No. 15-1736

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

PLANNED PARENTHOOD OF WISCONSIN, INC., et al.,

Plaintiffs-Appellees,

v.

BRAD D. SCHIMEL, et al.,

Defendants-Appellants.

On Appeal From The United States District Court
For The Western District Of Wisconsin
No. 13-cv-465, The Honorable William M. Conley, Presiding

BRIEF OF *AMICI CURIAE* THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, AND THE WISCONSIN MEDICAL SOCIETY IN SUPPORT OF PLAINTIFFS-APPELLEES' BRIEF SEEKING AFFIRMANCE OF THE DISTRICT COURT'S ORDER

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 15-1736

Short Caption: Planned Parenthood of Wisconsin, Inc. v. Schimel

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

American College of Obstetricians and Gynecologists

American Medical Association

Wisconsin Medical Society

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Dentons US LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: S/ Alan S. Gilbert Date: 6/24/2015

Attorney's Printed Name: Alan S. Gilbert

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Attorney's Signature: S/ Leah R. Bruno Date: 6/24/2015

Attorney's Printed Name: Leah R. Bruno

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None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

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Attorney's Signature: S/ Kristine M. Schanbacher Date: 6/24/2015

Attorney's Printed Name: Kristine M. Schabacher

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ____ **No** X

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STATEMENT OF *AMICI CURIAE*

The **American College of Obstetricians and Gynecologists** ("ACOG" or the "College"), the **American Medical Association** ("AMA"), and the **Wisconsin Medical Society** ("Society") submit this brief *Amici Curiae* in support of Plaintiffs-Appellees.[1]

ACOG is a non-profit educational and professional organization that was founded in 1951 and represents approximately 95% of all board-certified obstetricians and gynecologists practicing in the United States. The College's objectives are to foster improvements in all aspects of health care of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members. Sharing more than 56,000 members, including 853 in Wisconsin, the College and the Congress are the leading professional associations of physicians who specialize in the health care of women. The College recognizes that abortion is an essential health care service and opposes laws regulating medical care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

The **AMA** is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all US physicians,

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[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for *Amici Curiae* certify that: no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting this brief; and no person or entity, other than the *Amici Curiae,* its members, or its counsel, contributed money intended to fund the preparation or submission of this brief.

residents, and medical students are represented in the AMA's policy making process. AMA members practice and reside in all states, including Wisconsin. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

ACOG and the AMA have previously been granted leave to appear as *Amicus Curiae* in various courts throughout the United States including this Court and the Supreme Court. In addition, ACOG and the AMA's work has been cited frequently by the Supreme Court and other federal courts seeking authoritative medical data regarding childbirth and abortion.[2]

The **Society** is a non-profit association of physicians, chartered by the legislative assembly of the Territory of Wisconsin in 1841 to promote the science and art of medicine to improve public health. Today, the Society has over 12,700 physician, resident, and medical student members, and continues its mission to improve the health of Wisconsin's citizens by supporting and strengthening physicians' ability to practice high-quality medicine.

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[2] *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG's *amicus* brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG's *amicus* brief in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG publication in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *Gonzales v. Carhart*, 550 U.S. 124, 170-71, 175-78, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's *amicus* brief and congressional submissions regarding abortion procedures); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 168 (4th Cir. 2000) (extensively discussing ACOG's guidelines and describing those guidelines as "commonly used and relied upon by obstetricians and gynecologists nationwide to determine the standard and the appropriate level of care for their patients"); *Planned Parenthood Arizona, Inc. v. Humble*, 753 F.3d 905, 916-17, 930 (9th Cir. 2014) (citing ACOG and the AMA's *amicus* brief as further support for a particular medical regimen); *Stuart v. Camnitz*, 774 F.3d 238, 251-52, 254, 255 (4th Cir. 2014) (citing ACOG's and the AMA's *amicus* brief in assessing how an ultrasound requirement exceeded the bounds of traditional informed consent and interfered with physicians' medical judgment.); and *Planned Parenthood of Greater Texas Surgical Health Servs. v. Abbott*, 769 F.3d 330, 351 fn.9 (5th Cir. 2014) (Jones, J., dissenting) (citing ACOG's *amicus* brief in support of dissent's determination that the district court did not clearly err by finding that admitting privileges for abortion providers does not improve the quality of care a patient receives in the rare event of a severe complication).

The Society is actively involved in legislative affairs, policy research, and the review of legal issues that affect its members and their patients. The Society has previously been granted leave to appear as *Amicus Curiae* in Wisconsin state and appellate courts as well as the state's District Courts and the Seventh Circuit Court of Appeals, including earlier proceedings in this case in which both the Society and ACOG were *Amici Curiae*.

