No. 18-1323

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.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF NURSE-MIDWIVES, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN'S HEALTH, NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), the American Academy of Family Physicians ("AAFP"), the American Academy of Pediatrics ("AAP"), the American College of Nurse-Midwives ("ACNM"), the American College of Osteopathic Obstetricians and Gynecologists ("ACOOG"), the American College of Physicians ("ACP"), the American Society for Reproductive Medicine ("ASRM"), the National Association of Nurse Practitioners in Women's Health ("NPWH"), the North American Society for Pediatric and Adolescent Gynecology ("NASPAG"), and the Society for Maternal-Fetal Medicine ("SMFM") submit this amici curiae brief in support of Petitioners.[1]

ACOG is the nation's leading group of physicians providing healthcare for women. With more than 58,000 members—representing more than 90 percent of all obstetricians-gynecologists in the United States—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 care, for all women. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care.

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[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. Counsel of record for the parties received notice of amici's intent to file this brief at least ten days before its due date. The parties have consented to the filing of this brief.

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.

AAFP is the national medical specialty society representing family physicians. Founded in 1947 as a not-for-profit corporation, its 134,600 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of members with professionalism and creativity.

AAP was founded in 1930 and is a national, not-for-profit organization dedicated to furthering the interests of child and adolescent health. Since AAP's inception, its membership has grown from 60 pediatricians to more than 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past 89 years, AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. AAP has worked with the federal and state governments, healthcare providers, and parents on behalf of America's families to ensure the availability of safe and effective reproductive health services.

ACNM works to advance the practice of midwifery in order to achieve optimal health for women through their lifespan, with expertise in well woman and gynecologic care. Its members include approximately 7,000 certified nurse-midwives and certified midwives who provide primary and maternity care services to help

women of all ages and their newborns attain, regain, and maintain health. ACNM and its members respect each woman's right to dominion over her own health and care and ACNM advocates on behalf of women and families, its members, and the midwifery profession to eliminate health disparities and increase access to evidence-based, quality care.

ACOOG was founded in 1934 and is a 2,500-member organization dedicated exclusively to women's healthcare. An osteopathic obstetrician-gynecologist is committed to the physical, mental, and emotional health of women. ACOOG provides education, training, and community to its osteopathic obstetricians-gynecologists throughout the United States.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ASRM is a multidisciplinary not-for-profit organization dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals. ASRM accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated healthcare providers. ASRM is committed to facilitating and sponsoring educational activities for the lay public and continuing medical education activities for professionals who are engaged in the practice of and research in reproductive medicine.

NPWH is a national professional membership organization for advanced-practice registered nurses dedicated to women and their health since its inception in 1980. Its members champion state-of-the-science healthcare that holistically addresses the unique needs of women across their lifetimes. NPWH's mission is to ensure the provision of quality primary and specialty healthcare to women of all ages by women's health and women's health-focused nurse practitioners, including by protecting and promoting a woman's right to make her own choices regarding her health within the context of her personal, religious, cultural, and family beliefs.

NASPAG is dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. With its diverse membership including gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialties, its focus is to be the leading provider in pediatric and adolescent gynecology ("PAG") education, research, and clinical care; conduct and encourage multidisciplinary and interprofessional programs of medical education and research in the field of PAG; and advocate for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based practice of PAG.

SMFM supports the clinical practice of maternal-fetal medicine ("MFM") by providing education, promoting research, and engaging in advocacy to optimize the health of high-risk pregnant women and their babies. Founded in 1977, SMFM is the medical professional society for obstetricians who have additional training in the area of high-risk, complicated pregnancies. Representing over 4,000 members who care for high-risk pregnant women, SMFM works to increase

promotion of high-quality MFM research and expand access to MFM services to reduce healthcare disparities for high-risk pregnant women.

INTRODUCTION AND SUMMARY OF ARGUMENT

Reproductive healthcare is essential to a woman's overall health, and access to abortion care is an important component of reproductive healthcare. Amici curiae are leading medical societies, whose policies represent the considered judgments of physicians and other clinicians in this country. Amici's position is that laws regulating abortion should be supported by a valid medical justification, and certain amici previously submitted briefs in support of that position in *Whole Woman's Health* v. *Hellerstedt*.[2] In *Whole Woman's Health*, this Court held that a state's admitting privileges requirement did not advance women's health and imposed an unconstitutionally undue burden on access to abortion care.[3] Amici write now out of concern that permitting the Fifth Circuit's decision in *June Medical Services L.L.C.* v. *Gee*[4] to stand would contravene this Court's holding in *Whole Woman's Health* without any medical basis, restricting women's access to otherwise safe and important care.

