Nos. 18-1323 & 18-1460

IN THE

Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., et al.,
Petitioners,

v.

REBEKAH GEE, Secretary, Louisiana Department of Health and Hospitals,
Respondent.

REBEKAH GEE, Secretary, Louisiana Department of Health and Hospitals,
Petitioner,

v.

JUNE MEDICAL SERVICES L.L.C., et al.,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, ET AL. IN SUPPORT OF JUNE MEDICAL SERVICES, L.L.C., ET AL.

SKYE L. PERRYMAN
SHIRI A. HICKMAN
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th Street, SW
Washington, DC 20024
(202) 863-2585

KIMBERLY A. PARKER
Counsel of Record
JESSICA E. NOTEBAERT
EMILY A. FARMER
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Ave., NW
Washington, DC 20006
(202) 663-6000
kimberly.parker@wilmerhale.com

ADDITIONAL AMICI LISTED ON INSIDE COVER

AMERICAN COLLEGE OF NURSE-MIDWIVES, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN OSTEOPATHIC ASSOCIATION, AMERICAN PUBLIC HEALTH ASSOCIATION, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND SOCIETY OF OB/GYN HOSPITALISTS

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTEREST OF AMICI CURIAE 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 5

I. ABORTION IS EXTREMELY SAFE AND RARELY REQUIRES HOSPITAL ADMISSION 6

II. ADMITTING PRIVILEGES SERVE NO RELEVANT CREDENTIALING FUNCTION, AND PHYSICIANS AND OTHER CLINICIANS ARE FREQUENTLY DENIED PRIVILEGES FOR REASONS UNRELATED TO THEIR COMPETENCY 10

III. CONTINUITY OF CARE BETWEEN CLINICS AND HOSPITALS IS ACHIEVED THROUGH EMERGENCY PROTOCOLS AND COMMUNICATION, NOT THROUGH OUTPATIENT CLINICIANS HAVING HOSPITAL ADMITTING PRIVILEGES 14

A. Patients Seeking Hospital Care After An Abortion Often Will Not Go To The Hospital At Which Their Outpatient Clinician Would Be Required To Have Admitting Privileges 15

B. Emergency Protocols And Effective Communication Sufficiently Promote Patient Safety Without The Need For A Categorical Admitting Privileges Requirement 17

TABLE OF CONTENTS—Continued

Page

IV. ACT 620 JEOPARDIZES WOMEN'S HEALTH BY RESTRICTING ACCESS TO SAFE AND LEGAL ABORTION 21

V. LOUISIANA'S ARGUMENTS REGARDING PHYSICIANS' ASSERTION OF PATIENTS' ABORTION-RELATED CONSTITUTIONAL CLAIMS ARE BASED ON INCORRECT ASSUMPTIONS ABOUT MEDICAL PRACTICE AND MEDICAL ETHICS 26

CONCLUSION 31

TABLE OF AUTHORITIES

CASES

Page(s)

Singleton v. *Wulff*, 428 U.S. 106 (1976)................6, 27, 28

Warth v. *Seldin*, 422 U.S. 490 (1975) 26

Whole Woman's Health v. *Hellerstedt*, 136 S. Ct. 2292 (2016)..*passim*

Whole Woman's Health v. *Lakey*, 46 F. Supp. 3d 673 (W.D. Tex. 2014).......................................20, 25

STATUTES AND REGULATIONS

42 U.S.C. §1395dd...19

La. Admin. Code tit. 48, pt. I,
§ 4401..3
§ 4423...18

La. Rev. Stat.
§ 40:1061.3...14
§ 40:1061.4...14
§ 40:1061.10..3, 16

Louisiana Act 620 ....*passim*

84 Fed. Reg. 51,732 (Sept. 30, 2019)..........................19, 20

OTHER AUTHORITIES

ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists* (Dec. 2018), http://bit.ly/ACOGProfEthics..27

ACOG, *College Statement of Policy, Abortion Policy* (2014), http://bit.ly/ACOGabortion policy 4, 23, 30

TABLE OF AUTHORITIES—Continued

Page(s)

ACOG, Committee on Health Care for Underserved Women, *Committee Opinion No. 613*, *Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060 (2014) (reaff'd 2019) 4, 26, 28

ACOG, Committee on Health Care for Underserved Women, *Committee Opinion No. 649*, *Racial and Ethnic Disparities in Obstetrics and Gynecology* (2015) (reaff'd 2018), https://bit.ly/30AISph 23

ACOG, Committee on Patient Safety & Quality Improvement, *Committee Opinion No. 657*, *The Obstetric and Gynecologic Hospitalist* (2016) (reaff'd 2019), https://bit.ly/2VC0hKv 18

ACOG, *Guidelines for Women's Health Care: A Resource Manual* (4th ed. 2014) 17

ACOG, *Induced Abortion: What Complications Can Occur with an Abortion?* (May 2015), https://bit.ly/2ABQnAK 9

ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013) (reaff'd 2016), http://bit.ly/ACOGLegislativeInterference 4, 29

AMA, *Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships*, https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships (visited Nov. 27, 2019) 27

TABLE OF AUTHORITIES—Continued

Page(s)

AMA, *Code of Medical Ethics Opinion 1.2.10: Political Action by Physicians*, https://www.ama-assn.org/delivering-care/ethics/political-action-physicians (visited Nov. 27, 2019) 29

AMA, *Principles of Medical Ethics*, (rev. June 2001), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf 27

American College of Physicians, *Primary Care Hospital Care Team—Model Care Coordination Agreement*, http://bit.ly/ACP modelagmt (visited Nov. 27, 2019) 19

American Society for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745 (2011) 7

ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6 (Dec. 2014), https://www.ansirh.org/sites/default/files/publications/files/safetybrief12-14.pdf 7

APHA, *Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers* (2015), http://bit.ly/APHAopp 4

APHA, *Policy Statement, Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention* (2015), http://bit.ly/APHArestrictedaccess 4

TABLE OF AUTHORITIES—Continued

Page(s)

Barr-Walker, et al., *Experiences of Women who Travel for Abortion: A Mixed Methods Systematic Review* (2019), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0209991&type=printable 24

Bixby Center for Global Reproductive Health, *Abortion Restrictions Put Women's Health, Safety and Well-Being at Risk*, https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/Abortion%20restrictions%20risk%20women%27s%20health.pdf (visited Nov. 27, 2019).. 8

Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, https://bit.ly/2K7Ans3 (visited Nov. 27, 2019) 23

Dadlez, E.M. & William L. Andrews, *Post-Abortion Syndrome: Creating an Affliction*, 24 Bioethics 445 (2009) 8

Finer, Lawrence B. & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 Contraception 478 (2011).. 23

Grazer, Frederick M. & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436 (2000) 7

TABLE OF AUTHORITIES—Continued

Page(s)

Grossman, Daniel, et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496 (2014) 22

