health center, abused women trying to keep their choice confidential have to arrange to be away for all or most of two days.

The district court also considered the anecdotal evidence submitted by PPINK about nine women who could not obtain an abortion due to the burdens imposed by the new ultrasound law. The court considered the following narratives collected by PPINK from women who described their experiences as follows:

> • The nearest PPINK health center to a woman seeking an abortion was over an hour away, and due to the fact that she has two

young children and difficulty with transportation, she was unable to schedule the two lengthy trips during the thirteen week, six day timeframe in which an abortion is available.

• A woman from the Fort Wayne area did not schedule an abortion because of the two lengthy trips necessary. She was eleven weeks, four days pregnant when she contacted PPINK, but could not miss work twice within the short timeframe remaining.

• A woman who previously had an abortion at PPINK called to schedule another, but ultimately said she could not schedule one after she was informed she would have to make two trips to the PPINK health center in Bloomington, Indiana.

• A woman living in a shelter with two young children decided not to schedule an abortion appointment because of the transportation and childcare difficulties two appointments would cause.

• A woman who recently started a new job after a year of unemployment stated that she could not drive the three-hour roundtrip to a PPINK health center on two separate occasions due to the combination of work, childcare, and transportation expenses, in addition to her concerns regarding the confidentiality of the abortion.

> • A woman who did not learn she was pregnant for ten weeks faced a long delay before she could have her informed-consent appointment that required travel to a PPINK health center, and by the time of her appointment she was one day beyond the deadline for an abortion.
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> • A woman from Fort Wayne who had a previous abortion at PPINK called to schedule another, but once she was informed that she would have to make two lengthy trips to a PPINK health center, she said she could not afford to do so and did not schedule an abortion.
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> • A woman living an hour north of Fort Wayne who has special needs children declined to schedule an abortion after learning that she would have to make two lengthy trips for each appointment, as she could not afford to be away from her children for that long on two occasions.
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> • A woman from Fort Wayne who was approaching the deadline to have an abortion declined to schedule an appointment due to the required travel and risk of missing the deadline by the time she could schedule both appointments.

273 F. Supp. 3d at 1029–30 (citing R. 24–1 at 16–17; R. 38–1 at 1–2).

Before the district court, and again on appeal, the State argued that PPINK's examples were unreliable

as they were passed on to a PPINK staff member and then to the declarant without PPINK taking any action to verify the information. The district court considered the reliability issue but, noting that a court could base a preliminary injunction on less formal procedures and less extensive evidence than a trial on the merits (*citing Dexia Credit Local v. Rogan*, 602 F.3d 879, 885 (7th Cir. 2010)), the district court found the evidence to be sufficiently reliable for the purpose at hand. The court reasoned that the reports reflected a plausible, if not likely, consequence of the new ultrasound law. Moreover, the court recognized that, as we explore more fully below, the State's "*only* evidence that the law furthers its interest in promoting fetal life is from a woman whose testimony was admitted into evidence through the declaration of her physician." 273 F. Supp. 3d at 1030 (emphasis in original). In a good-for-the-goose-and-gander way, the district court pointed out that if, for purposes of the preliminary injunction, the court ignored all evidence not directly from its source, "the State would be left without any evidence directly supporting its position." *Id.* The district court's comparison was apt and its conclusions reasonable. We cannot say that this was an abuse of discretion to consider the anecdotal evidence on both sides.

The State argued that PPINK could mitigate these burdens by making different medical and business decisions, primarily by outfitting all of its health centers

with less expensive ultrasound equipment and by putting more resources toward abortion services.[7] PPINK's director of abortion services explained that the $25,000 machine that PPINK ordinarily purchases comes with an extended warranty, includes planned maintenance, replacement parts, software updates, support, and a guaranteed 24-hour response time if there are any problems with the machine. R. 38-1 at 3–4. It also integrates with PPINK's electronic record system which is critical when the ultrasound and abortion appointment occur at different health centers. *Id.* at 4. And, as PPINK points out, even if it could afford to buy the machines, it would still be limited by space and personnel. The district court rejected the State's mitigation argument, noting that the "undue burden inquiry does not contemplate re-examining every pre-existing policy or practice of abortion providers to see if they could further mitigate burdens imposed by a new abortion regulation." 273

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[7] Before the district court, the State also argued that PPINK should accept ultrasounds results from other providers, but has dropped that argument on appeal. The State law requires that the same provider who performs the ultrasound also engage the patient in the informed-consent process. The required informed-consent process is very specific and detailed and requires that the person providing the information provide some information that only the abortion provider might have, such as the name of the physician performing the abortion, the physician's medical license number, and the emergency phone number where the physician can be reached twenty-four hours a day, seven days a week. Ind. St. 16-34-2.1.1(a)(4). The district court found that, given these requirements, it seems unlikely that an outside provider could comply with the informed-consent procedure as dictated by the statute. We agree.

F. Supp. 3d at 1023. In general, courts do not micromanage an entity's business decisions. See *Riley v. Elkhart Cmty. Sch.*, 829 F.3d 886, 895 (7th Cir. 2016) (noting that, in the Title VII context, courts do not "second-guess[ ] employers' business judgments"). Provided PPINK set forth a reasonable explanation for purchasing these particular ultrasound machines—and it has, indeed, done so—the district court was entitled to defer to PPINK's justifiable business decisions and consider the burdens of the new ultrasound law within the context of the reality that exists for both PPINK in operating its business and for the patients it serves. We agree with the district court's assessment and its deference to PPINK's reasonable business decisions. In addition, we note that it also would be reasonable for PPINK to make decisions about its medical equipment needs based not only on economic concerns, but also on its ability to provide the best medical care for its patients, to attract certain medical professionals, for the safety of its technicians, to prevent malpractice claims, or for any number of other legitimate reasons.

The same can be said of PPINK's staffing decisions. The State thought that PPINK also could mitigate burdens by training nurse practitioners to interpret ultrasounds. This training, however is both expensive and requires four weeks away from clinical work. PPINK rationally could determine that it was not the best allocation of its resources. The State argues that the right to an abortion does not insulate PPINK from making difficult decisions about the allocation of resources. That may be true, but neither is

it appropriate for an opposing party or a court to dictate the best use of resources for a business, provided its choices are within the range of reasonableness—but particularly in the case of a non-profit agency with limited funding seeking to provide the most efficient health care services to a mostly poor population.

The district court credited the attestation by PPINK's president and CEO that PPINK was unable to supply each center with the equipment and staff it needed to provide ultrasounds. In response to the new law, PPINK did buy one new ultrasound machine for one of its non-abortion-providing health centers and trained a staff member to use ultrasound equipment at another, indicating its commitment to providing as much service as it could despite the burdens of the new law. The State's argument about PPINK merely needing to shift resources to afford the ultrasound machines is both odd and unworkable. Only 7% of PPINK's patients receive abortion services, so in theory PPINK could shift resources for the 93% of its other services to abortion services. It seems illogical for a state with an asserted interested in protecting fetal life to be encouraging PPINK to shift all of its resources from other healthcare, such as pregnancy prevention and cancer screening, to abortion services. It is unworkable because, as we noted, neither the State nor the courts has the authority to rewrite PPINK's mission and dictate how it must allocate its limited resources. PPINK operates in a world where limited health care dollars for mostly poor women must be allocated in an efficient way, and in a way that provides the greatest care for the greatest needs.

The fact that courts are bound by the reality in which the laws operate is reflected in other abortion cases. In *Whole Woman's Health*, the Court found that the requirement that all abortion facilities meet the standards for ambulatory surgical centers would reduce the number of abortion facilities in Texas from forty to seven and thus unconstitutionally burden the right to an abortion. *Whole Woman's Health*, 136 S.Ct. at 2301, 2318. The Court looked at the cost a facility would have to incur to meet the requirements—$1–$3 million—and assumed that the facilities would close rather than be able to meet the requirements, despite the fact that each facility could, in an alternate universe where resources were unlimited, simply make the changes. *Id.* at 2318.

Similarly, in *Schimel*, this court looked at the burden imposed by the proposed abortion law requiring physicians who provide abortion services to have admitting privileges at a hospital within thirty miles of the abortion clinic. *Planned Parenthood of Wisc., Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015). In granting an injunction, we recognized that the delays caused by the new law might cause some women to lose the chance to have an abortion within the time period that Planned Parenthood allowed. No one in that case suggested that Planned Parenthood provide later term abortions. *Id.* Instead this court spent most of the opinion examining the reality of what an emergent situation might look like in the abortion context and how a patient in such a situation might receive care. *Id.* at 912–16. Courts must consider the impact of the new ultrasound law based on the reality of the abortion provider and its patients, not as it could if

providers and patients had unlimited resources.

The State's arguments about mitigating child care burdens similarly miss the mark. The State suggests that women simply could bring along their children to the ultrasound—most of which are performed transvaginally at these early stages. See R. 35-5 at 27. But Planned Parenthood's policy prohibits children at ultrasound appointments, and with good reason. One wonders at what age a child could appropriately sit through such a procedure? A woman undergoing a transvaginal ultrasound must lie still while the transducer is inserted into her vagina and used to view the fetus and her organs. See https://www.healthline.com/health/transvaginal-ultrasound. She would have no way to soothe a crying baby or monitor a toddler running through the exam room. Neither the person performing the ultrasound nor the patient is in a position to monitor the safety of the child in a medical examination room, and PPINK submitted evidence of its concerns about the "serious risk of distraction" for the doctor performing the procedure. R. 35-5 at 26. Nor would most women wish to undergo such a procedure with a pre-teen son or daughter in the room, even with, as the State suggests, a sheet draped over her legs. Like all women, poor women deserve a level of dignity and choice about the confidentiality of their healthcare. Moreover, this is a perplexing argument from a State that wants women to seriously "reflect upon compelling evidence of fetal humanity," and form a bond with the fetus "while viewing this live, moving image of their baby, with arms and legs." Appellant's Brief at 2, 4. It seems likely that having children in the room would significantly decrease the

ability for serious reflection in the bulk of situations.

2. Benefits

Balanced against these substantial burdens, the district court considered the intended benefits of the new law. As we just noted, the State wishes to "encourage women to reflect upon compelling evidence of fetal humanity," and to persuade a woman to reconsider her decision to have an abortion. Appellant's Brief at 2, 18, 20, 23. The State argues that ultrasounds have a unique impact on a pregnant woman because they allow her to see her own fetus rather than a photograph or illustration of a generic fetus, and this, the State hopes, helps "create a bond that leads them to continue their pregnancy." Appellant's Brief at 4.

The new ultrasound law encourages women to carry pregnancies to term in two ways, the State argues. First, it gives them information about their particular fetus and, second, it gives them time to reflect upon that information before they make their final decision. According to the State, "A woman offered the chance to view an ultrasound 18 hours before an abortion may well have a different mindset than a woman who has already made a final decision and presents herself at the clinic to carry it out." Appellant's Brief at 25. To support its claim that ultrasounds matter, the State introduced a study demonstrating that for the 7% of women who seek abortions and have medium to low "decision certainty," (presumably meaning that they are not very certain about their choice), those who viewed an ultrasound image had a 95.2%

rate of proceeding with an abortion compared to 97.5% rate for women with high decision certainty who viewed an ultrasound. Mary Gatter et. al. *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81, 83 (2014). This evidence, however, is focused on the benefits of an ultrasound and not the benefits of an ultrasound eighteen hours before an abortion.

The State's strongest evidence that the eighteen-hour requirement provides some benefit, however, came from the testimony of Dr. Christina Francis, a board-certified obstetrician-gynecologist who testified that she had a patient who would have benefitted from the new law. The patient had a medication abortion at PPINK in Indianapolis and underwent the required ultrasound that day, as required by the law at the time. She told Dr. Francis, that she regretted having the abortion

> and feels that an ultrasound waiting period would have given her more time to consider her decision and change her mind.... She underwent the ultrasound on the day of her abortion, immediately prior to receiving the medication. She chose not to view the ultrasound image because she felt that if she saw an image of her baby it would cause her to change her mind. She told [Dr. Francis] that she did not want to be persuaded not to abort because she was already at the clinic, had paid for the abortion, and felt pressured by those circumstances to go through with it.

> [She] told [Dr. Francis] that had she undergone the ultrasound the day before the abortion, she likely would have viewed the image and she does not think she would have come back the next day to proceed with the medication abortion.

R. 35-1 at 5. This is the State's strongest evidence because it is the only evidence that the eighteen-hour waiting period matters for women seeking abortions, as opposed to the ultrasound itself.

The State also argued that voluntary waiting periods are common for other procedures where physicians give patients the opportunity to weigh the costs and benefits of various options and think of additional questions or concerns. As evidence, the state presented the declaration testimony of Dr. Francis, who explained her preference to "give patients time to reflect on the information they have received, weigh the possible risks and benefits of the procedure, discuss the procedure with loved ones, and ask questions of the doctor." R. 35-1 at 2–3. She stated that for "life altering" procedures, she provides informed-consent information one to four weeks prior to the procedure. R. 35-1 at 3. The State did not argue that a waiting period is mandatory for any of these procedures.

Finally, the State argues that the ultrasound law advances important state interests in the psychological health of women considering abortion. For this proposition it relied on a controversial and much maligned (see below) study by Priscilla K. Coleman which concluded that "quite consistently ... abortion is associated with moderate to highly increased risks

of psychological problems subsequent to the procedure." Priscilla K. Coleman, Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published, 1995-2009, 199 British Journal of Psychiatry, 180–86 (2011). Moreover, the State argued, the earlier ultrasound ensures that a woman does not become psychologically committed to having an abortion only to arrive for the procedure and learn that she has waited too long.

The district court unequivocally accepted the State's asserted interests as legitimate. Indeed, *Casey* instructs that "the State has a legitimate interest in promoting the life or potential life of the unborn." *Casey*, 505 U.S. at 870. And, of course, no one would argue that protecting maternal psychological health is not a legitimate state interest.

3. Weighing

After this thorough compilation of the burdens and benefits, the district court turned its attention to resolving the ultimate question—whether, after considering the burden the law imposes on abortion access, together with the benefits those laws confer, the new ultrasound law has "the effect of placing a substantial obstacle in the path of a woman's choice" to have an abortion. *Whole Woman's Health*, 136 S.Ct. at 2309 (citing *Casey*, 505 U.S. at 877). But before the court could weigh the benefits and burdens, it had to answer two baseline questions: first, what group of women should the court consider when weighing the burdens imposed, and second, on what aspect of the law should the court focus its benefit and burden

weighing analysis—in other words, what is the relevant question presented by this case. The Court in *Whole Woman's Health* made the answer to the first question clear by explaining that a court must look specifically at "those women for whom the provision is an actual rather than an irrelevant restriction." *Id.* (citing *Casey*, 505 U.S. at 895). In this case, the district court determined that the relevant group consisted of low-income women who live a significant distance from one of the six PPINK health centers offering informed-consent appointments.

