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CLERK OF THE SHAWNEE COUNTY DISTRICT COURT
CASE NUMBER: 2015-CV-000490

Court: Shawnee County District Court

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Case Title: Hodes & Nauser MDs PA vs. Derek Schmidt - Attorney General

Type: MEMORANDUM DECISION AND ORDER

SO ORDERED.

/s/ Honorable Teresa L Watson, District Court Judge

IN THE DISTRICT COURT OF SHAWNEE COUNTY, KANSAS
DIVISION THREE

HODES & NAUSER MDs PA, et al.,

Plaintiffs

2015-CV-490

DEREK SCHMIDT - ATTORNEY GENERAL, et al.,

Defendants

MEMORANDUM DECISION AND ORDER

Plaintiffs seek to void a Kansas law limiting the provision of dismemberment abortion. The district court in 2015 granted a temporary injunction preventing enforcement of the law, also known as Senate Bill 95, until further order of the Court or final judgment in this matter. Defendants appealed. The Kansas Court of Appeals sitting *en banc* affirmed in a split decision. The Kansas Supreme Court granted review and in 2019 issued a lengthy opinion affirming the district court's entry of a temporary injunction. The matter was returned to the district court for further proceedings and a determination on the merits. At the close of discovery, the parties filed cross-motions for summary judgment. The motions have been fully briefed and argued to the Court. The Court is ready to rule.

A brief discussion of the procedural history of this case helps frame the issues now before the Court.

THE PROVISIONS OF SENATE BILL 95.

The Kansas Legislature passed Senate Bill 95 in 2015. It is known as the Kansas Unborn Child Protection from Dismemberment Abortion Act ("the Act"). It is codified at K.S.A. 65-6741 *et seq*. The Act prohibits performance of Dilation and Evacuation ("D&E") on a living unborn child as part of an abortion procedure described in the Act as "dismemberment abortion." See K.S.A. 65-6743(a).

The Act defines dismemberment abortion as a procedure done "with the purpose of causing the death of an unborn child, knowingly dismembering a living unborn child and extracting such unborn child one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors or similar instruments that, through the convergence of two rigid levers, slice, crush or grasp a portion of the unborn child's body in order to cut or rip it off." See K.S.A. 65-6742(b)(1).

The term dismemberment abortion does not include "an abortion which uses suction to dismember the body of the unborn child by sucking fetal parts into a collection container," but it does include "an abortion in which a dismemberment abortion . . . is used to cause the death of an unborn child but suction is subsequently used to extract fetal parts after the death of the unborn child." See K.S.A. 65-6742(b)(2).

The Act provides exceptions when the abortion is "necessary to preserve the life of the pregnant woman" or "continuation of the pregnancy will cause a substantial and irreversible impairment of a major bodily function of the pregnant woman." See K.S.A. 65-6743(a).

The Act allows the attorney general or a county or district attorney to seek injunctive relief against a person who performs a dismemberment abortion in violation of the Act. See K.S.A. 65-6744. The Act provides for criminal penalties and creates a civil cause of action against a person who performs a dismemberment abortion in violation of the Act. See K.S.A. 65-6745 (civil cause of action); and K.S.A. 65-6746 (criminal penalties). There is no liability under the Act for a woman upon whom the abortion is performed or anyone not a physician acting at the direction of the physician performing the dismemberment abortion. See K.S.A. 65-6743(b).

THE TEMPORARY INJUNCTION.

On June 1, 2015, Dr. Herbert C. Hodes and Dr. Traci L. Nauser, and Hodes & Nauser, MDs, P.A. ("Plaintiffs") filed this action challenging Senate Bill 95 on behalf of themselves and their patients, arguing that Senate Bill 95 violates Sections 1 and 2 of the Kansas Constitution Bill of Rights. Plaintiffs did not raise a challenge under the federal constitution. Dr. Hodes has since retired and was dismissed from the case.

In an order dated June 30, 2015, Judge Larry D. Hendricks concluded that Sections 1 and 2 of the Kansas Constitution Bill of Rights protect "the fundamental right to abortion" and applied what is known as the undue burden test. Judge Hendricks determined that Plaintiffs would likely succeed on their challenge to the Act because the Act prohibited the most common form of second trimester abortion and left only unreasonable alternatives, creating an undue burden on the fundamental right to abortion. Judge Hendricks granted a temporary injunction staying enforcement of Senate Bill 95 until further order of the Court or until final judgment is entered in this matter. Defendants appealed.

THE COURT OF APPEALS DECISION.

The Kansas Court of Appeals considered the case *en banc*. Six judges agreed with the district court that the Kansas Constitution guaranteed a right to abortion similar to that found by the federal courts in the Due Process Clause of the Fourteenth Amendment. These six judges approved of the district court's application of the undue burden test set forth in *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833, 874-78 (plurality opinion). A seventh judge went further in a concurring opinion, concluding that the Kansas Constitution guaranteed a right to abortion entirely apart from the federally guaranteed right, and the district court should have applied the more stringent strict scrutiny test to evaluate the constitutionality of the Act. In any case, the seventh judge agreed with the result – that Plaintiffs were entitled to a temporary injunction.

The other seven Court of Appeals judges concluded that the Kansas Constitution did not guarantee an independent state law right to abortion, and since Plaintiffs did not invoke the protection of the federal constitution, the temporary injunction should be reversed. Because the Court of Appeals was evenly divided, the district court's decision was affirmed in the opinion filed January 22, 2016. See *Hodes & Nauser, MDs, P.A. v. Schmidt,* 52 Kan. App. 2d 274, 368 P.3d 667 (2016).

THE SUPREME COURT DECISION.

The Kansas Supreme Court granted Defendants' petition for review of the Court of Appeals decision. The Supreme Court affirmed the district court's grant of a temporary injunction and remanded for consideration on the merits.

The Supreme Court majority concluded that Section 1 of the Kansas Constitution Bill of Rights articulates rights that "are broader than and distinct from" those found by federal courts in

the Fourteenth Amendment to the federal constitution. The Supreme Court majority held that the Section 1 rights, which include a right to abortion, are fundamental rights. The majority directed the district court on remand to apply a strict scrutiny standard to Plaintiffs' Section 1 claims, which requires Defendants to show that the Act is narrowly tailored to serve a compelling government interest.