Guttmacher Institute, *State Facts About Abortion: Louisiana* (Sept. 2019), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana 22

Hanschmidt, Franz, et al., *Abortion Stigma: A Systematic Review*, 48 Perspectives on Sexual & Reproductive Health 169 (2016) 28

Howell, Eric, *Hospitalists Hold Key to Admissions Door for ED Patients*, The Hospitalist (Aug. 2013), http://bit.ly/keytoadmin 19

Jatloui, Tara C., et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. 1 (2018) 7, 16

Jones, Bonnie S., et al., *State Law Approaches to Facility Regulation of Abortion and Other Office Interventions*, 108 Am. J. Pub. Health 486 (2018) 7

Jones, Rachel K., et al., *Abortion Incidence and Service Availability in the United States, 2017* (2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf 17

TABLE OF AUTHORITIES—Continued

Page(s)

Levy, Barbara S., et al., *Consensus Guidelines for Facilities Performing Outpatient Procedures—Evidence Over Ideology*, 133 Obstetrics & Gynecology 255 (2019) 9

Louisiana Department of Health, State Registrar & Vital Records, *Induced Termination of Pregnancy by Weeks of Gestation and Type of Procedure Reported Occurring in Louisiana, 2015*, http://bit.ly/Louisianavitalrecords2015data 16

Louisiana Department of Health, State Registrar & Vital Records, *Induced Termination of Pregnancy by Weeks of Gestation and Type of Procedure Reported Occurring in Louisiana, 2018* (2018), http://bit.ly/Louisianavitalrecords 16

Louisiana Department of Health, State Registrar & Vital Records, *Induced Terminations of Pregnancy by Weeks of Gestation, Race, Age, and Marital Status, Reported Occurring in Louisiana, 2018* (2018), http://bit.ly/Louisianavitalrecords2 24

Morse, Jessica E., et al., *Reassessing Unintended Pregnancy: Toward a Patient-Centered Approach to Family Planning*, 44 Obstetrics & Gynecology Clinics 27 (2017) 23

National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018) .... *passim*

TABLE OF AUTHORITIES—Continued

Page(s)

National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* (Acad. of Med. Royal Colls. 2011) 8

Parks, Caitlin & Jeffrey F. Peipert, *Eliminating Health Disparities in Unintended Pregnancy with Long-Acting Reversible Contraception (LARC)*, 214 Am. J. Obstetrics & Gynecology 681 (2016) 23

Petersen, Emily E., et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 Morbidity & Mortality Weekly Rep. 762 (2019) 23

Peterson, Michael C., *A Systematic Review of Outcomes and Quality Measures in Adult Patients Cared for by Hospitalists vs Nonhospitalists*, 84 Mayo Clin. Proc. 248 (2009), http://unmhospitalist.pbworks.com/f/Does+hospitalist+care+improve+outcomes+review.pdf 18

Roberts, S.C.M., et al., *Corrigendum to "Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges,"* 95 Contraception 221 (2017) 22

TABLE OF AUTHORITIES—Continued

Page(s)

Roberts, S.C.M., et al., *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 Contraception 368 (2015) 15, 24

Singh, Gopal K., United States Department of Health & Human Services, *Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist* (2010), https://www.hrsa.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf 23

TalkPoverty, *Report of Louisiana 2018 Poverty Data*, https://bit.ly/2JKqFiO (visited Nov. 27, 2019) 25

TalkPoverty, *Report of Texas 2018 Poverty Data*, http://bit.ly/2WbkxH4 (visited Nov. 27, 2019) 25

Upadhyay, Ushma D., et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54 Health Servs. Research 425 (2019) 15, 19

Upadhyay, Ushma D., et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (2014) 24

TABLE OF AUTHORITIES—Continued

Page(s)

Upadhyay Ushma D., et al., *Distance Traveled for an Abortion and Source of Care After Abortion*, 130 Obstetrics & Gynecology 616 (2017) 15

Upadhyay, Ushma D., et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015) 8, 9, 15

White, Kari, et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422 (2015) 8, 17

INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the American Academy of Family Physicians, the American Academy of Nursing, the American Academy of Pediatrics, the American College of Nurse-Midwives, the American College of Osteopathic Obstetricians and Gynecologists, the American College of Physicians, the American Osteopathic Association, the American Public Health Association ("APHA"), the American Society for Reproductive Medicine, the North American Society for Pediatric and Adolescent Gynecology, the Society for Maternal-Fetal Medicine, and the Society of OB/GYN Hospitalists submit this amici curiae brief in support of Plaintiffs.[1] Amici are leading national medical and public health organizations committed to the provision of safe, quality reproductive healthcare, including abortion.

In particular, ACOG is the nation's leading group of physicians providing healthcare for women. With more than 58,000 physicians and partners in women's health, ACOG advocates for quality healthcare for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's healthcare. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive healthcare, including abortion

---

[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amici curiae, their members, and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. The parties have provided written consent to the filing of this brief.

care, for all women. ACOG and the other amici oppose medically unnecessary laws or restrictions that serve to delay or prevent care.

ACOG has previously appeared as amicus curiae in various courts throughout the country. ACOG's briefs and guidelines have been cited by numerous courts, including this Court, seeking authoritative medical data regarding childbirth and abortion.

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 represented in the AMA's policymaking 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. This Court and the federal courts of appeal have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.

INTRODUCTION AND SUMMARY OF ARGUMENT

Less than four years ago, in *Whole Woman's Health* v. *Hellerstedt*, five of the amici curiae joining this brief submitted to this Court that, based on the prevailing medical research, a state requirement that a clinician who provides abortions have admitting privileges at a hospital near the location at which the abortion is performed is not medically necessary and unconstitutionally restricts patients' access to essential reproductive healthcare. The Court correctly held that the admitting privileges requirement at issue in *Whole*

Woman's Health posed an unconstitutional and undue burden on abortion access.[2]

Now, those amici curiae find themselves in the same position they were in four years ago, urging the Court to invalidate an admitting privileges requirement that is substantively identical to the one it struck down in *Whole Woman's Health*—this time joined with even more of the nation's leading medical and public health organizations, whose policies continue to represent the considered judgment of clinicians, researchers, and other medical and public health professionals.

If not blocked by this Court, Louisiana's Act 620 will require a physician who provides abortions to obtain and maintain active admitting privileges at a hospital within thirty miles of the location where the abortion is performed.[3] However, since the Court's ruling in *Whole Woman's Health*, additional medical research and information has become available that conclusively demonstrates that abortion remains extremely safe and that state regulation of abortion clinicians through admitting privileges requirements is not medically necessary. Accordingly, for the same reasons that the Court struck down Texas's admitting privileges requirement in 2016, the Court must do the same with Louisiana's Act 620.

---

[2] *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2300, 2310-2311 (2016).

