No. 14-50928

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS, doing business as Reproductive Services; SHERWOOD C. LYNN, JR., M.D., on behalf of themselves and their patients; PAMELA J. RICHTER, D.O., on behalf of themselves and their patients; LENDOL L. DAVIS, M.D., on behalf of themselves and their patients,

Plaintiffs-Appellees - Cross-Appellants,

v.

DAVID LAKEY, M.D., Commissioner of the Texas Department of State Health Services, in his Official Capacity; MARI ROBINSON, Executive Director of the Texas Medical Board, in her Official Capacity,

Defendants-Appellants - Cross-Appellees.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division
Case No. 14-cv-00284-LY

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES - CROSS-APPELLANTS AND IN SUPPORT OF AFFIRMANCE

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December 1, 2014

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Defendants-Appellants - Cross-Appellees.

CERTIFICATE OF INTERESTED PERSONS

Amici curiae, the American College of Obstetricians and Gynecologists and the American Medical Association, are non-profit organizations, with no parent corporations or publicly traded stock. The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

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Other Interested Persons or Entities
Amici are unaware of any other interested persons or entities.

/s/ Kimberly A. Parker
KIMBERLY A. PARKER

December 1, 2014 *Counsel for Amici Curiae*

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STATEMENT OF INTEREST OF *AMICI CURIAE*

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

ACOG is a non-profit educational and professional organization founded in 1951. 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 57,000 members, the College and the Congress are the leading professional associations of physicians who specialize in the health care of women.

The membership of the Texas District of the Congress includes 2,532 obstetrician-gynecologists who provide medical care to the women of Texas. The

[1] Pursuant to Federal Rule of Appellate Procedure 29, the parties have consented to the filing of this *amicus* brief. Also pursuant to Rule 29, undersigned counsel for *amici curiae* certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than *amici curiae*, its members, and its counsel—contributed money intended to fund the preparation or submission of this brief.

College and the Congress recognize that abortion is an essential health care service and oppose laws regulating medical care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

The College has previously appeared as *amicus curiae* in various courts throughout the country, including the U.S. Supreme Court and the Fifth Circuit. In addition, the College's work has been cited frequently by the Supreme Court and other federal courts seeking authoritative medical data regarding childbirth and abortion.[2]

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 the AMA's House of Delegates, substantially all U.S. physicians, residents and medical students are

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[2] *See, e.g.*, *Stenberg v. Carhart*, 530 U.S. 914, 932-36 (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); *see also 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 procedure); *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").

represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state, including Texas.

SUMMARY OF ARGUMENT

Women are entitled to quality, evidence-based medical care, regardless of the state in which they live. When legislatures impose unnecessary restrictions on access to reproductive health care, they threaten women's health. In enacting Texas House Bill ("H.B.") 2, the Texas legislature has done just that.

H.B. 2 imposes government regulation on abortion care that is not based on scientific facts or the best available medical knowledge. Putting aside the legal infirmities presented by H.B. 2,[3] there is simply no medical basis for requiring that abortion facilities meet the standards for ambulatory surgical centers ("ASC requirement") or for enforcing a local admitting privileges requirement against abortion providers ("privileges requirement").[4] H.B. 2 does not serve the health of women in Texas but instead jeopardizes women's health by restricting access to abortion providers.

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[3] The history of legal challenges to H.B. 2 is set forth in Appellees' Principal and Response Brief at pages 1-10 and 54-61.

[4] Unless expressly discussed herein, and except as *amici* previously argued in Brief of *Amici Curiae* American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiffs-Appellees and in Support of Affirmance in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583 (5th Cir. 2014) (No. 13-51008), *amici* do not express an opinion on all or other aspects of H.B. 2 or the district court's opinion.

For the reasons set forth below, *amici* urge this Court to affirm the district court's judgment enjoining enforcement of H.B. 2's ASC and privileges requirements.[5]

ARGUMENT

Amici oppose legislative interference with the practice of medicine and with a woman's relationship with her doctor, especially when legislative enactments—like H.B. 2's ASC and privileges requirements—do nothing to protect the health of women and are incongruous with modern medical practice.[6]

I. H.B. 2'S ASC REQUIREMENT IMPOSES MEDICALLY UNNECESSARY DEMANDS ON ABORTION FACILITIES AND SERVES NO MEDICAL PURPOSE.

H.B. 2's requirement that abortion facilities[7] meet the standards for ASCs is devoid of any medical or scientific purpose. The legislation appears to be based on an assumption that abortion procedures would be safer if performed in ASCs, but

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[5] *Whole Woman's Health v. Lakey*, __ F. Supp. 2d __, No. 14-cv-00284-LY, 2014 WL 4346480, at *4 (W.D. Tex. Aug. 29, 2014).

[6] *See* ACOG, Comm. on Health Care for Underserved Women, *Opinion Number 613, Increasing Access to Abortion* 2-5 (2014) ("The College opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care."); ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013).