One justice concurred in the result, but urged that a Kansas version of the federal undue burden test should be applied to the Section 1 claims. One justice dissented. The Kansas Supreme Court opinion was filed on April 16, 2019. See *Hodes & Nauser, MDs, P.A. v. Schmidt*, 309 Kan. 610, 440 P.3d 461 (2019).

PROCEEDINGS ON REMAND.

The case was returned to the district court for further proceedings. Judge Richard D. Anderson entered a case management order containing deadlines for discovery and dispositive motions. Plaintiffs served and Defendants responded to requests for production and interrogatories. Defendants did not serve any written discovery on Plaintiffs.

Plaintiffs disclosed three fact and expert witnesses: 1) Plaintiff Dr. Nauser; 2) Dr. Anne Davis, a medical expert in obstetrics and gynecology, including the provision of abortions, currently serving as the Wyeth Ayerst Associate Professor of Obstetrics and Gynecology in the Department of Obstetrics and Gynecology at Columbia University Irving Medical Center and the Director of the Fellowship in Family Planning; and 3) Thomas Cunningham, an expert in clinical ethics, bioethics, philosophical ethics, and philosophy of medicine, currently serving as the Bioethics Program Director at Kaiser Permanente West Los Angeles Medical Center. Defendants did not depose any of these witnesses.

Defendants disclosed one expert witness. Plaintiffs deposed the expert. Defendants ultimately withdrew the expert designation. Plaintiffs filed rebuttal disclosures for their three witnesses. Neither party asked for an extension of the discovery period.

The parties filed cross-motions for summary judgment. The matter was transferred to the undersigned judge. This Court heard oral argument on the cross-motions for summary judgment.

STATEMENT OF UNCONTROVERTED FACTS

The parties have filed cross-motions for summary judgment raising opposite sides of the same legal arguments. Thus, the uncontroverted material facts necessary to deciding both summary judgment motions are combined and set forth below.

THE FACTS BEFORE THIS COURT ON REMAND.

1. Dr. Nauser is a board-certified obstetrician-gynecologist who works in private medical practice in Overland Park, Kansas.
2. Dr. Nauser's practice advertises under the name "Center for Women's Health" and is also a plaintiff in this case.
3. Dr. Nauser provides a full range of obstetrical and gynecological services to her patients, including family planning services, obstetrics, and previability abortions up to 21.6 weeks as measured from the woman's last menstrual period ("LMP").
4. Dr. Nauser has 23 years of experience providing first and second trimester abortions to patients from throughout Kansas and neighboring states.
5. According to Dr. Nauser, many OB-GYNs and perinatologists from Kansas and other states primarily or exclusively refer their patients to the Center for Women's Health when the patient seeks an abortion.

6. Plaintiffs submitted the affidavit of Dr. Anne Davis as an expert opinion in this case. Dr. Davis opined that legal abortion is one of the safest and most common medical procedures for women in the United States, and approximately one in four women will obtain an abortion by the age of 45.
7. Dr. Davis stated that nationwide, approximately 59% of women obtaining abortions already have had at least one birth, and women who are poor or low-income account for about 75% of abortions.
8. Dr. Davis stated that second trimester abortion is an important component of comprehensive reproductive healthcare, and those seeking second trimester abortion account for approximately 9.6% of women who obtain abortions each year.
9. Dr. Davis stated that circumstances that can lead to second trimester abortion include delays in confirming pregnancy; difficulty locating and travelling to a provider; delays based on medical conditions requiring hospital referral; and difficulty obtaining insurance coverage or funds for the procedure and related expenses, including travel, childcare, and lost wages.
10. Dr. Davis stated that the identification of major anatomic or genetic anomalies in the fetus most commonly occurs in the second trimester, and some women may choose to terminate their pregnancies for that reason.
11. Dr. Davis stated that in many areas of the United States, women have limited access to second trimester abortion; in 2014, 90% of all U.S. counties had no abortion clinic; not all clinics provide abortions after the first trimester; and in a census of abortion providers, only 64% reported providing abortions after 12 weeks' gestation.

12. Dr. Nauser stated that there were three locations in Kansas where abortions are available, including her clinic.
13. Kansas has other laws and regulations addressing the provision of abortions. For example, Kansas law prohibits abortion at 22 weeks LMP, except in circumstances in which the woman's life or health is at risk, K.S.A. 65-6723(f), 65-6724(a), and abortions are generally prohibited after viability, except where the woman's life or health is at risk. K.S.A. 65-6703(a).
14. Kansas law prohibits "partial birth abortions," defined in K.S.A. 65-6721(b), unless the procedure is necessary to preserve the woman's life.
15. Kansas law requires a 24-hour waiting period following the provision of certain required information to the patient before the abortion can be performed. K.S.A. 65-6709.
16. Medicaid patients may obtain coverage for abortion if the pregnancy is life-threatening or the result of rape or incest.
17. K.S.A. 40-2,190 provides that private insurance policies shall exclude coverage for elective abortions except those necessary to preserve the life of the mother, but may offer coverage for elective abortions through a separate optional rider. The statute further provides that policies offered through a government health insurance exchange shall not offer coverage for elective abortions.
18. State agencies and employees are prohibited from providing abortions, K.S.A. 65-6733(d), and abortions can be performed on University of Kansas properties only in a medical emergency, K.S.A. 76-3308(i).

19. Dr. Davis stated that because of its safety record and availability in an outpatient setting, D&E is a standard method of abortion and the most commonly used abortion procedure beginning at approximately 14 to 15 weeks LMP.

20. Dr. Davis stated that in the first trimester, abortions are performed using medications or surgical treatments. She said abortions commonly referred to as "surgical abortions" are not surgical in the usual sense because they do not involve any incision. She said surgical abortions in the first trimester are performed by dilating (opening) the uterine cervix and then using suction to empty the uterus. She said that until approximately 14 weeks' gestation, surgical abortions are usually completed using only suction.

21. Dr. Davis and Dr. Nauser stated that physicians begin using the D&E procedure at approximately 14 to 15 weeks LMP. They said first, the cervix is dilated; next, a combination of suction and forceps or the safest surgical instrument is used to remove the fetus, placenta, and uterine lining. Dr. Davis said usually, because the cervix is narrower than the fetus, some separation of fetal tissue occurs as the physician withdraws the fetal tissue and brings it through the cervix.