[3] La. Rev. Stat. § 40:1061.10(A)(2). "Active Admitting Privileges" means "the physician is a member in good standing of the medical staff of a hospital that is currently licensed by the department, with the ability to admit a patient and to provide diagnostic and surgical services to such patient." La. Admin. Code tit. 48, pt. I, § 4401.

To be clear, amici's position that an admitting privileges requirement is not medically necessary is not state-dependent. Nationwide, abortion is a safe medical procedure. Nationwide, qualified physicians and other clinicians who provide abortions are unable to obtain admitting privileges for reasons unrelated to their ability to safely and competently perform abortions. Nationwide, patients are harmed by medically unnecessary restrictions on abortion clinicians. Laws regulating abortion should be evidence-based and supported by a valid medical justification.[4] Because laws requiring clinicians who provide abortions to have local admitting privileges are neither, this Court should not allow them to stand, regardless of the state from which they originate.

Finally, in *Whole Woman's Health*, as in many prior cases brought by physicians and other medical professionals, the Court appropriately treated the physician and other medical professional petitioners as hav-

---

[4] *See, e.g.*, ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 613*, *Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060, 1062 (2014) (reaff'd 2019) (explaining that the College opposes medically unnecessary admitting privileges requirements); ACOG, *College Statement of Policy, Abortion Policy* 2 (2014) (opposing "unnecessary regulations that limit or delay access to care"), http://bit.ly/ACOGabortionpolicy; *see also* ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013) (reaff'd 2016) ("ACOG Legislative Interference"), http://bit.ly/ACOGLegislativeInterference; APHA, *Policy Statement*, *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention* (2015), http://bit.ly/APHArestrictedaccess; APHA, *Opposition to Requirements for Hospital Admitting Privileges and Transfer Agreements for Abortion Providers* (2015), http://bit.ly/APHAopp.

ing standing to assert their patients' abortion-related constitutional rights. In this case, Louisiana challenges the ability of clinicians to bring these cases on behalf of their patients. To deny clinicians the ability to pursue these claims on the basis of the state's arguments here would endorse a view that is not grounded in the realities of medical practice and ethics. Contrary to the state's assertions, physicians have an ethical obligation to act in the best interests of their patients and, in the face of medically unnecessary laws that restrict access to abortion, the interests of patients and clinicians are closely aligned.

ARGUMENT

Louisiana's local admitting privileges requirement for physicians who provide abortions is medically unnecessary.[5] This is as true today as it was less than four years ago when this Court noted a "virtual absence of any health benefit" associated with a substantively identical law.[6] Abortion is extremely safe, and patients who obtain abortions rarely require hospitalization. A mandatory admitting privileges requirement does not establish that a physician or other clinician is qualified to perform abortions because the hospitals that make admitting privileges determinations often evaluate and deny admitting privileges requests based on factors unrelated to a clinician's competency to provide abortions. In addition, in the unusual instance in which a patient

---

[5] National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 14 (2018) ("*Safety and Quality of Abortion Care*") ("The committee found no evidence indicating that clinicians that perform abortions require hospital privileges to ensure a safe outcome for the patient.").

[6] *Hellerstedt*, 136 S. Ct. at 2313.

requires emergency hospital care following an abortion, existing regulations and best practices ensure that regardless of whether her clinician has admitting privileges, the patient will be treated and will receive the same quality of hospital care. Thus, the admitting privileges requirement does not improve the health or safety of patients. It does, however, impede patients' access to abortion, especially for already vulnerable demographic groups.

Further, for over forty years, this Court has recognized that clinicians have standing to assert their patients' abortion-related constitutional claims.[7] There is no basis to overturn decades of settled precedent here. Clinicians who provide abortions share a close alignment of interests with their patients, who in turn face numerous hindrances to asserting their own rights. Clinicians thus rightly have been relied upon to assert their patients' rights to quality, evidence-based reproductive care in the courts.

In light of the facts of this case—which are materially the same as the facts in *Whole Woman's Health*—amici urge the Court to reverse the decision below. Act 620 cannot withstand constitutional scrutiny.

I. ABORTION IS EXTREMELY SAFE AND RARELY REQUIRES HOSPITAL ADMISSION

There is no evidence that an admitting privileges requirement improves patient safety when it comes to outpatient abortion care. Louisiana asserts that abortion procedures would be safer if performed by physi-

---

[7] *Singleton* v. *Wulff*, 428 U.S. 106, 117-118 (1976) (plurality opinion); Resp'ts Opp. to Cross-Pet. 17-20 (No. 18-1460).

cians with admitting privileges.[8] Yet, abortion has consistently been one of the safest medical procedures performed in the United States.[9] The risk of death resulting from an abortion has been exceptionally low for decades.[10] It is also extremely rare that an abortion will result in complications that require hospital admis-

---

[8] Pet. App. 4a.

[9] *Safety and Quality of Abortion Care* 10 ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective. Serious complications are rare."); *id.* at 36 ("rare" means affecting fewer than 1 percent of patients); *id.* at 51-68.

[10] *See* Jatloui et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. 1, 45 tbl. 23 (2018) (ranging from 0.00052 percent to 0.00078 percent for approximately five-year periods from 1978 to 2014).

Certain amici supporting Louisiana have implied that abortion procedures are more dangerous than other common office-based procedures. *See, e.g.*, Amicus Brief of American Center for Law and Justice 3 (No. 18-1460) (June 24, 2019). But abortion is safe not just on an absolute basis but on a comparative one: the mortality rates for colonoscopy and liposuction, both often done in an outpatient setting, are higher than the national mortality rate for abortion. American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000). The complication rates for abortion and colonoscopy are similar, and having one's wisdom teeth removed is more likely to result in complications than having an abortion. ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014), https://www.ansirh.org/sites/default/files/publications/files/safetybrief12-14.pdf. For additional information on the ways in which states have regulated clinicians who provide abortion differently from clinicians who provide other types of outpatient care, *see* Jones et al., *State Law Approaches to Facility Regulation of Abortion and Other Office Interventions*, 108 Am. J. Pub. Health 486 (2018).

sion.[11] The rate of major complications following an abortion is less than 0.25 percent.[12] Very few abortions are followed by an emergency department visit because, in the rare cases in which complications do arise following an abortion, patients can typically be treated

---

[11] *See Safety and Quality of Abortion Care* 55, 60.

[12] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 175 (2015) (defining major complications as requiring hospital admission, surgery, or blood transfusion); *see also* White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434, 435 tbl. 7 (2015) (finding the risk of hospitalization following a first-trimester aspiration abortion to be less than 0.5 percent). The higher rates of hospitalization reported in some studies in the White review were associated with procedures done using general anesthesia, which is infrequently used for first-trimester aspiration abortions in office-based clinics in the United States. White, 92 Contraception at 434; *Safety and Quality of Abortion Care* 60.