[7] Under Texas law, the term "abortion facility" applies to providers of abortions, such as outpatient clinics, that are not hospitals, ASCs, or physicians' offices (unless the office is "used substantially for the purpose of performing abortions"). Tex. Health & Safety Code § 245.004. In this brief, *amici* use the terms "abortion facilities" and "abortion clinics" interchangeably.

there is no scientific or medical evidence suggesting this is the case.[8] On the contrary, mandating that abortion facilities meet ASC standards deprives women of access to reproductive health care and is inconsistent with what appropriate and accepted medical practice requires.[9]

A. Abortion Is An Extremely Safe Medical Procedure And No Medical Evidence Suggests That Abortion Would Be Safer If Performed In An ASC Setting.

Abortion is one of the safest medical procedures performed in the United States. Nationally, the risk of death resulting from an abortion is exceptionally low—0.6 per 100,000 (or 0.0006 percent).[10] In Texas, publicly available data

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[8] *Amici* are aware that, in 2003, Texas enacted a law providing that abortions at sixteen weeks' gestational age and later be performed only in ASCs and hospitals. Tex. Health & Safety Code § 171.004. We confine our comments here to abortions occurring prior to sixteen weeks' gestational age, which were performed legally in clinics and offices prior to the enactment of H.B. 2.

[9] *Amici* oppose facility requirements, including those that require facilities to meet the physical plant standards of hospitals, that are enacted under the guise of patient safety but that impose medically unnecessary requirements designed to reduce access to abortion. ACOG, Comm. on Health Care for Underserved Women, *Opinion Number 613*, *supra* note 6, at 3.

[10] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); *see also* ACOG, *Guidelines for Women's Health Care: A Resource Manual* 719 (4th ed. 2014). The risk associated with childbirth is approximately fourteen times higher than abortion. Raymond & Grimes, *supra*. The American Center for Law and Justice ("ACLJ") attempts to refute the Plaintiffs' assertion that pregnancy is fourteen times riskier than abortion. *See* Br. of *Amici Curiae* of the American Center for Law and Justice and the Houston Coalition for Life, in Supp. of Defs.-Appellants and Supporting Reversal 6-8, Nov. 10, 2014. However, many of their arguments fail to challenge the findings of the

suggest the rate is even lower. According to Texas vital statistics data, 929,995 abortions have occurred between 2001 and 2012 (the years for which data is available online).[11] Only five deaths were reported in this period, accounting for a mortality rate of 0.54 per 100,000 (or 0.00054 percent).[12] From 2009 through 2012, there were zero reported deaths in 296,210 abortions performed in Texas.[13] The risk of major complications from this procedure is similarly low. There is less than a 0.2 percent risk of major complications that might require hospital care.[14] A recent study found that the risk of major complications from first trimester

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Raymond and Grimes article. For example, the ACLJ states that maternal mortality studies overreport maternal mortality because they include pregnancy outcomes other than live births. The Raymond and Grimes study, however, specifically omitted other pregnancy outcomes (spontaneous abortion, stillbirths, ectopic pregnancies, and gestational trophoblastic disease). Raymond & Grimes, *supra*, at 217-18. Further, the ACLJ neglects to mention that Raymond and Grimes found that the relative risk of pregnancy may, in fact, be understated in their study. *Id*. at 218.

[11] The calculations in the text accompanying this note, as well as notes 12, 13, 18, and 19, are based on annual abortion statistics data compiled from Texas Department of State Health Services, *Vital Statistics Annual Reports* (Nov. 14, 2014), http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm.

[12] *Id.*

[13] *Id*.

[14] Ushma D. Upadhyay et al., *Incidence of Post-Abortion Complications and Emergency Department Visits Among Nearly 55,000 Abortions Covered by the California Medi-Cal Program*, slide 28 (Jan. 28, 2014) (ANSIRH Grand Rounds presentation), http://www.ansirh.org/wp-content/uploads/2014/05/Upadhyay_Medi-Cal-Complications-Grand-Rounds_ANSIRH.pdf.

abortions by the aspiration method is even lower—0.05 percent.[15] The risk of hospitalization from a medical abortion (*i.e.*, abortion administered in pill form and not through surgery) is 0.06 percent.[16]

Outpatient clinics and physicians' offices are safe places to obtain abortions.[17] In the four years during which Texas had no reported abortion-related deaths, the overwhelming majority of abortions—84 percent—were performed in these settings, not in ASCs or hospitals.[18] From 2001 to 2012, when Texas statistics reflected an exceedingly low mortality rate of 0.54 per 100,000 abortions (or .00054 percent), 92 percent of abortions were performed in abortion facilities or physicians' offices.[19] Nationally, 95 percent of abortions are performed in nonhospital settings.[20] There is no medically sound reason to assume that

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[15] Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 458 (2013).