22. Dr. Davis stated that the safest D&E is done as quickly and gently as possible to minimize bleeding and risk of injury to the woman and preserve the health and fertility of the woman.

23. Dr. Davis stated that once adequate dilation has been achieved, the "evacuation process" takes between 10 to 15 minutes on average.

24. Dr. Davis stated that nationwide, the vast majority of D&E abortions are performed prior to 18 weeks, and it is extremely uncommon for a physician to cause fetal demise (death of the unborn child) before performing a D&E at 18 weeks or less. She said one national

survey found 74% of clinicians who performed D&Es at 18 weeks LMP or greater did not routinely induce preoperative fetal demise. Of those who did, 70% began at 20 weeks or more gestation. Dr. Nauser stated that it was never her practice to intentionally induce fetal demise prior to performing a D&E.

25. Senate Bill 95 prohibits the performance of a D&E while the unborn child is still living.

26. Senate Bill 95 may prevent or delay some abortions.

27. The risk of death to the mother associated with childbirth in the United States is approximately 14 times higher than that associated with abortion, estimated to be 8.8 per 100,000 live births compared to 0.7 per 100,000 abortion procedures.

28. Abortion-related death of the mother is lower than that for other common outpatient medical procedures, such as colonoscopy (2.9 deaths per 100,000 procedures).

29. Major complications occur in less than 1% of D&E cases. The low complication rate for second trimester abortion is, in large part, attributable to the low complication rate for the D&E method itself.

30. D&E can be performed on an outpatient basis in a clinical setting at a lower cost than other second trimester procedures performed after 14 weeks' gestation.

31. There is some variation as to how abortions are performed. For example, dilation can be accomplished by various methods and combinations of methods, and based on the method of dilation, the physician may start the dilation process for a D&E procedure one or two days before the procedure itself, or do the dilation and procedure on the same day.

32. Dr. Nauser stated that she provides D&E as a one-day procedure in most cases unless a two-day procedure is medically indicated for the patient.

33. Dr. Davis stated that the only alternative to D&E after approximately 14 to 15 weeks' gestation is an induction abortion procedure, in which physicians use medication to induce labor and delivery. Dr. Davis stated that although hysterotomy is another surgical abortion technique that can be performed after 14 weeks' gestation, it is not a viable alternative to D&E because it entails an incision through the woman's abdomen and uterus, which carries significant risks comparable to cesarean delivery.
34. Dr. Davis and Dr. Nauser stated that induced labor abortions must be performed on an inpatient basis in a hospital, can take up to 2 to 3 days, and are more expensive than outpatient D&E.
35. Dr. Davis said that a prolonged induction poses an increased risk of infection compared with D&E. Although serious complications are rare, complications occur more often in inductions than in D&E procedures.
36. Further, induction requires women to go through labor, offers less predictable timing, and may fail or cause uterine rupture.
37. Following an induction, between 10 to 33% of women have retained placenta and must undergo an additional medical procedure to have it removed.
38. Induction labor cannot be performed in an outpatient setting, and hospitals have their own policies that may restrict the availability of certain procedures.
39. Dr. Nauser stated that she does not have capacity to incorporate routine provision of induction abortions into her practice, and it is not a treatment option for most patients at the hospitals where she practices.

40. Dr. Nauser stated that she is the only physician who provides D&E at her practice. She said she does not induce fetal demise prior to performing a D&E because in her medical judgment doing so provides no benefit but does increase the risks to the woman.
41. The American College of Obstetricians and Gynecologists' ("ACOG") Second Trimester Practice Bulletin states: "No evidence currently supports the use of induced fetal demise to increase the safety of second trimester medical or surgical abortion."
42. The fetal demise methods evaluated by ACOG "include division of the umbilical cord, intraamniotic or intrafetal digoxin injection, or fetal intracardiac potassium chloride injection."
43. There is no evidence that inducing fetal demise prior to D&E serves women's mental health or should be required based on patient preference.
44. Dr. Davis said existing studies conclude that there is insufficient information to recommend inducing fetal demise prior to D&E.
45. The studies indicate that some physicians began using demise at 18 weeks or later not because they believed it offered medical benefits, but in order to comply with state and federal laws banning partial birth abortion.
46. Dr. Nauser stated that she cannot continue to provide D&E procedures and comply with the Act without altering her practice in a way that, in her view, increases the complexity and risk of the abortion.
47. Dr. Nauser stated that any means she would undertake to ensure that fetal demise occurs in every case will subject her patients to additional procedures which she said were medically "needless."

48. Dr. Nauser stated that, in order to continue providing D&E abortions under the Act, she would be compelled to follow certain legal requirements rather than simply provide the care that she believes is best for her patients.
49. Dr. Davis said that a minority of physicians, beginning around 18 to 20 weeks LMP, induce fetal demise prior to a D&E procedure by administering fetal intracardiac potassium chloride (KCl) or digoxin.
50. Among the minority of physicians who induce demise, the procedure most often used is an injection of digoxin, a medication that is also used to treat certain heart conditions.
51. To perform this procedure, physicians use a spinal needle to inject digoxin through the patient's abdomen, vagina, or cervix, into the uterus using ultrasound guidance.
52. Digoxin can be injected either into the amniotic fluid (intraamniotic injection) or the fetus (intrafetal injection).
53. These procedures are often technically difficult for the physician, especially at earlier gestational ages. They can also be physically and emotionally painful for the patient.
54. Because digoxin can take up to 24 hours to cause demise, it is usually administered 1 to 2 days before the D&E procedure.
55. This adds an extra day to the procedure and requires an additional trip in instances where, as with the majority of Dr. Nauser's patients, the physician does not begin cervical preparation the day before the procedure.
56. There is virtually no research on the use of digoxin to induce fetal demise prior to 18 weeks.

57. Research to date on the administration of digoxin to induce fetal demise prior to a D&E finds no clear medical benefit, but has shown increased risks of infection, vomiting, unplanned fetal delivery outside a medical facility, and hospitalization.

58. Though rare, digoxin toxicity poses an extreme risk, with documented incidence of hyperkalemic paralysis, which can be fatal.

59. Some women also have contraindications for digoxin injections, and digoxin injections are less likely to be successful on obese women or women with uterine fibroids, both of which are common.