The Society and the AMA join this brief on their own behalves and as representatives of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

SUMMARY OF ARGUMENT

Women are entitled to timely, high-quality health care, including access to abortion services. Legislatures should not interfere with patient care, patient access to safe medical procedures, and/or accepted medical practice without a strong public health justification. Scientific data establishes that abortion is an extremely safe medical procedure. The requirement of Wisconsin Act 37 ("Act 37") that abortion providers obtain "admitting privileges in a hospital within 30 miles of where the abortion procedure is performed" is not based on scientific research or data, has no legitimate public health justification, and does not reflect the realities of modern medical practice.[3] Rather, Act 37's admitting privileges requirement would significantly delay and/or restrict access to abortion procedures in Wisconsin, which would detrimentally impact the health and well-being of women in Wisconsin. Act 37 creates an unnecessary hurdle for Wisconsin women who seek an abortion and should not be allowed to take effect.

[3] Section 1 of 2013 Wisconsin Act 37, Wis. Stat. Ann. § 253.095. *See* Addendum A for the full text of Section 1 of Act 37.

For the reasons set forth below, *Amici Curiae* urge this Court to affirm the District Court's March 24, 2015 Order declaring Section 1 of Act 37 to be unconstitutional and permanently enjoining its enforcement.

ARGUMENT

I. ABORTION IS A SAFE MEDICAL PROCEDURE THAT ACT 37 ARBITRARILY TARGETS FOR DISPARATE TREATMENT.

Scientific research and empirical data conclusively establish that abortion is a very low-risk, safe medical procedure. Other outpatient procedures have higher complication rates. Yet, under Wisconsin law no outpatient providers, other than abortion providers, are required to obtain admitting privileges. Act 37 irrationally targets physicians who perform abortion procedures for disparate regulation.

A. Peer Reviewed Scientific Research Demonstrates Abortion Is An Extremely Safe Medical Procedure.

There are two types of abortion: (1) medication abortion, in which abortion is achieved by administering medications, most commonly mifepristone in combination with misoprostol,[4] and (2) surgical abortion, which involves the use of instruments to evacuate the contents of the uterus. *See* Doc. No. 266 p. 8; Trial Exhibit ("Ex.") 50 ¶ 3. Both types of abortion are extremely safe procedures in the United States. *See* Ex. 50 ¶ 7. In fact, two large scale, respected, peer reviewed studies[5] conclusively establish that complications associated with legal abortions are minimal and complications that require hospitalization are extraordinarily rare. *See* Doc. No. 266 pp. 30-31. The first study examined 233,805 medication abortions performed in the United

[4] *See* ACOG Practice Bulletin No. 143, *Medical Management of First-Trimester Abortion*, Clinical Management Guidelines for Obstetrician-Gynecologist, Vol. 123, 676 (Mar. 2014).

[5] The two peer reviewed studies are: Cleland, K., et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166 (2013) and Weitz, T. et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Public Health 454 (2013).

States and found that fewer than one percent (0.65%) of the patients undergoing this procedure experienced a significant complication and far fewer (0.06%) experienced a complication requiring hospitalization.[6] The second study analyzed 11,487 first-trimester surgical abortions and found that only 1.27% of these patients experienced minor complications that required outpatient treatment and only 0.052% experienced a major complication that required hospital admission.[7] Further, the most recent Wisconsin state data demonstrates that abortion, whether medical or surgical and whether performed in the first trimester or second trimester, is extremely safe.[8] Indeed, the state's data indicates that the rates of complication in Wisconsin are even lower than the national averages. Specifically, only 0.21% of Wisconsin residents, who had abortions throughout pregnancy, experienced complications of any kind.[9] Not only are abortion complications exceedingly rare; [10] in fact, women are more likely to experience complications carrying a pregnancy to term and after giving birth than with an abortion. As discussed in

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[6] Cleland, K., et al., *supra* note 5, at 169.

[7] Weitz, T., et al., *supra* note 5, at 458.

[8] Wis. Dep't. of Health Servs., Div. of Pub. Health, Office of Heath Informatics, *2013 Reported Induced Abortions In Wisconsin*, Table 9 (Aug. 2014) https://www.dhs.wisconsin.gov/publications/p4/p45360-13.pdf. 2013 is the most recent year for which data is available.

[9] *Id*. Additionally, this low rate of complication is arguably higher than the actual occurrence of complications because this report counts each type of complication, i.e. infection, retained products, cervical laceration, etc., as a separate complication even if the same patient experiences multiple issues. *See id.*

[10] *See* Cleland, K., et al., *supra* note 5, at 169; Weitz, T., et al., *supra* note 5, at 458; and Wis. Dep't. of Health Servs., *supra* note 8, at Table 9; *see also* Jones B. and Weitz, T., *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (April 2009) ("Abortion is very safe in both the first and second trimesters. Mortality risk is approximately .6 deaths per 100,000 abortions, and the risk of major complication is less than 1%. The risk associated with abortion increases with the weeks of pregnancy …. Second-trimester abortion, however, is still a very safe procedure.").

Dr. Douglas Laube's expert report, "every pregnancy-related complication is more common among women having live births than among those having abortions" and "[n]early three percent of all women who deliver vaginally have a prolonged hospital admission or early re-admission to the hospital [and with] a cesarean delivery … the figure is three times higher." Ex. 50 ¶¶ 7-8.