[16] Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 Obstetrics & Gynecology 166, 169 (2013).

[17] *See* ACOG, *Frequently Asked Questions, Induced Abortion* 2 (2011); ACOG, *Frequently Asked Questions, Dilation and Curettage* 1 (2012); *see also* John A. Rock & Howard W. Jones III, *TE Linde's Operative Gynecology* 783 (10th ed. 2011).

[18] *See supra* note 11.

[19] *Id*.

[20] Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 42 (2011); Theodore Joyce, *The Supply-Side Economics of Abortion*, 365 New Eng. J. Med. 1466, 1467 (2011).

abortions performed in a hospital or ASC setting would be safer than those performed in an abortion clinic or office. Indeed, scientific literature suggests that the safety of abortions performed in an office setting is equivalent to those performed in a hospital setting.[21] There is, thus, no medical basis to mandate that abortion clinics meet the standards for ASCs.

B. H.B. 2's ASC Requirement Imposes Medically Unnecessary, Costly Demands On Abortion Facilities.

Requiring that an abortion clinic meet the standard for ASCs is medically unnecessary because of the nature and relative simplicity of abortion procedures and because the complication rate associated with these procedures is exceptionally low. ASCs are meant to provide environments in which invasive surgeries historically performed in hospitals can be performed on an outpatient basis. Abortion procedures are not such surgeries.

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[21] David A. Grimes et al., *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30, 31 (1981); David A. Grimes et al., *Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities*, 51 Obstetrics & Gynecology 323, 324 (1978). There are no more recent studies directly comparing the safety of hospital-based (or ASC-based) abortions, presumably because nearly all abortion procedures have been performed in clinics since the legalization of abortion. *See* David A. Grimes, *Every Third Woman in America: How Legal Abortion Transformed Our Nation* 31-32 (2014). Indeed, "[c]ontrary to conventional wisdom, abortions performed in freestanding clinics proved safer than those provided in hospitals." *Id.* at 32.

1. Abortion Procedures Do Not Require The Full Operating Theater Or External Sterility Precautions That Are Mandated By H.B. 2.

The physical plant requirements mandated by H.B. 2 are not necessary for abortion procedures.[22] For example, an operating room—which is mandatory under H.B. 2—is unnecessary in clinics that provide abortions. An increasingly large percentage of abortions are medical, not surgical, abortions. No designated procedure space is required for these abortions because they involve taking pills to induce pregnancy termination, which then typically occurs at home.[23]

Even surgical abortions do not require an operating room. To conduct first-trimester surgical abortions, clinicians will have the patient recline on an examination table fitted with stirrups, taking the same position as for many gynecological exams. The number of personnel involved is minimal; little is

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[22] Current ACOG guidelines, which provide the most up-to-date and evidence-based information to practitioners based on well accepted medical practice, already provide physical plant standards that should be present in clinics and offices. *See* ACOG, *Guidelines for Women's Health Care*, *supra* note 10, at 142.

[23] *See* ACOG, *Practice Bulletin Number 143, Medical Management of First-Trimester Abortion* 3 (2014) (providing the most up-to-date evidence-based guidelines for medication abortions). In their brief supporting Appellants, the Alliance Defending Freedom ("ADF") cites an outdated ACOG publication regarding medication abortion. Br. of *Amici Curiae* Alliance Defending Freedom et al. in Supp. of Defs.-Appellants and Reversal of District Ct., 12, 16, Nov. 10, 2014. Specifically, ADF's reference to the suggestion that clinicians providing medical abortions work with clinicians trained in surgical abortions is outmoded, and current guidelines recognize that clinicians providing medical abortions may safely refer their patients to clinicians trained in surgical abortions. *See* ACOG, *Practice Bulletin Number 143*, *supra*, at 6.

required by way of equipment. These procedures are not commonly performed using general anesthesia, so designated space for equipment storage associated with general anesthesia is not generally required.[24] Surgical abortions simply do not require the size, layout, or equipment of a full operating theater.

Moreover, many of the burdensome construction requirements contained in the ASC regulations that are designed to maintain a sterile environment, such as restricted-access surgical suites, one-way traffic flow patterns, scrub equipment, and special ventilation units, are unnecessary in abortion clinics.[25] This is because clinicians performing abortions access the uterus through the vagina, which is known as a "clean-contaminated field" and is not naturally a sterile space. Therefore, "[r]outine sterile precautions (e.g., drapes, caps, masks, and gowns) are

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[24] In any event, as noted below, Texas law does not require many procedures that require general anesthesia to be performed in a facility that meets ASC standards. *See infra* note 29 and accompanying text.