As for the question of which benefits and burdens the court must weigh, the district court emphasized that the question it was required to consider was "whether the ultrasound law provides the asserted benefits *as compared to the prior law*." 273 F. Supp. 3d at 1031 (emphasis in original) (citing *Whole Woman's Health*, 136 S.Ct. at 2311). In other words, the only relevant burdens and benefits to consider as a court weighs one against the other are the burdens imposed by the requirement to have an ultrasound *at least eighteen hours before* an abortion, and the benefits of having the ultrasound *at least eighteen hours before* the procedure (not the burdens or benefits of the ultrasound itself). PPINK did not challenge the requirement that a patient undergo an ultrasound at some point prior to the abortion. Nor was it challenged when it was enacted. See Appellant's Brief at 4. Therefore the benefits of having an ultrasound at some time prior to an abortion (without regard to the "eighteen hour prior" requirement) are irrelevant. It is the burden of travelling twice which becomes the obstacle to access.

Having determined the proper focus of the inquiry, the district court could turn to its ultimate task of determining whether the burdens of the law's requirements were "disproportionate, in their effect on the right to an abortion" compared "to the benefits that the restrictions are believed to confer." *Schimel*, 806 F.3d at 919. To determine whether a burden is undue, the court must "weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests. If a burden significantly exceeds what is necessary to advance the state's interests, it is 'undue,' " and thus unconstitutional. *Schimel*, 806 F.3d at 919.

The district court found that the burdens were significant: additional travel expenses, childcare costs, loss of entire days' wages, risk of losing jobs, and potential danger from an abusive partner. 273 F. Supp. 3d at 1037. Increased travel distance, the *Whole Woman's Health* Court instructed, constitutes a concrete hardship that can ultimately contribute to the burden being undue. *Whole Woman's Health*, 136 S.Ct. at 2313. See also *Schimel*, 806 F.3d at 919 (noting that the 90-mile, one-way trip from Milwaukee to Chicago might not cause a significant burden to a person who can afford a car or train ticket, but was indeed an undue burden for the large percent of women seeking abortions who live below and far below the poverty line). These are just the types of burdens, the district court concluded, that prevent women from exercising their right to have an abortion.

The funneling of all informed-consent appointments to the six PPINK health centers with ultrasound equipment imposed other burdens. It required PPINK to double-book appointments which increased wait times for appointments and elongated the duration of those appointments. These were the kinds of incremental burdens that the Supreme Court considered in *Whole Woman's Health* as well, when it noted that "[t]hose closures meant fewer doctors, longer waiting times, and increased crowding," and that those burdens, along with increased driving distances were the type of incremental burdens, which, when taken together adequately support an "undue burden" conclusion. *Whole Woman's Health*, 136 S.Ct. at 2313.

On the other side of the scale, the district court found that the State's many arguments regarding the benefits of the ultrasound missed the mark by addressing the utility of the ultrasound itself as opposed to the period of reflection. But even considering the merits of that data submitted by the State, the district court noted that the ultrasound effect study relied upon by the State described the potential impact of viewing an ultrasound to have a "very small" effect on a potential pool of only about 7% of women seeking abortions—those who had low or medium decision certainty, and no impact on women with high decision certainty—those who make up 93% of women seeking abortions. 273 F. Supp. 3d at 1032–33 (citing Gatter, Obstetrics & Gynecology, Vol. 123 at 83). And although the study states that women with low decision certainty who viewed an ultrasound image had a 95.2% rate of proceeding with an abortion compared to 97.5% rate for women with high decision certainty

who viewed an ultrasound, (Gatter, Obstetrics & Gynecology, Vol. 123 at 83) the State does not tell us how many women with low decision certainty changed their minds even *without* seeing an ultrasound image. For the ultrasound to have any impact, the women must actually view the ultrasound, and only approximately 25% of PPINK patients chose to do so (We do not know whether that number differs between low and high decision-certainty patients because the State presented no evidence on that point.). This means that if there is any chance that this "very small" impact will succeed it will do so only for the pool of women consisting of the 7% of abortion seekers with low or medium decision certainty and only on whatever percentage of that 7% who actually choose to also view the ultrasound, but likely only 25% of that 7% or 1.75%. Nor can we tell if these low decision-certainty patients might have changed their minds even without the ultrasound. In general, the study that both parties cite of over 15,000 women seeking abortions at a Planned Parenthood in Los Angeles demonstrated that most visits end in abortion—98.8%. Gatter, Obstetrics & Gynecology, Vol. 123 at 82. For the whole population of women in that study who viewed an ultrasound, 98.4% had an abortion. *Id.* It seems from the study that increasing gestational age of the fetus (something that can be determined without ultrasound), had more to do with the decision not to proceed to abortion than viewing of an ultrasound. *Id.* The district court concluded that if viewing the ultrasound has little to no impact, then "[i]t is simply not a reasonable assumption ... that further time to deliberate on an image that has nearly no impact at the time, would create a meaningfully

stronger impact after eighteen hours." 273 F. Supp. 3d at 1034.

We agree with the State that it is entitled to try to persuade women not to have an abortion even if the impact is minimal. Nevertheless, in weighing the benefit of the particular measure at issue, a court may consider the minimal putative effects of the State's action. The more feeble the state's asserted interest, "the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013).

More importantly, even if the ultrasound does influence a very small percentage of women to alter their decision, all of that is irrelevant, because, as the district court explained, "[e]vidence that some women's decisions as to whether to have an abortion are impacted by viewing the ultrasound is not evidence that doing so at least eighteen hours before the abortion, rather than on the day of the abortion, has any additional persuasive impact." 273 F. Supp. 3d at 1032.

The State's argument that the additional eighteen hours gives women time for deeper reflection and to absorb information, actually does address the question at issue in the case, but its argument is unsupported by anything other than Dr. Francis' one anecdote. Moreover, one could just as easily infer that the impact of viewing the ultrasound image, for some women, dissipates over the eighteen hours before the abortion. The State asks us to infer that some women

who choose not to view the ultrasound do so because they are under a time pressure and because they have arrived at the health center having already made up their minds, but the State offers no evidence for this. Recall that even under the old law, women who arrived at the health center on the day of their abortion had already received copious information from the State designed to alter their decision to abort, and had plenty of time—at least eighteen hours—to digest and consider their options while not under an acute time pressure.

The only relevant evidence the State submitted to support the proposition that the eighteen-hour requirement increases a woman's ability to reflect more seriously on her decision came from the testimony of Dr. Francis who stated that one patient reported to her that she might have opted to view the ultrasound and then might have continued her pregnancy had she been given the option to view the ultrasound eighteen hours before her procedure, as opposed to at the time of the procedure. The district court noted that this was indeed some evidence that women may change their minds if they have more time to reflect on the decision, but it also found this singular example to be exceedingly speculative. "She can only say that she 'likely' would have viewed the ultrasound, if it was offered a day earlier" (which currently only about 25% of women do), and "she 'likely' would not have returned for an abortion the next day." 273 F. Supp.3d at 1035. The district court, when weighing how much weight to give this evidence, concluded that this was "far from compelling evidence that the new ultrasound law would have the impact desired by the

State, and as such, it must be given diminished weight in the balancing process." *Id.* We see no reason to disrupt the district court's vast discretion in weighing this evidence.

Dr. Francis' other testimony—that some of her pregnant patients have told her that "viewing an ultrasound image of their baby caused them to decide not to have an abortion" (R. 35-1 at 4)—does not add anything to the consideration of whether viewing the ultrasound *eighteen hours prior* to the abortion alters the calculus in any way.

The State's argument that doctors commonly use informed-consent waiting periods to give patients time to consider important medical decisions does come closer to the relevant question in the case—the benefit of a waiting period between acquisition of knowledge and a medical procedure itself. Dr. Francis testified about the importance of giving patients time to reflect, weigh risks and benefits, and think of questions. See R. 35-1 at 3. The district court noted, however, that Dr. Francis does not provide abortion services and therefore could not attest to the utility of a waiting period after an informed-consent process preceding an abortion. The district court instead gave more weight to PPINK's argument that abortion procedures are different than other procedures where doctors give information long before a procedure, because unlike in the context where a doctor is providing a previously unknown diagnosis to a patient and then detailing various options, a woman visiting PPINK to have an abortion knows her diagnosis (she

is pregnant), as well as her options—she may continue the pregnancy or have an abortion. Moreover, the law already requires that she be informed of her options and wait eighteen hours until the procedure. The only issue is whether having the ultrasound eighteen hours before alters the calculus. Finally, there is a qualitative difference between a state-mandated waiting period, which the State requires only for abortions, and other optional waiting periods, for all other procedures, where a doctor and her patient may decide together whether time for reflection would be optimal or whether, for example, waiting would cause the patient anxiety, inconvenience, or deter her from having the desired procedure at all.

Moreover, as the district court discussed, there are many office procedures that gynecologists might perform immediately after discussing the procedure and asking for consent, such as colposcopies and LEEP procedures. 273 F. Supp. 3d at 1034. And there are many times that doctors might need to perform an emergent procedure immediately after providing informed consent, or times in which patients might opt for immediacy even in a non-emergent situation for the sake of convenience or because they are certain of their decision. Unlike for a hysterectomy or tubal ligation, waiting a few weeks for an abortion is not an option because abortions are not available at PPINK after 13 weeks and six days post last menstrual period, and the most vigilant woman will not know she is pregnant until about four weeks after her last menstrual period. In short, abortions are far more time sensitive than most other elective procedures.

Ultimately, the district court's conclusion that the new ultrasound law posed an undue burden was solidified by the fact that the State had almost no evidence that the additional time to reflect advanced its interests. Almost all of the State's evidence on the benefits of the new eighteen-hour ultrasound law focused on the benefits women might receive from having an ultrasound, and not the benefits from having to wait eighteen hours after having an ultrasound to obtain the procedure. The district court noted this and therefore dismissed much of this evidence as irrelevant to the discussion at hand. But before the district court did so, it went above and beyond its duty and thoroughly evaluated the merits of the evidence nevertheless. For example, the district court rejected the State's evidence regarding women's mental health noting that the science behind Dr. Coleman's studies, described above, had been nearly uniformly rejected by other experts in the field. 273 F. Supp. 3d at 1036. The district court chose to credit instead two mental health organizations that conducted a comprehensive review of studies on mental health and abortion and concluded that "on the best evidence available ... [t]he rates of mental health problems for women with unwanted pregnancy were the same whether they had an abortion or gave birth." R. 38-3 at 3. A task force of the American Psychological Association similarly reviewed studies and concluded that, "the most methodologically sound research indicates that among women who have a single, legal, first trimester abortion of an unplanned pregnancy for non-therapeutic reasons, the relative risks of mental health problems are not greater than the risks among women who de-

liver an unplanned pregnancy." *Id.* at 2–3. That report specifically criticizes Dr. Coleman's 2002 report as being "characterized by a number of methodological limitations that make it difficult to interpret the results." *Id.* at 4. The district court, using its substantial discretion weighed the competing evidence and determined that PPINK's evidence was "significantly more persuasive on this issue, especially given that Dr. Coleman's studies are the subject of significant criticism." 273 F. Supp. 3d at 1036. This type of evidence weighing is well within the district court's province, and we see no reason to disturb its thoroughly reasoned findings.

More importantly, the court below noted, Dr. Coleman's study failed to address the relevant question: whether having an ultrasound eighteen hours before an abortion leads to more favorable psychological outcomes. *Id.* And, as we have discussed extensively, this was the ultimate question that the district court had to address.

The district court considered all of the following together: the fact that over a third of surgical abortions occur within three weeks of PPINK's deadline for performing abortions; the difficulty of making two lengthy trips in quick succession; the over-booking of informed-consent appointments; and the fact that physicians only provided abortions on limited days in each health center. Adding these burdens together, the district court concluded, "it would be surprising if the new ultrasound law did *not* prevent a significant number of low income women from obtaining an abor-

tion." 273 F. Supp. 3d at 1038. And indeed the evidence provided by PPINK from nine women who were, in fact, severely burdened and impeded in their attempts at obtaining an abortion in the short time that the law was in effect, confirms this prediction.

The district court did not err by concluding that the ultrasound law "imposes significant burdens against a near absence of evidence that the law promotes either of the benefits asserted by the State." *Id.* at 1039. See *Whole Woman's Health*, 136 S.Ct. at 2318 (striking down the challenged abortion restrictions because the law "provides few, if any, health benefits for women" and "poses a substantial obstacle to women seeking abortions."). "A statute that curtails the constitutional right to an abortion ... cannot survive challenge without evidence that the curtailment is justifiable by reference to the benefits conferred by the statute." *Schimel*, 806 F.3d at 921.

The State would like to simplify the court's complex burden and benefit weighing to a more cookie cutter approach and have us conclude that *Casey* paved the way for an almost per se approval of all reasonable waiting periods. Appellant's Brief at 20–22, 38. The Supreme Court in *Casey* upheld a twenty-four hour, informed-consent waiting period despite the fact patients would need to make two sometimes lengthy trips in order to obtain an abortion. *Casey*, 505 U.S. at 885–87. And we followed suit in *A Woman's Choice-E. Side Women's Clinic v. Newman*, 305 F.3d 684, 691 (7th Cir. 2002), upholding Indiana's eighteen-hour waiting period after an in-person in-

formed-consent meeting. But one of the primary lessons of *Whole Woman's Health* is that the burden and benefit weighing is context-specific. In *Whole Woman's Health*, the court based its conclusions about undue burden on the 280,000 square miles of Texas territory, the number of abortion-offering facilities that could operate after the enactment of the contested law, the number of patients each remaining facility would have to accommodate (1,200 per month), the distance women would have to travel to get to a clinic and the population numbers for women who would have to travel this far, the rate of deaths and complications from abortions in Texas, and the cost to clinics of coming into compliance with the new regulation. *Whole Woman's Health,* 136 S.Ct. at 2301–03. The Court spent much time discussing the importance of these facts in assessing the constitutionality of the contested law, noting that a statute valid as to one set of facts may be invalid as to another. *Id.* at 2306 (citing *Nashville, C. & St. L.R. Co. v. Walters,* 294 U.S. 405 (1935)).

The Court in *Casey* noted that "in theory at least, the waiting period is a reasonable measure to implement the State's interest in protecting the life of the unborn," and went on to analyze whether such a "waiting period is nonetheless invalid because *in practice* it is a substantial obstacle to a woman's choice to terminate her pregnancy." *Casey*, 505 U.S. at 885 (emphasis ours). This was the exact reasoning we adopted later, in light of *Casey*, where we noted that "[w]hile a twenty-four hour waiting period that requires two trips to an abortion provider has been

found not to impose an undue burden on Pennsylvania women based on the circumstances of that state at the time the Court decided *Casey,* a similar provision in another state's abortion statute could well be found to impose an undue burden on women in that state depending on the interplay of factors"—factors such as "the number of physicians who perform abortions, the number of abortion facilities, the distances women must travel in order to reach an abortion facility, and the average income of women seeking abortions." *Karlin v. Foust*, 188 F.3d 446, 485 (7th Cir. 1999). The language in these cases reflects that the facts and context rule the day when evaluating waiting periods. This is far from being a blanket stamp of approval on them.