In addition to the minimal complications associated with abortions, the mortality rate associated with abortion is also extremely low, only 0.0006%. For comparison purposes, the risk of death associated with childbirth is approximately 14 times higher, at a mortality rate of 0.0088%.[11]

As demonstrated by the prevailing peer reviewed scientific research, and as recognized by the District Court, the "overwhelming evidence demonstrates that abortion is safe[.]" *See* Doc. No. 266 p. 36; *see also* Doc. No. 244 7:24-8:3. Given the safety of abortion procedures and the very low risk of hospitalization, Act 37's potential restriction on abortion providers for purported safety reasons has no basis in science or fact.

B. Physicians Who Perform Other Outpatient Medical Procedures In Wisconsin, Including Procedures With Higher Risks of Morbidity And Mortality Than Abortion, Are Not Required To Obtain Admitting Privileges.

Wisconsin law does not require physicians who perform outpatient medical procedures, other than physicians who perform abortions, to obtain admitting privileges. *See* Doc. No. 200 ¶ 14 ("The State of Wisconsin does not require physicians who provide surgery at ambulatory surgery centers or in other outpatient settings to have hospital admitting privileges."); *see also* Doc. 266 p. 25 ("At trial, defendants conceded that an admitting privileges requirement has never been imposed on *any* outpatient procedure other than the provision of abortion services.")

[11] ACOG Practice Bulletin No. 135, *Second-Trimester Abortion*, Clinical Management Guidelines for Obstetrician-Gynecologist, Vol. 121, 1394, 1397 (June 2013); *see also* Raymond, E. and Grimes, D., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (Feb. 2012).

(emphasis in original). The scientific research and data does not support the singling out of abortion procedures for such disparate regulation.

Abortion is just as safe, if not safer, than other gynecological procedures such as cervical biopsies, endometrial biopsies, IUD insertions, and "LEEP" procedures[12] that doctors perform in outpatient settings without the requirement of admitting privileges. *See* Doc. No. 244 34:3-36:9; 41:24-43:16. To give just one example, the rate of heavy bleeding following a LEEP procedure is more than double the rate of heavy bleeding following a surgical abortion, and far greater than the risk associated with a medical abortion.[13] Yet physicians that perform LEEP procedures in outpatient settings are not required to obtain admitting privileges under Wisconsin law.

The arbitrariness of Act 37 becomes even clearer when one compares abortion procedures to other surgical procedures performed in outpatient settings, particularly those procedures that, unlike abortion procedures, use general anesthesia.[14] For example, procedures like laparoscopic hysterectomies and vaginal hysterectomies have higher complication rates than abortion procedures, yet physicians performing these outpatient procedures are not required to obtain admitting privileges under Wisconsin law. *See* Ex. 50 ¶ 23 and *see also* Doc. No. 266

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[12] Loop Electrosurgical Excision Procedures, often referred to as "LEEP" procedures, are a common gynecological procedure utilized to remove abnormal cervical tissue.

[13] *See* Sutthichon, P. and Kietpeerakool, C., *Perioperative Complications of an Outpatient Loop Electrosurgical Excision Procedures: A Review of 857 Consecutive Cases*, 10 Asian Pac. J. of Cancer Prevention 353 (2009); *see also* Paraskevaidis, E., et al., *Bleeding After Loop Electrosurgical Excision Procedure Performed in Either the Follicular or Luteal Phase of the Menstrual Cycle: A Randomized Trial*, Vol. 99 No. 6 Obstetrics & Gynecology, 999 (June 2002).

[14] General anesthesia itself carries additional risk, including cardiovascular and respiratory complications. *See, e.g.,* Harris M. and Chung F., *Complications of General Anesthesia*, 40 Clin. Plastic Surg. 503 (2013) (discussing risk of complications associated with general anesthesia); *see also* Gold, B. MD, et al., *Unanticipated Admission to the Hospital Following Ambulatory Surgery*, 262 J. Am. Med. Assoc. 3008, 3008-3010 (1989) (general anesthesia was one factor associated with increased likelihood of post-surgery hospital admission.).

pp. 25 & 27. The same is true for colonoscopies which have a mortality rate of 0.0345%, more than 50 times greater than the mortality rate for abortions.[15] Yet despite this substantially higher mortality rate, Wisconsin law does not require physicians who perform outpatient colonoscopies to obtain admitting privileges similar to Act 37.

It makes no scientific or common sense to burden abortion providers with an admissions privilege requirement when physicians who perform other outpatient procedures that carry similar or significantly greater risks of complications and mortality have no such requirement.[16] Act 37's requirement that abortion providers obtain admitting privileges is arbitrary, not scientifically based, and not supported by the medical data.

II. ACT 37'S ADMITTING PRIVILEGES REQUIREMENT IS AN UNNECESSARY REGULATION THAT HAS NO POSITIVE EFFECT ON THE QUALITY OF HEALTH CARE THAT A PATIENT RECEIVES.