[25] One specific example of a structural element designed to maintain a highly sterile environment in ASCs that is unnecessary in the abortion context is the requirement that operating rooms in ASCs have solid, finished ceilings. The apparent rationale for finished ceilings is to prevent dust or other debris from falling onto patients whose sterile body tissue is exposed on an operating table. However, because of the way patients are positioned for abortions and the lack of exposure of sterile body tissue, the concern about particulate matter potentially falling into an open surgical site is inapposite for abortion procedures. *See* Jack E. Sebben, *Sterile Technique and the Prevention of Wound Infection in Office Surgery—Part I*, 14 J. Dermatologic Surgery & Oncology 1364, 1365 (1988) (discussing office construction requirements in the context of outpatient dermatological surgery).

unnecessary"[26] under accepted medical practice. Indeed, accepted medical practice requires only that the clinician use sterile instruments and employ a "no-touch" technique, whereby he or she "wears sterile gloves and does not touch those ends and portions of the sterile instruments inserted into the uterus."[27] While Appellants appear to maintain that the external sterility requirements for ASCs are necessary for abortion procedures because instruments are inserted into the uterus during surgical abortions, *see* Appellant's Br. 13, this argument ignores the fact that unlike other gynecological procedures (such as cesarean sections and abdominal hysterectomies), surgical abortions do not involve exposure of the uterus to the external environment. For this reason (among others), ensuring the sterility of the portion of the surgical instruments that make contact with the uterus is sufficient to achieve the sterility needed for the procedure. In short, there has been no suggestion in any accepted scientific or medical literature that further sterility precautions would improve the already exceptionally low complication rate associated with abortions.

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[26] Rock & Jones, *supra* note 17, at 784.

[27] *Id.*; *see also* Maureen Paul, *Office Management of Early Induced Abortion*, 42 Clinical Obstetrics & Gynecology 290, 293-94 (1999).

2. Office-Based Surgery Is Common And Texas Law Does Not Require That Facilities Performing Certain Procedures With Higher Mortality Rates Than Abortion Meet The Standard For ASCs.

Office-based surgery is common and consistent with accepted medical practice. Indeed, it is the prevailing medical practice for many gynecological procedures to be performed in an office setting.[28] In Texas, office-based surgery is legal, including for surgical procedures with complication and mortality rates similar to or higher than those posed by abortion. Texas law authorizes physicians to perform surgeries in their offices—including surgeries involving general anesthesia, which are generally risker than procedures (such as the vast majority of abortions) that do not require general anesthesia—without meeting ASC standards.[29] For example, no law prevents colonoscopies or liposuction from being performed outside of an ASC or hospital setting. The mortality rate for colonoscopy-specific mortality is 0.007 percent.[30] The mortality rate for

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[28] *See, e.g.*, ACOG, *Patient Education Pamphlets: Colposcopy* (2013); ACOG, *Patient Education Pamphlets: Endometrial Hyperplasia* (2012) (endometrial biopsy and dilation and curettage); ACOG, *Patient Education Pamphlets: Loop Electrosurgical Excision Procedure* (2013); Mark Nichols et al., *A Comparative Study of Hysteroscopic Sterilization Performed In-Office Versus a Hospital Operating Room*, 13 J. Minimally Invasive Gynecology 447, 447-49 (2006) (hysteroscopy can be performed in office setting).

[29] *See* 22 Tex. Admin. Code §§ 192.1-192.6.

[30] Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 J. Gastrointestinal Endoscopy 745, 747 (2011). For a discussion of the

liposuction is around 0.02 percent.[31] There is no medical purpose or principled reason for Texas legislation requiring abortion facilities, but not other medical facilities that perform similar or even riskier outpatient procedures, to meet heightened ASC standards.

II. H.B. 2'S PRIVILEGES REQUIREMENT DOES NOT SERVE THE HEALTH OF WOMEN IN TEXAS.

Amici previously submitted a brief to this Court opposing H.B. 2's privileges requirement because the requirement adds no medical benefit to the treatment of Texas women and is contrary to current medical practice.[32] As discussed in the paragraphs below, *amici* maintain their position from their prior brief in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott* that there is no medically sound basis for H.B. 2's privileges requirement.

A. Clinicians Are Denied Medical Privileges For Reasons Unrelated To Their Competency.

While hospital privileges should be awarded based on the competency of clinicians, in some cases, obtaining privileges is difficult, if not impossible, for a clinician, irrespective of the clinician's technical competency. For example, some

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mortality rate associated with abortion, *see supra* notes 10 through 16 and accompanying text.

[31] Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000).

[32] Br. of *Amici Curiae* American College of Obstetricians and Gynecologists and the American Medical Association, *supra* note 4.

academic hospitals will only allow medical staff membership for clinicians who also qualify for and accept faculty appointments. Other hospitals require that clinicians admit a certain number of patients, or perform a certain number of deliveries or major obstetric or gynecological surgeries in order to be affiliated with the hospital. Providers who specialize in performing abortions are frequently unable to meet such requirements because abortion is a very safe procedure only rarely resulting in hospitalization. These factors result in a denial of privileges and have nothing to do with a provider's competence.

