IN THE SUPREME COURT OF IOWA

PLANNED PARENTHOOD OF THE HEARTLAND, INC. and DR. JILL MEADOWS, M.D.,	)	S. Ct. No. 14-1415
Petitioners/Appellants,	)	
v.	)	
IOWA BOARD OF MEDICINE,	)	
Respondent/Appellee.	)	

APPEAL FROM THE IOWA DISTRICT COURT
IN AND FOR POLK COUNTY
THE HONORABLE JEFFREY D. FARRELL

PETITIONERS/APPELLANTS' BRIEF

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Mark S. Cady, The Vanguard of Equality: The Iowa Supreme Court's Journey to Stay Ahead of the Curve on an Arc Bending Towards Justice, 76 Alb. L. Rev. 1991 (2013)

Renee Webb, Plan B: Diocesan Reaction to FDA Decision to Lower Age, The Catholic Globe (May 30, 2013)

Mike Wiser, Iowa Board of Medicine to Discuss Ending Telemedicine Abortions, The Gazette (Mar. 28, 2014)

ROUTING STATEMENT

This Appeal should be retained by the Supreme Court under Iowa Rules of Appellate Procedure 6.1101(2)(c) and (d) because it presents a substantial issue of first impression and presents a fundamental issue of broad public importance requiring ultimate determination by the Supreme Court: Whether this Court should declare a Board of Medicine Rule intended to prevent abortion services through telemedicine to be illegal and unconstitutional.

STATEMENT OF THE CASE

I. Nature of the Case

This case concerns a rule recently adopted by the Board of Medicine ("Board"), Final Rule ARC 1034c ("Rule"), that would radically limit the availability of abortion in Iowa. The Rule bans a method of providing safe medical, *i.e.*, non-surgical, abortion utilizing telemedicine technology to connect women with the physicians who can provide this treatment. Over the past six years, PPH has used this method to extend early abortion services to over 6000 women in rural and outlying Iowa communities.

The Rule adopts verbatim a proposal submitted via petition by groups dedicated to eliminating abortion. Moreover, although the Rule was presented as a "safety" measure, the evidence plainly shows that the Rule is medically unnecessary and will in fact *impose* medical risks on Iowa women. Indeed, the leading women's health organization in the country, the American College of Obstetricians and Gynecologists ("ACOG"), filed an amicus brief to make this point in support of a stay. (Amicus Brief of ACOG in Support of Motion for Stay, Sep. 15, 2014 ("ACOG Br.")).

II. Proceedings

Petitioners-Appellants Planned Parenthood of the Heartland ("PPH") and Dr. Jill Meadows, M.D. (collectively, "Petitioners") brought this action

on their own behalf and on behalf of their patients, seeking to have the Rule declared illegal under the following Iowa Code ("IC") provisions:

- § 17A.19(10)(a) because it is unconstitutional;
- § 17A.19(10)(e) because it was "motivated by an improper purpose";
- § 17A.19(10)(j) because it is "[t]he product of a decision-making process in which the agency did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision maker in similar circumstances would have considered prior to taking that action";
- § 17A.19(10)(k) because "[i]ts negative impact on the private rights affected is so grossly disproportionate to the benefits accruing to the public interest from that action that it must necessarily be deemed to lack any foundation in rational agency policy";
- § 17A.19(10)(i) because reasoning that ignores so many important facts is "so illogical as to render it wholly irrational";
- § 17A.19(10)(n) because such reasoning is "[o]therwise unreasonable, arbitrary, capricious, or an abuse of discretion."[1]

At the outset of the litigation, Hon. Karen Romano of the Polk County District Court stayed the Rule pending resolution of Petitioners' claims. (App. 6-21). The Court also bifurcated these claims from Petitioners' original action constitutional claims and stayed the latter pending resolution of Petitioners' petition for review. (Ruling on Respondents' Motion to Dismiss, Jan. 7, 2014). The case was then transferred to Hon. Jeffrey Farrell.

[1] At the June 16, 2014 merits hearing, Petitioners also asked the court to consider whether the Rule is based on "substantial evidence," as required by IC § 17A.19(10)(f). (June 16, 2014 Hearing, Transcript at 7:2-5 ("Tr.")).

After the Petitioners filed their merits brief and appendix in support, Respondent moved to strike part of Petitioners' appendix, which the District Court granted. (App. 150-156). Several of the struck documents were unearthed when the Board responded to document production in this litigation and an open records request from a media outlet. The District Court held that these documents were only admissible on a showing that they had been considered by current Board members, and struck them under that standard. Petitioners sought leave to conduct depositions to ascertain whether, in fact, Board members had reviewed these documents. That motion was denied. (App. 186-189).

On August 18, 2014, the District Court upheld the Rule, denied Petitioners' claims, and dismissed the petition. The District Court also denied Petitioners' pending motions to update and clarify the record. (App. 245-284). Petitioners filed a timely notice of appeal, and sought a stay pending the appeal, which a panel of this Court granted on September 16, 2014.

STATEMENT OF THE FACTS

I. Medication Abortion is Extremely Safe.

Medication abortion is an extremely safe and effective non-surgical method of terminating an early pregnancy (in the first nine weeks) that has

been available to women in the United States since 2000. (App. 107 ¶¶ 7-8, App. 111-112 ¶ 23).[2] It is a two-drug regimen: First, at the clinic, the patient takes mifepristone, which blocks the hormones necessary for a pregnancy to continue; then, at home two days later, she takes misoprostol, which induces contractions that empty the uterus. (Id. ¶ 8, App. 107). To date, over 1.75 million women in the United States have accessed this treatment. (App. 333).

Screening out the small number of women who have contraindications to medication abortion is a straightforward process, involving a blood test, a vital signs check, an ultrasound, and a medical history. (App. 107-108 ¶ 10, 333-334). Complications occur only after the patient has left the clinic, and they are rare—exponentially rarer than those associated with pregnancy and childbirth. (App. 109 ¶ 17); see generally ACOG, Practice Bulletin Number 143: Medical Management of First-Trimester Abortion, 123 Obstet. Gynecol. (Mar. 2014), available at http://www.acog.org/~/media/Practice%20Bulletins/Committee%20on%20P

[2] Per Iowa R. App. P. 6.904(4)(a), citations in this brief refer to the District Court record. Certain of the documents in Petitioners' Appendix, such as Dr. Grossman's affidavit, were struck by the District Court on the basis that they were not specifically reviewed by current Board members. As Petitioners argue in detail in Argument § II, that ruling was plainly inconsistent with IC § 17A.19(7), as well as with this Court's recognition that legislative facts should be considered for constitutional claims.

ractice%20Bulletins%20%20Gynecology/Public/pb143.pdf?dmc=1&ts=201

40520T1026105366 ("ACOG Bulletin").[3]

II. PPH's Telemedicine Program is a Safe and Appropriate Measure to Address Disparities in Access to Health Care.

The overwhelming majority of Iowa counties lack an abortion provider. (App. 40). As Judge Romano found in her stay ruling, Petitioners face "difficulty . . . providing abortion services in Iowa—especially rural Iowa," because Iowa law allows only physicians to perform abortions and "so few physicians in Iowa are willing to or capable of performing such services." (App. 17).[4] Even when physicians living in rural and outlying communities want to provide abortion services, it is often impossible for them to do so either because the practice they join prohibits it or because they would be stigmatized and unable to maintain an overall practice. App. 430-435 - Lori Freedman, Willing and Unable: Doctors' Constraints in

[3] To put these risks in perspective, the rate of clinically significant adverse events from medication abortion is 0.16 percent, comparable to those of commonly prescribed antibiotics. (App. 110); Nadine Shehab et al., Emergency Department Visits for Antibiotic-Associated Adverse Events, 47 Clinical Infectious Diseases 735, 738-39 (2008), available at http://cid.oxfordjournals.org/content/47/6/735.full.pdf.

[4] Iowa's "physician-only" law, IC § 707.7(3), was enacted in 1976, decades before safe medication abortion became available. Notably, twelve states and the District of Columbia allow non-physician clinicians to provide medication abortion (and in some cases surgical abortion). Guttmacher Institute, State Policies in Brief (Oct. 1, 2014), http://www.guttmacher.org/statecenter/spibs/ spib_OAL.pdf.

Abortion Care 92-97 (2010); Planned Parenthood Se., Inc. v. Strange, ___ F. Supp. 2d ___, 2014 WL 3809403, at *16-17 (M.D. Ala. Aug. 4, 2014).

PPH initiated its telemedicine delivery system in 2008 to improve access for patients in rural and outlying communities by connecting outlying clinics to a physician using a live, two-way video-conferencing system. PPH currently provides this service at seven clinics throughout Iowa. (App. 239 ¶ 4). If not for this program, women would have to travel vast distances—in many cases hundreds of miles—to obtain care.

PPH's telemedicine program assures that patients are professionally cared for in person at the clinic, under physician supervision. After trained PPH staff have provided counseling and taken a blood test, an ultrasound image, and a medical history to screen for contraindications, the physician reviews these results and reads the ultrasound to confirm an intrauterine pregnancy within the appropriate gestational age range. (App. 359-360). Notably, as with any pregnancy-related ultrasound, the machine itself estimates the gestational age. (App. 118 ¶ 44).

The physician then meets with the patient via videoconference (with a PPH staff member in the room with the patient), answers her questions, and confirms that she is an appropriate candidate for the treatment and is giving informed consent. (App. 360; Audio Recording of Public Hearing: Iowa

Board of Medicine Administrative Record (Iowa Board of Medicine 11/01/2013) ("Hearing Audio") at 1:01:01). If so, the physician presses a button that triggers the release of a drawer where the patient is sitting, providing her with the first medication she needs to take. Id. The physician and the other staff member observe her ingesting that medication, and the physician makes sure she understands the instructions for the rest of the regimen. Id.