As the District Court observed (Doc. No. 266 pp. 6-7), Wisconsin's leading medical and public health associations, including ACOG and the Society, opposed Act 37 because, among other reasons, requiring physicians who perform outpatient services to have admitting privileges is inconsistent with accepted medical practice. A physician's focus on ensuring prompt,

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[15] *See* Ko, C. MD, et al., *Complications of Colonoscopy: Magnitude and Management*, 20 Gastrointestinal Endoscopy Clinics of N. Am. 659, 659-671 (2010) and ACOG Practice Bulletin No. 135, *supra* note 11, at p. 1397.

[16] ACOG Committee Opinion No. 613, *Increasing Access to Abortion*, 1 (Nov. 2014) http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20150610T1549031081 (Target Regulation of Abortion Provider ("TRAP") laws are "enacted in some states, under the guise of promoting patient safety, single out abortion from other procedures and impose medically unnecessary requirements designed to reduce access to abortion …. [these TRAP laws] do not improve patient safety or quality of care."); *see also* Gold R. and Nash E., *TRAP Laws Gain Political Traction While Abortion Clinics--and the Women They Serve--Pay the Price*, Vol. 16 No. 2 Guttmacher Policy Review, 7 (2013) ("TRAP[] laws … have nothing to do with protecting women and everything to do with shutting down clinics …. [TRAP laws are] increasingly common, but they only make sense if the goal is to make abortion less accessible.").

effective medical care does not require that the medical provider have admitting privileges.[17] The AMA has joined ACOG and the Society here because Act 37's admitting privileges requirement is contrary to today's standard medical practice and because other policies and procedures already in place enable physicians to procure urgent care for their patients when necessary.

A. Act 37's Requirement That Abortion Providers Obtain Admitting Privileges Is Inconsistent With Accepted Medical Practice.

In today's medical practice, patients who undergo an abortion procedure, like all outpatient procedures, are provided aftercare instructions in the rare event that the patient experiences a complication after leaving the clinic. These instructions encourage patients to contact their clinic if they experience any complication so that the clinic can assess whether the patient should return for further treatment or in the case of a severe, urgent complication, be advised to go to the nearest hospital. *See* Ex. 50 ¶ 13. Complications that are not severe or urgent are appropriately treated in the abortion clinic or other outpatient clinic, and whether an abortion provider has admitting privileges is irrelevant.

In the extraordinary instance when a woman experiences a severe and urgent complication following an abortion, she will obtain the treatment she needs from the emergency

[17] *See* Inst. of Med., *Crossing the Quality Chasm: A New Health System for the 21st Century*, 8-9 (2011) (stating that patient care should be guided by certain rules, including that "[p]atients should receive care whenever they need it and in many forms, not just face-to-face visits … [and] that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits" and that "[c]lincians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.").

room physician and/or on-call specialist[18] at the hospital closest to her, which in many cases is not the same hospital at which her abortion provider has admitting privileges, if he/she has them. *See* Ex. 50 ¶ 13. In such situations, the emergency room physician and/or on-call specialist take over the treatment of a patient admitted to the hospital, which includes identifying key issues, concerns, and methods of treatment for the patient without any regard to whether the outpatient provider has admitting privileges. *See* Doc. No. 266 pp. 44-45 (citation omitted) (emphasis in original) ("Even in the expert colloquy, all experts presumed that the outpatient physician would *not* continue to treat a complication requiring hospitalization, rather this would be for a surgeon at the hospital or the ER doctor to manage" and "[e]mergency rooms operate by triaging patients depending on the seriousness of their condition, not based on whether … the outpatient provider has admitting privileges.").[19] In fact, even the most experienced abortion provider might not have the relevant expertise to treat a patient in an urgent situation. Today's health care model of specialized medical care seeks to ensure that a patient receives the most appropriate care at every stage (whether on an inpatient or outpatient basis), not that a single physician handle every issue that may arise in the course of a patient's care. As the District Court recognized, it is accepted

[18] Often hospitals now employ full-time, hospital-based physicians, referred to commonly as "hospitalists." Hospitalists do not have the same type of demands as physicians with private practices and often have greater experience in treating patients with conditions that they face when transferred to a hospital or emergency care setting. *See* ACOG Committee Opinion No. 459, *The Obstetric-Gynecologic Hospitalist*, (July 2010) http://www.acog.org/-/media/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/co459.pdf?dmc=1&ts=20150624T1610468624.