Analyzing the regulation in light of the reality of the facts in Indiana is precisely what the district court did in this case. A court cannot assess the law in a world where PPINK has unlimited resources to open dozens of clinics, each with the ability to provide ultrasound and abortions along with unlimited access to other health care needs, or in a world where all women have paid sick days, and reliable child care and transportation. The court must take the facts as they are presented before it and compare the burdens against the weight of the evidence of the benefits specific to the proposed law. *Whole Woman's Health*, 136 S.Ct. at 2310. The district court did just that and concluded that the evidence of benefits was exceptionally slight if any, and the burden imposed by the double travel requirement great. As the district court concluded, "the new ultrasound law creates significant financial and other burdens on PPINK and its patients,

particularly on low-income women in Indiana who face lengthy travel to one of PPINK's now only six health centers that can offer an informed-consent appointment. These burdens are clearly undue when weighed against the almost complete lack of evidence that the law furthers the State's asserted justifications of promoting fetal life and women's mental health outcomes." 273 F. Supp. 3d at 1043.

The State argues to this court that the district court's findings are clearly erroneous. We cannot agree. Under the clear error standard we can reverse a district court's factual findings only if "based on the entire record, we are left with the definite and firm conviction that a mistake has been committed." *United States v. Orillo*, 733 F.3d 241, 244 (7th Cir. 2013). The district thoroughly addressed each of the burdens and benefits asserted by the parties and engaged in a painstakingly thorough weighing. Its factual findings were not clearly erroneous and are entitled to our deference.

C. The remaining preliminary injunction considerations

That conclusion about the likelihood of success on the merits does not end the inquiry, although it certainly puts the heaviest weight on the scale. PPINK must also show that it is likely to suffer irreparable harm in the absence of preliminary relief and that it has no adequate remedy at law. *City of Chicago v. Sessions*, 888 F.3d 272, 282 (7th Cir. 2018). "If those burdens are met, the court must weigh the harm that the plaintiff will suffer absent an injunction against the

harm to the defendant from an injunction, and consider whether an injunction is in the public interest." *Id.*

For PPINK and its patients who lose the opportunity to exercise their constitutional right to an abortion, the irreparability of the harm is clear. Even an extended delay in obtaining an abortion can cause irreparable harm by "result[ing] in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal." *Planned Parenthood of Wis.*, 738 F.3d at 796. The evidence suggests that the new ultrasound law has already prevented some women from exercising their constitutional rights. It has caused delay to others. Because we, like the district court, have concluded that there is no substantial evidence that the law furthers its stated interest, any harm to the State is minimal, at worst. And the State certainly has myriad remaining methods to persuade women to carry a pregnancy to term in order to promote the State's interest in promoting fetal life.

The State argues that PPINK can avoid some of the harm by expending more resources on abortion services, buying more ultrasound machines, but again, the court must take the record as it finds it and not base its finding on what the facts might look like if the court could devise a different business or care model for PPINK. See, e.g., *Whole Woman's Health*, 136 S.Ct. at 2318. In any case, PPINK presented evidence that it has already shifted resources and tried to mitigate harm to the best of its ability. Some of these changes are unsustainable long term. Others cannot be made at all.

Balanced against the harm to PPINK patients is the State's claim of irreparable harm. The State faces the same harm any State faces when a democratically enacted law is enjoined. It also claims that it would prevent it from furthering its goal of promoting fetal life. This we think, is a minimal, potentially temporary harm in this case, compared with the burdens on the women that the district court identified. This is particularly true when we consider that—even crediting the State's asserted benefit of the law—the potential ability to alter any woman's decision in a manner that protects fetal life would be minimal, at best.

As for the public interest, the district court found that upholding constitutional rights serves an important public interest and we see no reason to add to or upset this finding. And because the State had not demonstrated that its interest would be served by the law, neither could the public's interest.

III.

The State asserts that its reason for this new eighteen-hour ultrasound requirement is to persuade women not to have an abortion. There is no doubt that this is a legitimate position for a state to take. But it is also true that women have the right to choose to have an abortion, albeit with some limitations. *Casey*, 505 U.S. at 846. Women, like all humans, are intellectual creatures with the ability to reason, consider, ponder, and challenge their own ideas and those of others. The usual manner in which we seek to persuade is by rhetoric not barriers. The State certainly is entitled to use these rhetorical tools to persuade

women not to have an abortion. It has chosen to do so by requiring an informed-consent process—the required contents of which it has designed and mandated—and an ultrasound and fetal heart beat requirement. It also requires every woman to receive a brochure about abortion, the contents of which the State controls in toto—from how it will present the images of fetuses to the decisions about which medical risks it includes and which it omits (for example, the brochure which a woman takes home and is supposed to ponder for eighteen hours, does not speak of the risk to the fetus from drugs and alcohol that a woman may have consumed prior to knowing about an unplanned pregnancy). Moreover, it states as fact that "human physical life begins when a human ovum is fertilized by a human sperm"—a proposition debated among scientists, religious leaders, and medical ethicists. The State has vast power to use the information that it provides to persuade women not to have an abortion. But the requirement that women have the ultrasound eighteen hours prior to the abortion places a large barrier to access without any evidence that it serves the intended goal of persuading women to carry a pregnancy to term. Instead, it appears that its only effect is to place barriers between a woman who wishes to exercise her right to an abortion and her ability to do so. Rhetoric and persuasion are certainly legitimate methods for a state to assert its preference, but it cannot force compliance with its otherwise legitimate views by erecting barriers to abortion without evidence that those barriers serve the benefit the state intended. "Until and unless *Roe v. Wade* is overruled by the Supreme Court, a statute likely to restrict access to abortion with no offsetting medical

benefit cannot be held to be within the enacting state's constitutional authority." *Schimel*, 806 F.3d at 916. In light of the evidence of substantial burdens imposed by the law and without evidence that the additional eighteen hours following an ultrasound has any legitimate persuasive effect on decision-making, the law constitutes an undue burden on those seeking an abortion without any known benefits to balance it. The opinion of the district court is AFFIRMED in all respects.

KANNE, *Circuit Judge*, concurring in the judgment. Our decision today is compelled by long-standing Supreme Court precedent. *See Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

The State's reason for the new 18-hour ultrasound requirement is to persuade women not to have an abortion. As the opinion notes, "[t]here is no doubt that this is a legitimate position for a state to take." Majority Op. at 833. This, of course, is weighed against the fact that "women have the right to choose to have an abortion, albeit with some limitations." *Id.*

In this case two evidentiary factors lead me to conclude that the 18-hour requirement imposes an undue burden on a woman's right to choose, which requires affirming the decision of the district court. The first factor is the additional travel necessitated by the availability of only six ultrasound imaging sites located in Indiana at PPINK health centers.* The second factor is that the State offered little evidence to show that an 18-hour wait following an ultrasound would persuade those seeking an abortion to preserve fetal life.

Based on the foregoing factors, I agree that, in the context presented by this appeal, Ind. Code § 16-34-2-1.1(a)(5)—as written—constitutes an undue burden

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* On appeal, the State did not pursue the argument that PPINK should accept ultrasound results from the many other Indiana providers of ultrasound imaging throughout the State. *See* Majority Op. at 24, n.6.

on women seeking an abortion.

This concurrence extends to the final judgment set forth by my esteemed colleague, Judge Rovner, but does not endorse the propriety of the ancillary findings of the district court.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC., Plaintiff, v. COMMISSIONER, INDIANA STATE DEPARTMENT OF HEALTH *et al.*, Defendants.	)	Case No. 1:16-cv-01807-TWP-DML

PRELIMINARY INJUNCTION PROHIBITING ENFORCEMENT OF SELECTED PROVISION OF INDIANA HOUSE ENROLLED ACT NO. 1337

The State of Indiana, its agents and agencies, and all political subdivisions thereof are prohibited from enforcing the following provision of Indiana House Enrolled Act No. 1337:

- New ultrasound law, Indiana Code § 16-4-2-1.1(a)(5).

Plaintiffs are not required to post a bond.

SO ORDERED.

Date: 3/31/2017

TANYA WALTON PRATT, JUDGE
United States District Court
Southern District of Indiana

Laura A. Briggs, Clerk

BY: _____
Deputy Clerk, U. S. District Court

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC.,	)	
Plaintiff,	)	Case No. 1:16-cv-01807-TWP-DML
v.	)	
COMMISSIONER, INDIANA STATE DEPARTMENT OF HEALTH *et al*.,	)	
Defendants.	)	

ORDER GRANTING PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

This matter is before the Court on a Motion for Preliminary Injunction filed pursuant to Federal Rule of Civil Procedure 65(a) by Plaintiff Planned Parenthood of Indiana and Kentucky, Inc. ("PPINK"). (Filing No. 6.) PPINK filed this suit against the Commissioner of the Indiana Department of Health, and the prosecutors of Marion County, Lake County, Monroe County, and Tippecanoe County (collectively, "the State"), all in their official capacities. PPINK maintains that a provision of Indiana House Enrolled Act No. 1337 ("HEA 1337"), which went into effect on July 1, 2016, creates an undue burden on a woman's right

to choose to have an abortion and is therefore unconstitutional. It seeks to enjoin this provision during the pendency of this litigation. The parties submitted evidence, and the Court held a hearing on PPINK's motion.

The provision challenged by PPINK is found in Indiana Code § 16–34–2–1.1(a)(5). Prior to the enactment of this provision, women in Indiana were required to have an ultrasound before having an abortion, but they could have it on the same day as the abortion. Women were also required to have an informed-consent appointment at least eighteen hours prior to an abortion, during which they received state-mandated information regarding pregnancy and abortion. The provision challenged by PPINK (hereinafter, "the ultrasound law" or "the new ultrasound law") now requires a woman to have an ultrasound at least eighteen hours prior to an abortion and at the same time she receives the informed-consent information otherwise required by the statute. The new ultrasound law combined two previously existing requirements—the ultrasound requirement and the eighteen-hour informed consent requirement.

For the reasons explained below, PPINK is likely to succeed on the merits of its challenge to the new ultrasound law because it creates an undue burden on a woman's right to choose to terminate her pregnancy. "To determine whether the burden imposed by the statute is undue (excessive), the court must weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests." *Planned*

Parenthood of Wisconsin, Inc. v. Schimel, 806 F.3d 908, 919 (7th Cir. 2015). PPINK presents compelling evidence that women, particularly low-income women, face significant financial and other burdens due to the new ultrasound law. The State's primary justification for the law is to promote fetal life—that is, to convince women to choose not to have an abortion by having them view their ultrasound at least the day before the abortion rather than the day of the abortion. But it presents little evidence, and certainly no compelling evidence, that the new ultrasound law actually furthers that interest. Simply put, the State has not provided any convincing evidence that requiring an ultrasound to occur eighteen hours prior to an abortion rather than on the day of an abortion makes it any more likely that a woman will choose not to have an abortion. Given the dearth of evidence that the State's interest is actually furthered by the new ultrasound law, the burdens it creates on women seeking to terminate their pregnancies—which are significant even if not overwhelming—dramatically outweigh the benefits, making the burdens undue and the new ultrasound law likely unconstitutional. PPINK faces irreparable harm of a significantly greater magnitude if this provision is not enjoined than that faced by the State from an injunction.

Accordingly, PPINK's motion for a preliminary injunction is **GRANTED**. (Filing No. 6).

I. LEGAL STANDARD

"A preliminary injunction is an extraordinary remedy never awarded as of right. In each case, courts

must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). "To obtain a preliminary injunction, a party must establish [1] that it is likely to succeed on the merits, [2] that it is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in its favor, and [4] that issuing an injunction is in the public interest." *Grace Schools v. Burwell*, 801 F.3d 788, 795 (7th Cir. 2015); *see Winter*, 555 U.S. at 20. "The court weighs the balance of potential harms on a 'sliding scale' against the movant's likelihood of success: the more likely he is to win, the less the balance of harms must weigh in his favor; the less likely he is to win, the more it must weigh in his favor." *Turnell v. CentiMark Corp.*, 796 F.3d 656, 662 (7th Cir. 2015). "The sliding scale approach is not mathematical in nature, rather it is more properly characterized as subjective and intuitive, one which permits district courts to weigh the competing considerations and mold appropriate relief." *Stuller, Inc. v. Steak N Shake Enterprises, Inc.*, 695 F.3d 676, 678 (7th Cir. 2012) (citation and internal quotation marks omitted). "Stated another way, the district court 'sit[s] as would a chancellor in equity' and weighs all the factors, 'seeking at all times to minimize the costs of being mistaken.'" *Id.* (quoting *Abbott Labs. v. Mead Johnson & Co.*, 971 F.2d 6, 12 (7th Cir. 1992)).

II. BACKGROUND

PPINK operated twenty-three health centers in Indiana on the date this action commenced, but financial considerations have required PPINK to close and consolidate several of its health centers. When this process is complete, PPINK will operate seventeen health centers across Indiana. Four of PPINK's seventeen health centers offer abortions services. Three of the health centers, located in Bloomington, Merrillville, and Indianapolis, offer both surgical and medication abortion services. The health center in Lafayette provides only medication abortions. The only providers of non-medically indicated abortion services in Indiana that are not affiliated with PPINK are located in Indianapolis.

PPINK performs surgical abortions through the first trimester of pregnancy, which is thirteen weeks and six days after the first day of a woman's last menstrual period. Medication abortions are available up to nine weeks after the first day of a woman's last menstrual period. The only providers of abortion services in Indiana after the first trimester are hospitals or surgical centers that generally provide abortions only when the abortion is medically indicated because of fetal abnormality or a threat to the woman's health. Abortions at these locations are rare: in 2015, only 27 out of the 7,957 abortions performed in Indiana occurred in a hospital or surgical center.

The Indiana legislature enacted HEA 1337, which went into effect on July 1, 2016. This Act created sev-

eral new provisions and amends several others regarding Indiana's regulation of abortions and practices related to abortions. In this action PPINK challenges just one of those provisions: the new ultrasound law. The parties do not dispute the key background facts related to the new ultrasound law. The Court will therefore briefly set forth the challenged provision and summarize the undisputed background evidence related to it.

Indiana Code § 16–34–2–1.1(a) provides that "[a]n abortion shall not be performed except with the voluntary and informed consent of the pregnant woman upon whom the abortion is to be performed." Consent to an abortion is "voluntary and informed" if the information set forth in the statute is provided to the patient at least eighteen hours prior to the abortion. *See id.* For example, the mandated information includes the nature of the proposed procedure; scientific information regarding the risks of and alternatives to the procedure; notification "[t]hat human physical life begins when a human ovum is fertilized by a human sperm"; the probable gestational age of the fetus at the time the abortion is to be performed, including a picture of the fetus and other information about the fetus at its current stage of development; notice that a fetus can feel pain at or before twenty weeks; and information regarding alternatives to abortion and other support services available. Ind. Code § 16–34–2–1.1(a)(1)–(2).

Prior to the enactment of the new ultrasound law, the statute also provided that "[b]efore an abortion is

performed, the provider shall perform, and the pregnant woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone," unless the woman elected in writing to not view the ultrasound or listen to the fetal heart tone. Ind. Code § 16–34–2–1.1 (repealed). The new ultrasound law changed the timing, but not the substance, of this requirement. It provides:

> At least eighteen (18) hours before an abortion is performed and at the same time that the pregnant woman receives the information required by subdivision (1), the provider shall perform, and the pregnant woman shall view, the fetal ultrasound imaging and hear the auscultation of the fetal heart tone if the fetal heart tone is audible unless the pregnant woman certifies in writing, on a form developed by the state department, before the abortion is performed, that the pregnant woman:
>
> > (A) does not want to view the fetal ultrasound imaging; and
> >
> > (B) does not want to listen to the auscultation of the fetal heart tone if the fetal heart tone is audible.