60. The injection of digoxin is not 100% effective or 100% reliable in inducing fetal demise.

61. After 18 to 20 weeks, intraamniotic injections of digoxin (versus intrafetal injections) take longer to take effect and have an increased failure rate.

62. A recent randomized controlled trial found failure rates in causing fetal demise using digoxin to be 20% for intraamniotic injections. The study also found that due to the technical difficulty of the intrafetal injection, one out of five attempts to perform an intrafetal injection were unsuccessful, forcing the physicians to resort to the less effective intraamniotic injection.

63. Dr. Davis stated that administration of digoxin for pregnancies prior to 18 weeks would be even more technically challenging. At lower gestational ages, when most D&E abortions are performed, the fetus is smaller, and the difficulty of digoxin injection would be expected to increase, resulting in a greater percentage of intraamniotic rather than intrafetal injections.

64. Dr. Davis opined that for these reasons, injections prior to 18 weeks would likely have even higher failure rates, and it may be technically impossible to do an intrafetal injection.

65. Dr. Davis said that if fetal demise does not occur in the expected time period after the first digoxin injection, a second injection would be necessary to induce fetal demise. Dr. Davis and Dr. Nauser were not aware of any published information showing that multiple doses of digoxin to induce demise is either safe or effective.

66. Dr. Davis opined that requiring physicians to perform a digoxin injection prior to 18 weeks or to provide a second injection, and delay the procedure even further, is untested and confers even greater risk.

67. Dr. Davis stated that, used less commonly than digoxin, some physicians with specialized training use potassium chloride (KCl) to induce demise.

68. KCl injection to induce fetal demise prior to D&E poses risks with no established medical benefit.

69. KCl is administered via needle injection through the woman's abdomen, cervix, or vagina using ultrasound guidance and injected into the fetal heart.

70. KCl does not cause fetal demise when injected into the amniotic fluid or any other part of the fetus.

71. Dr. Davis said that this procedure requires a high level of skill and is typically performed by Maternal-Fetal Medicine OB-GYNs in a hospital setting using ultrasound guidance, following a specialized fellowship to gain advanced training and extensive practice. Training to perform KCl injections is not part of obstetrics and gynecology residency training, and it is not part of the training program of family planning fellowships.

72. KCl carries risks, including maternal cardiac arrest and infection.

73. It can also be even more technically challenging or impossible in women with obesity or uterine fibroids.

74. There are no studies on the failure or complication rate of KCl injection performed by physicians without specialized training or in outpatient settings.

75. Generally, KCL injection is used for selective termination in a multifetal pregnancy which, unlike demise prior to D&E, does confer safety benefits by reducing the risks associated with multifetal gestation.

76. Another technique proposed to induce demise prior to D&E is umbilical cord transection.

77. Dr. Davis stated that there is no established medical benefit from performing umbilical cord transection.

78. Attempting to locate and transect the umbilical cord within a patient's uterus, while the cervix is dilated prior to D&E, makes the procedure more complex and increases risks and procedure time.

79. Dr. Davis said it is likely that attempting this procedure would carry risks of pain, uterine perforation, infection, and bleeding. This method is not 100% reliable.

80. Dr. Davis said transecting the cord prior to D&E to induce fetal demise cannot be accomplished in every case. Umbilical cord transection would require the physician to break the amniotic sac, remove the amniotic fluid, and then use an appropriate surgical instrument to locate the cord and divide it.

81. Dr. Davis said a physician cannot guarantee that he or she will be able to locate the umbilical cord in utero separately from the fetus. Attempting to sever the umbilical cord using forceps or another surgical instrument could result in fetal tissue being

inadvertently torn before fetal demise. A physician cannot predict whether transection can be accomplished before attempting it.

82. Dr. Davis said that transection to induce fetal demise prior to D&E would be even more challenging at earlier gestational ages.

83. The use of transection to induce fetal demise has only been addressed in a single retrospective study that does not discuss the feasibility of identifying and transecting the cord without severing other fetal tissue.

84. The authors of this study note that its main limitation is "a potential lack of generalizability."

85. Because attempting to transect the umbilical cord necessarily entails breaking the amniotic sac and draining the amniotic fluid, a provider would be compelled to either proceed with performing the D&E procedure, or delay performing the D&E to attempt another method of inducing demise, which would expose the patient to heightened risk of serious complications such as pain, uterine perforation, infection and hemorrhage.

86. Dr. Nauser said that attempting to induce demise using another method such as digoxin injection after the failure of umbilical cord transection is not the subject of any study.

87. Dr. Nauser opined that without the presence of amniotic fluid, neither intraamniotic digoxin administration nor KCl administration would be practicable or safe.

88. Dr. Nauser does not induce demise prior to performing D&E procedures. In her opinion, no reliable evidence supports the claim that causing demise prior to D&E will improve the safety of abortion procedures or promote women's health at any stage of pregnancy, and any purported benefits do not outweigh the risks.

89. It is Dr. Nauser's medical judgment that, as to induction of demise using digoxin prior to 18 weeks in particular, and given the lack of study on the topic, performing such procedures amounts to experimenting on patients.

90. Dr. Nauser believes that, to comply with Senate Bill 95, she will have to alter her practices with respect to D&E procedures in ways that will cause her patients harm.

91. She believes that, if the Act is allowed to take effect, women seeking abortions beginning at 14 to 15 weeks will be forced to either forgo a D&E procedure or undergo a fetal demise procedure that provides no medical benefit, but does increase the risk and complexity of the procedure.

92. Dr. Nauser believes that inducing fetal demise prior to D&E entails additional risks with no benefits, and her compliance with the Act raises serious ethical concerns for her.

93. Plaintiffs submitted the affidavit of Thomas Cunningham as an expert opinion in this case. Cunningham opined that there is no universally accepted consensus that certain methods of terminating a pregnancy are more dignified than others. He said people hold a wide range of beliefs about abortion and what constitutes dignified or humane treatment of a fetus or fetal tissue.

94. Cunningham opined, and Dr. Nauser agreed, that under fundamental principles of medical ethics, physicians should not require patients to undergo medically unnecessary procedures in order to obtain other care.

95. Cunningham opined, and Dr. Nauser and Dr. Davis agreed, that under these principles, women seeking D&E procedures prior to 18 weeks should not be subjected to an untested and unstudied procedure.