[19] *See also Planned Parenthood of Wisconsin, Inc. v. J.B. Van Hollen*, 738 F.3d 786, 793 (7th Cir. 2013) *cert. denied*, 134 S. Ct. 2841 (2014) ("The trend in the hospital industry is for the hospital to require the treating physician to hand over his patient who requires hospitalization to physicians employed by the hospital, rather than allowing the treating physician to continue participating in the patient's treatment in the hospital. Wisconsin is trying to buck that trend—but only with regard to abortions, though there is no evidence that the complications to which abortion can give rise require greater physician continuity than other outpatient procedures.").

medical practice for hospital-based physicians to take over the care of a patient and whether the abortion provider has admitting privileges has no impact on the course of the patient's treatment. *See* Doc. No. 266 pp. 44-48; *see also* Ex. 50 ¶ 16.

Act 37's privileges requirement is completely out of step with modern medical practice and today's prevalent health care model.

B. Other Policies and Procedures Already In Place Effectively Help Abortion Providers Procure Urgent Care For A Patient In The Event Of A Complication.

One reason that abortion is so safe in the United States is that abortion providers follow rigorous, evidence-based guidelines that ensure outpatient and hospital physicians work together for the health and safety of the patient. As discussed above, in the unlikely event of a complication requiring emergency treatment, whether an abortion provider has admitting privileges will not impact the treatment that a patient receives.[20] There are existing, national guidelines that require abortion providers to have an emergency plan in place to ensure prompt, quality, emergency treatment.[21] Under these guidelines, an abortion provider contacts the receiving hospital and conveys the patient's complications, prior treatment, medications, and vital signs in order to ensure continuity of care. *See* Doc. No. 266 pp. 42-43; *see also* Ex. 50

[20] *See also* ACOG Committee Opinion No. 613, *supra* note 16 (requiring physicians who perform abortions to obtain hospital admitting privileges "do[es] not improve patient safety or quality of care.").

[21] ACOG, *Guidelines for Women's Health Care* (4th ed. 2014) (stating that physicians who perform abortions should have a plan to provide prompt emergency services in the event of a complication); Nat'l Abortion Fed'n, *2015 Clinical Policy Guidelines*, 42 ("Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance"). "The National Abortion Federation first published its *Clinical Policy Guidelines* in 1996, which are updated annually using a process developed by a scientific advisor affiliated with the [F]ederal Agency for HealthCare Research and Quality …. Planned Parenthood Federation of America maintains similarly detailed requirements for affiliates offering abortion services." Gold R. and Nash, E., *supra* note 16.

¶ 15. Having an emergency plan in place is the prevailing medical practice, as an emergency plan allows the physician providing the abortion to effectively and efficiently navigate the steps to take during a severe, urgent complication so that the patient receives appropriate emergency care as soon as possible.[22] Admitting privileges do nothing to further an outpatient physician's ability to effectuate such an emergency plan or to ensure the safety of a patient receiving urgent care.

As the District Court found, both Planned Parenthood of Wisconsin, Inc. ("PPW") and Milwaukee Women's Medical Services d/b/a Affiliated Medical Services ("AMS"), Wisconsin's primary outpatient abortion providers, already have protocols and policies in place that establish a plan for their respective abortion providers to follow in the event of an emergency complication. *See* Doc. No. 266 p. 43. Additionally, as the District Court recognized, both PPW and AMS comply with Wis. Admin. Code MED § 11.04(1)(g), which is also medically unnecessary, but nonetheless requires abortion providers, and only abortion providers, to have transfer arrangements with a local hospital for admission of patients requiring emergency care. *See id.* at p. 43. Requiring admitting privileges within 30 miles of an abortion clinic does nothing to improve upon existing patient protections[23] or existing Wisconsin law, and thus does nothing to improve the care of Wisconsin women. *See* Doc. No. 121 ¶ 3.

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[22] Nat'l Abortion Fed'n, *supra* note 21, at p. 42 ("Appropriate management of abortion emergencies reduces morbidity and mortality.").

[23] ACOG Committee Opinion No. 613, *supra* note 16 (admitting privileges and other TRAP laws "do not improve patient safety or quality of care."); *see also* Gold R. and Nash E., *supra* note 16 ("Requiring admitting privileges does little, if anything, to add to the[] existing patient protections. But it does establish a requirement that is very difficult, and in some cases impossible, for providers to meet.").

III. ACT 37 WOULD NEGATIVELY IMPACT THE HEALTH AND WELLBEING OF WOMEN IN WISCONSIN BECAUSE IT WOULD DELAY AND/OR PREVENT ACCESS TO ABORTION PROVIDERS IN WISCONSIN.

Delaying and/or preventing access to legal abortion causes significant physical and mental harm to women. If Act 37's admitting privileges requirement is allowed to take effect it will, at a minimum, result in a significant delay for abortion procedures in Wisconsin. Such a result would be detrimental to the health and safety of women in Wisconsin.