Ind. Code § 16–34–2–1.1(a)(5).

Before the new ultrasound law, PPINK provided the state-mandated information to its patients at least eighteen hours prior to the abortion during an informed-consent appointment, which were offered at

any of PPINK's seventeen health centers across the state. This allowed women who live a long distance from one of the four health centers that offer abortion services to make only one lengthy trip in order to obtain an abortion. These women would typically have an ultrasound on the day of the abortion and would at that time be offered the opportunity to view the ultrasound image and listen to the auscultation fetal heart tone, as required by law. The physician who would perform the abortion would interpret the ultrasound and answer any questions the woman might have.

The new ultrasound law required PPINK to change its practices, given that ultrasounds must now occur during the informed-consent appointment, yet ultrasounds were only available at the four PPINK health centers that offer abortion services. Thus women living a significant distance from one of those four health centers were faced with either two lengthy trips to one of those health centers or an overnight stay nearby. PPINK attempted to ease this burden by offering ultrasounds at two additional health centers that do not offer abortion services. Specifically, PPINK purchased ultrasound equipment for its Mishawaka health center and trained a staff member at its Evansville health center to use ultrasound equipment already located there. Therefore, women can now travel to one of six PPINK health centers for their informed-consent appointment, which includes the mandated ultrasound, before travelling at least eighteen hours later to one of the four PPINK health centers that offers abortion services. Despite its ability to partially mitigate the burdens imposed by the new ultrasound law, PPINK contends that the new

ultrasound law creates an undue burden on its patients' constitutional right to terminate their pregnancies.

III. DISCUSSION

To obtain a preliminary injunction, PPINK must establish the following four factors: "[1] that it is likely to succeed on the merits, [2] that it is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in its favor, and [4] that issuing an injunction is in the public interest." *Grace Schools*, 801 F.3d at 795. The first two factors are threshold determinations; "[i]f the moving party meets these threshold requirements, the district court 'must consider the irreparable harm that the nonmoving party will suffer if preliminary relief is granted, balancing such harm against the irreparable harm the moving party will suffer if relief is denied.' " *Stuller, Inc.*, 695 F.3d at 678 (quoting *Ty, Inc. v. Jones Group, Inc.*, 237 F.3d 891, 895 (7th Cir. 2001)). The Court will address the first two threshold factors in turn, before addressing the final two factors together.

A. Likelihood of Success on the Merits

The parties acknowledge that the propriety of issuing a preliminary injunction rests almost entirely on whether PPINK has a likelihood of success on the merits of its claim. The importance of this factor has led the parties to vigorously dispute both the proper legal test and how that legal test should apply to the

evidence presented. The Court's analysis of these disputes begins with an overview of the constitutionally protected right for a woman to choose to terminate her pregnancy, before turning to the parties' disputes regarding the legal standard and its application.

The Supreme Court has long held that "[i]t is a constitutional liberty of the woman to have some freedom to terminate her pregnancy." *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion). This right is grounded in the right to privacy rooted in "the Fourteenth Amendment's concept of personal liberty." *Roe v. Wade*, 410 U.S. 113, 153 (1973). But as the Supreme Court's "jurisprudence relating to all liberties ... has recognized, not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right." *Casey*, 505 U.S. at 873. Therefore, "[t]he fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id*.

From the recognition that no rights are absolute follows the necessity of a legal test to determine whether a particular regulation that incidentally affects the exercise of a right is constitutional. In the context of abortion regulations, the undue burden test governs. The Supreme Court recently set forth this test as follows: "there 'exists' an 'undue burden' on a woman's right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the 'purpose or effect' of the provision 'is to place a substantial obstacle in the path of a woman seeking

an abortion before the fetus attains viability.' " *Whole Woman's Health v. Hellerstedt*, 136 S.Ct. 2292, 2299, (2016) (emphasis omitted) (quoting *Casey*, 505 U.S. at 878 (plurality opinion)).

Both the Supreme Court and the Seventh Circuit have made clear that applying the undue burden test requires balancing: "The rule announced in *Casey* ... requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Id.* at 2309; *see Schimel*, 806 F.3d at 919 ("To determine whether the burden imposed by the statute is undue (excessive), the court must weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests. If a burden significantly exceeds what is necessary to advance the state's interests, it is undue, which is to say unconstitutional.") (citation and quotation marks omitted). Importantly, this balancing does not involve a determination of the applicable level of scrutiny and then an application of the State's justification to that level of scrutiny. See *Whole Woman's Health*, 136 S.Ct. at 2319 ("[T]he balancing in the abortion context should not be equated with the judicial review applicable to the regulation of a constitutional protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue."). Instead, the Court must simply weigh the burdens against the benefits and determine if the burdens "significantly exceed[ ] what is necessary to advance the state's interest." *Schimel*, 806 F.3d at 919.

Also important when conducting the required balancing is the extent to which the Court defers to legislative findings or, instead, independently evaluates the evidence presented by the parties. The Supreme Court has made clear that courts should do the latter: "when determining the constitutionality of laws regulating abortion procedures, [the Supreme Court] has placed considerable weight upon evidence and argument presented in judicial proceedings." *Whole Woman's Health*, 136 S.Ct. at 2310; *see Gonzales v. Carhart*, 550 U.S. 124, 165, (2007) ("The Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.").

1. <u>The Proper Legal Standard</u>

PPINK maintains that this Court need only apply the undue burden test outlined above, which requires weighing the burdens imposed by the new ultrasound law against the benefits to the State's asserted interest. The State takes issue with courts balancing the burdens against the benefits of an abortion regulation in cases such as this one where the State's primary asserted interest is promoting fetal life. It argues that the Court should simply apply Casey, not the Supreme Court's recent decision in *Whole Woman's Health*, because the balancing in *Whole Woman's Health* "applies only to abortion restrictions designed to protect maternal health." (Filing No. 35 at 15). This is true, the State says, because the asserted state interest in *Whole Woman's Health* was to protect maternal health, and the standards applied in that case are limited to that context; that type of balancing "is a poor fit for this type of regulation" because "the two

sides' interests [here] are fundamentally at odds with one another. PPINK's goal is to help the woman carry out her decision to terminate her pregnancy and the State's goal is to persuade the woman to reconsider that decision." (Filing No. 35 at 17.) PPINK replies that the State "fundamentally misconstrues *Whole Woman's Health*" because the Supreme Court in that case was not applying an alternative standard; it instead "definitively interpreted [and applied] *Casey*'s 'undue burden' standard." (Filing No. 38 at 9.)

The Court agrees with PPINK. The premise of the State's argument—that different standards are applied in *Casey* and *Whole Woman's Health*—is belied by those decisions. Not once in *Whole Woman's Health* did the Supreme Court suggest that different versions of the undue burden test apply depending on the State's asserted interest, or even that different versions of the test exist at all. Instead, the Supreme Court in the introduction of *Whole Woman's Health* explicitly stated that it was applying *Casey* 's undue burden test. See *Whole Woman's Health*, 136 S.Ct. at 2299 ("We must here decide whether two provisions of Texas' House Bill 2 violate the Federal Constitution as interpreted in *Casey*."). Given that the Supreme Court made clear in *Whole Woman's Health* that it was applying *Casey,* it inexorably follows that there are not two distinct undue burden tests applied *in Casey* and *Whole Woman's Health*.

Three additional considerations place this question beyond dispute. First, the State points to the fact that the Supreme Court in *Whole Woman's Health* focuses on whether the regulations at issue benefit

women's health. But the Supreme Court did so only because that was the state's interest that Texas argued that the challenged regulations furthered—not because it is the only context in which balancing is appropriate. This is evident because, when the legal standard is set out in *Whole Woman's Health*, it is not set forth in terms limiting it to laws justified on the basis of maternal health; it is often stated in general terms such that it clearly applies regardless of whether the state's interest is promoting women's health or otherwise. *See id.* at 2309 ("The rule announced in *Casey* ... requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer."). The Seventh Circuit has similarly stated the balancing test in general terms. *See Schimel*, 806 F.3d at 919 ("To determine whether the burden imposed by the statute is undue (excessive), the court must weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests."); *id.* at 921 ("[A] statute that curtails the constitutional right to an abortion ... cannot survive challenge without evidence that the curtailment is justifiable by reference to the benefits conferred by the statute.").

Second, the Supreme Court in Casey applied the undue burden standard when evaluating both provisions justified as promoting women's health and those justified as promoting fetal life, but it did not at all suggest that the undue burden test applies differently to those provisions. *See Casey*, 505 U.S. at 877–78, (discussing abortion regulations "designed to persuade [a woman] to choose childbirth over abortion"

and regulations "designed to foster the health of a women seeking an abortion" as both valid as long as they do not constitute an undue burden). If, as set forth in *Casey*, there is a singular undue burden test that applies regardless of the State's asserted justification, and if the Supreme Court in *Whole Woman's Health* applied the undue burden test in *Casey*, its articulation and application of that singular test is binding on this Court irrespective of the State's asserted justification for the new ultrasound law.

Third, and perhaps most tellingly, the Supreme Court in *Whole Woman's Health* directly points to abortion regulations challenged in *Casey* that were not justified as promoting women's health as support for its conclusion that the undue burden test requires balancing the burdens against the benefits of the challenged law. The Supreme Court rejected the notion that "a district court should not consider the existence or nonexistence of medical benefits when considering whether a regulation of abortion constitutes an undue burden." *Whole Woman's Health*, 136 S.Ct. at 2309. And in the very next sentence and the citations accompanying it, the Supreme Court made clear that this concept is not limited to the assessment of *medical* benefits, but to whatever benefits the State asserts that the challenged law provides. Specifically, the Supreme Court stated that "[t]he rule announced in *Casey* ... requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer," and then it cited to portions of *Casey* where this balancing was applied to provisions—the spousal notification and parental consent provisions—that were not justified on women's

health grounds. *Id.* (citing *Casey*, 505 U.S. at 887–98, 899–901). If the balancing discussed in *Whole Woman's Health* was limited to the context of abortion regulations justified as promoting women's health, the Supreme Court would not have cited to portions of *Casey* applying that balancing to abortion regulations with other justifications.

For all of these reasons, the State's position that the balancing set forth in *Whole Woman's Health* that requires weighing the burdens and benefits of the challenged law applies only to abortion regulations justified as promoting women's health is based on the false premise that the undue burden test changes based on the State's asserted justification for the law. The Supreme Court and the Seventh Circuit have only discussed the undue burden test as a singular test, and this Court's application of that test is directed by how these courts have explicated and applied that test. It is to the application of the undue burden test that the Court now turns.

2. Whether the New Ultrasound Law Creates an Undue Burden

In *Whole Woman's Health*, the Supreme Court concluded that the district court "applied the correct legal standard" when it "considered the evidence in the record—including expert evidence, presented in stipulations, depositions, and testimony"—and it "then weighed the asserted benefits against the burdens." 136 S.Ct. at 2310. This is therefore the approach the Court must take here. The Court will first make findings and evaluate the persuasiveness of the evidence

regarding the burdens and benefits created by the new ultrasound law, including by discussing the parties' responses to each other's evidence. The Court will then weigh the burdens against the benefits.

a. Burdens

PPINK maintains that the new ultrasound law is burdensome because it requires women seeking an abortion who live significant distances from one of the six PPINK health centers that provide ultrasounds during the informed-consent appointments to make two lengthy trips to have an abortion—one for the informed-consent appointment and a second for the abortion itself. In order to evaluate the burdens imposed by the new ultrasound law, the Court must first define the group of women whose burdens must be analyzed.

"The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894; *see id.* ("The analysis does not end with the [subset] of women upon whom the [challenged] statute operates; it begins there."). Thus the class of women on whom the Court must focus, as in *Casey* and *Whole Woman's Health*, is "a class narrower than 'all women,' 'pregnant women,' or even 'the class of *women seeking abortions*.'" Whole Woman's Health, 136 S.Ct. at 2320 (quoting *Casey*, 505 U.S. at 894–95). As discussed in detail below, the new ultrasound law is a restriction for women for whom an additional lengthy trip to a PPINK health center for their informed-consent appointment acts as an impediment

to their ability to have an abortion. More specifically, the burdened group is low-income women who do not live near one of PPINK's six health centers at which ultrasounds are available. This is because, as noted above, PPINK now only offers the informed-consent appointments at six rather than seventeen of its health centers, since the new ultrasound law requires the mandatory ultrasound to occur during this appointment.

It is unsurprising that the financial burdens discussed below disproportionately impact PPINK's low-income patients, who constitute a significant portion of PPINK's patients receiving abortion services. Poverty experts generally use 200% of the Federal Poverty Line ("FPL") as an approximation of the income necessary to survive on one's own. (Filing No. 24–2 at 4.) Many experts describe those at or below 100% of the FPL as "poor," and individuals between 100% and 200% of the FPL as "low-income." (Filing No. 24–2 at 4.) Statistics from the 2016 fiscal year reveal the following regarding PPINK's patient's income levels relative to the FPL:

Income Range	**Percent of Patients**
Unknown	22%
0-100% FPL	37%
101-150% FPL	11%
151-200% FPL	8%
201-250 % FPL	5%
251%+ FPL	16%

(Filing No. 24–1 at 14). The income levels of PPINK's patients are similar to national statistics, which reflect that approximately 75% of abortion patients

have incomes at or below 200% FPL, and 49% had incomes at or below 100% FPL. (Filing No. 24–2 at 5.)

Having set forth the relevant group, PPINK's evidence regarding the burdens faced by this group due to the new ultrasound law are discussed in four overlapping categories: (1) increased travel distances; (2) delays in obtaining abortion services; (3) expert testimony; and (4) specific women who have reported adverse effects from the ultrasound law. The State's challenge, if any, to this evidence is discussed and evaluated in conjunction with each category.

i. Increased Travel Distance to Informed–Consent Appointments

Lengthy Travel. Many women will have to travel hundreds of miles to their informed-consent appointments now that PPINK can only offer these appointments at six, rather than seventeen, of their health centers. Such travel is especially difficult for low-income women who do not have access to a car. For example, women from Allen County—which contains Fort Wayne, the second most populous city in Indiana—have to travel approximately 174 miles roundtrip for their informed-consent appointment, assuming that they can get an appointment at the nearest ultrasound-equipped health center in Mishawaka. (Filing No. 24–1 at 13–14.) In fiscal year 2016, 251 women from Allen County obtained abortions from PPINK. Prior to the new ultrasound law, over 86% of women from Allen County who had an abortion with PPINK had their informed-consent appointment at the PPINK health center located in Fort Wayne. (See

Filing No. 24–1 at 3–4.) All of these women—and women who similarly do not live near one of the six PPINK health centers offering ultrasounds—now face lengthy travel to their informed-consent appointments.[1]

The State suggests that PPINK could avoid requiring its patients to undertake additional lengthy travel by simply accepting ultrasounds from other healthcare providers, which it currently does not permit. (Filing No. 35 at 32.) The State also contends that PPINK could mitigate the burdens caused by lengthy travel by simply making different business decisions, such as buying less expensive ultrasound machines so that more health centers can offer the informed-consent appointment. (Filing No. 35 at 33.) These arguments are two of the State's primary attempts to undermine PPINK's evidence of burdens and are addressed in turn.