Whether the patient meets with a physician in person or via telemedicine, she takes the second medication in the regimen, misoprostol, at home.[5] Id. For nearly all patients, misoprostol is the medication that induces the expulsion of the products of conception. (App. 108 ¶ 11). Thus, whether or not the Rule goes into effect, women will not be in the room with

[5] The District Court stated that "the FDA's approval of mifepristone requires" an additional visit for the misoprostol and that the FDA only approved mifepristone when used in the first 49 days of pregnancy (App. 246-247, 269). That is incorrect. As with any drug, the FDA approved mifepristone based upon testing done pursuant to a particular protocol, and approved its manufacturer's final printing label (FPL) outlining that protocol for informational purposes. The FDA does not approve or "require" particular protocols, and has never required physician-supervised administration of misoprostol or imposed a gestational age limitation on medication abortion. See generally Planned Parenthood Ariz., Inc. v. Humble, 753 F.3d 905, 907-09 (9th Cir. 2014). And home administration of misoprostol (which is not at issue in this litigation) has been endorsed by ACOG as safe and effective, and is the current national standard of care. (See generally App. 111-112 ¶ 23; ACOG Bulletin at 3).

a physician when they miscarry.[6] (Ross Comments, Hearing Audio 29:20). (In fact, many women choose medication abortion for precisely this reason: to terminate their pregnancy in private at home, surrounded by loved ones of their own choosing). (App. 116 ¶ 36).

Not surprisingly, given the lack of any clinical need for the physician to be physically present for routine screening tests or for the oral ingestion of the first medication, there have been no patient complaints out of over 6000 patients who have received this care over the past six years in Iowa and not a single telemedicine patient testified in support of the Rule. (App. 104 ¶ 9, 114-115 ¶ 31). Moreover, studies of PPH's program have shown that it has an equally low incidence of complications and high patient satisfaction rate, as compared to PPH's medication abortion services in sites where the physician is physically present.[7] (App. 114-115 ¶¶ 30-31 (citing three publications included in appendix) App. 362-363; App. 33-34). In fact, rates of attendance at follow-up appointments were *higher* for telemedicine patients. (App. 119 ¶ 46).

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[6] To ensure patient safety, PPH gives its patients a number to call around the clock to speak to a medical professional if they have any concerns that they might be experiencing a complication. (App. 334).

[7] The District Court inexplicably dismissed these studies as "based on a review of records and . . . not clinical in nature." (App. 249). In fact, they are based on patient interviews as well as record review. (Dr. Grossman Comments, Hearing Audio 1:57:56).

Researchers also found that PPH's program has improved women's health by significantly reducing the incidence of more invasive, surgical second-trimester abortions in Iowa. (App. 115 ¶ 32; Dr. Shaw Comments Hearing Audio 1:20:01). PPH is also reducing the risk of undiagnosed ectopic pregnancies in Iowa—by enabling more women to access care, and to do so earlier in their pregnancy. (App. 242-243 ¶ 7); compare Kelly Cleland et al., Significant Adverse Events and Outcomes After Medical Abortion, A121 Obstetrics & Gynecology 166, 168 (2013), available at http://unmfm.pbworks.com/w/file/fetch/69626856/Significant_Adverse_Events_and_Outcomes_After.25.pdf with Andreea Creanga, Trends in Ectopic Mortality in the United States 1985-2007, 117(4) Obstetrics & Gynecology 837 (2011) available at http://thehowardcenter.com/articles/Trends_in_Ectopic_Pregnancy_Mortality_in_the.11.pdf (mortality rate for ectopic pregnancy among abortion patients lower than national maternal mortality rate from ectopic pregnancy)).[8] These public health benefits have prompted

[8] "An ectopic pregnancy is a pregnancy growing outside the uterus, generally in the fallopian tubes, and is dangerous for the pregnant woman because, as it grows, it can rupture that tube." (App. 242 ¶ 4). This danger is the same regardless of whether or not a woman terminates her pregnancy, and the key to minimizing the danger is early detection (for which ultrasound is optimal). Ectopic pregnancies are a "contraindication" for medication abortion only because the effects of the drugs can mask the symptoms of an ectopic pregnancy, thus delaying treatment. (Id. ¶ 7).

ACOG to confirm that PPH's program is a safe and acceptable way to extend care to medically underserved communities. (ACOG Bulletin at 11).

Indeed, the Board itself approved PPH's program in 2010. That year, the anti-abortion group Operation Rescue ("OR") filed a complaint against physicians providing abortions through PPH's telemedicine program, claiming that the program was unsafe. After a thorough investigation and internal report, the Board dismissed OR's complaint without requiring a single modification to PPH's program. (Tony Leys, Board Physician Says Decision Was About Politics, Not Science, Des Moines Register (Mar. 8, 2014), http://www.desmoinesregister.com/story/news/2014/03/09/board-physician-says-decision-was-about-politics-not-science-/6194707/ ("Leys"); App. 337-338; App. 35-37).

III. The Rule Intentionally and Drastically Reduces Access to Abortion, and Jeopardizes Women's Health.

In spite of this major step forward for the health of rural women in Iowa, opponents of safe and legal abortion have openly sought to eliminate PPH's telemedicine program so as to reduce access to abortion care. (App. 48, 49-100). In the wake of the Board's careful investigation, consideration, and rejection of the OR complaint against the PPH program, Governor Branstad reconstituted the Board by appointing new members as each current member's term expired. Randal K. O'Bannon, Iowa Board of

Medicine to Write Rules Governing Web-cam Abortion, National Right to Life News, Aug. 9, 2013, available at http://www.nationalrighttolifenews.org/news/2013/08/iowa-board-of-medicine-to-write-rules-governing-web-cam-abortions/#.VFlRHIvF_vh. Then, the petition proposing the new Rule was submitted to the Board.

The petition was orchestrated by anti-abortion groups and the Governor's office. (See App. 47; App. 44-46) (notifying recipients that the Petition had been filed, and attaching IRL press release)).[9] The new Board members—with unprecedented speed and over numerous objections, see Argument § III.A.i—reversed course and adopted, verbatim from the petition, the new Rule.

The Rule makes telemedicine impossible by requiring that the "physician must be physically present with the woman at the time the abortion-inducing drug is provided." Iowa Admin. Code r. 653-13.10(3). It doubles down on this requirement by also requiring that the physician perform the physical examination to determine the gestational age and intrauterine location of the pregnancy. Id. r. 653-13.10(2). The District Court

[9] The involvement of Iowa Right to Life, the Iowa Catholic Conference, and the Governor in orchestrating the petition was fully uncovered only through a private e-mail obtained by the Des Moines Register through an open records request to the Governor's office. However, it was widely suspected, and this suspicion was repeatedly voiced to the Board. (See App. 321, 329, 351-352).

deferred to the Respondent's justifications for these requirements: 1) medication abortion has certain contraindications such as ectopic pregnancy; 2) of the millions of women who have had medication abortions, there have been isolated cases of undiagnosed ectopic pregnancies (although the associated mortality rate is still *below* the general rate among pregnant women, see Statement of Facts ("Facts") § II); and 3) "concern with the quality of the ultrasound performed to determine the gestational age" of the pregnancy. (App. 266 (referencing Board Statement App. 318 ¶ 6)).[10]

These facts support the requirement of a physical examination, usually an ultrasound, to determine gestational age, location of the pregnancy, and absence of any other contraindication such as an ectopic pregnancy. As noted above, PPH does all of this and, while their physicians do not perform the ultrasound personally, they review the ultrasound image and the machine's determination of gestational age to ensure their adequacy and correctness. (See Facts § II). The Board's Statement does not explain why the Board's "concern" justifies the risks and burdens the Rule would impose

[10] The Board also justified the Rule as ensuring the availability of a physician to perform a pelvic exam where necessary. (App. 318 ¶ 6). But, as was explained to the Board, in the rare case where a patient at a telemedicine site needed a pelvic exam, it would be performed on site by an advanced-practice nurse (well within her scope of practice), or the patient would be referred to a health center where a physician was present. (Buchacker Comments, Hearing Audio 1:02:58).

on patients by drastically reducing access to early and non-surgical abortion.[11]

The Rule will make abortion unavailable in most of the communities where it was previously provided, leaving it available only in Iowa City and Des Moines (and one day each week in Ames). (App. 239 ¶ 4).[12] As a result, women will have to travel up to hundreds of additional miles to obtain an abortion. For example, a woman living in Rock Rapids will have to travel

[11] The protocol outlined on the FPL approved by the FDA does not require that physicians perform these tasks. (App. 112-113 ¶ 26).

[12] The District Court found that PPH currently has four facilities with a physician on site, where women could obtain an abortion under the Rule. (App. 277-278). That was clear error. As explained to the District Court (App. 239 ¶ 4), due to physician shortages, PPH was only able to offer in-person physician services at *two* clinics, in Des Moines and Iowa City. Although not in the record because it occurred since Petitioners filed this appeal, Petitioners are now able to offer in-person abortion services one day each week at their Ames clinic. Because of capacity constraints, Petitioners do not anticipate being able to expand these services. (App. 239 ¶ 3). This development does not substantially change the distances at issue here.

The court also assumed there currently are other *known* providers outside Des Moines and Iowa City (App. 278), although there is no evidence of this. (To the contrary, see Find a Provider, National Abortion Federation, available at http://prochoice.org/thinkyoure-pregnant/find-a-provider/ (last visited Nov. 6, 2014) (click on Iowa) (listing only PPH and the Emma Goldman Clinic in all of Iowa)). Based on these clear errors, the court incorrectly reasoned that the distances at issue are less than those considered in Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), when in fact they are greater, see 744 F. Supp. 1323, 1352 (E.D. Pa. 1990).

over 400 miles round trip—twice—to a clinic in Ames (or further to Des Moines), for a total driving time of more than 14 hours, whereas she otherwise could access a medication abortion via telemedicine at a much closer clinic in Sioux City.