A. Delaying And/Or Preventing A Woman's Access to Safe, Legal Abortion Procedures Has Serious Health Consequences.

As discussed previously, scientific data has proven that legal abortion is an extremely safe medical procedure (*see* pp. 4-6 *supra*), though the risks increase the longer that an abortion is delayed. *See* Ex. 50 p. 4, fn. 6 (citations omitted).[24] Therefore, any delay that affects when a woman can obtain an abortion negatively impacts the safety of the procedure and needlessly subjects the woman to higher risks. At the same time, a delay in receiving an abortion could also potentially push a woman entirely out of the pre-viability zone, preventing her from receiving an abortion at all (*see* Doc. No. 266 p. 75) and thereby forcing her to continue an unwanted pregnancy and subjecting her to the higher risks of childbirth.[25]

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[24] *See also*, ACOG Practice Bulletin No. 135, *supra* note 11, at p. 1397 ("The mortality rate associated with abortion is low (0.6 per 100,000 legal, induced abortions) …. [However, a]bortion-related mortality increases with each week of gestation, with a rate of 0.1 per 100,000 procedures at 8 weeks of gestation or less, and 8.9 per 100,000 procedures at 21 weeks of gestation or greater.").

[25] *See* Jerman J. and Jones R., *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, Women's Health Issues (2014) http://www.guttmacher.org/pubs/journals/j.whi.2014.05.002.pdf (in 2009 "an estimated 4,000 women were unable to obtain abortions because they were past facilities' gestational age limits by the time they made it there.").

Of even more concern, women who are delayed and/or prevented from obtaining a legal abortion may turn to illegal, unsafe methods to terminate an unwanted pregnancy.[26] Women who attempt to self-induce an abortion use a variety of techniques, including "inserting objects into the uterus, ingesting harmful substances, exerting external force, or using medications such as misoprostol."[27] Of these self-induced abortion methods, women are increasingly resorting to self-induced medication abortion when access to timely, legal abortion is restricted.[28] Although medication abortion is very safe when properly performed (*see* pp. 4-5 *supra*), when women are forced to go outside the established health care system to obtain a medication abortion, these women face a host of dangers, including misbranded drugs and incomplete or incorrect

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[26] *See Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1355 (M.D. Ala.), *as corrected* (Oct. 24, 2014), *supplemented*, 33 F. Supp. 3d 1381 (M.D. Ala. 2014) *and amended*, No. 2:13CV405-MHT, 2014 WL 5426891 (M.D. Ala. Oct. 24, 2014) ("with the advent of illegal sales over the internet, there is significant risk that women who are unable to procure abortions would turn to unsupervised and unsafe use of abortion-inducing medications."); *see also* Warriner I. and Shah I, eds., *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action*, Guttmacher Institute (2006) http://www.who.int/reproductivehealth/publications/unsafe_abortion/0939253763.pdf?ua=1 ("Legal obstacles to the provision of safe abortion services give women little choice but to resort to unsafe abortion when faced with an unintended pregnancy."); and Grossman, D., et al., *Self-induction of abortion among women in the United States*, 18 Reprod. Health Matters 136 (2010).

[27] Grossman, et al. *supra* note 26, at 136.

[28] *See* Grossman, D., et al., *The public health threat of anti-abortion legislation*, Vol. 89 Contraception, 73 (2014) http://www.utexas.edu/cola/orgs/txpep/_files/pdf/Grossman,White,Hopkins,Potter-PublicHealthThreatofAnti-abortionLegislation-Contraception-2014.pdf (2012 survey of 318 women seeking an abortion found that 7% of the women reported attempting a self-induced abortion prior to coming to an abortion clinic; whereas a 2008 national survey found that 2.6% of women reported attempting a self-induced abortion).

information about how to take the medication and the appropriate dosage. These problems can lead to serious consequences.[29]

Not only does restricted access to legal abortion needlessly increase a woman's risk of serious complications and even death; it also negatively impacts a woman's mental, emotional, and financial health. As the District Court acknowledged, some women who are comfortable having a first trimester abortion are not comfortable having a second trimester abortion. *See* Doc. No. 266 p. 75. And as a result of delayed access, women may be denied their right to choose whether to have a legal abortion.[30] Further, second trimester abortions are generally more expensive than first trimester abortions,[31] which can also cause women to experience additional needless emotional stress and discomfort. Indeed, the greater cost alone may entirely prevent some women from obtaining an abortion.

Delaying and/or preventing access to legal abortion is detrimental to women's health and well-being on multiple levels.[32] In order to prevent these significant physical, mental, emotional, and financial harms, women in Wisconsin must be able to access timely, legal abortion procedures -- Act 37 is contrary to this goal.

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[29] *Strange*, 33 F. Supp.3d at 1362 ("there are serious dangers for women who take unknown drugs which advertise themselves to be abortion-inducing, but which may not actually contain what is listed on the label."); *see also* Grossman, D., et al., *supra* note 28, at p. 74 (misoprostol in the second trimester increases "risk of hemorrhage that might require surgical intervention or transfusion, as well as the risk of uterine rupture" if inappropriately high dosages are used).

[30] *See* Grossman, D., et al., *supra* note 26, at p. 140 (several women "whose attempts [at self-induced abortion] were unsuccessful decided to continue the[ir] pregnancy" because they did not realize their attempted self-induced abortion failed until one or more months later, "by which time they felt they were too far along to have an abortion.").