There are two difficulties with the State's position as to PPINK's pre-existing policies. First, the undue burden inquiry does not contemplate re-examining every pre-existing policy or practice of abortion providers to see if they could further mitigate burdens imposed by a new abortion regulation. The Seventh Circuit's analysis in *Schimel* illustrates this. When assessing the burdens imposed, the Seventh Circuit

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[1] There is no evidence regarding how many or what proportion of PPINK's patients live near one of the six PPINK health centers offering the informed-consent appointment. This number, however, is ultimately irrelevant because for women for whom one such center is local, the new ultrasound law is "irrelevant" and thus they are not the focus of the Court's burden analysis. *Casey*, 505 U.S. at 894.

accepted Planned Parenthood's policies and then evaluated how the challenged law burdened the right to choose to have an abortion given those polices. It did not suggest that Planned Parenthood had an obligation to change its policies to lessen the burden.

For example, the Seventh Circuit noted that Planned Parenthood in Wisconsin performs abortions for women who have been pregnant up to eighteen weeks and six days. *See Schimel*, 806 F.3d at 918. It recognized that delays in obtaining abortions caused by the challenged law would "push [some women] past the ... deadline for Planned Parenthood clinics' *willingness* to perform abortions." *Id.* (emphasis added). And it did not suggest that Planned Parenthood could provide later term abortions like another abortion clinic in Wisconsin offered; it instead counted this fact as a burden imposed by the challenged law, not as one caused by Planned Parenthood's policy. *See id.* ("Women seeking lawful abortions that late in their pregnancy, either because of the waiting list or because they hadn't realized their need for an abortion sooner, would be unable to obtain abortions in Wisconsin.").

Accordingly, PPINK is correct that undue burden inquiry asks, "given the reality of how PPINK provides its abortion services, ... is [there] an undue burden on its patients." (Filing No. 38 at 13.) The State has not pointed to any case in which a court suggested that burdens created by a new abortion regulation were undermined based on the abortion provider's failure to change a pre-existing policy, and therefore the Court will not re-examine each pre-existing

PPINK policy and determine whether, if it were changed, it would mitigate the burdens imposed by the new ultrasound law.

Second, even if this were a proper consideration, the State's suggested policy change is not a feasible one. To support its position regarding PPINK's failure to accept ultrasounds from other medical providers, the State points to the deposition testimony of PPINK's medical director Dr. John Stutsman that he would not necessarily decline to permit outside ultrasounds, but that is PPINK's national policy. (Filing No. 35–4 at 27.) But as PPINK points out, the new ultrasound law *requires* that the ultrasound be provided "at the same time that the pregnant woman receives" the other mandated informed-consent information, *see* Ind. Code § 16–34–2–1.1(a)(5), and there is no evidence to suggest that a woman could receive that information at a non-PPINK hospital or healthcare facility. This is especially true given that, at the time of the ultrasound, the law requires the patient to provide the name of the physician performing the abortion, the physician's license number, and a telephone number at which they can be reached at any time. Ind. Code § 16–34–2–1.1(a)(1)(A). There is no evidence that an abortion patient could provide such information if she was not at a PPINK health center. Thus, the State's suggestion that PPINK could simply change its policy and begin accepting ultrasounds from other providers—even if it were a proper consideration—is not an available method to mitigate the lengthy travel that is now necessary for many women in Indiana.

Like the State's position with regards to PPINK's pre-existing policies, its contention that PPINK could make different business decisions to mitigate the burdens caused by the new ultrasound law is unpersuasive. As an initial matter, the State has again failed to point to a case in which a court has discounted burdens imposed by a new ultrasound regulation because the abortion provider could have made better or different financial choices.

To the extent this is a proper consideration at all, the State has failed to show that PPINK's business decisions are in any way causing the burdens at issue. For example, the State argues that PPINK could purchase cheaper ultrasound machines and therefore have them available at more than six health centers. (Filing No. 35 at 33–34.) PPINK's ultrasound machines cost $25,000.00, and the State presents evidence that high-quality, portable ultrasound machines are available for as little as $4,250.00 to $8,500.00. (Filing No. 35–1 at 6). In response, PPINK's Director of Abortion Services, Forest Beeley, explains why PPINK purchases the $25,000.00 machine from GE Healthcare. Specifically, she notes that this ultrasound machine comes with an extended warranty that cheaper machines do not have, and the contract with GE Healthcare includes planned maintenance, replacement parts, software updates, support, and a guaranteed 24–hour response time if there are issues, among other benefits. (Filing No. 38–1 at 3–4.) Moreover, the ultrasound machine integrates with PPINK's electronic record system, which is critical for when the ultrasound and abortion appointments occur at different health centers. (Filing No. 38–1 at 4.)

Given all of these additional services and features that are in PPINK's view "essential," Ms. Beeley testifies that these ultrasound machines are the most economical available. (Filing No. 38–1 at 4.) Thus, while the State has pointed to a very specific purchase by PPINK and suggested they could make a better purchase decision, the evidence reveals that PPINK is making the most economical decision available for its needs.

Moreover, given all the evidence presented, the Court credits the attestation of PPINK's President and CEO, Betty Cockrum, that "PPINK is unable to afford the expenses, both in terms of equipment and staffing, of providing ultrasound machines and technicians at all of its health centers." (Filing No. 24–1 at 8.) Notably, PPINK reacted to the new ultrasound law by providing ultrasounds at two health centers at which they were previously unavailable. This undercuts any notion that PPINK is in any way not providing abortion services to the greatest extent possible; indeed, it is hard to fathom that an organization dedicated to providing abortions services would not do so. And the evidence here reveals that PPINK has.

Finally, to the extent the State argues that PPINK is simply failing to shift more resources toward abortion services, this also does not undermine PPINK's evidence of burdens. As a general matter, if the State could simply point out ways in which PPINK could allocate its resources differently to mitigate burdens imposed by the new ultrasound law, PPINK would never be able to make a successful undue burden chal-

lenge, given that only 7% of its patients receive abortion services. (*See* Filing No. 35–5 at 35 (noting that only 7% of PPINK patients receive abortion services)). This leaves all of the resources it dedicates to the healthcare needs of the other 93% of its patients, which of course *could* be dedicated to abortion services. But this would essentially mean that no organization could challenge an abortion regulation as an undue burden unless it is dedicating 100% of its resources to abortions.

Moreover, if the State believes that PPINK could offer more abortion services than it does, it is the State's obligation to present specific evidence, not just a general assertion, that this is so. *See Whole Woman's Health*, 136 S.Ct. at 2317. To the extent it has, such as with the price of ultrasound equipment, that evidence is unpersuasive. Otherwise, a general assertion that PPINK should shift more resources toward abortion services is insufficient.

For these reasons, the State has failed to undermine PPINK's significant evidence of burden of increased travel due to the new ultrasound law. The State's contentions that PPINK's pre-existing policies and business decisions could further mitigate these burdens constitutes either an improper inquiry generally or are otherwise unpersuasive.

Absence from Employment. Because the new ultrasound law now forces many women to travel significant distances for their informed-consent appointment, these women must now take an additional day

away from work in order to have an abortion. However, many low-income women do not have employment that pays them for days during which they do not work. (Filing No. 24–1 at 15.) The new ultrasound law thus requires these women to lose an additional day's wages, which adds yet another financial cost. Many of these same women feel unable to take this additional time off work due to fear of losing their jobs for taking off two days in a short time period. (*See* Filing No. 24–1 at 15.) As seen in the examples and expert testimony addressed below, this is yet another factor that makes the new ultrasound law burdensome for low-income women.

Child Care Expenses. PPINK's policy prohibits children from being present during an ultrasound, which means the new ultrasound law prevents women from bringing their children to the informed-consent appointment when they used to be able to do so. Therefore, women that must travel long distances to their informed-consent appointments must now bear the additional expense of child care for an additional day. It is also not uncommon for women to delay scheduling an appointment because they cannot arrange childcare, which they now must do on two occasions rather than one. (*See* Filing No. 24–1 at 15.)

The State points out that PPINK's policy regarding children's presence during an ultrasound is its choice. The State presents the declaration of Dr. Christina Fuchs who testifies that such a policy is not required and that she frequently performs ultrasounds with children in the room simply by appropriately covering the mother with a sheet. (Filing No.

35–1 at 6.) PPINK disagrees; it notes that it is a Planned Parenthood policy to not allow children at the ultrasound appointment because there is "a pretty serious risk of distraction." (Filing No. 35–5 at 26.)

The State is again asking PPINK to change its pre-existing policy that is in place because PPINK believes that children are distracting to both the doctor and the patient during an important ultrasound procedure; indeed, it is this very procedure that the State contends will lead women to reflect and change their minds about having an abortion. Yet, the State suggests PPINK should change a policy that facilitates a woman's ability to focus on the procedure to lessen the burden created by the new ultrasound law. This is perplexing given that the State's asserted goal is to promote fetal life by encouraging women to reflect on the ultrasound image. But in any event, as discussed above regarding PPINK's ultrasound policy, burdens are not evaluated by hypothesizing all of the ways in which abortion providers could change their pre-existing policies to mitigate the burdens imposed by a new abortion regulation. Thus the State's suggestion that PPINK simply change its current policy does not undermine PPINK's evidence that childcare concerns present a burden for women, especially low-income women, who now have to travel long distances to their informed-consent appointments.

Keeping Abortions Confidential from Abusive Partners. Some women who seek abortions from PPINK are in abusive relationships and fear for their safety if their partner were to discover that they were pregnant or that they wanted an abortion. (*See* Filing

No. 24–1 at 17–18.) PPINK is aware that some of its patients face this problem, and one national study showed that 13.8% of women who had an abortion had been in an abusive relationship within a year before the abortion. (Filing No. 24–1 at 17–18.) For women in such relationships, it can be very difficult to arrange another lengthy day of travel and have it remain confidential. (*See* Filing No. 24–1 at 17–18.) This, like the employment and childcare difficulties discussed above, is yet another burden caused by the ultrasound law.

ii. Delays in Abortion Services

Decrease in Health Center Availability. All informed-consent appointments are now scheduled at six PPINK health centers rather than seventeen. To accommodate the demand on these centers, PPINK often double-books appointments. This, of course, causes women to wait much longer for their appointments when both women scheduled for an appointment show up, which exacerbates the problems caused by lengthy travel time—lost wages, childcare expenses, and confidentiality concerns. Moreover, there is no guarantee that women can be scheduled for an informed-consent appointment at the PPINK health center nearest them, so the travel distances may be even farther for some women. (*See* Filing No. 24–1 at 9–10.) PPINK is currently asking staff to stay as late as necessary to complete all of the appointments, which is an unsustainable solution for the organization. (Filing No. 24–1 at 11.) Because abortion services are only a small percentage of the health services provided by PPINK, at some point in the near

future it will have to revert to its "normal"—that is, pre-July 1, 2016—allocation of resources, which will cause further delays in women being able to schedule their ultrasound appointments and therefore their abortion appointments. (Filing No. 24–1 at 12.)

As to concerns regarding the availability of the nearest health center, the State points out that PPINK's President and CEO, Ms. Cockrum, admitted during her deposition that she is uncertain how many women are unable to travel to the health center closest to them, and her statement that some women are unable to do so is "anecdotal." (Filing No. 35–5 at 31.) But even discounting this aspect of the availability of the nearest health center, the fact that the health centers have to double-book appointments—which can cause patients to wait for their appointment for a significant time—exacerbates the problems discussed above associated with significant travel in that it makes an already lengthy trip potentially much longer.

Delays Prevent Women from Obtaining an Abortion within the Limited Timeframe. The latest date a woman can obtain a surgical abortion at a PPINK health center is thirteen weeks and six days after her most recent menstrual period. In the 2016 fiscal year, 22.2% of women who had an abortion at a PPINK health center were between eleven weeks and thirteen weeks, six days pregnant, which is to say at most three weeks from the deadline. When medication abortions are excluded from these statistics, the percentage of surgical abortions occurring in the three weeks before the deadline increases to 34.3%. (Filing

No. 24–1 at 7–8.) This is caused by a variety of factors, including a lack of recognition of pregnancy for several weeks and low-income women's difficulty amassing the funds and making the necessary logistical arrangements to have an abortion. (*See* Filing No. 24–1 at 7–8.)

Prior to the new ultrasound law, PPINK could usually accommodate a woman who sought an abortion close to the deadline by scheduling her for an informed-consent appointment at her local PPINK health center and then, the next day, an abortion. Due to the fact that many women now have to make two separate, lengthy trips to obtain an abortion and the delays caused by overburdened health centers, this is no longer possible, and some of these women will no longer be able to obtain an abortion within the required timeframe. (*See* Filing No. 24–1 at 12.)

This is especially true given that physicians are only available at the four health centers offering abortion services at limited times: Indianapolis (3 days/week); Bloomington (1 day/week); Merrillville (1.5 days/week); and Lafayette (1 day/week). (Filing No. 24–1 at 6.) With such limited availability, it is evident that even short delays scheduling the informed-consent appointment could significantly delay the abortion appointment such that women will be unable to obtain an abortion within the thirteen week, six day timeframe.

iii. Expert Testimony

PPINK's expert in gender studies, poverty, and low-wage labor markets, Dr. Jane Collins, provides extensive evidence regarding how the increased expenses imposed by the new ultrasound law, for myriad reasons, burden low-income women in Indiana who seek an abortion. She concludes that the new ultrasound law will cause some low-income women to "delay their abortions as they attempt to come up with the necessary money and make the logistical arrangements," and this will ultimately cause some of those women to be unable "to obtain an abortion at all." (Filing No. 24–2 at 3.) Her conclusion is based on an analysis of low-income families' budgets and the additional costs associated with the new ultrasound law for women who live a significant distance from one of the six PPINK health centers where the informed-consent appointments must now occur. (*See* Filing No. 24–2 at 5–19.) Specifically, Dr. Collins discusses the additional costs of transportation, lost wages due to missed work, and child care created by the new ultrasound law, and shows that these additional costs, even though they would be insignificant to some, can dramatically impact low-income women's ability to obtain an abortion. (*See* Filing No. 24–2 at 9–19.)

For example, Dr. Collins demonstrates how, for a woman living in Fort Wayne, Indiana seeking an abortion who has children and would lose wages for a day away from work, the additional expense caused by the new ultrasound law would be between $219.00 and $247.00. (Filing No. 24–2 at 18.) While these ad-

ditional costs can be absorbed by a middle-class family, many low-income families have a discretionary monthly budget of approximately $40.00, and additional expenses of over $200.00 represents approximately a quarter of their entire monthly budget for all of life's necessities. (Filing No. 24–2 at 19.)

Notably, these are expenses in addition to the costs of the abortion itself—namely, $410.00 for the abortion and $100.00 for the ultrasound. (Filing No. 24–1 at 8; Filing No. 35–5 at 35.) Dr. Collins explains that, to cover the costs associated with abortions, low-income women often have to go to great lengths. For example, one survey revealed that one-third of women delayed or stopped paying basic bills in order to afford the cost of an abortion. (Filing No. 24–2 at 21.) Other women—50% as reported in one study—have to borrow the money from family and friends. (Filing No. 24–2 at 20.) For women faced with the already high costs of an abortion and a lack of means to afford them, the additional expenses of lengthy travel, lost wages, and child care created by the new ultrasound law create a significant burden.