The same amici referenced *supra* note 10 have suggested that complications immediately following an abortion are not the only risks to consider because of a purportedly heightened risk of mental health issues or substance abuse resulting from an abortion. Amicus Brief of American Center for Law and Justice 21-22 (No. 18-1460). This claim is unsubstantiated. *See, e.g.*, Dadlez & Andrews, *Post-Abortion Syndrome: Creating an Affliction*, 24 Bioethics 445, 450, 452 (2009) ("Numerous studies have found no link between abortion and psychological trauma."); *Safety and Quality of Abortion Care* 150 ("[T]he rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth.") (quoting National Collaborating Ctr. for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* 8 (Acad. of Med. Royal Colls. 2011)); Bixby Ctr. for Glob. Reprod. Health, *Abortion Restrictions Put Women's Health, Safety and Well-Being at Risk* 2 (collecting studies), https://bixbycenter.ucsf.edu/sites/bixbycenter.ucsf.edu/files/Abortion%20restrictions%20risk%20women%27s%20health.pdf (visited Nov. 27, 2019).

by follow-up procedures at a clinic and/or with antibiotics.[13]

Since this Court's ruling in *Whole Woman's Health*, additional research has been published regarding the safety of abortion and the medically unnecessary nature of admitting privileges requirements. This research supports and strengthens the conclusions reached by this Court in *Whole Woman's Health.* For example, in 2018, the National Academies of Sciences, Engineering, and Medicine published a report on the safety and quality of abortion care in the United States. In addition to confirming the safety of abortion, the authors "found no evidence indicating that clinicians that perform abortions require hospital privileges to ensure a safe outcome for the patient."[14] Moreover, certain amici and other national organizations recently undertook a comprehensive study regarding the safe performance of gynecologic procedures, including abortion, in offices and clinics, and concluded that clinicians performing such procedures did not require hospital admitting privileges to ensure patient safety.[15]

In *Whole Woman's Health*, this Court cited a list of evidence relied upon by the district court that abortion is an extremely safe medical procedure and concluded

---

[13] Upadhyay, 125 Obstetrics & Gynecology at 180 tbl. 4 (naming the most common types of complications following an abortion); ACOG, *Induced Abortion: What Complications Can Occur with an Abortion?* (May 2015), https://bit.ly/2ABQnAK; *Safety and Quality of Abortion Care* 116.

[14] *Safety and Quality of Abortion Care* 14.

[15] Levy et al., *Consensus Guidelines for Facilities Performing Outpatient Procedures—Evidence Over Ideology*, 133 Obstetrics & Gynecology 255, 258-259 (2019).

that this evidence adequately supported the district court's determination that the admitting privileges requirement provided no health-related benefit.[16] None of this evidence was limited in its applicability to Texas. Rather, the same evidence that the Court credited in *Whole Woman's Health* applies equally here. Unsurprisingly, then, the *June Medical Services* district court made nearly identical findings that abortion is "one of the safest medical procedures in the United States," that most complications can be managed in an outpatient setting, and that serious complications requiring transfer to a hospital "are extremely rare."[17] Abortion is no less safe now than at the time of this Court's consideration of *Whole Woman's Health*; once again, there is "no significant health-related problem that the new law helped to cure."[18]

II. ADMITTING PRIVILEGES SERVE NO RELEVANT CREDENTIALING FUNCTION, AND PHYSICIANS AND OTHER CLINICIANS ARE FREQUENTLY DENIED PRIVILEGES FOR REASONS UNRELATED TO THEIR COMPETENCY

The Fifth Circuit held that Act 620 promotes women's health by serving a credentialing, or qualifying, function.[19] If this were true, Act 620 would not need to impose a 30-mile limitation on the hospital at which the physician maintains privileges because a physician is

---

[16] *Hellerstedt*, 136 S. Ct. at 2311-2312; *see also id.* at 2313 (referencing the "virtual absence of any health benefit" of Texas's admitting privileges requirement).

[17] Pet. App. 209a, 210a. For similar findings specific to Louisiana, *see* Pet. App. 218a-219a.

[18] *Hellerstedt*, 136 S. Ct. at 2311.

[19] Pet. App. 36a-39a.

just as qualified (i.e., has the same personal experience and skill) regardless of whether a given hospital is near her practice or far away; there is no local expertise needed to safely perform abortions. Further, the process of obtaining admitting privileges is specific to a hospital-based practice and the business of operating a hospital—it has little or nothing to do with whether a clinician is qualified to perform abortions on an outpatient basis.[20] As this Court held in *Whole Woman's Health*, "[t]he admitting-privileges requirement does not serve any *relevant* credentialing function"[21] because a clinician's meeting the criteria for inpatient admitting privileges does not improve the safety of outpatient abortion services.

Hospital admitting privileges are not a barometer of a clinician's competency to perform abortions because clinicians are frequently denied privileges for reasons unrelated to their ability or patient safety. The district court found that no federal or Louisiana statute defined the standards for granting or denying privileges.[22] Some academic hospitals will only allow admitting privileges for clinicians who qualify for and accept faculty appointments.[23] Additionally, some hospitals require that clinicians admit a certain number of patients or perform a certain number of inpatient obstetric-gynecologic procedures to obtain or maintain privileges. Clinicians who provide abortions will not meet such

---

[20] Louisiana already has means of addressing competency through licensing and disciplinary regulations. *See* Pet. App. 272a.

[21] *Hellerstedt*, 136 S. Ct. at 2313 (emphasis added).

[22] Pet. App. 168a.

[23] *Hellerstedt*, 136 S. Ct. at 2312 (citing amici curiae brief of ACOG and other medical associations).

requirements because abortion is a safe, typically outpatient procedure rarely resulting in hospitalization.[24]

The Fifth Circuit attempted to contrast the instant case with *Whole Woman's Health* by stating that Louisiana hospitals' bylaws less frequently required applicants for admitting privileges to admit a threshold number of patients than did Texas hospitals' bylaws.[25] However, even assuming this is accurate, the district court indicated that hospital bylaws do not necessarily dictate how admitting privileges are granted in practice.[26] Moreover, this is only one factor in the privileges-granting process. Hospitals retain extensive discretion over privileges decisions, and hospital-based track records and the hospital's business needs, which are often unrelated to a clinician's competency to perform outpatient abortions, are often determinative. Even Louisiana hospitals' "competency requirement," as characterized by the Fifth Circuit, is about hospital-based performance—requiring recent admissions at a hospital or a provisional admittance period during which a hospital can evaluate the applicant's competency at inpatient procedures—not competency to perform outpatient abortions.[27]

In *Whole Woman's Health*, this Court reviewed the substantial evidence in the record that admitting privileges determinations were often based on prerequisites having nothing to do with the ability to perform abortions and found that the "admitting-privileges require-

---

[24] *See supra* Section I.