These distances will be a hardship for Iowa women seeking a safe and legal abortion. Most of these women are low-income, which makes it particularly hard for them to arrange transportation, childcare, and time off work. Rachel K. Jones et al., Characteristics of U.S. Abortion Patients, 2008, Guttmacher Institute (May 2010) at 8, http://www.guttmacher.org/pubs/US-Abortion-Patients.pdf. Most are caring for children, and over 30 percent have multiple children. Id. And many face additional logistical obstacles, such as abusive or coercive family members or inflexible work schedules. (App. 336-337, 353-355 (citing Kate Grindlay et al., Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine, 23(2) Women's Health Issues e117, 119 (2013), available at App. 124); App. 361-363; App. 322; App. 328). (Of course, these are reasons why so many women, when counseled about their various options, have chosen a telemedicine abortion. (App. 124).

During the hearing before the Board, for example, a certified sexual assault advocate testified about a nineteen-year-old woman who came into a

rural outreach center after being raped and impregnated by her father. (Natalie Scarpino Comments, Hearing Audio 2:44:30). The woman decided to terminate her pregnancy, but a significant obstacle for her was getting to a clinic, "as she had very little income, no transportation, and no support system." Id. The advocate testified that "[i]t was *only through telemedicine* that this woman was able to access her legal right to termination at her local clinic." Id. (emphasis added).

Researchers have studied the factors that influence the timing of abortions, and have found that the farther a woman has to travel to reach a provider, the more likely she is to have the abortion later in pregnancy. For example, a study in Washington found that women who had to travel more than 75 miles to obtain an abortion were two to three times more likely than other women to terminate their pregnancy after 12 weeks. (App. 115 ¶ 33). Indeed, PPH's program significantly reduced the incidence of second-trimester abortions by making first-trimester abortions far more accessible; it follows that banning the program will push a significant number of women past the nine-week window when medication abortion is available and into

their second trimester before they can obtain an abortion.[13] (Id. ¶ 32; App. 362-363).

By delaying women in their efforts to obtain an abortion, the Rule exposes them to medical and safety risks. Some women have medical conditions that make medication abortion significantly safer than surgical abortion. If delayed past nine weeks, they will be deprived of their safest option and left only with higher-risk options. (See App. 116-117 ¶ 37) (explaining conditions for which medication abortion is safer than surgical abortion); see also Planned Parenthood Cincinnati Region v. Taft, 444 F.3d 502, 511-12 (6th Cir. 2006)). Other women are at risk unless they can conceal their abortion from abusive family members (harder to do the farther they must travel) (App. 322), or disguise it as a miscarriage (as medication abortion, but not surgical abortion, allows them to do) (App. 108 ¶ 11).

By depriving many women of their only non-surgical abortion option, the Rule also imposes psychological harms on them. Many women have deeply personal reasons for preferring a medication abortion, including that it "is less invasive than surgical abortion, which is a particularly important consideration for survivors of rape or sexual abuse." Planned Parenthood

[13] This window is narrow; it is measured from a woman's last menstrual period, *i.e.* weeks before she is even pregnant and several weeks before she would have any reason to suspect she is pregnant. (App. 107 ¶ 8).

Ariz., Inc. v. Humble, 753 F.3d 905, 908 (9th Cir. 2014); (see also App. 353). Seventy-one percent of women who choose medication abortion express a strong preference for this form over surgical abortion. (App. 116 ¶ 36).

By causing delay, the Rule also imposes risk on patients in general because, although abortion is a safe procedure generally, it is safest when performed early in pregnancy. (ACOG Br. at 8-9; App. 363). Moreover, women who are delayed in accessing care are at a *greater* risk of having an undiagnosed ectopic pregnancy, and women who must travel farther for follow-up care are at a *greater* risk of not receiving that care. See Facts § II.[14]

For some women, this reduction in access will not only delay them but prevent them altogether from reaching a legal abortion provider. (App. 336-337; ACOG Bulletin at 11 (noting that, after PPH implemented its program, "women in remote parts of the state were more likely to obtain an abortion than before"); Theodore Joyce, The Supply Side Economics of Abortion, 365 New Eng. J. Med. 1466 (Oct. 20, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1109889; Humble, 753 F.3d at 916 (noting evidence that distances similar to the ones at issue here

[14] Perversely, the Board cited the risk of undiagnosed ectopic pregnancy as a reason *for* the Rule, when the Rule only *heightens* this risk.

prevent women from obtaining an abortion)). Those who, as a result, are forced to carry their unwanted pregnancy to term face the risks of pregnancy and childbirth, which are exponentially higher than those associated with early medication abortion. (App. 109 ¶ 17; ACOG Br. 8-9). Some of these women will also be exposed to increased risk of domestic violence. Sarah CM Roberts, Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion, 12 BMC Medicine 144 (Sep. 29, 2014), available at http://www.biomedcentral.com/content/pdf/s12916-014-0144-z.pdf.

Some women, moreover, will attempt to self-induce an abortion out of desperation, a result that carries its own medical risks. (See App. 20, 323; Erica Hellerstein, The Rise of DIY[Do it Yourself] Abortions in Texas, The Atlantic, June 27, 2014, http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/; Emily Bazelon, A Mother In Jail for Helping Her Daughter Have an Abortion, N.Y. Times Magazine, Sept. 22, 2014, http://www.nytimes.com/2014/09/22/magazine/a-mother-in-jail-for-helping-her-daughter-have-an-abortion.html?_r=0 (Pennsylvania woman jailed for ordering abortion medication over the internet for her daughter; family had

limited transportation and lived 70 miles from the nearest abortion provider)).

IV. While Encouraging the Use of Telemedicine Generally, The Rule Singles Out and Effectively Bans Telemedicine For Medical Abortion.

Apparently with the sole exception of medical abortion, the Board is committed to "reduc[ing]" regulatory barriers to telemedicine services." (App. 29).[15] Thus, in Iowa, telemedicine delivery systems are used for a broad range of services including psychiatric care, surgery, geriatric care, family medicine, and pediatrics. (App. 23, 357).

For example, the University of Iowa has a federal grant to increase the use of telemedicine for rural patients with "complex illnesses," such as "heart disease, kidney disease, cancer, endocrine and gastrointestinal disorders, psychiatric disorders, and geriatric issues." Great Plains Telehealth Resource & Assistance Center, University of Iowa Telehealth Project, Sept. 22, 2012, http://www.gptrac.org/university-of-iowa-telehealth-project/. And telemedicine is frequently used to provide psychiatric services

[15] Notably, The Iowa Department of Human Services ("HHS") reimburses for Medicaid services provided through telemedicine. HHS Memorandum (Dec. 29, 2008), available at https://www.legis.iowa.gov/DOCS/LSA/IntComHand/2009/IHPAF026.PDFNational organizations such as the American Medical Association ("AMA") and ACOG also have stressed the public health importance of telemedicine. (App. 113-114 ¶ 29 (quoting AMA and ACOG publications)).

to rural areas of Iowa: there are an estimated 66 sites in 49 counties participating in the delivery of psychiatric services via telemedicine. Iowa Psychiatric Society, Telehealth Psychiatric Services: Improved Access in Iowa (last visited Oct. 22, 2014), http://www.iowapsych.org/Pages/TelehealthinIowa.aspx. Prescription of medications, including medications that require monitoring and carry significantly greater risks than the mifepristone or misoprostol, are also provided via telemedicine. (App. 330, 335-336).

Indeed, an Ad Hoc Committee of the Board, tasked with developing a policy on telemedicine, drafted a Report in 2010 stating that "[t]he patient evaluation need not be in-person if the telemedicine technology is sufficient to provide the same information to the physician as if the evaluation had been performed face-to-face." (App. 26). The Report also recognized that physicians need not examine their patients in person to establish "an appropriate physician-patient relationship." Id.[16]

[16] This position is also reflected in a draft document, dated only three days before the Board voted to proceed with banning telemedicine abortions. (See App. 101-102). Although the Board disclaims these documents now, a senior Board representative expressed this position to the public the very same day that the latter document was generated. (See App. 30). Notably, this position, which the Board now disclaims, mirrors the approach taken by the Federation of State Medical Boards. See Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (April 2014) §§ 2, 4, available

Yet, against this backdrop, the Board adopted the Rule at issue here, using the requirement of a physical examination conducted by the physician as the pretext to eliminate telemedicine abortion and with it access to early, safe, medical abortion for the women of rural Iowa.[17]

ARGUMENT

I. The District Court Failed to Provide Meaningful Judicial Review of the Rule.

Standard of Review: The scope of review of agency action is set forth in Iowa Code sections 17A.19 and 17A.20. This Court reviews the District Court's decision for errors in law "as in other civil cases." IC § 17A.20. The Court's "duty is to correct errors of law made by the District Court." Iowa Bankers Ass'n v. Iowa Credit Union Dept., 335 N.W.2d 439, 442 (Iowa 1983) (noting the Court applies standards of sections 17A.19 and 17A.20 and that standards are the same for contested case and rule-making,

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at http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf.

[17] The Board has just announced that it intends to initiate a rule-making process to regulate telemedicine in general. Draft Rule available at https://medicalboard.iowa.gov/Board%20News/2014/Press%20release%20-%20Board%20votes%20to%20establish%20standards%20for%20physicians%20who%20use%20telemedicine%20-%20October%2010,%202014.pdf. The draft released by the Board would permit telemedicine abortion services, but for a surely purposeful "poison pill" provision at the end that requires the physician to be in the same location as the patient when—as is uniquely the case for abortion—state law requires that the medication at issue be administered by a physician.

except that rule-making review allows the Court to consider additional evidence).