[31] Jerman, J. and Jones, R., *supra* note 25 ("In 2011 and 2012, the median charge for a surgical abortion at 10 weeks gestation was $495 …. The median charge for an abortion at 20 weeks' [sic] gestation … was $1,350.").

[32] ACOG Committee Opinion No. 613, *supra* note 16, at p. 5.

B. In the Likely Event That AMS Is Forced To Close Due to Act 37, Access to Abortion In Wisconsin Will Be Significantly Reduced, Which Is Harmful To The Health And Well-being Of Women In Wisconsin.

The District Court found that in Wisconsin there are currently four clinics where women can obtain abortions: AMS operates one clinic and PPW operates three. *See* Doc. No. 266 p. 10. At trial AMS established that in 2013, it performed approximately 2,500 abortions; further, AMS is the only outpatient provider in Wisconsin that currently offers abortions from 18.6 weeks LMP. *See* Doc. No. 243 29:15-17 & Doc. No. 266 pp. 73-74.

Should AMS close, a likely outcome if Act 37 takes effect,[33] PPW would be unable to accommodate the thousands of women who would be left in need of abortion services. *See* Doc. No. 243 149:22-150:5.[34] But even assuming PPW could find a way to accommodate these women, PPW could not immediately perform abortions from 18.6 through 22 weeks LMP. [35] Accordingly, if AMS closes there is no other abortion provider in Wisconsin who could immediately perform abortions after 18.6 weeks LMP.

Requiring women to travel out of state in order to obtain a timely abortion will decrease the number of Wisconsin women who can successfully obtain a legal abortion.[36] Traveling out

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[33] The District Court found, "if Act 37 takes effect, AMS will likely close." Doc. No. 266 p. 72.

[34] The District Court also found that due to the shortage of abortion providers, lack of space, support staff, equipment, and infrastructure, PPW demonstrated that it "will not be able to absorb the demand for abortions should AMS close." *See id*. at pp. 73-74; *see also* Doc. No. 243 152:6-16.

[35] In order to perform abortions past 19.6 weeks LMP, PPW would need to obtain a waiver from Planned Parenthood Federation. *See* Doc. No. 243 151:10-15. Even if PPW obtained this waiver, PPW would need to make multiple large infrastructure changes, before PPW could being performing abortions after 18.6 weeks LMP. *See* Doc. No. 243 151:16-152:5.

[36] *Strange*, 33 F. Supp. 3d at 1356 (explaining studies show a woman who lives farther from abortion facilities will be less likely to obtain an abortion and that one study found "an increase of 100 miles in travel distance reduces the abortion rate by almost 22%.").

of state to procure an abortion is very burdensome, because it adds additional time and monetary costs, such as time away from work and childcare, gas, tolls, and hotel room stays. *See* Doc. No. 266 p. 77. In Wisconsin, many of the women who seek abortions are at or below the federal poverty threshold (*see id.* at p. 76) and for some of these women, the additional out of state travel costs can reach a tipping point in which the costs become too much and as a result, these women are forced to forego an abortion. *See* Doc. No. 243 264:5-9 & 270:4-23. As pointed out above, women who are forced to continue an unwanted pregnancy face higher health risks than do women who are able to procure an abortion.[37]

Not only is traveling out of state to procure an abortion prohibitively burdensome for many women, such travel would significantly diminish the continuity of care these women receive following an abortion.[38] For example, a woman who has to travel out of state to obtain an abortion "would almost certainly be more likely to miss a scheduled follow-up visit" at the abortion clinic.[39] Out of state travel also inhibits the continuity of care in the rare event that a woman experiences a minor complication, because she will likely experience the complication after she returns home and therefore, she will probably seek treatment at a different, nearby, clinic.[40]

At the same time, since Act 37 would likely have the effect of shuttering at least one abortion provider in Wisconsin, the distance a woman from within the state will need to travel to obtain a timely, legal abortion will likely increase. Enactment of Act 37 will result in many

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[37] ACOG Practice Bulletin No. 135, *supra* note 11, at p. 1397 & Raymond, E. and Grimes, D., *supra* note 11, at p. 216.

[38] *Strange*, 33. F.Supp.3d at 1372.

[39] *Id.*

[40] *Id.*

abortion patients traveling much farther than the Act's 30 mile radius to obtain her procedure. This end result essentially nullifies any stated purpose for requiring the admitting privileges in the first place.

If Act 37 is allowed to take effect, a significant number of women in Wisconsin will be delayed and/or prevented from obtaining timely, legal abortion procedures in Wisconsin and it will diminish the continuity of care for those women who leave Wisconsin to obtain an abortion. Simply, Act 37 would have a profoundly negative impact on the health and safety of women in Wisconsin who seek abortions.