The State attempts to undermine Dr. Collins's evidence, primarily via reliance on evidence from their expert sociologist Dr. Anne Hendershot. She attests that "Dr. Collins provides no concrete sociological evidence demonstrating that low-income women will be deterred from getting abortions due to the Ultrasound Law." (Filing No. 35–3 at 3.) This is true to the extent that Dr. Collins did not conduct specific sociological studies on how the new ultrasound law has impacted access to abortion in Indiana. Dr. Collins's analysis

instead rests on extrapolations from existing data and reasonable assumptions therefrom. But that does not make Dr. Collins's examples and conclusions unpersuasive. Although she did not conduct a study of low-income women in Indiana who have had an abortion, her thorough analysis of the costs imposed by the new ultrasound law appears well-grounded in the available data regarding the costs of transportation, lost wages, and child care. This is especially true given that the State fails to take issue with any specific portion of Dr. Collins's predicate facts or overall analysis.

The only specific evidence presented by Dr. Hendershot that is in any way contrary to Dr. Collins's analysis and conclusion is Dr. Hendershot's statement that "[i]t is clear that the difficulties low-income women may face in accessing abortion services have not deterred women who are intent on terminating their pregnancies." (Filing No. 35–3 at 3.) She bases this conclusion on studies from 2014 that show "as incidence of abortion has declined throughout the United States, the number of low-income women obtaining abortions continues to climb—demonstrating that low-income women are not deterred from accessing these services." (Filing No. 35–3 at 3.)

While increased numbers of low-income women throughout the United States may be having abortions, this fact does not speak to the narrow question before the Court, which is whether the new ultrasound law unduly burdens the right to an abortion for low-income women in Indiana who live a significant distance from one of the six relevant health centers.

In other words, one cannot extrapolate from an increase in the number of low-income women obtaining abortions nationally that the specific Indiana women at issue here are not unduly burden by the new ultrasound law. Thus Dr. Hendershot's conclusion based solely on national statistics and not targeted to the group of Indiana women burdened by the new ultrasound law fails to undermine Dr. Collins's evidence.

To summarize, Dr. Collins's analysis demonstrates how burdens that may seem less significant to wealthier women can pose significant hurdles for low-income women who seek abortions. Based on her analysis, especially given its congruence with the other evidence regarding burdens discussed herein, the Court finds credible and persuasive her ultimate conclusion that "as a result of the [new ultrasound law], a significant number of poor and low-income women [in Indiana] will no longer be able to obtain the abortions they seek or will be delayed in doing so." (Filing No. 24–2 at 23.)

iv. Specific Examples

During the one-month period from the time that the new ultrasound law went into effect, July 1, 2016 and on August 1, 2016, PPINK became aware of at least from six women who could not obtain an abortion due to the new ultrasound law. (*See* Filing No. 24–1 at 16–17.) PPINK subsequently provided evidence of three more women who could not obtain an abortion due to the ultrasound law. (*See* Filing No. 38–1 at 2.) These nine women serve as concrete examples of how the burdens discussed above can prevent

certain low-income women from obtaining an abortion:

- The nearest PPINK health center to a woman seeking an abortion was over an hour away, and due to the fact that she has two young children and difficulty with transportation, she was unable to schedule the two lengthy trips during the thirteen week, six day timeframe in which an abortion is available.

- A woman from the Fort Wayne area did not schedule an abortion because of the two lengthy trips necessary. She was eleven weeks, four days pregnant when she contacted PPINK, but could not miss work twice within the short timeframe remaining.

- A woman who previously had an abortion at PPINK called to schedule another, but ultimately said she could not schedule one after she was informed she would have to make two trips to the PPINK health center in Bloomington, Indiana.

- A woman living in a shelter with two young children decided not to schedule an abortion appointment because of the transportation and childcare difficulties two appointments would cause.

- A woman who recently started a new job after a year of unemployment stated that she could not drive the three-hour roundtrip to a

PPINK health center on two separate occasions due to the combination of work, childcare, and transportation expenses, in addition to her concerns regarding the confidentiality of the abortion.

- A woman who did not learn she was pregnant for ten weeks faced a long delay before she could have her informed-consent appointment that required travel to a PPINK health center, and by the time of her appointment she was one day beyond the deadline for an abortion.

- A woman from Fort Wayne who had a previous abortion at PPINK called to schedule another, but once she was informed that she would have to make two lengthy trips to a PPINK health center, she said she could not afford to do so and did not schedule an abortion.

- A woman living an hour north of Fort Wayne who has special needs children declined to schedule an abortion after learning that she would have to make two lengthy trips for each appointment, as she could not afford to be away from her children for that long on two occasions.

- A woman from Fort Wayne who was approaching the deadline to have an abortion declined to schedule an appointment due to the required travel and risk of missing the deadline

> by the time she could schedule both appointments.

(Filing No. 24–1 at 16–17; Filing No. 38–1 at 1–2).

The State assails this evidence on two bases, neither of which are persuasive. First, the State argues that these examples are unreliable because they were passed on by the women to a PPINK staff member and then to the declarant, and neither the declarant nor anyone else at PPINK took any steps to verify the accuracy of the women's reports. (*See* Filing No. 35–5 at 31–33.) While the former concern is true, this evidence remains sufficiently reliable for assessing the propriety of a preliminary injunction. The Seventh Circuit has made clear "that a district court may grant a preliminary injunction based on less formal procedures and on less extensive evidence than a trial on the merits," *Dexia Credit Local v. Rogan*, 602 F.3d 879, 885 (7th Cir. 2010), including by considering hearsay evidence, *see S.E.C. v. Cherif*, 933 F.2d 403, 412 n.8 (7th Cir. 1991).

In terms of reliability generally, including the lack of verification of the women's reports, there is no reason to think that the women have a motivation to be dishonest with PPINK employees. After all, the women were contacting PPINK because they *wanted an abortion*, and they changed their minds only after realizing what that would take. Moreover, the examples represent a plausible, if not likely, consequence of the new ultrasound law, which requires certain women in Indiana make an additional lengthy trip in

order to obtain an abortion. The reliability of these examples is therefore increased by the fact that they fall squarely within the foreseeable consequences for low-income women who now have to take on additional time and expense to obtain an abortion.

It is also worth noting that the State asks the Court to discount this evidence because it does not come directly from the impacted women nor has it been otherwise verified, when, as discussed further below, the State's only evidence that the law furthers its interest in promoting fetal life is from a woman whose testimony was admitted into evidence through the declaration of her physician. If for the purposes of this preliminary injunction the Court failed to consider any evidence not directly from its source, the State would be left without any evidence directly supporting its position.

Second, the State points out that it is unclear whether any of the women obtained an abortion from a different provider. (Filing No. 35–5 at 33.) But the only non-PPINK abortion providers in Indiana are located in Indianapolis. It makes little sense to think that women who contacted PPINK to schedule an abortion but ultimately could not obtain one because of the difficulties caused by an additional lengthy trip to a PPINK health center could any more easily make an additional trip to a different abortion provider in Indianapolis, where PPINK also provides abortion services. And to the extent these women could have obtained an abortion in another state, the availability of abortions across state lines cannot justify otherwise unduly burdensome abortion laws. *See Schimel,* 806

F.3d at 918–19 (rejecting the State's position that women prevented from obtaining an abortion in Wisconsin could travel to Chicago to obtain one).

In the end, the specific examples of women who have been unable to obtain an abortion are certainly reliable enough for consideration when assessing the propriety of a preliminary injunction in this case, and they constitute additional significant evidence that the new ultrasound law creates barriers for low-income women seeking an abortion in Indiana.

b. Benefits

The Court turns next to the evidence that the new ultrasound law furthers the interests asserted by the State. According to the State, the "main purpose" of the new ultrasound law "is to give women seeking an abortion the opportunity to view an image of her baby before making her decision, with hope that she will reflect on that image (and other information provided) and decide against abortion." (Filing No. 35 at 16.) This is undoubtedly a legitimate interest for the State to pursue. *See Casey*, 505 U.S. at 870 ("[T]he State has a legitimate interest in promoting the life or potential life of the unborn."); *id.* at 886 ("[A] State is permitted to enact persuasive measures which favor childbirth over abortion, even if those measures do not further a health interest."). The State also asserts an alternative justification—namely, that the law promotes "maternal psychological health." (Filing No. 35 at 27–28.) This is also a legitimate state interest. *See Schimel*, 806 F.3d at 910.

Although these are legitimate interests, nearly all of the State's evidence addresses the wrong question and, as such, fails to demonstrate that the new ultrasound law furthers its asserted interests. The relevant question is whether the ultrasound law provides the asserted benefits *as compared to the prior law*. *See Whole Woman's Health*, 136 S.Ct. at 2311 ("We have found nothing in Texas' record evidence that shows that, *compared to the prior law*, ... the new law advanced Texas' legitimate interest in protecting women's health."); *id.* at 2314 ("The record contains nothing to suggest that [the challenged law] *would be more effective than pre-existing Texas law*...") (emphasis added); *id.* at 2315 (concluding that the district court's findings were "well supported" that the new regulations did not advance women's health any more than the previous regulations). Therefore, the specific question here is not whether viewing the ultrasound promotes fetal life or improves women's mental health outcomes; even before the new ultrasound law was passed, women were required to have the opportunity to view the ultrasound prior to an abortion, and thus any such benefits from viewing the ultrasound were already present. Instead, the question is whether requiring women to have an ultrasound *at least eighteen hours prior to an abortion* increases any such benefits. Most of the State's evidence does not address this question. Nevertheless, the Court will address the evidence presented in support of each of the two interests in turn.

i. Promoting Fetal Life

Viewing the Ultrasound. The State contends that viewing the ultrasound image is more likely to discourage a woman from having an abortion than the representations of fetuses that are included in the materials provided at the informed-consent appointment. Dr. Christina Francis, an a physician with an OB/GYN practice, attests that in her practice she has advised women considering abortion, and "[s]ome of these patients ... [have] told [her] that viewing an ultrasound image of their baby caused them to decide not to obtain an abortion. They have told [her] that seeing the live, moving images of their babies, with arms and legs and a heartbeat, helped them bond with the child and view it as more than just a clump of cells." (Filing No. 35–1 at 4–5.)

The evidence from Dr. Francis that viewing the ultrasound image was relevant to some of her patients' decision as to whether to have an abortion certainly constitutes evidence that viewing the ultrasound may impact some women's decisions regarding whether they should have an abortion. However, PPINK rightly points out that even if viewing the ultrasound has any effect on a woman's decision to have an abortion, the degree to which it does so is questionable given that the law permits each woman to choose whether or not they will view the ultrasound, and most women choose not to. In fiscal year 2016, only 25% of women who had an abortion at a PPINK health center viewed the ultrasound. (Filing No. 24–1 at 6.) It is difficult to conclude then that the new ultrasound law promotes fetal life in any significant

way when three-fourths of women in Indiana do not even view the ultrasound image.

But there is a more fundamental issue with this evidence. As noted above, even if there is evidence that viewing the ultrasound convinces some women not to have an abortion, this is not evidence of the critical question, which is whether viewing the ultrasound *eighteen hours before the abortion* increases its impact. Evidence that some women's decisions as to whether to have an abortion are impacted by viewing the ultrasound is not evidence that doing so at least eighteen hours before the abortion, rather than on the day of the abortion, has any additional persuasive impact.

Statistical Evidence Regarding Voluntary Viewing of an Ultrasound. The State also relies on statistical evidence to support its position that women who view the ultrasound are less likely to have an abortion. Specifically, the State points to a 2014 study that examined the impact that voluntarily viewing an ultrasound image had on women's decisions whether to have an abortion. (*See* Filing No. 35 at 25.) The study reviewed more than 15,000 women who had sought abortion services from a Planned Parenthood health center in Los Angeles, California and had the option of viewing their ultrasound. The State notes that the study concluded that "voluntary viewing [of an ultrasound] was associated with some women's decision to continue the pregnancy." (Filing No. 35 at 25 (quoting Mary Gutter, et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81, 85 (2014))).

PPINK's response to this study is three-fold and worthy of detailed examination, as this study ultimately reveals how meager the evidence is regarding any connection between voluntary viewing of an ultrasound and the decision to have an abortion, let alone evidence that any such connection is enhanced if the ultrasound if viewed eighteen hours prior to an abortion.

First, the study's specific conclusion is far from compelling support for the position that viewing the ultrasound impacts women's decisions whether to have an abortion; it concluded that "the effect [of viewing the ultrasound] was very small—and should be considered with caution—and limited to the 7% of patients with medium or low decision certainty." *Id.* Of the 15,000 pregnant women considered by the study, 98.8% of pregnancies ended in abortion; 99.0% ended in abortion when the woman did not view the ultrasound; and 98.4% ended in abortion when the woman viewed the ultrasound. *Id.* at 83. For women with "high decision certainty," which was the vast majority of women, viewing the ultrasound had no effect. *Id.* at 84. For women with medium or low decision certainty (7.4%), the effect was "very small." *Id.* at 85. Thus, even for the minority of women who view the ultrasound—at PPINK facilities in Indiana it is approximately 25%—the overwhelming majority of them have a high decision certainty and thus there is no impact for them at all. (*See* Filing No. 24–1 at 7 (noting that in the experience of PPINK's staff, "women have made a firm and well-thought out decision to have an abortion before they arrive for their appointment," and "virtually all women who [go] to

[PPINK] for abortion services and receive an ultrasound do get an abortion and that this figure is not influenced or altered by whether or not the woman views the ultrasound or listens to the fetal heart tone")). For the substantial minority of women who have medium or low decision certainty—only 7.4% in the 2014 study—and choose to view the ultrasound, the effect is "very small." This all amounts to a "very small" impact on a small percentage of abortion patients.

Second, the study notes that the gestational age of the fetus is a more important factor in predicting whether a woman will decide to go through with an abortion. Specifically, it concludes "women's comfort terminating their pregnancies decreases as gestation advances." *Id.* at 86. This, says the study, shows that "it is the information the ultrasound sound scan renders—ie, gestational dating—rather than the image that influences women's decision-making." *Id.* In Indiana, although the ultrasound confirms gestational age, Indiana law requires women to be provided the "probable gestational age" of the fetus during the informed-consent appointment, regardless of whether they choose to view the ultrasound. Ind. Code § 16–34–2–1.1(a)(1)(F). This evidence, in conjunction with Indiana law, undermines the premise of the State's goal—to "give women seeking an abortion the opportunity to view an image of her baby before making her decision, with hope that she will reflect on that image ... and decide against abortion," (Filing No. 35 at 16)—which is predicated on *the ultrasound image* impacting women's decisions. Simply put, if it is the gestational age rather than the ultrasound image creating

a small impact on women's decisions, and women in Indiana are given that information whether or not they view the ultrasound, the State's desired persuasive impact is occurring irrespective of the ultrasound, and thus the ultrasound itself has no additional effect.