This Court reviews the constitutional issues raised by Petitioners de novo, and is bound by neither the agency nor the District Court's findings. Gartner v. Iowa Dep't of Pub. Health, 830 N.W.2d 335, 344 (Iowa 2013).

Error Preservation: Error was preserved on this issue. Before the District Court, Petitioners presented the proper standards for review of an agency decision, both on statutory grounds found in IC § 17A.19, as well as constitutional claims. (See generally Petitioners' Brief, Jan. 21, 2014; Revised Petitioners' Brief, Apr. 14, 2014.)

Argument: The District Court gave an excessive and unwarranted level of deference to the Board of Medicine that finds no support in § 17A.19 or Iowa law. The District Court took the view that, because the Board is composed partly of physicians, the Court was not in a position to question the Board's conclusion that an in-person physical examination by a physician and follow-up at the same facility are always necessary to the safe provision of medication abortion. (See, e.g., App. 267-268). To the lower court, the compelling evidence Petitioners submitted showing that this conclusion makes no medical sense (and even defies common sense) showed nothing more than "disagreement." This over-deference renders judicial

review of Board action meaningless, and disregards that courts are routinely called on to evaluate the opinions of physicians. This Court should apply the standard of judicial review mandated by § 17A.19 in evaluating the Board's actions (as well as a de novo standard with respect to Petitioners' constitutional claims).

A. The District Court Failed to Provide the "Intensive" Review Required by the Iowa Code.

Section 17A.19 of the Code, amended in 1998, sets forth how Iowa courts shall review agency actions. As Professor Arthur Bonfield, reporter-draftsman for the 1998 amendments, explains, these amendments reflected concern that courts were not always providing meaningful review. To ensure adequate review, the legislature added "language specially calculated *to ensure an intensity of review* [of agency actions] . . . by elaborating in much more detail the substantive content of" this review. App. 388-409 - Arthur Bonfield, Amendments to Iowa Administrative Procedure Act, Report on Selected Provisions to Iowa State Bar Association and Iowa State Government 59-60 (1998) ("Bonfield") (emphasis added).

Accordingly, as this Court recognized in Cedar Rapids Cmty. Sch. Dist. v. Pease, 807 N.W.2d 839 (Iowa 2011), while judicial review is deferential, "[o]ur review of the [agency's] record is 'fairly intensive,' and we do not simply rubber stamp the agency finding of fact." Id. at 845

(quoting Wal-Mart Stores, Inc. v. Caselman, 657 N.W.2d 493, 499 (Iowa 2003)). When reviewing whether an agency's fact-finding is supported by substantial evidence, "subparagraph (3) [of § 17A.19(10)(f)] clearly indicates the court's obligations to view the *reasonableness* of the agency fact finding in view of the 'whole record,' including *all of the contrary evidence and the extent to which that contrary evidence precludes the agency from reasonably finding the facts as it did.*" App. 401 at 65 (emphasis in original). The question on appeal is "whether the evidence supports the findings actually made." Grant v. Iowa Dep't of Human Servs., 722 N.W.2d 169, 173 (Iowa 2006) (citation and internal quotation marks omitted).

Petitioners challenge the conclusion reached by the Board, *i.e.*, its application of law to facts. Thus, as this Court recognized in Meyer v. IBP, Inc., 710 N.W.2d 213, 218-19 (Iowa 2006), this Court must evaluate whether the Board's conclusions were afflicted with "irrational reasoning; failure to consider relevant facts; or irrational, illogical, or wholly unjustifiable application of law to the facts." Id. (citing § 17A.19(10)(c), (i), (j) & (m)). See also Midwest Auto. III, LLC v. Iowa Dep't of Transp., 646 N.W.2d 417, 430-32 (Iowa 2002) (evaluating each specific piece of evidence that the agency was alleged to have ignored). Judicial review is no less

"intensive" for Board of Medicine actions, even though the Board includes some physician members. See Smoker v. Iowa Bd. of Med., 834 N.W.2d 83, 2014 WL 1760185 (Iowa Ct. App. 2013) (reversing Board determination); cf. Arora v. Iowa Bd. of Med. Exam'rs, 564 N.W.2d 4, 6-8 (Iowa 1997) (finding Board determination valid after intensive review of the record).

The District Court failed to follow this precedent. For example, instead of evaluating under § 17A.19(10)(j) whether the Board had failed to consider evidence that was relevant, important, and would have been considered by a rational decision maker, the District Court held that "it is not for the court to review medical studies and determine which is the most persuasive" (App. 268), and concluded that the Board had adequately "considered" the evidence against the Rule's advisability because "[t]he record shows that the [B]oard . . . reviewed studies submitted." Id. These quotations reflect that the District Court essentially abdicated its important role in independently reviewing the evidence before it.

The District Court also accepted, without any independent analysis, the Board's bare assertion that it had "considered" all of these facts but simply "disagreed" with them; however, if § 17A.19(10)(j) means anything, it requires more than that an agency list the objections to a rule and then mechanically state that it "disagrees" with them; rather, the agency must

explain why they are unfounded or outweighed by other legitimate considerations, and reviewing courts must critically evaluate that explanation.

B. The District Court Overlooked that Courts Routinely Evaluate Medical Opinion.

More generally, courts are often called upon to evaluate medical opinion. In the analogous context of considering expert medical testimony, this Court explained in Wells v. Wells, 168 N.W.2d 54, 59 (Iowa 1969), that "[a]lthough the courts in this jurisdiction hold opinions of medical experts in high regard, they cannot abdicate the authority, and perforce duty, to view them in the light of recognized standards of the law, and if need be to reject them in whole or in part." The decisions of the Board of Medicine are not insulated from judicial review by virtue of the medical expertise of certain members of the Board.

Indeed, independent evaluation of the evidence is particularly important in the context of abortion restrictions, where medical opinions often may be colored by antipathy to the very concept of abortion as health care. See, e.g., Planned Parenthood Se., Inc. v. Strange, ___ F. Supp. 3d ___, 2014 WL 5339294, at *3-5, 11 (M.D. Ala. Oct. 20, 2014) (discounting testimony of multiple state witnesses, and finding one witness's testimony "driven more by a bias against abortion…than by a true desire to reach an

accurate [assessment]"); Planned Parenthood of Wis., Inc. v. Van Hollen, No. 13-CV-465-WMC, 2013 WL 3989238, at *4 n.16 (W.D. Wis. Aug. 2, 2013) (expressing doubts about the objectivity of the state's proposed witnesses); Whole Women's Health v. Lakey, ___ F. Supp. 2d ___, 2014 WL 4700226, at *5 n.3 (W.D. Tex. Aug. 29, 2014).

Thus, particularly in the context of abortion restrictions, courts must evaluate medical opinions and assertions in light of the overall record. The District Court's failure to do so here was error.

II. The District Court Abused its Discretion in Striking Petitioners' Evidence.

Standard of Review: Evidentiary rulings are reviewed by this Court for abuse of discretion. Office of Consumer Advocate v. Iowa Utils. Bd., 770 N.W.2d 334, 342-43 (Iowa 2009).

Error Preservation: Error was preserved on this issue as Petitioners have challenged the District Court's ruling striking portions of the evidence at every opportunity. (See App. 137-149; Motion for Additional Time to Conduct Discovery, Mar. 28, 2014; Petitioners'/Appellants' Application for Interlocutory Appeal and Stay of District Court Proceedings, April 23, 2014; App. 285-286).

Argument: The District Court abused its discretion in striking evidence that was admissible to support Petitioners' state and federal

constitutional claims and administrative law claims. (See App. 150-156; see also App. 254). The District Court reasoned that it could only consider evidence specifically before current Board members, not staff or former Board members. (See App. 153 ("Petitioners cannot submit documents that were provided to agency staff members without a showing that a board members had knowledge of the document.")). Then, having struck this evidence under an unprecedented evidentiary standard, the District Court further abused its discretion by denying Petitioners' request for permission to conduct further discovery to determine which of the excluded documents, if any, were known to individual Board members and therefore admissible. (App. 188).

A District Court "abuses its discretion when its ruling is based on grounds that are unreasonable or untenable. The grounds for a ruling are unreasonable or untenable when they are based on an erroneous application of the law." Giza v. BNSF Ry. Co., 843 N.W.2d 713, 718 (Iowa 2014) (internal quotation marks and citations omitted). In addition, "[a] court abuses its discretion when it fails to exercise any discretion." Lawson v. Kurtzhals, 792 N.W.2d 251, 257 (Iowa 2010) (quoting State v. Hager, 630 N.W.2d 828, 836 (Iowa 2001)).

Here, the District Court's decision to strike much of Petitioners' evidence was contrary to Iowa law. First, regardless of any limitations on the record for purposes of assessing the reasonableness of an agency decision, such limitations are inapplicable and inappropriate with respect to the court's de novo review of Petitioners' constitutional claims. Second, contrary to the District Court's ruling, a petitioner need not show that a piece of evidence was expressly reviewed by an individual member of the rulemaking body for the evidence to be admissible under the Iowa Administrative Procedure Act ("IAPA"): instead, the evidence must merely highlight, as Petitioners' did, what actually occurred before the agency or serve to impeach the agency's stated reasons for its action.

A. Petitioners' Legislative Facts Were Admissible to Support their Constitutional Claims.

With respect to constitutional law claims, legislative facts beyond the agency record are both admissible and integral to a court's de novo consideration of these claims. See Varnum v. Brien, 763 N.W.2d 862, 881 (Iowa 2009). Though Petitioners' administrative review and constitutional law claims demand separate and distinct analyses, the District Court reasoned that the presence of administrative review claims in the Petition made it in appropriate to consider facts outside the agency record, even for Petitioners' constitutional law claims. (App. 254 n.4). This was error.