The difficulty of obtaining privileges is not theoretical; as the trial court recognized, clinicians in Texas—including providers at Plaintiffs' clinics in McAllen and El Paso—have been denied privileges for reasons unrelated to screening clinicians for competency.[33] In Texas, a significant percentage of abortion clinics were forced to stop providing abortions because providers did not have privileges.[34] Requiring that clinicians obtain medical privileges—when such privileges may be denied for any number of reasons having nothing to do with a clinician's competency or the quality of care that he or she provides—does not promote the wellbeing of Texas women.

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[33] *Whole Woman's Health*, 2014 WL 4346480, at *9-10.

[34] Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 74 (2014) [hereinafter *Public Health Threat*].

B. H.B. 2's Privileges Requirement Is Inconsistent With Accepted Medical Practice And Provides No Benefit To Patient Care Or Health Outcomes.

H.B. 2 is also inconsistent with prevailing medical practices, which focus on ensuring prompt medical care and continuity of care and do not require that each individual abortion provider has admitting privileges.[35] For example, instead of requiring that clinicians who perform abortions have admitting privileges at a local hospital, accepted medical practice requires that an abortion provider's facility has a plan to provide prompt emergency services and (if needed) to transfer a patient to a nearby emergency facility if complications occur.[36] This practice ensures that in the rare instance when a woman experiences a complication after an abortion and

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[35] *See* Inst. of Med., *Crossing the Quality Chasm: A New Health System for the 21st Century* 8-9 (2001) (finding 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]linicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care").

[36] ACOG, *Guidelines for Women's Health Care*, *supra* note 10, at 720 ("Clinicians who perform abortions … should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment."); *see also* Am. Ass'n for Accreditation of Ambulatory Surgery Facilities, Inc., *Regular Standards and Checklist for Accreditation of Ambulatory Surgery Facilities* 49 (2014); Nat'l Abortion Fed'n, *2013 Clinical Policy Guidelines* 55 (2013).

seeks hospital-based care,[37] consistent with prevailing medical practice, she can be appropriately treated by a trained emergency-room clinician or the hospital's on-call specialist. The care a woman receives at the emergency room is independent of, and not contingent on, her abortion provider having admitting privileges.

In fact, the transfer of care from the abortion provider to an emergency room clinician is consistent with the growing divide between ambulatory and hospital care in the medical field more broadly.[38] That is, throughout modern medical practice, often the same clinician does not provide both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" who provide care only in a hospital setting.[39] Continuity of care is achieved through communication and collaboration between specialized health care providers,[40] which does not depend on those providers having hospital privileges.

Prior to the enactment of H.B. 2, Texas law adequately required compliance with prevailing medical practice by requiring that abortion facilities have protocols to ensure that patients could be transferred to a hospital in the rare event of an

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37 The trial court recognized that "such complications are exceedingly rare in Texas, nationwide, and specifically with respect to the Plaintiff abortion providers." *Whole Woman's Health*, 2014 WL 4346480, at *9.

38 *See, e.g.*, ACOG, Comm. on Patient Safety & Quality Improvement, *Opinion Number 459, The Obstetric-Gynecologic Hospitalist* (2010).

39 *Id.*

40 *See* Inst. of Med., *supra* note 35, at 9, 62, and 133-34.

emergency requiring hospital treatment.[41] Indeed, before the Texas legislature enacted the privileges requirement, the McAllen and El Paso clinics safeguarded the health and wellbeing of their patients and, consistent with national statistics, the levels of serious complications among the women who received their services were extremely low.[42] There is no medical basis on which to conclude that women's health would be advanced by requiring that clinicians in these clinics obtain privileges. Doing so is inconsistent with prevailing medical practice and imposes unnecessary restrictions on the ability of clinicians to provide abortion care.

Nor would H.B. 2's privileges requirement assist Texas women in the rare event that they experienced complications after being discharged and returning home. It is unlikely that the hospital at which a woman should seek treatment (*i.e.*, a hospital near her home) is the one at which her provider maintains privileges (*i.e.*, a hospital within thirty miles of the abortion provider's clinic). Texas is a large state, and many women do not live within a thirty-mile radius of a clinic. If these women need emergency care, it would be inappropriate to transport them an

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41 25 Tex. Admin. Code § 139.56(a) (requiring a "readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital").