96. Cunningham opined, and Dr. Nauser agreed, that the Act denies Dr. Nauser's patients the autonomy to freely choose among medically appropriate treatment options and will undermine the physician-patient relationship by forcing Dr. Nauser to comply with a government mandate that she does not believe is in her patients' best interests.

CONCLUSIONS OF LAW

The Kansas Supreme Court determined that Section 1 of the Kansas Constitution Bill of Rights guarantees rights to abortion that "are broader than and distinct from" those found by federal courts in the Fourteenth Amendment to the federal constitution. The Kansas Supreme Court determined that this Court must evaluate any challenge to the Act under a strict scrutiny standard, requiring Defendants to prove that the Act is narrowly tailored to serve a compelling government interest. While this Court firmly disagrees with the legal reasoning and conclusions of the Kansas Supreme Court as set forth in the majority opinion, this Court is duty bound to follow its direction. *Henderson v. Board of Montgomery County Com'rs,* 57 Kan. App. 2d 818, 830, 461 P.3d 64 (2020).

STANDARDS FOR SUMMARY JUDGMENT.

The Court considers the following rules when deciding a motion for summary judgment:

> "Summary judgment is appropriate when the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. The trial court is required to resolve all facts and inferences which may reasonably be drawn from the evidence in favor of the party against whom the ruling is sought. When opposing a motion for summary judgment, an adverse party must come forward with evidence to establish a dispute as to a material fact. In order to preclude summary judgment, the facts subject to the dispute must be material to the conclusive issues in the case." *Shamberg, Johnson & Bergman, Chtd. v. Oliver,* 289 Kan. 891, 900, 220 P.3d 333 (2009).

THE MOTIONS FOR SUMMARY JUDGMENT.

The Kansas Supreme Court found a fundamental right to abortion in Section 1 of the Kansas Constitution Bill of Rights. The Kansas Supreme Court concluded that a strict scrutiny test applies to any claims of violation. The strict scrutiny test begins with determining whether government action burdens or infringes on the articulated right. And "once a plaintiff proves an infringement—regardless of degree—the government's action is presumed unconstitutional. Then, the burden shifts to the government to establish the requisite compelling interest and narrow tailoring of the law to serve it." 309 Kan. at 669.

On remand, the parties agree that there are no material facts in dispute and that summary judgment is appropriate. The parties agree that the Act infringes on the Section 1 fundamental right to abortion as defined by the Kansas Supreme Court. This narrows the salient issues on summary judgment to two: whether the Act serves a compelling government interest, and whether the Act is narrowly tailored to further that interest.

COMPELLING GOVERNMENT INTEREST.

The Kansas Supreme Court said here that a compelling interest is more than merely legitimate or valid. Rather, "when the State has to show a compelling interest under strict scrutiny, it must show something that is 'not only extremely weighty, possibly urgent, but also rare—much rarer than merely legitimate interests and rarer too than important interests.'" 309 Kan. at 670, citing Richard H. Fallon, Jr., *Strict Judicial Scrutiny,* 54 UCLA L. Rev. 1267, 1273 (2007).

Defendants assert the following compelling government interests supporting the Act: 1) promoting respect for the value and dignity of human life, born and unborn; 2) protecting the innocent victims of abortion; and 3) regulating and protecting the medical profession.

Defendants acknowledge that the first two stated interests are related enough to collapse into one category to be considered together.

1. PROMOTING RESPECT FOR THE VALUE AND DIGNITY OF HUMAN LIFE.

The United States Supreme Court in *Roe v. Wade,* 410 U.S. 113, 162 (1973), recognized the "important and legitimate interest in protecting the potentiality of human life." The court in *Roe* set up a trimester framework to aid in its analysis of government regulation of abortion, determining that the "compelling point" of the government's interest in potential life begins at viability. *Id.* at 163-64. Under *Roe,* "almost no regulation at all is permitted during the first trimester of pregnancy; regulations designed to protect the woman's health, but not to further the State's interest in potential life, are permitted during the second trimester; and during the third trimester, when the fetus is viable, prohibitions are permitted provided the life or health of the mother is not at stake." *Casey,* 505 U.S. at 872.

But the court later abandoned this framework "as a rigid prohibition on all previability regulation aimed at the protection of fetal life" because it "undervalues the State's interest in potential life, as recognized in *Roe*." *Casey,* 505 U.S. at 873. Indeed, the *Casey* court emphasized that the government has a "profound interest in potential life, throughout pregnancy." *Id.* at 878. With *Casey,* the United States Supreme Court began applying what is known as the undue burden test, which essentially evaluates whether a law "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus" and whether the "means chosen by the State to further the interest in potential life [are] calculated to inform the woman's free choice, not hinder it." *Id.* at 877.

More recently, the United States Supreme Court reiterated that the government has "legitimate interests from the outset of the pregnancy in protecting the health of the woman and

the life of the fetus that may become a child." *Gonzales v. Carhart,* 550 U.S. 124, 145 (2007) (applying undue burden test and upholding partial birth abortion ban). Indeed, the "government may use its voice and its regulatory authority to show its profound respect for the life within the woman." *Id.* at 157.

Lower courts following *Casey* and *Gonzales* in applying the undue burden standard to abortion regulation have likewise recognized that the government's "interest in protecting human life and the dignity of the medical profession is legitimate." *Planned Parenthood Sw. Ohio Region v. Yost,* 375 F. Supp. 3d 848, 865 (S.D. Ohio 2019) (but dismemberment abortion statute failed undue burden test). See also *W. Alabama Women's Ctr. v. Miller,* 299 F. Supp. 3d 1244, 1285 (M.D. Ala. 2017) (court assumed government interests in "the dignity of the fetal life and the regulation of the medical profession" were legitimate, but dismemberment abortion statute failed undue burden test).

Plaintiffs argue that this Court must use *Roe's* trimester framework to reject the notion that there can be any compelling government interest in life prior to viability. But *Casey* and *Gonzales* demonstrate that the United States Supreme Court believes *Roe* undervalues the government's interest, notably in the regulation of previability abortion. Plaintiffs assert that the Kansas Supreme Court did not credit *Casey* or *Gonzales* on this point because it spurned those cases' application of the undue burden standard.