Third and most critically, the State's reliance on this study suffers from the same deficiency as its evidence presented by Dr. Francis. Even accepting that there is evidence that viewing the ultrasound has a small impact on a woman's decision whether to have an abortion, any such evidence is entirely irrelevant to the legal question before the Court. Again, the Court must assess whether viewing the ultrasound at least eighteen hours before the abortion has a greater impact on a woman's decision than viewing it the day of the abortion. PPINK is correct that "[t]his study sheds absolutely no light on that question." (Filing No. 38 at 17.)

Accordingly, like Dr. Francis's attestation that some of her patients have been impacted by viewing the ultrasound image, the statistical evidence fails to in any way support the State's position that the new ultrasound law advances its goal in promoting fetal life.

Informed–Consent Waiting Periods. The State introduces evidence that informed-consent waiting periods are commonly used to give patients time to consider important medical decisions. Specifically, Dr. Francis attests that informed-consent waiting periods "give patients time to reflect on the information they

have received, weigh the possible risks and benefits of the procedure, discuss the procedure with loved ones, and ask questions of the doctor." (Filing No. 35–1 at 2–3.) She states that, for life-altering procedures, she provides informed-consent information one to four weeks prior to the procedure. (*See* Filing No. 35–1 at 3.) Dr. Francis does not, however, appear to provide abortion services and thus does not attest to an informed-consent practice for abortion services.

PPINK argues that abortions are different than many other procedures where lengthy informed-consent periods are utilized because, unlike in those contexts where the doctor discusses with the patient a previously undiagnosed medical condition, a woman at a PPINK informed-consent appointment "already knows her diagnosis (that she is pregnant), knows her options (continue the pregnancy or have an abortion), and has received a great deal of information about abortion, including the risks and benefits." (Filing No. 38 at 16.) Moreover, PPINK disputes Dr. Francis's testimony by pointing to Dr. Stutsman's statement that he does a range of "office procedures," such as colposcopies and LEEP procedures, on the same day as he provides the informed-consent information. (Filing No. 35–4 at 6.)

It is undoubtedly correct that informed-consent waiting periods generally provide patients time to consider information they have received. *See Casey*, 505 U.S. at 885 ("[T]he idea that important decisions will be more informed and deliberate if they follow some period of reflection does not [seem] unreasona-

ble."). The State presents this general evidence regarding informed-consent waiting periods ostensibly in an attempt to characterize the new ultrasound law—and the shifting of the ultrasound requirement from the day of an abortion to the informed-consent appointment—as fitting neatly into a method of promoting fetal life by providing time for deliberation. But the general notion that informed-consent waiting periods provide time for deliberation does not address the narrower question of whether the timing of the ultrasound increases its impact on a woman's decision whether or not to have an abortion.

The evidence that informed-consent periods give patients time to reflect on their decisions only furthers the State's position if there is specific evidence that *additional time to reflect on the ultrasound image*—assuming women choose to view it, which only 25% do—decreases the likelihood that women will go through with an abortion. As discussed herein, there is little to no concrete evidence that this is true. Undoubtedly the ultrasound image is a piece of information on which women could use the eighteen-hour period to reflect. But the evidence, including the study regarding voluntary ultrasound viewing discussed above, reveals that viewing the ultrasound likely has little to no impact. It is simply not a reasonable assumption, given the absence of specific evidence on the question, that further time to deliberate on an image that has nearly no impact at the time, would create a meaningfully stronger impact after eighteen hours. Indeed, in the absence of evidence one way or another, it is just as reasonable to assume that the

impact of viewing the ultrasound image dissipates, rather than increases, over time.

Specific Example. Dr. Francis testified regarding one of her patients who may have been impacted by the new ultrasound law had it been in effect at the time. She provided similar testimony to the Indiana legislature regarding this woman before it passed the new ultrasound law. Specifically, Dr. Francis testified that the woman had an abortion but:

> regretted doing so and feels that an ultrasound waiting period would have given her more time to consider her decision and change her mind.... [On the day of her abortion,] [s]he chose not to view the ultrasound image because she felt that if she saw an image of her baby it would cause her to change her mind. She told [Dr. Francis] that she did not want to be persuaded not to abort because she was already at the clinic, had paid for the abortion, and felt pressured by those circumstances to go through with it. [She] told [Dr. Francis] that had she undergone the ultrasound the day before the abortion, she likely would have viewed the image and she does not think she would have come back the next day to proceed with the medication abortion.

(Filing No. 35–1 at 5.)

PPINK responds that this evidence is the State's "only" evidence addressing the relevant question and

argues that it is "speculation on top of speculation." (Filing No. 38 at 18.) Specifically, PPINK argues that:

> not even from the perspective of hindsight can the woman say that receiving the ultrasound earlier would have definitely led to her deciding to view the ultrasound, let alone determining not to proceed with the abortion ('she likely would have viewed the image,' 'she does not think she would have come back the next day').

(Filing No. 38 at 18).

The evidence from Dr. Francis undoubtedly constitutes at least some evidence that certain women may change their minds about having an abortion if the ultrasound occurs prior to the day of the abortion. PPINK is correct, however, that this evidence is exceedingly speculative. While acknowledging that in hindsight the woman thinks her decision-making process regarding her abortion may have been altered had the ultrasound occurred the day before the abortion, her own statements concerning what she may have done in hindsight contain multiple layers of speculation. She can only say that she "likely" would have viewed the ultrasound image if it was offered a day earlier and, had she, she "likely" would not have returned for the abortion the next day. This is far from compelling evidence that the new ultrasound law would have the impact desired by the State, and as such, it must be given diminished weight in the balancing process.

Pressure at Appointments. The State posits that the new ultrasound law will remove the pressure some women face on the day of the abortion to go through with the procedure, which is caused by the fact that they are already at the clinic and have paid for their abortion. The only specific evidence of this is the example already discussed above of a woman who felt such pressure and the State's reference to PPINK's "apparent lack of refund policy." (Filing No. 35 at 26.)

Although PPINK's President testified that she was uncertain whether PPINK has a refund policy, PPINK's Director of Abortion Services, Ms. Beeley, attests that PPINK has a refund policy: any woman who opts not to have an abortion following the ultrasound would be refunded all funds, not including the fee paid for the ultrasound. (Filing No. 38–1 at 3.) The evidence is clear that—whether the ultrasound is performed the day before the abortion or the day of—the $100.00 ultrasound fee will not be reimbursed, and thus the financial pressure to go through with the abortion will be present. Either way, the woman can receive a full refund of the $410.00 abortion fees after the ultrasound but before the abortion. Therefore, the new ultrasound law does not relieve any pressure caused by financial concerns.

ii. Promoting Women's Mental Health

The State's alternative justification for the new ultrasound law is that "viewing the [ultrasound] image has important psychological benefits" for the woman.

(Filing No. 35 at 27.) The State presents little evidence to support this justification, and it indeed notes that its "main" justification is promoting fetal life.

The State's psychiatry expert, Dr. Aaron Kheriaty, states in his declaration that "[m]any abortion patients are morally and emotionally conflicted about the abortion decision, and those who choose to go through with the procedure often report conflicted feelings of ambivalence, regret, or distress afterwards." (Filing No. 35–2 at 2.) Both Dr. Kheriaty and the State's sociologist, Dr. Hendershot, point to studies done by Dr. Priscilla Coleman, one of which showed that the rate of "mental health claims of low-income California women ... was 17 percent higher for the women who aborted than for those who gave birth." (Filing No. 35–3 at 4.)

PPINK's response to this evidence is two-fold. First, it presents a declaration from Dr. Stutsman who points to two literature reviews that criticize Dr. Coleman's studies as outliers that have been almost uniformly rejected by other experts in the field. (*See* Filing No. 38–3 at 2–5.) For example, two mental health organizations did a comprehensive review of studies on mental health and abortion, one of which concluded that the rates of mental health issues were the same for women who had an abortion and those who gave birth, and the other found that women who "have a single, legal, first-trimester abortion of an unplanned pregnancy for non-therapeutic reasons" had the same risk of mental health problems as women who give birth. (Filing No. 83–3 at 2–3 (citing Filing No. 83–4, 83–5).) Moreover, both of these mental

health organizations specifically criticized Dr. Coleman's studies as lacking: one study cited by the State was described as having "a number of methodological limitations making it difficult to interpret the results" and simply "poor," while another study cited by the State was described as similarly having methodological problems that bring "into question both the results and conclusions." (Filing No. 35–3 at 4–5 (citing Filing No. 83–4, 83–5).) In short, PPINK's evidence is significantly more persuasive on this issue, especially given that Dr. Coleman's studies are the subject of significant criticism.

Second, and more importantly, PPINK is again correct that the State's evidence fails to address the relevant question. Even if the results of Dr. Coleman's studies are accepted, this is not evidence that women having an ultrasound eighteen hours prior to the abortion as opposed to the day of the abortion have more favorable psychological outcomes.

In sum, while many abortion patients are undoubtedly morally and emotionally conflicted about their decision, there is no evidence that the new ultrasound law promotes women's psychological health. The State admitted that it had no "direct evidence" that it did. Like much of the State's evidence discussed above, Dr. Coleman's studies do not address the relevant question of whether having an ultrasound at least eighteen hours before an abortion mitigates any of the consequences that purportedly exist. Accordingly, there is no evidence that the new ultrasound law furthers the State's interest in safeguarding women's psychological health.

c. Weighing the Burdens and Benefits

Having reviewed the parties' evidence, the Court must resolve the ultimate question of whether the new ultrasound law creates an undue burden. "To determine whether the burden imposed by the statute is undue (excessive), the court must weigh the burdens against the state's justification, asking whether and to what extent the challenged regulation actually advances the state's interests. If a burden significantly exceeds what is necessary to advance the state's interests, it is undue, which is to say unconstitutional." *Schimel*, 806 F.3d at 919 (citation and quotation marks omitted); *see Whole Woman's Health*, 136 S.Ct. at 2309.

The Court must assess the burdens for those whom the burdens are an "actual rather than an irrelevant restriction," *Whole Woman's Health*, 136 S.Ct. at 2320, which is low-income women who live a substantial distance from one of the six PPINK health centers offering informed-consent appointments. The evidence reveals that these women face various and substantial burdens due to a significantly increased travel distance to the informed-consent appointments. Not only do these women have to pay for the additional travel expenses, but many have difficulty obtaining or paying for childcare, will lose up to an entire day's wages, and risk losing their employment altogether. They also have greater difficulty keeping their abortion confidential from abusive partners. Both the Supreme Court and the Seventh Circuit

have recognized that burdens associated with an increase in required travel are significant, especially for low-income women.

As noted by the Seventh Circuit,

> [it is true that] a 90—mile trip is no big deal for persons who own a car or can afford an Amtrak or Greyhound ticket. But more than 50 percent of Wisconsin women seeking abortions have incomes below the federal poverty line and many of them live in Milwaukee (and some north or west of that city and so even farther away from Chicago). For them a round trip to Chicago, and finding a place to stay overnight in Chicago should they not feel up to an immediate return to Wisconsin after the abortion, may be prohibitively expensive. The State of Wisconsin is not offering to pick up the tab, or any part of it. These women may also be unable to take the time required for the round trip away from their work or the care of their children.

Schimel, 806 F.3d at 919; *see Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013) (noting that requiring women to travel "400 miles" for their two required appointments is a "nontrivial burden on the financially strapped and others who have difficulty traveling long distances to obtain an abortion, such as those who already have children"). The Supreme Court addressed burdens associated with lengthy travel caused by an abortion regulation in *Whole Woman's Health*, and although it

noted that they "do not always constitute an 'undue burden,' " they are a legitimate burden that, depending on the other particulars of the case, can ultimately contribute to the burdens being undue. 136 S.Ct. at 2313.

The new ultrasound law has not only made it more difficult for women to make the necessary arrangements to travel to the informed-consent appointment, but it has also funneled all of the informed-consent appointments into six instead of seventeen PPINK health centers. This has required PPINK to double-book appointments, which has increased the wait times for women at the health centers. *Cf. Whole Woman's Health*, 136 S.Ct. at 2313 (noting, while assessing the burdens caused by the closure of abortion clinics, that "[t]hose closures meant fewer doctors, longer waiting times, and increased crowding").

Dr. Collins's testimony and the specific examples of nine Indiana women reveal how the foregoing burdens combine in a variety of ways to ultimately prevent some women from obtaining an abortion that they otherwise would. Given that (1) over a third of surgical abortions at PPINK occur within three weeks of the thirteen week, six day deadline, (2) making two lengthy trips for low-income women in quick succession is often difficult, (3) the PPINK health centers offering informed-consent appointments are now overburdened, and (4) abortion appointments are only available as little as once a week and at most three times a week at PPINK's health centers, it would be surprising if the new ultrasound law did *not* prevent a significant number of the low-income women from

obtaining an abortion. And, indeed, PPINK's evidence reveals that it already has for several women. *See Schimel*, 806 F.3d at 908 (weighing as a burden the fact that "[w]omen seeking lawful abortions ... late in their pregnancy, either because of the waiting list or because they hadn't realized their need for an abortion sooner, would be unable to obtain abortions in Wisconsin").

In sum, PPINK's evidence credibly reveals—at least at this early stage in the litigation—that the new ultrasound law significantly burdens the category of women for whom the law is "actual rather than an irrelevant restriction." *Whole Woman's Health*, 136 S.Ct. at 2320. The combination of burdens discussed above places a substantial obstacle in the path of these women seeking an abortion.

Against these burdens, the Court must weigh the evidence that the new ultrasound law furthers the State's asserted interests in promoting fetal life and women's mental health. The State has almost no evidence that the new ultrasound law promotes fetal life—except for one relatively speculative example—or women's mental health.

As to promoting fetal life, the State's statistical evidence shows that viewing the ultrasound impacts some women's decisions regarding abortion. But, as explained in detail above, the study on which the State relies describes the impact as a "very small" impact only on the 7% of women who had a low or medium decision certainty and no impact on the other women who have a high decision certainty. Moreover,

for *any* impact to occur, the women who have low or medium decision certainty must actually view the ultrasound. Indiana law does not require them to do so, and only 25% of PPINK's patients do. In total, this means that the impact of viewing the ultrasound on women's decisions about their abortion amount to a "very small" impact on only the women who both have a low or medium decision certainty (7%) and who also view the ultrasound (25%). As a statistical matter, this impact is at best marginal. Moreover, the impact may be caused by women learning the gestational age of the fetus, which Indiana law requires women to learn independently of the ultrasound viewing. And most importantly, even this paltry evidence says nothing about the impact of viewing the ultrasound *at least eighteen hours prior to the abortion* rather than the day of the abortion, which is the critical question.

The State's best evidence is the example from Dr. Francis regarding one of her patients who had an abortion and says that her decision-making process would have been different had the ultrasound occurred at the informed-consent appointment. While this is at least some evidence that a woman might change her mind about having an abortion if the ultrasound occurs prior to the day of the abortion, the evidence is speculative and thus entitled to little weight, especially because it is not corroborated by any other evidence. Therefore the State's evidence that the new ultrasound law increases the likelihood that women will choose not to have an abortion by requiring the ultrasound to occur at least eighteen hours prior borders on nonexistent, save one speculative example suggesting that it might have an impact.