42 *Whole Woman's Health*, 2014 WL 4346480, at *9.

additional distance to the hospitals at which their abortion providers maintain privileges.[43]

Noting the lack of scientific basis for the privileges requirement, federal courts have recently recognized that requiring privileges provides no medical benefit to women who undergo abortion procedures. For example, the Seventh Circuit recently affirmed a district court's preliminary injunction of a Wisconsin statute containing a privileges requirement that is nearly identical to the Texas requirement.[44] The court found "no evidence that women who have complications from an abortion recover more quickly or more completely or with less pain or discomfort if their physician has admitting privileges at the hospital to which the patient is taken for treatment of the complications."[45] In setting aside Alabama's privileges requirement, the United States District Court for the Middle District of Alabama found that mandating privileges "falls outside the range of standard medical practice for complication care" for abortion procedures and "would, in reality, undermine the State's goal of continuity of care" because women in

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[43] Indeed, H.B. 2 acknowledges that the prevailing practice is for a patient to receive emergency care at a facility near her home. Tex. Health & Safety Code § 171.0031(a)(2)(B) (requiring that a woman be given "the name and telephone number of the nearest hospital to the home of the pregnant woman at which an emergency arising from the abortion would be treated").

[44] *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786 (7th Cir. 2013).

[45] *Id*. at 793.

Alabama would lose local access to the clinics forced to close under the privileges requirement.[46] As these courts recognized, laws like H.B. 2 limit or delay access to care while providing no benefit to patient care. This Court should join the other federal courts that have set aside privileges laws that serve no medical benefit.

III. H.B. 2 JEOPARDIZES WOMEN'S HEALTH BY RESTRICTING ACCESS TO SAFE AND LEGAL ABORTION.

Legislatures jeopardize the ability of women to obtain safe and early abortions when they pass laws that impose burdensome requirements on clinicians who perform abortions or require that abortion facilities meet needless, burdensome standards. By imposing unnecessary ASC and privileges requirements on abortion providers and facilities, H.B. 2 harms women's health in Texas by reducing access to safe and legal abortion.[47]

H.B. 2's requirement that abortion providers obtain privileges at a local hospital has already had a detrimental effect on women's access to abortion providers because almost half of Texas clinics closed or stopped providing abortion services by the time the privileges requirement went into effect.[48] A number of providers, including Plaintiffs' clinics in McAllen and El Paso, cannot satisfy H.B. 2's privileges requirement because, as noted above, they cannot obtain

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46 *Planned Parenthood Se., Inc. v. Strange*, __ F. Supp. 2d __, No. 2:13-cv-405-MHT, 2014 WL 3809403, at *41 (M.D. Ala. Aug. 4, 2014).

47 *See* ACOG, *College Statement of Policy, Abortion Policy* (2014).

48 *Whole Woman's Health*, 2014 WL 4346480, at *6.

privileges for reasons that have nothing to do with the quality of care they provide.[49] Evidence shows that when the average distance to the nearest provider of abortion services for women in Texas is significantly increased, access to abortion services for women in Texas is restricted or delayed as a result.[50]

H.B. 2's privileges requirement is particularly devastating for the 275,000 women of reproductive age living in the lower Rio Grande Valley near the Texas–Mexico border. While the privileges requirement has restricted abortion access throughout Texas,[51] the women living in the Valley represent an especially

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[49] *See Whole Woman's Health*, 2014 WL 4346480, at *9-10; News Release, Am. Congress Obstetricians & Gynecologists, *Statement on State Legislation Requiring Hospital Admitting Privileges for Physicians Providing Abortion Services* (Apr. 25, 2013), http://www.acog.org/About-ACOG/News-Room/News-Releases/2013/Hospital-Admitting-Privileges-for-Physicians-Providing-Abortion-Services (opposing legislation requiring abortion providers to have hospital admitting privileges and stating that such physicians should have a plan to ensure prompt emergency services in the case of a complication).

[50] For example, after Texas's Women's Right to Know Act went into effect in January 2004, requiring that all abortions performed at or after 16 weeks of gestation be performed in an ASC, the average distance to the nearest abortion provider offering services at or after 16 weeks increased from 33 miles to 252 miles. Between 2003 and when the Act went into effect in 2004, the annual number of abortions performed at or after 16 weeks dropped from 3,642 to 446, or 88%, while the number of Texas women who sought abortions out of state increased from 187 to 736, or nearly 400%. *See* Joyce, *supra* note 20, at 1467 (citing data from Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. Pol'y Analysis & Mgmt. 775, 795 (2011)).

[51] Women living in the cities and surrounding areas of Lubbock, Midland, San Angelo, Beaumont, Stafford, Killeen, and Waco are now without access to abortion services in their areas because the reproductive health clinics in those cities either closed completely or had to stop providing abortion services under the

vulnerable population because this area suffers from disproportionately high rates of poverty.[52] The only two abortion clinics located in the Valley, including the McAllen clinic, were forced to close under H.B. 2 because their providers were unable to obtain hospital privileges, leaving women in the Valley without a provider in the four-county-wide area.[53] If this Court reverses the district court's ruling and the McAllen clinic is again subject to the privileges requirement, women living in the lower Rio Grande Valley will once again lose access to a provider within their large region of Texas.[54]

H.B. 2's requirement that abortion clinics meet the minimum standards for ASCs will have an even more devastating effect of restricting or delaying women's access to abortion providers across Texas than the privileges requirement because, as the district court found, the number of clinics that will continue to provide

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privileges requirement. *See* Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498 (2014) [hereinafter *Change in Abortion Services*].