This Court has long recognized that constitutional analysis is "a task 'entirely within the province of the judiciary,'" with no deference given to the agency regarding the constitutionality of the rule. See, e.g., Gartner, 830 N.W.2d at 344 (quoting NextEra Energy Res. LLC v. Iowa Utils. Bd., 815 N.W.2d 30, 44 (Iowa 2012)). In part, this is based on the idea that the courts, "free from the political influences in the other two branches of government," better protect individual rights. Varnum, 763 N.W.2d at 875.

When a petitioner challenges the constitutionality of an agency action, the court makes an "independent evaluation of the totality of evidence from which the assertion of unconstitutionality arises." Iowa-Ill. Gas & Elec. Co. v. Iowa State Commerce Comm'n, 412 N.W.2d 600, 604 (Iowa 1987); see also Gartner, 830 N.W.2d at 344; Silva v. Emp't Appeal Bd., 547 N.W.2d 232, 234 (Iowa Ct. App. 1996). Most commonly, a court must consider "legislative facts" (or "constitutional facts"), which include "social, economic, political, or scientific facts," that assist the court in determining whether any circumstances exist that "constitutionally either legitimate the exercise of legislative power or substantiate the rationality of the legislative product." Varnum, 763 N.W.2d at 881 (citation omitted). Whether or not these facts are in the administrative record is irrelevant.

In Varnum, this Court reviewed all of the evidence submitted by the parties, holding that the District Court had erred in excluding this evidence: "[T]estimony relating to constitutional facts is only presented as authority for the legal decision the court is required to make, and it would be inconsistent to apply formal rules of evidence to [such] facts." Id. at 881. Similarly, here, excluded evidence plainly qualifies as admissible social, economic, political, or scientific facts that should have been considered by the District Court, and should now be considered by this Court, in evaluating Petitioners' constitutional claims.[18]

B. Petitioners' Other Evidence Was Admissible to Highlight What Occurred at the Agency Level and to Impeach the Board's Statement of Reasons.

The District Court abused its discretion for a second independent reason: it improperly struck Petitioners' evidence based on an erroneous understanding of IC § 17A.19(7). This provision governs the submission of

[18] The excluded evidence includes, for example: expert testimony and related articles on the safety of telemedicine abortion and the medical risks associated with restricted access to abortion; testimony concerning how few Iowa abortion clinics would be able to provide services if the Rule went into effect; evidence showing the Board previously accepted the use of telemedicine without an in-person examination; and correspondence showing that the Petition for Rulemaking was coordinated with the Governor's office and orchestrated by groups opposed to all safe and legal abortion. (App. 152-154). The excluded evidence was relevant to the court's constitutional analysis under either strict scrutiny or an undue burden standard.

supplemental evidence in a judicial review of agency action under the IAPA. By its terms, a reviewing court may hear and consider evidence from outside of the agency record "as it deems appropriate." Id.

As Professor Bonfield's Report on the amended § 17A.19 explains, subsection (7) permits consideration not only of the evidence presented to the agency, but also of "*any other evidence* relevant to the legality of the matter at issue offered to the court by any party." (App. 401) (emphasis added). Bonfield notes that while the agency is bound by the contemporaneous reasons it proffered for the rule, "the agency and opposing party are free to supplement the record before the court with relevant *new* evidence to support or impeach those reasons." Id. (emphasis added).

Notably, although § 17A.19(7) limits expansion of the record in appeals concerning contested cases, it does not impose these same limitations in the context of judicial review of agency rulemaking; this underscores the legislature's intent to allow for a more expanded record when courts are reviewing an agency rule. See, e.g., Greenwood Manor v. Iowa Dep't of Pub. Health, State Health Facilities Council, 641 N.W.2d 823, 835 (Iowa 2002) (use of different language in two sections of a statute reflected the legislature's deliberate choice that the two sections be applied differently).

Included in the excluded evidence were:

- A 2010 draft Board policy on the use of telemedicine, and a related press release regarding this policy. (App. 23-28).

- A communication by the Board's Director of Legal Affairs to a member of the public consistent with these documents. (See App. 30).

- The affidavit of Daniel Grossman, M.D., who studied Petitioners' telemedicine program. (App. 105-121). The affidavit provides comprehensive information about basic medical facts that the Board failed to consider in adopting the Rule. These facts include the rarity of complications from telemedicine abortion, the ways in which telemedicine improves patient care, and the identical in-person and telemedicine protocols.

- E-mails, discovered through open records requests and litigation discovery, showing that the petition for rulemaking was coordinated with the governor's office and anti-abortion organizations, that staff were suspicious of the Board's political motivations, and that a Board member made statements declaring an intention to restrict abortion by any lawful means. (App. 43, 44-46, 47, 48).

This Court has consistently stated that, although additional evidence may not be used to retry the factual issues in District Court, it may be used to "highlight[] what actually occurred in the agency." Iowa Power & Light Co. v. Iowa State Utils. Bd., 448 N.W.2d 468, 470 (Iowa 1989) (citation omitted); see also Medco Behavioral Care Corp. of Iowa v. State Dep't of Human Servs., 553 N.W.2d 556, 562 (Iowa 1996) ("[A] court may base its judicial determination on consideration of an amplified factual record, not

just the information available to the agency"). All of the excluded evidence fits within these holdings.

The District Court justified its exclusion of any evidence not shown to have been considered by an individual member of the current Board, as opposed to a Board staff member or former Board member, by stating that only the ten members of the current Board can adopt rules for the agency. (App. 152). This reasoning unrealistically constricts this Court's holding in Iowa Power & Light and places petitioners at an insurmountable disadvantage when seeking judicial review of a flawed agency action. This is especially true when applied to documents in the possession of the Board as an entity and combined with a refusal to allow additional discovery regarding whether documents were available to individual members of the Board.

The Rule was enacted by the Board as an entity. Regardless of what information individual members reviewed in reaching their conclusions, the body of information submitted to or existing within the Board as an entity is relevant. The universe of relevant material must include, at a minimum, information possessed by the Board's senior staff and senior staff communications relating to telemedicine and the proposed Rule. For example, the Executive Director of the Board, who is one of the individuals

on many of the e-mails excluded by the District Court, plays a significant role in managing the affairs of the Board, including communicating with the public on its behalf. See Iowa Admin. Code r. 653-1.4(17A). The other participants on the excluded e-mails, such as the Board's Director of Legal Affairs and Medical Advisor, likewise have job duties that require frequent contact and coordination with Board members.

Presumably, Board members consult these staff members when considering a contentious petition for rulemaking. They would, or at least should, do so to access information submitted by the public, learn about the presence or absence of past complaints, investigations or proposed policies related to the rulemaking, inquire about the proposed rule's medical basis, and evaluate any legal issues raised by the rule. Thus, documents attributed to the Board of Medicine or its staff members, even if not reviewed by a current Board member, are relevant to what occurred before the Board.

This is especially important here, where the Board acted in contradiction both of its earlier dismissal of a complaint about the same telemedicine practice, and of its previously expressed views on telemedicine, and did so in a manner that raised concerns about the process it was following. Either Board members were aware of some or all of the excluded documents or they chose to insulate themselves from these materials—a fact

that itself would undermine the Rule's validity, see Argument § III.A.i. Thus, documents in the possession of, or attributable to, the Board or its staff members, even if not reviewed by a current Board member, are relevant to what occurred below. See App. 401 (evidence admissible to impeach agency reasons); Modesto Irrigation Dist. v. Gutierrez, 619 F.3d 1024, 1034 (9th Cir. 2010) ("Courts will not assume [an agency] has engaged in reasoned decision making when it implicitly departs from its prior precedent and provides no explanation for doing so." (punctuation omitted) (quoting Dillman v. Nat'l Transp. Safety Bd., 588 F.3d 1085, 1091 (D.C. Cir. 2009)).

For these reasons, the District Court abused its discretion by requiring Petitioners to show that a document was expressly considered by a current Board member: such a rule finds no support in Iowa law, and led to the improper exclusion of important and relevant evidence.

III. The Rule is Invalid.

Standard of Review: The IAPA provides various grounds for invalidating an agency action. This Court reviews the District Court's decision for errors in law "as in other civil cases." IC § 17A.20. The Court's "duty is to correct errors of law made by the District Court." Iowa Bankers Ass'n, 335 N.W.2d at 442.

This Court reviews the constitutional issues raised by Petitioners de novo, and is bound by neither the agency nor the District Court's findings. Gartner, 830 N.W.2d at 344.

Error Preservation: The Arguments made in this section were preserved for appeal. Petitioners raised each of the grounds for seeking to have the rule declared illegal and invalid in their Petition, Brief, and one ground was raised during the June 16, 2014 hearing. (See First Amended and Recast Petition for Review ¶¶ 45-54, Jan. 17, 2014; Petitioners' Brief at 12-31; App. 167-183; Tr. at 7:2-5).

Argument: This Court should find the Rule invalid under numerous provisions of § 17A.19(10), both administrative and constitutional, because the Rule has no basis in medicine, is driven by a desire to restrict abortion access, and will actively harm women. As the Montana Supreme Court stated when faced with a similarly pretextual "health" restriction:

> [W]hen . . . the [government] thrusts itself into [the] protected zone of individual privacy under the guise of protecting the patient's health, but, in reality, does so because of prevailing political ideology and the unrelenting pressure from individuals and organizations promoting their own beliefs and values, then the state's infringement of personal autonomy is not only constitutionally impermissible, it is, as well, intellectually and morally indefensible.

Armstrong v. State, 989 P.2d 364, 384 (Mont. 1999). This Rule is equally impermissible and indefensible.