In this case, the Kansas Supreme Court said it rejected the district court's application of the undue burden test because: 1) Kansas courts have not applied it in the past, 2) it is hard to understand and apply; 3) it allows subjective factors to creep into the analysis; and 4) it is less stringent than strict scrutiny. Regarding stringency, the Kansas Supreme Court observed that undue burden is more of a balancing test and strict scrutiny places the burden squarely on the

Defendants to prove compelling interests and narrow tailoring. Further, the undue burden test requires only that government interests be "valid" or "legitimate" versus the requirement that they be "compelling" in order to meet strict scrutiny. 309 Kan. 665-71.

If the Kansas Supreme Court meant to say that there can be no compelling government interest in life prior to viability, it would have done so, and there would have been no need for a remand. Instead, the court specifically said "on remand to the trial court for a full resolution of the issues on the merits, the State is certainly free to assert any interests it believes compelling and show how S.B. 95 is narrowly tailored to those interests." 309 Kan. at 680. The Kansas Supreme Court did not foreclose the possibility of a compelling government interest in the value and dignity of human life, born or unborn, at any gestational age. Rather, it said to apply the most stringent test available to measure the importance of the interest and whether and how it is advanced by the Act.

Another state court applying the strict scrutiny standard to abortion regulation has recognized that the government "indeed has a compelling interest in promoting potential life." *Planned Parenthood of the Heartland v. Reynolds ex rel. State,* 915 N.W.2d 206, 239-41 (Iowa 2018) (but 72-hour waiting period prior to abortion failed strict scrutiny test at the narrow tailoring stage of the analysis).

Kansas courts have not applied the strict scrutiny standard to abortion regulation. But in *State v. Ryce,* 303 Kan. 899, 957, 368 P.3d 342, 377 (2016), *adhered to on reh'g,* 306 Kan. 682 (2017), it was applied to a statute criminalizing a driver's refusal to submit to a blood alcohol test on suspicion of driving under the influence. In order to determine whether the State had a compelling interest justifying the criminal refusal statute, the Kansas Supreme Court looked to the legislative history of the statute (including testimony presented to legislative committees) as

well as State interests previously recognized in other statutes related to driving under the influence. 303 Kan. at 957-59. The court said the State's interests were:

> "(1) criminal justice interests—deterring test refusals, deterring recidivism, holding offenders accountable, and reducing the difficulties in prosecution and potential evasion of prosecution altogether; (2) encouraging public safety; and (3) protecting the safety of those who deal with the suspect and perform the test. We do not dispute that these interests are compelling." *Id.* at 959.

Following the method used by the Kansas Supreme Court in *Ryce* here, it is appropriate to look to the legislative history of the Act for expressions of the State's compelling interests, as well as to survey State interests recognized in other statutes related to abortion regulation in Kansas.

Defendants first point to testimony provided to legislative committees in support of Senate Bill 95. The proponents, some of whom were medical doctors, provided testimony mostly under the category of promoting respect for the value and dignity of human life, born and unborn. One physician proponent who had performed such abortions described a dismemberment abortion in horrifying detail. Another physician proponent, Kansas' then lieutenant governor Jeff Colyer, described dismemberment abortion as a "gruesome procedure" and a "tortuous act that literally dismembers an unborn child limb-by-limb." Another proponent described dismemberment abortion, complete with illustrations, as a "dehumanizing" way to kill an unborn child. See Minutes, House Federal and State Affairs Committee, March 9, 2015.

This testimony was reflected in the comments of legislators who voted for the bill. One representative said he favored Senate Bill 95 because it furthered a governmental interest in protecting unborn children from an inhumane death. Eleven senators said they voted in favor of Senate Bill 95 because dismemberment abortion is a "brutal and inhumane procedure" that "will further coarsen society to the humanity of the unborn, as well as all vulnerable and innocent

human life." Senate Bill 95 passed in the House by a vote of 98 to 26. House J. 2015, p. 548. Senate Bill 95 passed in the Senate by a vote of 31 to 9. Senate J. 2015, p. 141.

Other statutes express the State's compelling interest in the value and dignity of human life from the moment of conception. For example, K.S.A. 65-6732 is a sweeping legislative declaration that says in pertinent part:

> "(a) The legislature hereby finds and declares the following:
>
> (1) The life of each human being begins at fertilization;
>
> (2) unborn children have interests in life, health and well-being that should be protected; and
>
> (3) the parents of unborn children have protectable interests in the life, health and well-being of the unborn children of such parents.
>
> (b) On and after July 1, 2013, the laws of this state shall be interpreted and construed to acknowledge on behalf of the unborn child at every stage of development, all the rights, privileges and immunities available to other persons, citizens and residents of this state, subject only to the constitution of the United States, and decisional interpretations thereof by the United States supreme court and specific provisions to the contrary in the Kansas constitution and the Kansas Statutes Annotated."

While this statute may not "alter the constitutional rights secured" in Section 1 of the Kansas Constitution Bill of Rights in that "the legislature cannot mandate how the courts construe constitutional protections," 52 Kan.App.2d at 311 (concurring opinion), it does serve as a strong indication of the State's compelling interest here.

To the same effect, K.S.A. 21-5419 defines "person" or "human being" as applied to certain crimes to include an "unborn child," which means "a living individual organism of the species homo sapiens, in utero, at any stage of gestation from fertilization to birth." This means that a murder, manslaughter, vehicular homicide, or battery committed against an unborn child may be prosecuted to the same extent as one committed against any other person. The statute

includes exceptions for any act committed by the mother of the unborn child, medical procedures including abortions, and lawful dispensation of medicine. Likewise, K.S.A. 60-1901 allows one to sue for the wrongful death of an unborn child (same definition found in K.S.A. 21-5419), with exceptions for any act committed by the mother of the unborn child, medical procedures including abortions, and lawful dispensation of medicine.

Finally, Section 1 of the Kansas Constitution Bill of Rights says: "All men are possessed of equal and inalienable natural rights, among which are life, liberty, and the pursuit of happiness." The first equal and inalienable natural right listed there is life. Section 1 in general terms reflects a commitment to life at least equal to its commitment to liberty and the pursuit of happiness. Even so, Defendants do not argue that the word life alone in Section 1 represents a complete counterbalance to the fundamental right to abortion found by the Kansas Supreme Court in the concepts of liberty and pursuit of happiness. But at the very least it is consistent with Defendants' claim that the State has a compelling interest in the value and dignity of human life.