[52] *Id.* at 497.

[53] The McAllen clinic was permitted to reopen by order of the Supreme Court on October 14, 2014, pending this Court's decision in this appeal. *Whole Woman's Health v. Lakey*, 135 S. Ct. 399, 399 (2014).

[54] Furthermore, even if the McAllen clinic were not prohibited from providing abortion services under the privileges requirement, it would still be unable to provide abortion services if this Court upholds the ASC requirement. *See Whole Woman's Health*, 2014 WL 4346480, at *5.

abortion services will be reduced to, at most, eight.[55] More than a dozen of the clinics that remained open after the privileges requirement went into effect—including all clinics south or west of San Antonio—cannot satisfy H.B. 2's ASC requirement because of the expense and time necessary to conform to the newly applicable regulations.[56]

The closure of so many abortion facilities will inevitably lead to increased delays in obtaining abortions and, for some women, may block access entirely.[57] Many women will be required to travel farther to obtain an abortion, which is likely to lead to delay.[58] Research suggests that since the enactment of H.B. 2, women are waiting longer to obtain abortions. In 2012, the proportion of abortions performed in Texas during the second trimester was 10.7 percent.[59] During the first six months following the implementation of H.B. 2's privileges requirement, the proportion of abortions performed in the second trimester climbed to 13.9 percent.[60] Unsurprisingly, delays are most prevalent among lower income

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55 *Id*. at *6.

56 *See id.* at *5-6.

57 *See* Grossman et al., *Public Health Threat*, *supra* note 34, at 73-74.

58 *Id*.

59 Grossman et al., *Change in Abortion Services*, *supra* note 51, at 499.

60 *Id.*

women,[61] which is particularly problematic in Texas, where 40 percent of women seeking abortions are at or below 100 percent of the Federal Poverty Level and where many of these women already have to travel some distance to the nearest abortion provider.[62]

Delays in obtaining an abortion endanger women's health. If a woman requires an abortion, it should be performed safely and as early as possible.[63] While abortion procedures are among the safest medical procedures, the risk of complications associated with abortion procedures increases with the length of the pregnancy.[64] Medical studies consistently show that the mortality rate for abortion-related deaths in the first trimester, when almost nine in ten abortions are performed, is no more than four in one million abortions.[65] However, the mortality

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61 *See* Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (2014); *see also* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004); Grossman et al., *Public Health Threat*, *supra* note 34. This is likely because the time needed to raise money, including for travel, is one of the principal reasons women delay obtaining an abortion.

62 *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 769 F.3d 330, 347 (5th Cir. 2014) (Dennis, J., dissenting from denial of rehearing en banc).

63 ACOG, *College Statement of Policy*, *supra* note 47.

64 *See* Bartlett et al., *supra* note 61, at 735.

65 Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 Guttmacher Pol'y Rev. 7, 7 (2013) (citing Bartlett et al., *supra* note 61).

rate increases significantly throughout the second trimester to approximately one death per 58,000 when abortion is performed between thirteen and fifteen weeks, one death per 29,000 when an abortion is performed between sixteen and twenty weeks, and one death per 11,000 when an abortion is performed at twenty-one weeks or later.[66] The increased percentage of women who underwent second-trimester abortions after the enactment of H.B. 2 were exposed to risk above what they would have experienced had they obtained abortions earlier in their pregnancies.

In addition to causing women to delay obtaining abortions, the clinics' closures also will likely result in some women not being able to obtain legal abortions at all. The additional eight hours of travel time for women in the lower Rio Grande Valley to reach a clinic in San Antonio—the nearest clinic if the district court's decision is reversed and H.B. 2's ASC requirement is permitted to take effect and its privileges requirement is enforced—is likely to be prohibitive for many women.[67] Preliminary research supports this conclusion. In the six-

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[66] *See* Daniel Grossman et al., *Complications After Second Trimester Surgical and Medical Abortion*, 16 Reprod. Health Matters 173, 173 (2008) (citing Bartlett et al., *supra* note 61); Guttmacher Inst., *Facts on Induced Abortion in the United States* 2 (2014), *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.pdf.

[67] Grossman et al., *Public Health Threat*, *supra* note 34, at 74. Moreover, if a woman needs to obtain a medical abortion, Texas law would require a woman to travel these distances at least three times. *Id.*

month period following the implementation of H.B. 2's privileges requirement and the closures of the only two clinics in the Valley, the number of women living in the Valley who obtained abortions decreased 18.3 percent from the previous six months.[68] The state-wide decrease for the same period was only 5.6 percent.[69]

Moreover, as women are prevented from seeking legal abortions due to the added burden imposed by the ASC and privileges requirements, some women are likely to attempt to self-induce abortion or seek an illegal abortion.[70] Findings suggest that attempts to self-induce an abortion have become more common since the provisions of H.B. 2 have increasingly restricted abortion access.[71] Although

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[68] *See* Grossman et al., *Change in Abortion Services*, *supra* note 51, at 499. The future impact of these clinics' closures may be more severe than it was in the past because approximately half of women from the Valley who obtained abortions during this time period did so at a clinic in Corpus Christi, which has since closed. *Id.*

[69] *Id*.