[25] Pet. App. 2a-3a, 41a.

[26] Pet. App. 170a-172a.

[27] *See* Pet. App. 41a.

ment does not serve any relevant credentialing function."[28] This evidence was not confined to hospital practice in Texas, and the same non-competency-based reasons this Court cited in *Whole Woman's Health* for denials or revocations of privileges apply nationwide.[29] Because admitting privileges processes present the same challenges for clinicians who provide abortions across the United States, it is not surprising that on the Louisiana-specific facts of this case, the district court here found that privileges were denied to—or would be revoked from—the relevant Louisiana clinicians for several of the same reasons cited by this Court in *Whole Woman's Health*. The reasons cited by the district court here were all irrelevant to a clinician's competency to perform outpatient abortions; they included (i) business reasons (no need for "a satellite primary care physician"); (ii) requirements that a clinician live and/or practice within a particular distance from the hospital; (iii) the inability to identify another on-staff physician who would cover the clinician's patients if needed; or (iv) the lack of intention and inability to admit a requisite number of patients.[30] These doctors' practice of providing abortions also negatively impacted their candidacy for privileges.[31] No Louisiana law prohibits discrimination against clinicians who provide abortion care and, in fact, one Louisiana statute immun-

---

[28] *Hellerstedt*, 136 S. Ct. at 2312-2313.

[29] *Id.* at 2312 (citing amici curiae briefs discussing hospital practices and admitting privileges application processes).

[30] Pet. App. 172a-173a, 177a-179a; *see also* Pet. App. 172a-179a (identifying additional reasons why admitting privileges might be denied).

[31] Pet. App. 173a-178a, 186a, 221a, 226a-227a, 230a-231a.

izes hospitals from lawsuit for their "refusal to permit or accommodate the performance of any abortion in [its] facility or under its auspices" and another provides that a hospital may not be discriminated against or "otherwise be pressured in any way for refusing to permit its facilities, staff or employees to be used in any way for the purpose of performing any abortion."[32]

Contrary to the Fifth Circuit's claims, requiring hospital admitting privileges for clinicians who provide abortions is as irrelevant to credentialing and to promoting the well-being of patients here as it was in *Whole Woman's Health.*

III. CONTINUITY OF CARE BETWEEN CLINICS AND HOSPITALS IS ACHIEVED THROUGH EMERGENCY PROTOCOLS AND COMMUNICATION, NOT THROUGH OUTPATIENT CLINICIANS HAVING HOSPITAL ADMITTING PRIVILEGES

The Fifth Circuit's opinion was ambiguous as to whether it believed Act 620 provided a benefit in terms of continuity of care, communication, or preventing the abandonment of patients, so amici find it necessary to be clear: Act 620 is not medically necessary to advance those goals, just as the Texas law in *Whole Woman's Health* was not. In the extremely rare case that a patient seeks hospital care after an abortion, federal law requires any hospital with an emergency department to treat the patient. Furthermore, the patient would be more likely to seek hospital care after returning home from the clinic, possibly far away from the hospital at which her clinician would be required to have admitting privileges under Act 620. Finally, Louisiana's prior regulations, which did not categorically require outpa-

[32] *See* Pet. App. 175a-176a; La. Rev. Stat. §§ 40:1061.3, 40:1061.4(C).

tient abortion clinicians to have admitting privileges, allowed for planning and communication between outpatient and hospital-based medical professionals to ensure quality and consistency of care for the rare patient admitted to a hospital as a result of abortion-related complications.

A. Patients Seeking Hospital Care After An Abortion Often Will Not Go To The Hospital At Which Their Outpatient Clinician Would Be Required To Have Admitting Privileges

Act 620's requirement that a clinician have admitting privileges at a hospital within thirty miles of his or her clinic makes the regulation particularly futile. Of the small number of patients who seek hospital care following an abortion, most do so the day after the procedure or later.[33] And, as with any emergency, it is likely that a woman would seek treatment at the hospital nearest to her at the time. In 2014, even before Act 620, patients in Louisiana traveled an average of 116 miles round trip for abortion care;[34] thus, a patient is unlikely to be near the hospital at which her clinician would be required to have admitting privileges in the event a rare complication occurs.[35] This is especially

---

[33] Upadhyay et al., *Distance Traveled for an Abortion and Source of Care After Abortion*, 130 Obstetrics & Gynecology 616, 619 (2017); *see also* Upadhyay et al., 125 Obstetrics & Gynecology at 180-181; Upadhyay et al., *Admitting Privileges and Hospital-Based Care After Presenting for Abortion: A Retrospective Case Series*, 54 Health Servs. Research 425, 434 (2019).

[34] Roberts et al., *Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges*, 91 Contraception 368, 370 (2015).

true for the significant and increasing fraction of Louisiana (and nationwide) patients who obtain non-surgical abortions (i.e., those accomplished by medication), in which the medication that completes the abortion is typically taken at home.[36]

---

[35] *See Safety and Quality of Abortion Care* 116 ("Women traveling longer distances … were significantly more likely than those traveling 25 miles or less to seek follow-up care in a local emergency department instead of returning to their original provider." (citation omitted)). Indeed, Act 620 elsewhere acknowledges that the prevailing practice is for a patient to receive emergency care at a facility near her home. La. Rev. Stat. § 40:1061.10(A)(2)(b)(ii) (requiring a clinician providing abortion to provide the patient with "[t]he name and telephone number of the hospital nearest to the home of the pregnant woman at which an emergency arising from the abortion would be treated").

[36] *See Safety and Quality of Abortion Care* 10 ("No special equipment or emergency arrangements are required for medication abortions."); *id.* at 56; *id.* at 79 (explaining that the effects of the medication occur after women leave the clinic and that the risks of medication abortion are similar in magnitude to the risks of taking commonly prescribed and over-the-counter medications such as antibiotics and NSAIDs like aspirin or ibuprofen).

In 2015, the last year for which there was access to analogous national (CDC) data and Louisiana-specific data, approximately 25 percent of patients who obtained abortions obtained non-surgical abortions (i.e., those accomplished by medication) at eight weeks' gestation or less. *See* Louisiana Department of Health, State Registrar & Vital Records, *Induced Termination of Pregnancy by Weeks of Gestation and Type of Procedure Reported Occurring in Louisiana, 2015*, http://bit.ly/Louisianavitalrecords2015data; Jatloui, 67 Morbidity & Mortality Weekly Rep. at 32-33 tbl. 11. In 2018, in Louisiana, these non-surgical abortions occurring at 8 weeks' gestation or less accounted for approximately 36 percent of abortions. Louisiana Department of Health, State Registrar & Vital Records, *Induced Termination of Pregnancy by Weeks of Gestation and Type of Procedure Reported Occurring in Louisiana, 2018*, http://bit.ly/Louisianavitalrecords. Nationwide, in 2017, it was estimated that medication abortion (not limited to 8 weeks'

B. Emergency Protocols And Effective Communication Sufficiently Promote Patient Safety Without The Need For A Categorical Admitting Privileges Requirement

Accepted medical practice requires a clinic to have a plan to provide access to prompt emergency services and (if needed) to transfer a patient to a nearby emergency facility if complications occur.[37] This practice ensures that, in the rare instance where a woman experiences an abortion-related complication at an outpatient location and needs hospital-based care, she can be treated appropriately by a trained emergency-room clinician or the hospital's on-call specialist.[38] Emergency rooms are required by federal law to accept such patients and hospital-based practitioners provide care without regard to whether the abortion clinician has admitting privileges. Indeed, prior to the enactment of

---

gestation) accounted for approximately 39 percent of abortions. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017* 1 (2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf.