Kansas law provides many indications that the value and dignity of human life from conception is a consideration that is weighty, urgent, and rare. The Kansas Supreme Court in *Ryce* found public safety and criminal justice considerations to be compelling interests. Certainly in Kansas the government's interest in the value and dignity of human life at the very least equals those interests, and indeed surpasses them. Defendants have met their burden to prove a compelling government interest exists in promoting respect for the value and dignity of human life, born and unborn.

2. REGULATING AND PROTECTING THE MEDICAL PROFESSION.

Defendants assert that the State has a compelling interest in regulating the medical profession and maintaining the ethical integrity of the medical profession. They first cite *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997), a challenge to an assisted suicide ban, where the United States Supreme Court acknowledged that the State "has an interest in protecting the integrity and ethics of the medical profession." But the interest was not declared to be compelling. Rather, the court held that there was no fundamental right to assisted suicide and evaluated the ban using a rational basis test. *Id.* at 735.

Other states have recognized a government interest in regulating and protecting the medical profession in the context of abortion regulation. See, e.g., *Yost*, 375 F.Supp.3d at 865; *Miller*, 299 F.Supp.3d at 1285 (both concluding the interest is "legitimate," applying the undue burden test).

Defendants also cite *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975), a challenge under the Sherman Act to a bar association's compulsory minimum attorney fee schedule for real estate transactions. There, the United States Supreme Court recognized that the State has "a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests they have broad power to establish standards for licensing practitioners and regulating the practice of professions." *Id.* at 792. This quote in isolation is not helpful because in *Goldfarb* no fundamental rights were at stake, there was no strict scrutiny analysis, and the court simply determined that the bar associations were not exempt from the Sherman Act. *Id.* at 791-92.

The other cases cited by Defendants are likewise inapposite. Defendants argue that the government has a compelling interest in regulating and protecting the ethical integrity of the

medical profession in the context of abortion regulation. The interest in regulating the medical profession is certainly legitimate and important. But Defendants fail to persuade that it is an interest that is extremely weighty, urgent, or rare on the same level as the government's interest in the value and dignity of human life. It is Defendants' burden to establish a compelling State interest in regulating the medical profession in this context, and they have failed to carry it.

NARROW TAILORING.

The next question is whether the Act is narrowly tailored to serve the government's compelling interest in promoting respect for the value and dignity of human life. "[I]n giving the state its due recognition that its interests are compelling, we must also hold the state to its convictions under the constitution. A regulation must further the identified state interest that motivated the regulation not merely in theory, but in fact." *Planned Parenthood of the Heartland,* 915 N.W.2d at 239-40. Narrow tailoring "ensures all state forays into constitutionally protected spheres . . . commit no greater intrusion than necessary." *Id.* at 240. It "demands that the fit between the government's action and its asserted purpose be as perfect as practicable." Stephen A. Siegel, *The Origin of the Compelling State Interest Test and Strict Scrutiny,* 48 Am. J. Legal Hist. 355, 360 (2006) (citations omitted).

There is no clear cut definition of narrow tailoring in Kansas law, though the Kansas Supreme Court has said at least that "[p]recision of regulation must be the touchstone." *Ryce,* 303 Kan. at 956-57. And in *Ryce,* the court found the statute criminalizing a driver's blood test refusal was not narrowly tailored to the State's compelling interests because there was a constitutional alternative for addressing such interests – obtaining a warrant. *Id.* at 963.

Defendants argue here that the law is narrowly tailored because: 1) there are exceptions allowing D&E on a living unborn child to save the life of the mother or to prevent substantial

and irreversible physical harm to her; 2) violation of the Act does not punish accidents – it requires knowingly dismembering a living unborn child with the purpose of causing the child's death; 3) it leaves other abortion options available; 4) the Act imposes criminal and civil liability only upon the physician who performs the abortion; and 5) it allows courts the option of protecting the identity of a woman who received an unlawful abortion in the course of legal proceedings against the physician who performed it. Thus, Defendants say, if the Act "were restricted or narrowed any further, it would cease to exist."

The essence of Defendants' narrow tailoring argument is that even with enforcement of the Act there are other second trimester abortion options available. The burden is on the Defendants to demonstrate narrow tailoring not just in theory, but in fact. Defendants assert that a woman seeking a second trimester abortion can either elect another procedure or seek an alternative means of fetal demise prior to the D&E. The problem with this argument lies with the evidence (or lack thereof) before the Court. The evidence is that because of its safety record and availability in an outpatient setting, D&E is a standard method of abortion and the most commonly used abortion procedure beginning at approximately 14 to 15 weeks LMP. Defendants suggest the Act is narrowly tailored because a woman in her second trimester may elect another method of abortion.

Plaintiffs' evidence was that there are two other second trimester possibilities, induction abortion and hysterotomy. Induction abortion requires the woman to go through labor. It must be performed on an inpatient basis in a hospital, can take 2 to 3 days, is more expensive than D&E, and many hospitals have their own policies restricting these procedures. A prolonged induction poses an increased risk of infection or uterine rupture. Although serious complications are rare, complications occur more often in inductions than in D&E procedures. Following an induction,

between 10 to 33% of women have retained placenta and must undergo an additional medical procedure to have it removed. Plaintiffs' evidence was that hysterotomy is not a realistic alternative to D&E because it entails an incision through the woman's abdomen and uterus, which carries significant risks comparable to cesarean delivery. The only evidence before the Court is that there is no reasonable alternative procedure to D&E in the second trimester.

Defendants then urge that there are ways to cause fetal demise prior to the D&E, and this results in a more dignified death of the unborn child. Plaintiffs' evidence was that there are essentially three ways to cause death to the unborn child prior to D&E: intraamniotic or intrafetal digoxin injection, fetal intracardiac potassium chloride injection, or division of the umbilical cord.

Digoxin injections require physicians to use a spinal needle to inject digoxin through the patient's abdomen, vagina, or cervix, into the uterus using ultrasound guidance. Digoxin can be injected either into the amniotic fluid (intraamniotic injection) or the fetus (intrafetal injection). These procedures are technically difficult for the physician, especially at earlier gestational ages, and physically painful for the patient. Because digoxin can take up to 24 hours to cause demise, it is usually administered 1 to 2 days before the D&E procedure.