[70] *See* ACOG, Comm. on Health Care for Underserved Women, *Opinion Number 613*, *supra* note 6, at 2-3 ("[H]istorical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers."); Elizabeth G. Raymond et al., *Mortality of Induced Abortion, Other Outpatient Surgical Procedures and Common Activities in the United States*, 90 Contraception 476, 478 (2014).

[71] *Whole Woman's Health*, 2014 WL 4346480, at *9; Direct Test. of Amy Hagstrom Miller, *Whole Woman's Health v. Lakey*, __ F. Supp. 2d __, No. 14-cv-00284-LY, 2014 WL 4346480 (W.D. Tex. Aug. 29, 2014), ECF No. 171 ¶ 19. This is particularly problematic because Texas already had a higher-than-national average number of attempts to self-induce an abortion.

the true number of Texas women who self-induce abortion is impossible to capture, reports of women procuring abortion-inducing drugs over the Internet, over-the-counter in Mexico, and illegally trafficked into Texas have proliferated since H.B. 2 went into effect.[72] Self-induction endangers women's health because women are at risk for injury or death caused by fake medications, improper dosage, lack of instructions, taking medications under the wrong circumstances, or the absence of medical supervision.[73]

Finally, if H.B. 2's ASC provision goes into effect, then the few remaining providers will be left to shoulder the entire state-wide demand for abortion services. When the non-ASC clinics closed, one of the eight remaining clinics reported receiving an overwhelming 500 phone calls in a single day—a six-fold increase in normal call volume.[74] Even if seven or eight ASCs could increase

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[72] *See, e.g.*, Esme E. Deprez, *Legal Abortions Made Harder, Texans Turn to Flea Market Pills*, Bloomberg (July 11, 2013), http://www.bloomberg.com/news/2013-07-11/flea-market-abortions-thrive-as-texas-may-close-clinics.html; Erica Hellerstein, *The Rise of the DIY Abortion in Texas*, The Atlantic (June 27, 2014), http://www.theatlantic.com/health/archive/2014/06/the-rise-of-the-diy-abortion-in-texas/373240/; Amelia Thomson-Deveaux, *It's Really Hard to Measure the Effects of Abortion Restrictions in Texas*, FiveThirtyEight (Aug. 28, 2014), http://fivethirtyeight.com/features/its-really-hard-to-measure-the-effects-of-abortion-restrictions-in-texas/.

[73] *See* Alyson Hyman et al., *Misoprostol in Women's Hands: A Harm Reduction Strategy for Unsafe Abortion*, 87 Contraception 128 (2013).

[74] Carrie Feibel, *Despite Legal Reprieve on Abortion, Some Texas Clinics Remain Closed*, NPR (Oct. 16, 2014), http://www.npr.org/blogs/health/2014/10/16/356638657/despite-legal-reprieve-on-abortion-some-texas-clinics-remain-closed.

existing capacity by the necessary 400 percent to accommodate the abortion services that Texas women require, delays in obtaining abortions will likely rise.[75]

Legal abortions as practiced in Texas prior to H.B. 2 met or exceeded safety expectations for outpatient medical procedures.[76] H.B. 2 is an unnecessary regulation that presents risks to women's health by restricting and delaying access to safe abortion, and, accordingly, should be set aside.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to uphold the district court's decision.

This occurred prior to the Supreme Court's order reopening many of the clinics, which remains in effect pending this appeal.

[75] *See* Grossman et al., *Change in Abortion Services*, *supra* note 51, at 500.

[76] *See* Raymond et al., *supra* note 70, at 478-79.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), I hereby certify that this brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 32(a)(7)(B) and 29(d).

1. In compliance with Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6), the brief has been prepared in proportionally spaced Times New Roman font with 14-point type using Microsoft Word 2010.

2. Exclusive of the exempted portions of the brief, as provided in Federal Rule of Appellate Procedure 32(a)(7)(B) and Fifth Circuit Rule 32.2, the brief contains 6,846 words. As permitted by Federal Rule of Appellate Procedure 32(a)(7)(C), I have relied upon the word count feature of Microsoft Word 2010 in preparing this certificate.

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CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of December, I electronically filed the foregoing Brief of *Amici Curiae* American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiffs-Appellees – Cross-Appellants and In Support of Affirmance with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system. Counsel for all parties to the case and *amici curiae* are registered CM/ECF users and will be served by the appellate CM/ECF system.

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