[37] ACOG, *Guidelines for Women's Health Care: A Resource Manual* 720 (4th ed. 2014) ("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."); *Safety and Quality of Abortion Care* 14 ("Providers should, however, be able to provide or arrange for patient access or transfer to medical facilities equipped to provide blood transfusions, surgical intervention, and resuscitation, if necessary.").

[38] *See* White, 92 Contraception at 435 ("In the rare event that a hospital transfer is needed, the clinician who is most qualified to treat a woman experiencing a major complication may not be the one who performed the abortion.").

Act 620, Louisiana law sufficiently reflected this 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 emergency requiring hospital treatment.[39]

Current medical practice involves thorough communication between physicians who specialize in outpatient settings and those who work in hospitals, which makes an outpatient clinician's having admitting privileges at that same hospital redundant. Transferring care from the abortion clinician to an emergency-room clinician is consistent with the broader practice throughout modern medicine for inpatient and outpatient care to be provided by practitioners who specialize in each setting.[40] It is no longer the case that the same clinician necessarily provides both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" who practice only in a hospital setting.[41] This division of labor promotes patient care and provides for improved health outcomes, shorter hospital stays, and financial savings through more efficient treatment.[42] Thus, even where a patient is transferred to the hospital at which her clinician has admitting priv-

---

[39] La. Admin. Code tit. 48, pt. I § 4423(B)(3)(c).

[40] *See, e.g.*, ACOG, Comm. on Patient Safety & Quality Improvement, *Committee Opinion No. 657, The Obstetric and Gynecologic Hospitalist* (2016) (reaff'd 2019), https://bit.ly/2VC0hKv.

[41] *Id.* at 2.

[42] Peterson, *A Systematic Review of Outcomes and Quality Measures in Adult Patients Cared for by Hospitalists vs Nonhospitalists*, 84 Mayo Clin. Proc. 248, 249-251 (2009), http://unmhospitalist.pbworks.com/f/Does+hospitalist+care+improve+outcomes+review.pdf.

ileges, the way hospitals structure their admission processes makes it unlikely the clinician who provided the abortion would actually admit the patient.[43] Instead, communication and collaboration between specialized healthcare professionals prevents abandonment of patients and achieves continuity of care.[44]

Further underscoring that admitting privileges are not necessary to provide for continuity of care or patient safety, earlier this year, the Centers for Medicare & Medicaid Services ("CMS") repealed a requirement that ambulatory surgical centers ("ASCs") participating in the Medicare or Medicaid program have hospital physician admitting privileges or a written hospital transfer agreement. In concluding that such requirements are "obsolete and unnecessary" and pose an "administrative burden," CMS acknowledged:

- The Emergency Medical Treatment & Labor Act ("EMTALA"), which has been in effect since 1986, already requires emergency departments to stabilize and treat any patient.[45]

---

[43] *See, e.g.*, Upadhyay, 54 Health Servs. Research at 433-434 (describing case studies); Howell, *Hospitalists Hold Key to Admissions Door for ED Patients*, The Hospitalist (Aug. 2013), http://bit.ly/keytoadmin.

[44] *See* Upadhyay, 54 Health Servs. Research at 435 ("For both transfers and referrals, continuity of care was evident when abortion providers took an active role in calling hospitals before the patient arrived, in order to provide clinical information and advocate for the best course of action for their patient."); *see, e.g.*, American College of Physicians, *Primary Care Hospital Care Team—Model Care Coordination Agreement*, http://bit.ly/ACP modelagmt (visited Nov. 27, 2019).

[45] 42 U.S.C. §1395dd; 84 Fed. Reg. 51,732, 51,738, 51,790 (Sept. 30, 2019).

- Transfers to a hospital are rarely necessary.[46]
- Outpatient providers had difficulty complying with the requirements because hospitals prioritized their own business needs.[47]

There is no medical reason why clinics that provide abortion care should be subject to the same requirements as (much less more stringent requirements than) ASCs, which offer more complicated or risky surgical procedures. The same reasons why an admitting privileges requirement is not necessary in the ASC context apply with equal force to the outpatient abortion context. EMTALA applies not only to patients treated at an ASC, but also to patients treated at any outpatient facility, including one that provides abortions. Transfers to a hospital from outpatient abortion clinics are exceedingly rare. And clinicians at outpatient sites providing abortion face the same challenges, perhaps to a greater degree, to obtaining hospital admitting privileges that ASC physicians face.

Consistent with this view, both the *Whole Woman's Health* and *June Medical Services* district courts found that requiring admitting privileges would not improve continuity of care.[48] The striking similarity of the district court findings regarding continuity of care further demonstrates that there is no material difference between the admitting privileges requirement in *Whole Woman's Health* and the requirement at issue here.

---

[46] 84 Fed. Reg. at 51,738.

[47] *Id.*

[48] *Whole Woman's Health* v. *Lakey*, 46 F. Supp. 3d 673, 685 (W.D. Tex. 2014); Pet. App. 217a-218a.

IV. ACT 620 JEOPARDIZES WOMEN'S HEALTH BY RESTRICTING ACCESS TO SAFE AND LEGAL ABORTION

Admitting privileges requirements unnecessarily impede women's access to timely and quality abortion care.[49] This is because, as described above, they unnecessarily limit the pool of physicians and other clinicians who are able to perform abortions, leaving the same demand for abortion services (women who wish to exercise their constitutional right to have an abortion) with less supply (clinicians who are permitted by state law to provide abortions). Although the specific clinicians and outpatient facilities affected by admitting privileges requirements would necessarily vary by state, the overall effect is a reduction in the pool of clinicians who are able to perform abortion under state law, which impacts the availability of services for women seeking care. The district court's specific findings here—that enforcing Act 620 would likely leave one physician at one clinic in Louisiana to perform abortions and, therefore, an estimated 70 percent of would-be patients unable to obtain abortions in the state—are consistent with this broader pattern.[50]

Act 620 would increase the strain on already pressed resources in Louisiana; even without this law, the state only has three clinics providing abortions, and this number has been decreasing, leaving the majority of Louisiana women of reproductive age in a county

---

[49] *Cf. Safety and Quality of Abortion Care* 77 ("[M]any of these laws have been documented to reduce the availability of care by imposing unneeded regulations on abortion providers and the settings in which abortion services are delivered.").