A. The Rule Violates IC § 17A.19(10)(j).

The Rule violates IC § 17A.19(10)(j) because it is "[t]he product of a decision-making process in which the agency did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision maker in similar circumstances would have considered prior to taking that action." Id. The text of § 17A.19(10)(j) requires the reviewing court to grant relief from a prejudicial agency action if the agency overlooked even *one* relevant and important matter; here, the Board overlooked *many*.

i. The Board's decision-making process was rushed and inadequate.

At the outset, because the language of IC § 17A.19(10)(j) centers on "process," it is important to consider the irregularity of the Board's decision-making process here, which even the District Court acknowledged "invited scrutiny." (App. 261). (This irregularity also supports Petitioners' claim, argued below, that the Board had improper motivations.) The Board based the Rule, verbatim, on a petition written by an anonymous author—and, as the Board was repeatedly warned, orchestrated behind the scenes by anti-abortion groups working together with the Governor's office. See Facts § III.

The petition was not supported by any medical professional organization. Moreover, it was based on assertions about the safety of PPH's

telemedicine program that had been thoroughly investigated and rejected by the Board less than three years earlier. Facts § II. Nonetheless, and within three days of receiving the petition, the Board voted to move forward and notify the public that it proposed adopting it verbatim. This was so inappropriate and unprecedented that the Iowa Medical Society ("IMS") took the unusual step of criticizing the Board for having failed to study the issue and having failed to seek specialist professional input before moving forward. (App. 326-327).

After the Rule had been finalized (again without any independent analysis), the IMS went further, stating that the Rule was "not credible" and citing the Board's failure to adhere to the proper process in adopting it:

> The IBM, in adopting this rule, failed to engage in a robust examination of the rule in light of medical practice standards, failed to call upon medical expertise with demonstrable knowledge and experience in the delivery of this telemedicine procedure, and failed to conduct an objective determination of the necessity and appropriateness of each of the rule's criteria for assuring patient health and safety.

(App. 4).

Similarly, the Board's Legal Director, Kent Nebel, criticized the Board's actions (as "unprecedented" in his 15 years of service), as did Assistant Attorney General Theresa Weeg. Mike Wiser, Iowa Board of Medicine to Discuss Ending Telemedicine Abortions, The Gazette (Mar. 28,

2014), http://thegazette.com/2013/06/29/iowa-board-of-medicine-to-discuss-ending-telemedicine-abortions/#sthash.hAUfsv46.dpuf. Board Member Ann Gales expressed her concern with the Board's openly political approach. (App. 369). Board Medical Advisor John Olds also expressed his concern that the Board's actions seemed political. (App. 43). Dr. Olds has since disclosed that the Board refused to *consider* the results of the Board's 2010 investigation or to let him address the Board on the matter. See Leys, Facts § II.

In short, the Board acted without gathering the information it needed; with willful blindness to the information placed before it; and with a haste that was uncharacteristic, inappropriate in light of the interests at stake, and unsupported by any facts indicating urgency.

ii. The Board overlooked numerous important matters.

In its results-driven haste, the Board failed to consider numerous matters that any rational decision-maker would have considered important. Petitioners will highlight six of these here.

First and foremost, the Board overlooked the health risks and other burdens the Rule imposes on women. Without telemedicine, many Iowa women will be forced to travel significantly further to obtain an abortion, in some cases over 400 miles round-trip, multiple times. Facts § III. These

distances are burdensome, and in some cases will be prohibitive, for women who face poverty-related and logistical obstacles to traveling for an abortion—including limitations related to transportation, childcare, abusive or coercive family members, or work schedule. Id. Indeed, studies showed that PPH's program had enabled more women in outlying areas to access abortion services. See ACOG Bulletin at 11.

As the Board knew, or should have known, from studies showing that PPH's program has reduced the incidence of second-trimester abortions in the state, the Board's decision to ban the program also means that those women who manage to travel hundreds of miles for an abortion are likely to do so later in pregnancy, when medication abortion may not be an option and the risks attendant to surgical abortion are higher. Facts § III. (In addition to facing increased medical risk, these women will be deprived of a strongly-preferred non-surgical option). Id. This delay will be particularly risky for those women whom the Board professed to be *protecting* with the Rule—women with ectopic pregnancies—because *early* detection is the key to safely treating this condition. Facts §§ II & III.

Those prevented from obtaining a safe and legal abortion will either be forced to carry their pregnancy to term, which carries significantly higher risks than medication abortion (in addition to other personal costs), or resort

to dangerous efforts to self-induce an abortion. Facts § III. The Board dismissed these serious concerns with a single, conclusory and non-responsive statement that removing access was necessary to ensure that all women have "the same high level of health care." (App. 317 ¶ 1). The Board did not explain how depriving some women of abortion care altogether, and delaying others until they face fewer (and less safe) medical options, would ensure all women receive "the same high level of health care."

Second, the Board refused to consider its own recent, extensive investigation of PPH's program and conclusion that this program did not even need to be modified, let alone banned. See Facts § II. The Board dismissed this fact as irrelevant because "[t]he membership of the Board has changed completely." (App. 317 ¶ 4). This empty response, devoid of a substantive explanation of what had changed, is surely suggestive of the truth: The Rule was not motivated by the medical merits or demerits of PPH's telemedicine practice, but by other, legally disqualifying, concerns.

Third, the Board failed to consider its own policies and statements favoring telemedicine generally, and specifically its own statements that patient evaluations can take place via videoconferencing. Facts § IV. To take one particularly striking example, in response to a physician inquiry into the Board's position on telemedicine, Legal Director Kent Nebel enumerated

several "general principles that the Board has considered when evaluating telemedicine," including that "the patient evaluation may not need to be in-person if the telemedicine technology is sufficient to provide the same information as if the evaluation had been performed face-to-face." (App. 30). This correspondence occurred on July 24, 2013, just three days before the Board notified the public of its intention to ban telemedicine abortion.[19]

Fourth, the Board failed to consider the actual facts of PPH's telemedicine program and the role of PPH's physicians within that program. PPH's telemedicine protocols do not differ in any medically significant respect from its protocols for delivering services where a physician is physically present. In either case, the physician: 1) reviews the patient's laboratory results, ultrasound images, and medical history to screen for contraindications; 2) interviews and counsels the patient to ensure that she understands, and is an appropriate candidate for, the treatment and gives

[19] The District Court stated that the Board also requires physicians to examine a patient in person before prescribing *pain* medicine (and reasoned from this that the Board had not singled out abortion providers entirely). (App. 265). This is incorrect. To address the widespread abuse of addictive pain medication (which raises concerns absent from the medication abortion context), the Board requires in-person screening, but does not dictate who performs this screening. Iowa Admin. Code r. 653-13.2(5)a.

informed consent; and 3) dispenses the medications.[20] Facts § II. In neither case does the physician himself estimate gestational age; that is done by the machine, with the physician checking the image to confirm the machine's reading. Id. Moreover, any complications that may arise would arise *after* the woman has returned home from the clinic. Id. Nothing about this process requires the physician's physical presence or sets medication abortion apart from the myriad medical services that are routinely provided to Iowans through telemedicine.[21] Facts § IV.

Fifth, the Board overlooked the fact that medication abortion is exceptionally safe, significantly safer than later-term abortion, and far safer than childbirth. See Facts § I. The Board overlooked that medication abortion has a limited number of contraindications that can easily be screened for using telemedicine abortion. Id. The Board also overlooked that

[20] It is far from routine for physicians to dispense medications in person (see App. 330), but, unlike a number of other states, see note 4, Iowa law requires that medication abortion be performed by a physician.

[21] The Board's Statement of Reasons cited concerns over the quality of the ultrasounds staff were generating (without any evidence of a single gestational age error among the thousands of women treated) (App. 318-319), but it is routine for physicians to read transmitted images from a different location and abortion providers do not need a highly detailed image to accurately confirm an intrauterine pregnancy or estimate gestational age. (App. 41-42, 118-119 ¶¶ 44-45). At any rate, even if these concerns had been valid, they would not support the unique requirement imposed here that *physicians* generate the ultrasound images themselves.

abortion medications have an incidence of serious complications comparable to that of many commonly-prescribed medications. Id. & note 3.

Finally, the Board overlooked the demonstrated safety of PPH's telemedicine program (statistically equal to the safety record of its medication abortion services generally); the data showing that women are equally, and in some respects more, satisfied with telemedicine abortion, experience no increased complication rates, and are even *more* likely to obtain follow-up care;[22] and the fact that the Board has not registered a single complaint from any of the thousands of Iowa women who have obtained medication abortions through PPH's telemedicine program. See Facts § II.

In short, the Board overlooked *numerous* medical and general facts that should have been highly relevant to its decision—facts that established the safety of PPH's program, the significant benefits it affords women in medically underserved communities, and the real risks and harms associated with banning it. For this reason, the Rule violates IC § 17A.19(10)(j). (For

[22] This oversight is particularly noteworthy given that the District Court relied on the Board's "finding" that an in-person meeting with a physician and patient would increase the likelihood of a follow-up exam as one of the bases for adopting the Rule. (App. 267). In fact, the data show precisely the opposite. Facts § II.

substantially the same reasons, the Rule also violates § 17A.19(10)(e) because it is not supported by substantial evidence.)

B. The Rule Violates Subsections (k), (i), and (n) of Section 17A.19(10).

The Rule also violates IC § 17A.19(10)(k) because "its negative impact on the private rights affected is so grossly disproportionate to the benefits accruing to the public interest from that action that it must necessarily be deemed to lack any foundation in rational agency policy." A Rule is invalid under this provision if the court finds a lack of "reasonable proportion" between the benefits and the costs of the agency action. Zieckler v. Ampride, 743 N.W.2d 530, 533 (Iowa 2007) (striking down agency rule).