As to the State's asserted interest in promoting women's mental health, the State's evidence that abortions cause negative mental health outcomes is suspect at best, and PPINK's evidence that there is no such correlation is convincing. But, again, even if there were such evidence, the State has no evidence regarding whether *the timing* of the ultrasound impacts a woman's mental health outcomes.

Given the foregoing evidence, the Court is left to weigh concrete and compelling evidence that the new ultrasound law imposes significant burdens against a near absence of evidence that the law promotes either of the benefits asserted by the State. This is similar to the balancing in *Schimel* and *Whole Woman's Health*, where the Seventh Circuit and Supreme Court, respectively, found that an undue burden existed because the challenged laws burdened the right to an abortion and there was little to no evidence that the laws actually furthered the State's justification. The Seventh Circuit explained:

> [A] statute that curtails the constitutional right to an abortion ... cannot survive challenge without evidence that the curtailment is justifiable by reference to the benefits conferred by the statute. The statute may not be irrational, yet may still impose an undue burden—a burden excessive in relation to the aims of the statute and the benefits likely to be conferred by it—and if so it is unconstitutional.

806 F.3d at 921; *see id*. at 919 ("The feebler the medical grounds (in this case, they are nonexistent), the likelier is the burden on the right to abortion to be disproportionate to the benefits and therefore excessive."); *Whole Woman's Health*, 136 S.Ct. at 2318 (striking down the challenged abortion restrictions because the law "provides few, if any, health benefits for women" and "poses a substantial obstacle to women seeking abortions"); *see also Van Hollen*, 738 F.3d at 798 ("The feebler the medical grounds, the likelier the burden, *even if slight*, to be 'undue' in the sense of disproportionate or gratuitous.") (emphasis added).

It is not irrational for the State to posit that viewing the ultrasound image a day before the abortion might impact some women's choices regarding whether to go through with an abortion. As noted above when discussing the State's evidence regarding waiting periods generally, waiting periods can of course provide additional time for thoughtful deliberation. *See Casey*, 505 U.S. at 885. But this case is not about waiting periods generally; it is about moving a particular step of the abortion process—the voluntary ultrasound viewing—from the day of the abortion to the informed-consent appointment with the hopes that further deliberation on the ultrasound image will impact women's decision. Yet the evidence presented by the State that this actually accomplishes its goal lacks force. Not only is the impact of viewing the ultrasound slight and may not even be caused by viewing the ultrasound image, but women are not even required to view it at all. And there is no evidence that this slight impact—for the women who choose to view

it—is enhanced if it occurs at least eighteen hours before the abortion rather than the day of the abortion. The Court is therefore left with a statute that undoubtedly "curtails the right to an abortion," but with no evidence "that the curtailment is justifiable by reference to the benefits conferred by the statute." *Schimel*, 806 F.3d at 921. The burdens imposed by the new ultrasound law are thus undue in the sense that they are excessive in relation to the benefits conferred, making the it likely unconstitutional.

The State resists this conclusion on two related bases, neither of which are ultimately persuasive. First, the State points to cases such as *Casey* and *A Woman's Choice–East Side Women's Clinic v. Newman*, 305 F.3d 684 (7th Cir. 2002), where the courts held that twenty-four hour informed-consent waiting periods did not impose an undue burden, even though they required two sometimes lengthy trips in order to obtain an abortion. (See Filing No. 35 at 20–21.) But these cases do not dictate the same result here. Inherent in the undue burden test is that the evidence of burdens and benefits must be examined in the context presented. *See Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 914 (9th Cir. 2014) (noting that the Seventh Circuit in *Van Hollen* recognized that the undue burden test is "context-specific," which is to say that it "requires [courts] to weigh the extent of the burden against the strength of the state's justification in the context of each individual statute or regulation"). Thus, while the State is correct that laws requiring a waiting period and therefore two trips to a health center in order to have an abortion have been

upheld, it does not follow that all such laws, regardless of the specific burdens imposed and benefits conferred, are constitutional.

The Supreme Court's analysis of the twenty-four hour waiting period requirement in *Casey* demonstrates this. In analyzing whether the waiting period imposed an undue burden, it first recognized that the "idea that important decisions will be more informed and deliberate if they follow some period of reflection [is] not ... unreasonable, particularly where the statute directs that important information become part of the background of the decision." 505 U.S. at 885. The Supreme Court reasoned that *"[i]n theory*, at least, the waiting period is a reasonable measure to implement the State's interest in protecting the life of the unborn, a measure that does not amount to an undue burden." *Id.* (emphasis added). But importantly, this was only in theory. The Supreme Court went on to analyze whether the provision was "nonetheless invalid because in practice it is a substantial obstacle to a woman's choice to terminate her pregnancy," which was "closer question." *Id.* Ultimately, it was not an undue burden "on the record" before the Court, noting that the "District Court did not conclude that the waiting period is [a substantial] obstacle even for the women who are most burdened by it." *Id.*

The analysis in *Casey* reveals that the undue burden analysis is case specific and that, in another case with different evidence, the result may be different. Here, PPINK does not challenge waiting periods generally, but challenges the requirement that the volun-

tary ultrasound viewing be a part of the informed-consent appointment. The State has produced nearly no evidence that this change has the benefits it asserts, and PPINK has provided significant evidence that this law is burdensome such that the Court has concluded it poses a substantial obstacle for the group of women at issue.

Second and relatedly, the State argues that the burdens caused by the ultrasound law are relatively light compared to the burdens caused in other cases. (Filing No. 35 at 29.) For example, in *Whole Woman's Health*, the challenged law led to the closure of half of the abortion clinics in Texas. 136 S.Ct. at 2312. While this is undoubtedly true, this argument, like that above, fails to recognize the case-specific nature of the undue burden inquiry. *See Humble*, 753 F.3d at 914. This inquiry requires a comparison not of the burden in this case against burdens deemed undue in other cases, but a weighing of the particular burdens and benefits based on the evidence presented. *See Whole Woman's Health*, 136 S.Ct. at 2309; *Schimel*, 806 F.3d at 919.

Nevertheless, other cases can of course provide guidance. The Court has heavily relied on the guidance provided in *Schimel* and *Whole Woman's Health* to conclude that when, as here, the evidence of benefits is slight, evidence of burdens need not be overwhelming for the burdens to be undue. Moreover, comparing the burdens here to those in *Whole Woman's Health* supports the Court's conclusion. While the new ultrasound law did not lead to the clo-

sure of any abortion clinics in Indiana like the challenged Texas law, it at least had a similar effect as it relates to the mandatory informed-consent appointment. Now, instead of being able to attend one of seventeen PPINK health centers for an informed-consent appointment, women must travel to one of only six PPINK health centers that offer them. The ultrasound law has essentially closed nearly two-thirds of the PPINK health centers available for this necessary appointment. Thus, although the burdens here are not nearly as extensive as in *Whole Woman's Health*, they are similar in kind such that they are significant enough to outweigh the almost complete lack of benefits.

In sum, the State's arguments fail to undermine the above balancing. That balancing reveals that the new ultrasound law creates an undue burden on a woman's right to terminate her pregnancy. PPINK therefore has a strong likelihood of success on the merits of its claim.

B. Irreparable Harm

The parties' assessment of the remaining preliminary injunction factors is succinct, likely because they each acknowledge that the assessment of PPINK's likelihood of success on the merits is essentially determinative. Nevertheless, the Court must address the remaining factors in order to determine whether a preliminary injunction is warranted.

The second preliminary injunction factor requires PPINK to show "that it is likely to suffer irreparable

harm in the absence of preliminary relief." *Grace Schools*, 801 F.3d at 795. To demonstrate irreparable harm, PPINK points to the fact that the new ultrasound law presents substantial obstacles for many of its patients such that some are unable to obtain an abortion altogether. (Filing No. 24 at 30.) The State responds that PPINK can mitigate these harms by expending more financial resources on abortion services, and therefore the harm to it cannot be considered irreparable. (Filing No. 35 at 37–38.)

The evidence shows that the new ultrasound law has and will continue to prevent PPINK from providing abortion services to certain Indiana women, and the Court has determined that this law is likely unconstitutional. For PPINK and its patients who lose the opportunity to exercise their constitutional right to choose to terminate their pregnancy, the irreparable harm is clear. *See Van Hollen, 738 F.3d at 796.*

As to the State's contention that PPINK can simply expend more resources to avoid this harm, the evidence does not reveal this as a viable option for PPINK. It already responded to the new ultrasound law by shifting resources to allow two more health centers to offer ultrasounds and to keep their health centers open longer hours to work through double-booked appointments. (See Filing No. 24–1 at 9–12.) Some of these changes are temporary solutions that PPINK cannot sustain. (Filing No. 24–1 at 12.) Accordingly, the evidence as found by the Court does not support the State's position.

Even if this were not the case, the harm flowing from a violation of a person's substantive due process rights is presumed irreparable. *See Planned Parenthood of Indiana & Kentucky, Inc. v. Commissioner*, 2016 WL 3556914, *12 (explaining how the presumption of irreparable harm applicable to certain constitutional violations apply to substantive due process violations). For both of these reasons, PPINK has made the requisite showing of irreparable harm.

C. Balance of Harms, Public Policy Considerations, and Sliding Scale Analysis

"To obtain a preliminary injunction, the moving party must show that its case has some likelihood of success on the merits and that it has no adequate remedy at law and will suffer irreparable harm if a preliminary injunction is denied." *Stuller, Inc.*, 695 F.3d at 678. For the reasons stated above, PPINK has made these showings. "If the moving party meets these threshold requirements, the district court 'must consider the irreparable harm that the nonmoving party will suffer if preliminary relief is granted, balancing such harm against the irreparable harm the moving party will suffer if relief is denied.'" *Id.* (quoting *Ty, Inc.*, 237 F.3d at 895). "The district court must also consider the public interest in granting or denying an injunction." *Id.*

PPINK argues that its likelihood of success on the merits is strong and thus it need not make a particularly strong showing regarding the balance of harms. It can make this showing easily, in its view, because

the State will not be harmed by maintaining the status quo, nor can the State maintain that being required to comply with the Constitution is harmful. (Filing No. 24 at 31.) The State offers little in response, arguing generally that it faces the harm caused when a democratically enacted law is enjoined and that an injunction would prevent it from furthering its legitimate goal of promoting fetal life. (Filing No. 35 at 38.)

The harms faced by PPINK and its patients are irreparable and substantial. The evidence reveals that the new ultrasound law has already prevented several women from obtaining an abortion, and given the obstacles it creates and the burden these obstacles impose particularly on low-income women in Indiana, it will continue to do so absent a preliminary injunction. Although the State's interest in promoting fetal life is a legitimate one, the State failed to present nearly any evidence that the timing of the ultrasound furthers this interest or its interest in furthering women's mental health. This leaves only the State's generalized harm caused by the delay of the implementation of its democratically enacted law, which is clearly outweighed by the harm to PPINK and its patients. *See Van Hollen*, 738 F.3d at 796 ("[I]t is beyond dispute that the plaintiffs face greater harm irreparable by the entry of a final judgment in their favor than the irreparable harm that the state faces if the implementation of its statute is delayed. For if forced to comply with the statute, only later to be vindicated when a final judgment is entered, the plaintiffs will incur in the interim the disruption of the services that the abortion clinics provide.").

PPINK is also correct that the public interest would be served by enjoining the new ultrasound law, as the vindication of constitutional rights serves the public interest. *See Joelner v. Vill. of Washington Park, Ill.*, 378 F.3d 613, 620 (7th Cir. 2004) ("Surely, upholding constitutional rights serves the public interest.") (citation and quotation marks omitted); *see also Preston v. Thompson*, 589 F.2d 300, 303 n.3 (7th Cir. 1978) ("The existence of a continuing constitutional violation constitutes proof of an irreparable harm, and its remedy certainly would serve the public interest.").

Having examined all of the relevant factors, the Court must "weigh[ ] the balance of potential harms on a 'sliding scale' against the movant's likelihood of success: the more likely he is to win, the less the balance of harms must weigh in his favor; the less likely he is to win, the more it must weigh in his favor." *Turnell*, 796 F.3d at 662. Given the almost complete absence of evidence that the new ultrasound law furthers the State's asserted interests, PPINK has a strong likelihood of success on its challenge to the new ultrasound law. PPINK thus need not make an especially strong showing that the balance of harms weighs in its favor, but it nevertheless has. Accordingly, PPINK is entitled to an injunction prohibiting the enforcement of the new ultrasound law pending the resolution of this litigation.

IV. CONCLUSION

The Court has "weigh[ed] all the factors" and sought "at all times to minimize the costs of being mistaken." *Stuller, Inc.*, 695 F.3d at 678. The Court has done so in light of the Supreme Court's warning that "injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter*, 555 U.S. at 376. Nevertheless, PPINK has demonstrated that it is entitled to the injunction it seeks.

The new ultrasound law creates significant financial and other burdens on PPINK and its patients, particularly on low-income women in Indiana who face lengthy travel to one of PPINK's now only six health centers that can offer an informed-consent appointment. These burdens are clearly undue when weighed against the almost complete lack of evidence that the law furthers the State's asserted justifications of promoting fetal life and women's mental health outcomes. The evidence presented by the State shows that viewing an ultrasound image has only a "very small" impact on an incrementally small number of women. And there is almost no evidence that this impact is increased if the ultrasound is viewed the day before the abortion rather than the day of the abortion. Moreover, the law does not require women to view the ultrasound imagine at all, and seventy-five percent of PPINK's patients choose not to. For these women, the new ultrasound has no impact whatsoever. Given the lack of evidence that the new ultrasound law has the benefits asserted by the State,

the law likely creates an undue burden on women's constitutional rights.

For these reasons, PPINK's Motion for Preliminary Injunction (Filing No. 6) is **GRANTED**. Pursuant to Federal Rule of Civil Procedure 65(d), the Court **ISSUES A PRELIMINARY INJUNCTION** prohibiting the State from enforcing the portion of the new ultrasound law found in Indiana Code § 16–34–2–1.1(a)(5) that requires the mandatory ultrasound to occur at least eighteen hours before an abortion and at the same time the other informed-consent information mandated by law is provided to the patient. Because the State has not disputed PPINK's position that the State will not incur monetary damages from an injunction, PPINK need not post a bond.

SO ORDERED.

Date: 3/31/2017

TANYA WALTON PRATT, JUDGE
United States District Court
Southern District of Indiana

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United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

October 5, 2018
Before

WILLIAM J. BAUER, *Circuit Judge*

MICHAEL S. KANNE, *Circuit Judge*

ILANA DIAMOND ROVNER, *Circuit Judge*

No. 17-1883

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC., *Plaintiff-Appellee*,	Appeal from the United States District Court for the Southern District of Indiana, Indianapolis Division.
v.	No. 1:16-cv-01807
COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, *et al.*, *Defendants-Appellants*.	Tanya Walton Pratt, *Judge*.

ORDER

A majority of the panel voted to deny rehearing. A judge in regular active service requested a vote on the Petition for Rehearing and Rehearing En Banc, filed

by Defendants-Appellants on August 22, 2018. A majority of the judges in active service voted to deny rehearing en banc.

IT IS HEREBY ORDERED that the Petition for Rehearing and Rehearing En Banc is **DENIED**.