[50] Pet. App. 255a-257a. The district court also concluded that there would be no clinician providing abortions between 17 weeks' and 21 weeks, six days' gestation. Pet. App. 260a.

without a clinician providing abortion care.[51] Further, the average distance patients would need to travel to obtain an abortion would significantly increase under Act 620.[52] These increased burdens would delay and potentially prevent women from obtaining abortions.

Because Act 620 contains the same admitting privileges requirement as Texas's H.B. 2, the way in which H.B. 2 delayed or prevented Texas women from obtaining abortions is instructive here. During the first six months following the implementation of H.B. 2's privileges requirement, when at least one-third of Texas's clinics closed, there was a demonstrable increase in the proportion of abortions performed in the second trimester compared to the prior twelve-month period.[53] Delays in obtaining an abortion can compromise health. Once a patient decides to have an abortion, she should

---

[51] Guttmacher Inst., *State Facts About Abortion: Louisiana* (Sept. 2019), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-louisiana.

[52] Roberts et al., *Corrigendum to "Implications for Women of Louisiana's Law Requiring Abortion Providers to Have Hospital Admitting Privileges,"* 95 Contraception 221, 221 (2017) (estimating that travel distances would approximately double if two clinics were to remain open).

[53] Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498-499 & tbl. 1 (2014). This study observed H.B. 2's effects for a limited period of time; the overall impact of H.B. 2 was more drastic. In the months leading up to H.B. 2 taking effect, eight abortion clinics closed; eleven more closed on the day the requirement took effect; and, as of the time the requirement began to be enforced, the number of facilities providing abortions had fallen from forty to twenty. *Hellerstedt*, 136 S. Ct. at 2312 (referring to district court's findings).

receive that medical care as early as possible[54] because, although abortion procedures are among the safest medical procedures, the associated rate of complications increases as the pregnancy progresses.[55]

Laws that unnecessarily restrict women's access to abortion—like Act 620—disproportionately impact poor women, women of color, and young women. Women in these groups are more likely than others to experience unintended pregnancies.[56] They are also more likely than others to seek abortion care.[57] Women of color are also more likely to experience complications or deaths in attempting to carry a pregnancy to term.[58] In Loui-

---

[54] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 4, at 2.

[55] *Safety and Quality of Abortion Care* 75.

[56] Parks & Peipert, *Eliminating Health Disparities in Unintended Pregnancy with Long-Acting Reversible Contraception (LARC)*, 214 Am. J. Obstetrics & Gynecology 681, 681-682 & n.2 (2016) (citing Finer & Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, 84 Contraception 478 (2011)); *see also* Morse et al., *Reassessing Unintended Pregnancy: Toward a Patient-Centered Approach to Family Planning*, 44 Obstetrics & Gynecology Clinics 27, 27 (2017).

[57] *Safety and Quality of Abortion Care* 29-31.

[58] Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016*, 68 Morbidity & Mortality Weekly Rep. 762, 762 (2019); Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, https://bit.ly/2K7Ans3 (visited Nov. 27, 2019); Singh, U.S. Dep't of Health & Human Servs., *Maternal Mortality in the United States, 1935-2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist* 1-2 & fig. 2 (2010), https://www.hrsas.gov/sites/default/files/ourstories/mchb75th/mchb75maternalmortality.pdf; ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 649*, *Racial and Ethnic Disparities in Ob-*

siana specifically, most patients seeking abortion are women of color[59] and have a lower median income and higher incidence of poverty than the Louisiana average.[60]

Women in these groups may face unique challenges in obtaining an abortion that Act 620 is likely to exacerbate.[61] For example, one of the primary causes in delaying abortion care is the time it takes to raise money for travel and procedure costs (which continue to increase as the pregnancy progresses),[62] and, in Louisiana, a fifth of working-age women live below the feder-

---

stetrics and Gynecology, at 2 & tbl. 1 (2015) (reaff'd 2018), https://bit.ly/30AISph.

[59] Roberts, 91 Contraception at 371; Louisiana Department of Health, State Registrar & Vital Records, *Induced Terminations of Pregnancy by Weeks of Gestation, Race, Age, and Marital Status Reported Occurring in Louisiana, 2018*, at 1 (2018), http://bit.ly/Louisianavitalrecords2.

[60] Roberts, 91 Contraception at 371.

[61] *See Safety and Quality of Abortion Care* 165 ("State-level abortion regulations are likely to affect women differently based on their geographic location and socioeconomic status. Barriers (lack of insurance coverage, waiting periods, limits on qualified clinicians, and requirements for multiple appointments) are more burdensome for women who reside far from clinicians and/or have limited resources.").

[62] *See* Barr-Walker et al., *Experiences of Women who Travel for Abortion: A Mixed Methods Systematic Review* 18 (2019) (other logistical burdens include arranging childcare and obtaining time off work), https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0209991&type=printable; Upadhyay, et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689, 1692 (2014).

al poverty line (a higher percentage than in Texas).[63] For younger women, increased travel distances may exacerbate existing difficulties associated with restrictions like waiting periods because they may not have driver's licenses or sufficient personal funds for longer trips. Both the *Whole Woman's Health* and *June Medical Services* district courts recognized the already substantial burdens on women in these underserved groups seeking abortions.[64] Creating more medically unnecessary obstacles to obtaining an abortion will harm these women even more.

The same factors that this Court held in *Whole Woman's Health* supported a finding that the impact on women of Texas's admitting privileges requirement was an "undue burden"—fewer clinics providing abortions, fewer doctors eligible to perform procedures, longer waiting times, increased crowding, and increased driving distances—would apply here if Act 620 were allowed to go into effect.[65] There is no reasonable way to distinguish this case from *Whole Woman's Health* on the basis of the law's potential impact on patients.

---

[63] TalkPoverty, *Report of Louisiana 2018 Poverty Data*, https://bit.ly/2JKqFiO (visited Nov. 27, 2019); TalkPoverty, *Report of Texas 2018 Poverty Data*, http://bit.ly/2WbkxH4 (visited Nov. 27, 2019) (both relying on U.S. Census Bureau, American Community Survey, 2017 data).

[64] *Compare* Lakey, 46 F. Supp. 3d at 682-683 (citing lack of availability of child care, unreliability of transportation, inability to get time off work, and the expense of traveling long distance as factors that increasingly delay or impede access to abortion, particularly for women in vulnerable groups), *with* Pet. App. 261a-263a (citing the same factors).

[65] *Compare Hellerstedt*, 136 S. Ct. at 2313, *with* Pet. App. 249a, 258a, 262a, 264a.