C. Act 37 Would Make It Even More Difficult To Recruit Abortion Providers To The State.

As recognized by the District Court, several factors, including the harassment that abortion providers experience, lack of training opportunities, personal and professional stigmatization, and limitations in a physician's hospital or practice group contract, make it difficult to recruit and retain abortion providers in Wisconsin. *See* Doc. No. 266 pp. 58-61; *see also* Doc. No. 233 70:1-71:20. Act 37's admitting privileges requirement would make recruitment of abortion providers even more difficult. *See* Doc. No. 266 p. 59. This additional hurdle heaped onto an area of medicine that already faces significant barriers to recruitment presents a real and serious threat to the continued availability of timely, legal abortion procedures in Wisconsin. *See id.* at p. 61. Without the ability to recruit physicians who perform abortions, the number of physicians who can and will perform abortions in Wisconsin will inevitably decrease over time. Any decrease in the number of physicians in Wisconsin who are able and willing to perform abortions necessarily decreases the ability of women in Wisconsin to obtain a timely, legal abortion.

Act 37's privileges requirement is a threat to the continued availability of abortion providers in Wisconsin, which is ultimately a threat to women's health in Wisconsin. Therefore, in the interest of the health, well-being, and safety of the women of Wisconsin, Act 37's admitting privileges requirement should not be allowed to take effect.

CONCLUSION

Act 37's admitting privileges requirement is a harmful, counterproductive, and unnecessary regulation that stands in stark contrast with scientific research, data, and the realities of modern medical practice. Further, whether an abortion provider has admitting privileges will not have a positive impact on the medical treatment a patient receives in the event of a complication requiring emergency hospital care. However, requiring admitting privileges for abortion providers in Wisconsin will have serious, immediate, and long term effects on the health and well-being of women in the state.

For all the foregoing reasons, *Amici Curiae*, the American College of Obstetricians and Gynecologists, the American Medical Association, and the Wisconsin Medical Society, urge this Court to uphold the District Court's March 24, 2015 Order.

Dated: June 24, 2015

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

In accordance with Rule 32(a)(7)(C) of the Federal Rules of Appellate Procedure, I certify that the foregoing brief complies with the type-volume limitation provided by Rules 29(d) and 32(a)(7)(B)(i) of the Federal Rules of Appellate Procedure. This brief contains 6,350 words, beginning with the words "Statement of *Amici Curiae*" and ending with the words "Respectfully Submitted" in the Conclusion section, as recorded by the word count of the Microsoft Word software application used to prepare the brief.

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CERTIFICATE OF SERVICE

The undersigned, an attorney for the American College of Obstetricians and Gynecologists, the American Medical Association, and the Wisconsin Medical Society, certifies that on June 24, 2015, the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following participants in the case, who are registered CM/ECF users:

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ADDENDUM A

Wis. Stat. Ann. § 253.095 - Requirements to perform abortions:

(1) Definition. In this section, "abortion" has the meaning given in s. 253.10(2)(a).

(2) Admitting privileges required. No physician may perform an abortion, as defined in s. 253.10(2)(a), unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed.

(3) Penalty. Any person who violates this section shall be required to forfeit not less than $1,000 nor more than $10,000. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

(4) Civil remedies. (a) Any of the following individuals may bring a claim for damages, including damages for personal injury and emotional and psychological distress, against a person who performs, or attempts to perform, an abortion in violation of this section:

1. A woman on whom an abortion is performed or attempted.

2. The father of the aborted unborn child or the unborn child that is attempted to be aborted.

3. Any grandparent of the aborted unborn child or the child that is attempted to be aborted.

(b) A person who has been awarded damages under par. (a) shall, in addition to any damages awarded under par. (a), be entitled to not less than $1,000 nor more than $10,000 in punitive damages for a violation that satisfies a standard under s. 895.043(3).

(c) A conviction under sub. (3) is not a condition precedent to bringing an action, obtaining a judgment, or collecting the judgment under this subsection.

(d) Notwithstanding s. 814.04(1), a person who recovers damages under par. (a) or (b) may also recover reasonable attorney fees incurred in connection with the action.

(e) A contract is not a defense to an action under this subsection.

(f) Nothing in this subsection limits the common law rights of a person that are not in conflict with sub. (2).

(5) Confidentiality in court proceedings. (a) In every proceeding brought under this section, the court, upon motion or sua sponte, shall rule whether the identity of any woman upon whom an abortion was performed or induced or attempted to be performed or induced shall be kept confidential unless the woman waives confidentiality. If the court determines that a woman's identity should be kept confidential, the court shall issue

orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the woman's identity from public disclosure. If the court issues an order to keep a woman's identity confidential, the court shall provide written findings explaining why the woman's identity should be kept confidential, why the order is essential to that end, how the order is narrowly tailored to its purpose, and why no reasonable less restrictive alternative exists.

(b) Any person, except for a public official, who brings an action under this section shall do so under a pseudonym unless the person obtains the written consent of the woman upon whom an abortion was performed or induced, or attempted to be performed or induced, in violation of this section.

(c) This section may not be construed to allow the identity of a plaintiff or a witness to be concealed from the defendant.