The Rule will deprive hundreds of Iowa patients each year of accessible, safe, early abortion services. Judge Romano noted this significant concern in granting a stay below, noting that denying a stay of the Rule would "interfere with the relationships between physicians who provide telemedicine abortions and their patients," would compromise Petitioners' "ability to care for their patients," and "could delay. . . [these patients'] ability to obtain a chemical abortion past the date where chemical abortions are prohibited, and force them to consider having a surgical abortion, or even forgo having an abortion altogether." (App. 15-17). In so doing, the

Rule subjects patients to unwarranted health risks and other burdens, in violation of their constitutional rights.

Given that there is no evidence of *any* public health benefit to justify the substantial harm caused by the agency action, (see App. 18-20; Facts §§ II & III), the Rule fails IC § 17A.19(10)(k)'s proportionality requirement.[23] For substantially the same reasons, the Rule is "so illogical as to render it wholly irrational," and is "[o]therwise unreasonable, arbitrary, capricious, or an abuse of discretion." § 17A.19(10)(i)&(n).

C. The Rule Was Motivated By An Improper Purpose.

The Board violated IC § 17A.19(10)(e) because it was "motivated by an improper purpose," namely, the purpose of restricting access to abortion. The Rule is taken verbatim from a petition coordinated (covertly) by Governor Branstad's office, together with Iowa Right to Life and the Iowa Catholic Conference, two groups that are dedicated—not to making abortion safer—but to *preventing* abortion. See Facts § III. The Rule was not supported by any medical professional organization; to the contrary, the IMS and IOMA urged the Board not to adopt it. (App. 326-327, 330). The Board

[23] Even if there were some safety reason to have the physician present while the patient is screened for contraindications and takes the first medication (and there is not), that would not explain why the Rule requires the patient to return *to the same facility* to confirm termination—thereby doubling the distance she must travel—when she could just as safely do so at a clinic closer to home.

was warned of these facts, but chose to disregard them. Facts § III & note 9.[24]

The underhanded fashion in which the petition was introduced, the unacknowledged involvement of anti-abortion groups, and the Board's decision to adopt the petition verbatim despite warnings that it came from groups dedicated to eliminating abortion entirely all indicate that the Rule's adoption was motivated, partly or wholly, by a desire to restrict access to lawful abortion. Even Board Medical Advisor John Olds warned that "the impetus [for the Petition] seems to be politically, morally, and religiously motivated." (App. 43).

[24] The District Court waved away this concern, noting that the Petition for Rulemaking was signed by five physicians. (App. 267). However, these signatures support, rather than dispel, the inference that the petition was intended to obstruct abortions. Two of these physicians have explicitly stated that they oppose telemedicine abortions because they oppose all abortion. (Richard Ratino Comments, Hearing Audio 2:52:13; App. 436-437 - Katie Lefebevre, Iowa Board of Medicine Adopts Rule Prohibiting Webcam Abortions, The Catholic Globe (Sep. 19. 2013) (to be included in forthcoming proposed appendix)). All but one of these physicians are publicly associated with the viewpoint that abortion should be eliminated (and some oppose access to *contraception*). See id.; Renee Webb, Plan B: Diocesan Reaction to FDA Decision to Lower Age, The Catholic Globe (May 30, 2013), http://www.scdiocese.org/news.cfm?story=121736; Vitae Family Care, Our Team, http://vitaefamilycare.com/the-vitae-team/, Our Mission, http://vitaefamilycare.com/who-we-are/; Staff, InnerVisions HealthCare, http://www.innervisionshealthcare.org/about-us/; FAQ, InnerVisions HealthCare, http://www.innervisionshealthcare.org/faq/; Mission and Vision, National Institute of Family and Life Advocates, http://www.nifla.org/about-us-mission-and-vision.asp (sites last visited Nov. 5, 2014).

Another indication of this improper motivation is the outsized role played by Monsignor Frank Bognanno, a Board member who had previously advocated for a ban because he was concerned—not about the relative safety of telemedicine abortions—but about the effect of accessible abortion (as he called it, "abortion on demand") on "the fundamental value of promoting the dignity of human life from the moment of conception." (App. 48).

Once the Rule was proposed by a coalition organized by anti-abortion groups, Msgn. Bognanno actively lobbied his colleagues to approve it, sending each of them a collection of hand-annotated materials (including from unmarked sources) that discussed medication abortion not as health care that could be improved, but as a moral wrong that must be stopped at all costs. (See App. 49-100). Aware that his obvious bias would raise legal issues for the Board, Msgn. Bognanno did not himself move for the Board to accept the petition, but rather asked fellow member Allison Schoenfelder to do so and "helped her with the wording." (App. 128-130).

That the Board was motivated by the desire to restrict access to lawful abortion is further apparent from the utter lack of medical rationale for the Rule, the Board's refusal even to consider the contrary results from the 2010 investigation, see Facts § II, and the stark inconsistency between how the Board has chosen to regulate telemedicine abortion and how it treats all

other forms of telemedicine in Iowa, Facts § IV. As Iowa courts have recognized, an illegitimate purpose may be inferred when a policy lacks a sufficient relationship to the asserted legitimate interests. See Gartner, 830 N.W.2d at 353 (noting that the state policy of treating same-sex parents differently did not serve the state's asserted interest in administrative efficiency, and concluding that this poor fit "demonstrate[s] . . . that some other unarticulated reason, such as stereotype or prejudice, may explain the real objective of the State").[25]

Thus, both because the evidence shows that anti-abortion views were a driving force behind the Rule and because the Board has utterly failed to dispel the inference of impropriety by explaining the medical necessity of banning telemedicine abortion, the Rule is invalid under IC § 17A.19(10)(e).

[25] Other jurisdictions, considering analogous "health" restrictions on abortion, have similarly found evidence of impermissible purpose based on flaws in the state's offered rationale. See, e.g., Cline v. Okla. Coal. for Reprod. Justice, 313 P.3d 253, 262 (Okla. 2013) (state's restriction on medication abortion "**so completely at odds with the standard that governs the practice of medicine** that it can serve no purpose other than to prevent women from obtaining abortions and to punish and discriminate against those women who do" (emphasis in original) (quoting district court with approval)); Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 790-91 (7th Cir. 2013).

D. The Rule Violates Rights To Due Process and Equal Protection Secured to Petitioners and Their Patients by the Iowa Constitution.[26]

The Rule also violates the rights of Petitioners and their patients under the Iowa Constitution, and should thus be invalidated under IC § 17A(10)(a). Specifically, the Rule violates Petitioners' patients' due process rights by needlessly burdening their private reproductive health care decisions. The Rule also violates Petitioners' and their patients' equal protection rights because it singles out medication abortion and treats it differently from non-pregnancy-related—not to mention equally or more risky and complex—medical care.

i. This Court should hold explicitly that, under the Iowa Constitution, abortion is a fundamental right and that the Rule is subject to strict scrutiny review.

Because reproductive choice is central to dignity, bodily integrity, and equality, numerous state Supreme Courts have concluded that abortion is a protected fundamental right. As the Minnesota Supreme Court explained:

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[26] Below, Petitioners also raised claims under the federal constitution. In this Court, Petitioners rely solely on the Iowa Constitution. As explained at the outset, Petitioners have also filed an original action challenging the Rule as unconstitutional, which is currently stayed below. See Statement of the Case § II. This original action would allow Petitioners to build a full evidentiary record, including further discovery and expert testimony. Thus, should this Court affirm the district court's evidentiary rulings, and also find that (on the record thus limited) the Rule is not invalid under IC § 17A.19(10), Petitioners ask the Court to limit its holding to that record and continue the existing stay so that Petitioners may be fully heard in their original action.

> We can think of few decisions more intimate, personal, and profound than a woman's decision between childbirth and abortion. Indeed, this decision is of such great import that it governs whether the woman will undergo extreme physical and psychological changes and whether she will create lifelong attachments and responsibilities.

Women of Minn. by Doe v. Gomez, 542 N.W.2d 17, 19 (Minn. 1995). The Alaska Supreme Court, similarly, has explained that "reproductive rights are fundamental" because "few things are more personal than a woman's control of her body, including the choice of whether and when to have children." Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 968-69 (Alaska 1997) (internal quotation marks omitted).

Other state courts have reached the same conclusion. See, e.g., Right to Choose v. Byrne, 450 A.2d 925, 934 (N.J. 1982) (A woman has a "fundamental right . . . to control her body and destiny. That right encompasses one of the most intimate decisions in human experience, the choice to terminate a pregnancy or bear a child."); Armstrong, 989 P.2d at 375; cf. Planned Parenthood Ass'n v. Dep't of Human Res. Or., 663 P.2d 1247, 1258 (Or. 1983) (recognizing "important" interest in access to abortion); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851 (1992) (abortion right "central to personal dignity and autonomy" (internal quotation marks and citations omitted)); Lawrence v. Texas, 539 U.S. 558,

565 (2003) (decision whether to terminate a pregnancy a "fundamental decision[] affecting [a woman's] destiny").[27]

This Court has also been clear that it will not be bound by federal standards for adjudicating restrictions on rights protected by the Iowa Constitution. See State v. Ochoa, 792 N.W.2d 260, 267 (Iowa 2010) (holding that, because of "the independent nature of our state constitutional provisions . . . [t]he degree to which we follow United States Supreme Court precedent . . . depends solely upon its ability to persuade us with the reasoning of the decision"). Rather than simply deferring to the federal courts on the meaning of the individual rights set forth in the federal and Iowa constitutions, this Court has strived to be at the forefront in protecting individual rights. Varnum, 763 N.W.2d at 877 n.4; see also Mark S. Cady, The Vanguard of Equality: The Iowa Supreme Court's Journey to Stay Ahead of the Curve on an Arc Bending Towards Justice, 76 Alb. L. Rev. 1991 (2013). This Court should continue that tradition and hold that, under the Iowa Constitution, the right to choose abortion is a fundamental right.[28]

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[27] When an abortion restriction takes away a safe medical option previously available to women, another protected right in addition to the right to choose abortion is also at stake: "an individual's right to chart his or her own plan of medical treatment." Rasmussen by Mitchell v. Fleming, 741 P.2d 674, 682 (Ariz. 1987) (internal quotation omitted).