V. LOUISIANA'S ARGUMENTS REGARDING PHYSICIANS' ASSERTION OF PATIENTS' ABORTION-RELATED CONSTITUTIONAL CLAIMS ARE BASED ON INCORRECT ASSUMPTIONS ABOUT MEDICAL PRACTICE AND MEDICAL ETHICS

It has been well established since the 1970s that physicians and other clinicians have standing to assert their patients' abortion-related constitutional rights.[66] This is true for good reasons. Clinicians' and patients' rights and interests are interdependent and closely aligned. At the same time, patients face numerous hindrances to asserting their own rights.

The "close relationship" required for third-party standing has been recognized in various contexts, one of which exists "when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights."[67] Louisiana physicians who provide abortions and their patients satisfy this test because, as described above, enforcement of Act 620 against these physicians will negatively impact their patients' constitutional right to have an abortion. Patients' access to abortion care depends on their physicians' ability to provide this care unimpeded by medically unnecessary regulations.[68] Accordingly, "the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination

[66] Resp'ts Opp. to Cross-Pet. 17-20 (No. 18-1460) (collecting cases).

[67] *Warth* v. *Seldin*, 422 U.S. 490, 510 (1975).

[68] *See* ACOG, *Committee Opinion No. 613*, 124 Obstetrics & Gynecology at 1062.

against, [the constitutionally protected abortion] decision."[69]

Louisiana argues that a conflict of interest exists between physicians and patients because physicians' financial self-interest would favor less regulation of their practices even where additional regulation would benefit patients.[70] This argument is baseless and premised on the incorrect assumption that a categorical admitting privileges regulation benefits patients. It does not, so there is no conflict of interest here. Even if such a conflict of interest were to arise, physicians who provide abortions, like all medical professionals, must adhere to their profession's ethical responsibilities, the most important of which is to "regard responsibility to the patient as paramount."[71] This includes "plac[ing] patients' welfare above the physician's own self-interest or obligations to others."[72] These requirements further negate Louisiana's suggestion that phy-

---

[69] *Singleton*, 428 U.S. at 117 (plurality opinion).

[70] Cross-Pet. 25-27 (No. 18-1460).

[71] AMA, *Principles of Medical Ethics* (rev. June 2001), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf; *see also* ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists* 1 (Dec. 2018) ("ACOG Code of Ethics"), http://bit.ly/ACOGProfEthics.

[72] AMA, *Code of Medical Ethics Opinion 1.1.1: Patient-Physician Relationships*, https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships (visited Nov. 27, 2019); ACOG Code of Ethics 1-2 (including as an "ethical foundation" that the "welfare of the patient ... is central to all considerations in the patient-physician relation" and that an "obstetrician-gynecologist should serve as the patient's advocate").

sicians' interests in challenging Act 620 are in conflict with the interests of their patients.

Physicians and other clinicians providing abortion also appreciate that patients face obstacles to bringing their own abortion-related claims. Many patients consider reproductive healthcare to be intensely private[73] and, although abortion care is essential reproductive healthcare, social stigma attaches to it.[74] This stigma dissuades patients from speaking openly even to friends and family,[75] so the publicity involved in consulting an attorney and filing a lawsuit is especially daunting. Further, patients are often prevented from asserting their own rights because they lack resources. Laws and regulations that restrict access to legal abortions impact low-income patients disproportionately.[76] Because privacy, stigma, and cost concerns hinder patients' ability to enforce their own constitutional rights to abortion care, these rights will not be vindicated unless physicians have standing to do so on their patients' behalf.

---

[73] *Singleton*, 428 U.S. at 117 (plurality opinion) ("As to the woman's assertion of her own rights, there are several obstacles. For one thing, she may be chilled from such assertion by a desire to protect the very privacy of her decision from the publicity of a court suit.").

[74] *See* Pet. App. 183a-189a (describing hostile climate including harassment and threats of violence surrounding abortion clinics in Louisiana).

[75] Hanschmidt et al., *Abortion Stigma: A Systematic Review*, 48 Perspectives on Sexual & Reprod. Health 169, 171-173 (2016); ACOG, *Committee Opinion No. 613*, 124 Obstetrics & Gynecology at 1062.

[76] *See supra* Section IV.

Physicians and other clinicians providing abortion may also be better positioned than pregnant women to assert abortion rights because of the unique nature of pregnancy-related claims. The window of time during which a patient can obtain an abortion is narrow and the risks increase as time passes. Therefore, litigating a constitutional claim at the same time she is working to overcome any number of other obstacles, including waiting periods, financial constraints, traveling long distances while pregnant, obtaining time off work, other childcare responsibilities, and maintaining her own safety and privacy, presents an overwhelming challenge for most abortion patients. Physicians and other clinicians do not face the same obstacles.

Further, even if a patient overcame these obstacles and obtained emergency court-ordered relief during the short window, she would no longer have a need (and may also lack the resources) to continue to litigate the case, potentially for years, through its resolution. Physicians and other clinicians, by contrast, are themselves harmed by medically unnecessary abortion regulations like Act 620 on an ongoing basis, and see patients harmed by such regulations every day. They therefore have sufficient incentives to continue to litigate the claim. Physicians must be permitted to assert their patients' constitutional claims to abortion care in order to fulfill their "ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients."[77]

---

[77] AMA, *Code of Medical Ethics Opinion 1.2.10: Political Action by Physicians*, https://www.ama-assn.org/delivering-care/ethics/political-action-physicians (visited Nov. 27, 2019); *see also* ACOG, *Legislative Interference*, *supra* note 4 ("[ACOG]

* * *

In sum, far from safeguarding women's health, Act 620's privileges requirement jeopardizes women's health in the same way that H.B. 2 did in *Whole Woman's Health*. Act 620, like H.B. 2, would impede, if not outright prevent, access to safe, legal, evidence-based abortion care despite, as this Court has already acknowledged, the "virtual absence of any health benefit."[78] Amici oppose laws that, in the absence of any valid medical justification, have this potentially devastating result.[79] Permitting Act 620 to stand would contravene this Court's important decision in *Whole Woman's Health* and leave open a dangerous avenue through which states can strip women of their constitutional right to legal, quality abortion care.

---

urge[s] physicians to advocate against undue legislative interference in patient care.").

[78] *Hellerstedt*, 136 S. Ct. at 2313.

[79] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 4, at 2.

CONCLUSION

For the foregoing reasons, amici urge the Court to reverse the decision below.

Respectfully submitted.

SKYE L. PERRYMAN
SHIRI A. HICKMAN
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th Street, SW
Washington, DC 20024
(202) 863-2585

KIMBERLY A. PARKER
Counsel of Record
JESSICA E. NOTEBAERT
EMILY A. FARMER
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Ave., NW
Washington, DC 20006
(202) 663-6000
kimberly.parker@wilmerhale.com

DECEMBER 2019