There is virtually no research on the use of digoxin to induce fetal demise prior to 18 weeks. Research on the administration of digoxin to induce fetal demise prior to a D&E finds no clear medical benefit, but has shown increased risks of infection, vomiting, unplanned fetal delivery outside a medical facility, and hospitalization. Though rare, digoxin toxicity poses an extreme risk, with documented incidence of hyperkalemic paralysis, which can be fatal. Digoxin injections are less likely to be successful on obese women or women with uterine fibroids, both of which are common. Digoxin is not 100% effective or 100% reliable in inducing fetal demise.

After 18 to 20 weeks, intraamniotic injections of digoxin (versus intrafetal injections) take longer to take effect and have an increased failure rate.

Some physicians with specialized training use potassium chloride (KCl) to induce demise. KCl is administered via needle injection through the woman's abdomen, cervix, or vagina using ultrasound guidance and injected into the fetal heart. KCl injection to induce fetal demise prior to D&E poses risks, including maternal cardiac arrest and infection, with no established medical benefit. There are no studies on the failure or complication rate of KCl injection performed by physicians without specialized training or in outpatient settings.

Umbilical cord transection involves a physician locating and transecting the umbilical cord within a patient's uterus while the cervix is dilated prior to D&E. It requires the physician to break the amniotic sac, remove the amniotic fluid, and then use an appropriate surgical instrument to locate the cord and divide it. Transecting the cord prior to D&E to induce fetal demise cannot be accomplished in every case and a physician cannot predict whether transection can be accomplished before attempting it. There is no established medical benefit from performing umbilical cord transection. It increases risks of pain, uterine perforation, infection, and bleeding to the woman. This method is not considered reliable.

Because attempting to transect the umbilical cord necessarily entails breaking the amniotic sac and draining the amniotic fluid, if the transection could not be completed, a physician would be compelled to either proceed with performing the D&E procedure, or delay performing the D&E to attempt another method of inducing demise, which would expose the patient to heightened risk of serious complications such as pain, uterine perforation, infection and hemorrhage. Attempting to induce demise using another method such as digoxin injection after the failure of umbilical cord transection is not the subject of any study, and without the

presence of amniotic fluid, neither intraamniotic digoxin administration nor KCl administration would be practicable or safe.

Plaintiffs' experts, including Dr. Nauser, opined that no evidence supports the claim that causing demise prior to D&E will improve the safety of abortion procedures or promote women's health at any stage of pregnancy, and any benefits do not outweigh the risks. Dr. Nauser stated that, to comply with Senate Bill 95, she will have to alter her practices with respect to D&E procedures in ways that will cause her patients harm. She stated that if the Act is allowed to take effect, women seeking abortions beginning at 14 to 15 weeks will be forced to either forgo a D&E procedure or undergo a fetal demise procedure that provides no medical benefit, but does increase the risk and complexity of the procedure. For these reasons, Dr. Nauser said complying with the Act raises serious ethical concerns for physicians.

In short, Plaintiffs offered evidence that there is no reasonable alternative to dismemberment abortion beginning at 14 to 15 weeks LMP. The only evidence in the record is that fetal demise procedures currently available provide no medical benefit to the woman, but increase the risk, complexity, duration, and cost of the procedure. Most of these alternatives are virtually untested and not entirely reliable. Defendants offered no evidence to rebut this, or even undermine it.

Again, it is Defendants' burden to prove that the Act is narrowly tailored to serve a compelling state interest not only in theory, but in fact. Banning dismemberment abortion is not a narrowly tailored solution to the compelling state interest Defendants seek to address because, according to the evidence before the Court, it would leave no alternative for second trimester abortions other than more complicated, less reliable, less tested, and higher risk procedures. And tearing a living unborn child apart and removing the pieces is a horrible death, but so is death by

induced labor or caesarean section prior to viability, cutting the umbilical cord, or injecting lethal chemicals into the womb or into the heart of the unborn child. Defendants offer no facts and little argument about how these alternatives for bringing death promote greater respect for the value and dignity of human life as a substitute for D&E; instead, they offer only a theory. The facts do not demonstrate that the net effect of the Act will be to bring a more dignified death to the unborn child before it is removed from the mother's body. The facts do not demonstrate that the Act is narrowly tailored to further the compelling government interest under the Kansas Supreme Court's call for strict scrutiny in this case.

The Kansas Supreme Court defined the fundamental right to abortion under Section 1 of the Kansas Constitution Bill of Rights and directed this Court to apply strict scrutiny to evaluate the constitutionality of the Act. While there is a compelling government interest in promoting respect for the value and dignity of human life, the Act is not narrowly tailored to further this interest. This Court has applied the standard to the uncontroverted facts of this case and finds the Act unconstitutional as a violation of the fundamental right to abortion under Section 1 as defined by the Kansas Supreme Court.

OTHER ISSUES.

Plaintiffs argue in their motion for summary judgment that the Act also fails under the undue burden standard. The Kansas Supreme Court directed this Court to apply the strict scrutiny standard, not the undue burden standard, thus there is no need to consider the issue here.

Further, Plaintiffs articulated eight separate claims for relief in their petition. They moved for summary judgment on the fundamental right to abortion claim but did not seek summary judgment on the others. Defendants sought summary judgment on some of Plaintiffs' ancillary claims. This Court has already found the Act unconstitutional as a violation of the fundamental

right to abortion under Section 1. Thus, there is no need to address whether Defendants are entitled to summary judgment on Plaintiffs' other claims as it would not change the result.

CONCLUSION

For the reasons set forth above, Plaintiffs' motion for summary judgment is granted. Defendants' motion for summary judgment is denied. Under the Kansas Supreme Court's interpretation of Section 1 of the Kansas Constitution Bill of Rights, and requisite application of the strict scrutiny standard to the uncontroverted facts as found by this Court, the Act is unconstitutional and unenforceable. Plaintiffs' request for a permanent injunction prohibiting enforcement of the Act is granted.

This Order is effective on the date and time shown on the electronic file stamp.

IT IS SO ORDERED.

HON. TERESA L. WATSON
DISTRICT COURT JUDGE

CERTIFICATE OF SERVICE

I hereby certify that a copy of the above document was filed electronically on the date stamped on the order, providing notice to the following:

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