[28] In Sanchez v. State, 692 N.W.2d 812 (Iowa 2005), this Court has already indicated that abortion is a fundamental right. Id. at 820.

When considering laws that impinge on fundamental rights, this Court has consistently applied strict scrutiny. See, e.g., State v. Groves, 742 N.W.2d 90, 93 (Iowa 2007); Hensler v. City of Davenport, 790 N.W.2d 569, 580 (Iowa 2010); see also In re JL, 779 N.W.2d 481, 490-91 (Iowa Ct. App. 2009); State v. Jorgenson, 785 N.W.2d 708, 715 (Iowa Ct. App. 2009). It should do so here.[29] As many other state courts have concluded, lesser standards such as the federal "undue burden" standard do not sufficiently protect a woman's fundamental privacy rights. See, e.g., Planned Parenthood of Cent. N.J. v. Farmer, 762 A.2d 620, 626 (N.J. 2000) (right to abortion merits "greater respect" than Casey gave); Gomez, 542 N.W.2d at 19 (providing "broader protection" than Casey); Valley Hosp. Ass'n, 948 P.2d

[29] Before refusing to apply strict scrutiny, Judge Farrell questioned this Court's decision in Racing Association of Central Iowa v. Fitzgerald, 675 N.W.2d 1 (2004) ("RACI"). (App. 279-280). The continuing validity of RACI, however, is irrelevant here. RACI concerns the application of rational basis review to economic legislation, and whether this standard is more robust under the Iowa Constitution than it is under the federal constitution. Critiques of RACI have focused on the deference traditionally afforded to the legislature in taxation matters, as well as the unique procedural posture of that case. Regardless of RACI, this Court continues to reaffirm its long tradition of providing greater protection for individual rights under the Iowa Constitution than federal courts have provided under the federal constitution. See, e.g., State v. Short, 851 N.W.2d 474, 507 (Iowa 2014) (Cady, J., concurring) ("our history of robust protection of human rights owes in no small part to our authority within America's federalist system to independently interpret our constitution. . . . Today's decision is another step in the steady march towards the highest liberty and equality that is the birthright of all Iowans; it will not be the last.").

at 969 (rejecting Casey's "narrower definition of [the abortion] right"); Armstrong, 989 P.2d at 376 (requiring "more than that the State simply not impose an undue burden on a person's exercise of his or her right of individual privacy"); Planned Parenthood of Middle Tenn. v. Sundquist, 38 S.W.3d 1, 16-17 (Tenn. 2000) (rejecting undue burden standard as overly subjective, in favor of strict scrutiny, "a recognized principle of constitutional law"), superseded by constitutional amendment;[30] N.M. Right to Choose/NARAL v. Johnson, 975 P.2d 841, 853 (N.M. 1998) (applying test identical to strict scrutiny); see also Women's Health Ctr. v. Panepinto, 446 S.E.2d 658, 663-64 (W.Va. 1993); N. Fla. Women's Health & Counseling Servs., Inc. v. State, 866 So.2d 612, 634-35 (Fla. 2003); Simat Corp. v. Ariz. Health Care Cost Containment Sys., 56 P.3d 28, 32-33 (Ariz. 2002).

This Court should join these other state courts in honoring the fundamental nature of reproductive rights by applying strict scrutiny to abortion restrictions such as those at issue here.

ii. The Rule fails strict scrutiny.

Under the strict scrutiny standard, for both due process and equal

[30] This Court recently cited Sundquist with approval as an example of a state declining to walk in lockstep with "uncertain and fluctuating federal standards." Short, 851 N.W.2d at 488.

protection purposes,[31] "[t]he *State* must prove [a challenged law] is narrowly tailored to the achievement of a compelling state interest." Sanchez, 692 N.W.2d at 817 (emphasis added). The Board essentially conceded below that its Rule would fail strict scrutiny, ignoring this standard and arguing instead that the court should adopt a less demanding standard. As explained in the Statement of the Facts, the Rule (and the distinction it draws between abortion medications and all other medications) does not come close to advancing a compelling state interest; still less is it "narrowly tailored" to do so. To the contrary, the Rule undermines the Board's asserted interest by jeopardizing patient health. Thus, this Court should find the Rule violates both substantive due process and equal protection rights protected by the Iowa Constitution.

iii. Alternatively, the Rule violates "heightened scrutiny" applicable to regulations that discriminate on the basis of sex.

Even if this Court were to conclude that abortion is not a fundamental right under the Iowa Constitution, the Rule would still be subject to heightened scrutiny because it facially discriminates against women. See Quaker Oats Co. v. Cedar Rapids Human Rights Comm'n, 268 N.W.2d 862,

[31] Because the Rule creates a classification that "affect[s] [a] fundamental right," strict scrutiny is appropriate for both analyses, Varnum, 763 N.W.2d 880.

866-67 (Iowa 1978) ("[A]ny classification which relies on pregnancy as the determinative criterion is a distinction based on sex." (citation and internal quotation marks omitted)), superseded by statute on other grounds, IC § 216.29; see also N.M. Right to Choose/NARAL, 975 P.2d at 854 (treating abortion restriction as gender-based and applying heightened scrutiny because "[s]ince time immemorial, women's biology and ability to bear children have been used as a basis for discrimination against them" (citation omitted)); cf. Casey, 505 U.S. at 856 (access to legal abortion necessary to enable women "to participate equally in the economic and social life of the Nation").

Thus, even if abortion were not a fundamental right, the Rule would violate the Iowa Constitution because it is not "substantially related to" patient safety. See Varnum, 763 N.W.2d at 880 (under the Iowa Constitution, a law that classifies on the basis of gender "must not only further an important governmental interest and be substantially related to that interest, but the justification for the classification must be genuine and must not depend on broad generalizations").

iv. Even if this Court applies an "undue burden" standard to enforce Petitioners' patients' rights under the Iowa Constitution, the Rule fails.

Even if this Court adopts the "undue burden" standard as the standard to be applied under the Iowa Constitution, the Rule fails. Under that standard, a regulation is unconstitutional if it "has the purpose or the effect of imposing a substantial obstacle" on a woman's access to abortion. Casey, 505 U.S. at 877.

The reasons why the Rule fails this standard are fully discussed in earlier portions of this Brief. Petitioners demonstrate that the Rule is nothing more than a pretext for curtailing access to abortion, (Facts § III; Argument § III.C), that it does nothing to advance women's health, (Facts § II & III), and that its effect will be to accomplish its real purpose of dramatically curtailing access to abortion. (Facts § III).

Where an abortion restriction enacted as a health protection fails to actually advance women's health *or* imposes a substantial obstacle on access to abortion that is disproportionate to a minimal health benefit, it is unconstitutional. See, e.g., Planned Parenthood of Wis., Inc. v. Van Hollen, 738 F.3d 786, 798 (7th Cir. 2013), cert. denied, 134 S. Ct. 2841 (2014); Humble, 753 F.3d at 912-13; Strange, 2014 WL 3809403, at *5 ("[T]he more severe the obstacle a regulation creates, the more robust the government's justification must be, both in terms of how much benefit the regulation provides towards achieving the State's interests and in terms of

how realistic it is the regulation will actually achieve that benefit" (citation omitted)). The Rule is unconstitutional for both reasons.

The District Court ignored this precedent, instead relying on the Fifth Circuit's approach in Planned Parenthood of Greater Texas Surgical Health Services v. Abbott, 748 F.3d 583 (5th Cir. 2014). (App. 276-277). As demonstrated, *e.g.*, by the cases cited above, Abbott does not accurately reflect the federal standard. More importantly, Abbott does not reflect a standard that *this* Court should find "persuasive" and employ under the Iowa Constitution. See Ochoa, 792 N.W.2d at 267 (court follows federal precedent only to the degree its reasoning is persuasive). This is because, as argued above, reproductive choice is central to a woman's autonomy, bodily integrity, and equality. Without meaningful, fact-based review of state "health" restrictions on abortion, courts cannot fulfill their necessary role in giving "real and substantial protection" to these critical values. Lawrence v. Texas, 539 U.S. 558, 565 (2003).

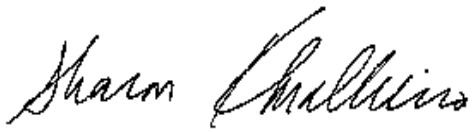
Accordingly, even under an "undue burden" standard under the Iowa Constitution, the Rule must be found to violate Petitioners' patients' rights.

CONCLUSION

For the reasons set forth above, the Petitioners respectfully request that the Court invalidate the Rule and provide such other relief that the Court deems warranted.

REQUEST FOR ORAL ARGUMENT

Petitioners/Appellants respectfully request that this matter be heard orally before this Court.



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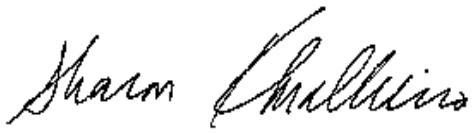

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CERTIFICATE OF FILING AND SERVICE

I, Sharon Malheiro, hereby certify that on the 22nd day of December, 2014, I electronically filed the foregoing Petitioners/Appellants' Brief with the Clerk of the Iowa Supreme Court by using the EDMS system and all persons who have filed appearances are registered EDMS users and that service will be accomplished by the EDMS system on the following:

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