Louisiana Act 620 requires a physician providing abortions to have "active admitting privileges" at a hospital within thirty miles of the location where the abor-

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[2] Brief for Amici Curiae ACOG et al. in Support of Petitioners, *Whole Woman's Health* v. *Cole*, 136 S. Ct. 499 (2015) (No. 15-274) (in support of petition for a writ of certiorari); Brief for Amici Curiae ACOG et al. in Support of Petitioners, *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274).

[3] *Hellerstedt*, 136 S. Ct. at 2300, 2311.

[4] Pet. App. 1a; *id.* 104a.

tion is performed.[5] Act 620 is substantively identical to the Texas privileges requirement struck down by this Court in *Whole Woman's Health*. Amici, therefore, have the same objections to Act 620 that were raised in the context of *Whole Woman's Health*: Legal abortions performed in Louisiana prior to the passage of Act 620 were safe and rarely required hospital admission; admitting privileges are unnecessary for safe patient care and can be difficult or impossible to obtain for reasons unrelated to a clinician's competence; and imposing these unjustified burdens on abortion providers impedes women's access to quality, evidence-based medicine.

Patient safety is of paramount concern to amici, and amici support laws that are necessary to protect patient safety. Laws that regulate abortion should be evidence-based and designed to improve women's health.[6] In *Whole Woman's Health*, this Court concluded there was no evidence in the record that even one woman's treatment would have been improved had her abortion provider had admitting privileges, and,

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[5] 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.

[6] *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"), https://bit.ly/2HAmqUb; *see also* ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013) (reaff'd 2016), https://bit.ly/2JogEsj.

further, found that the "admitting-privileges requirement does not serve any relevant credentialing function."[7] Nothing since the Court's decision in *Whole Woman's Health* has changed the extremely safe nature of abortion procedures or the fact that admitting privileges requirements, such as Act 620, confer no health or safety benefit. Accordingly, the Court should grant petitioners' request for a writ of certiorari and summarily reverse the Fifth Circuit's decision.

ARGUMENT

There is no medical benefit to a local admitting privileges requirement for abortion providers.[8] Abortion is an extremely safe procedure, and patients who obtain abortions rarely require hospitalization. Even in the rare instances in which patients require admission to a hospital, they will be admitted whether their abortion provider has admitting privileges or not, and emergency protocols can achieve the goal of continuity of care absent privileges. Further, whether a clinician has hospital admitting privileges cannot be used to judge his or her competency to perform abortions because clinicians are often denied admitting privileges for reasons unrelated to their competency. Stated plainly, the privileges requirement does nothing to improve the health or safety of women.

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[7] *Hellerstedt*, 136 S. Ct. at 2311-2312, 2313.

[8] 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*") (conclusion of committee tasked with answering the question "What safeguards are necessary to manage medical emergencies arising from abortion interventions?" is, "The committee found no evidence indicating that clinicians that perform abortions require hospital privileges to ensure a safe outcome for the patient.").

Not only does the admitting privileges requirement lack any medical basis, it also substantially burdens women's access to abortion. In light of the facts of this case—which are effectively the same as the facts in *Whole Woman's Health*—amici urge the Court to grant the petition for a writ of certiorari and summarily reverse the decision below. Act 620 cannot withstand constitutional scrutiny following *Whole Woman's Health*.

I. ABORTION IS AN EXTREMELY SAFE MEDICAL PROCEDURE THAT RARELY REQUIRES HOSPITAL ADMISSION

Louisiana asserts that abortion procedures would be safer if performed by physicians with admitting privileges.[9] Yet, abortion has consistently been one of the safest medical procedures performed in the United States.[10] The risk of death resulting from an abortion has been exceptionally low for decades.[11] It is also extremely rare that an abortion will result in complications that require hospital admission. The most common complications fol-

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[9] Pet. App. 4a.

[10] *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 ("In this report, 'rare' is used to describe outcomes that affect fewer than 1 percent of patients."); *id.* at 51-68 (summarizing methods for performing abortions and their associated complication rates).

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

lowing an abortion[12] can typically be treated by follow-up procedures at the clinic and/or with antibiotics.[13] In a comprehensive review of published studies, researchers found that most studies regarding office-based clinics reported a less than 0.5 percent risk of hospitalization following a first-trimester aspiration abortion (the most frequent type of abortion).[14]

Both the *Whole Woman's Health* and *June Medical Services* district courts made consistent findings about the safety of abortion. In *Whole Woman's Health*, the district court found, "The great weight of the evidence demonstrates that, before the act's passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring

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[12] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 180 tbl. 4 (2015) (incomplete abortion or infection).

[13] ACOG, *Induced Abortion: What Complications Can Occur with an Abortion?* (May 2015), https://bit.ly/2ABQnAK; *Safety and Quality of Abortion Care* 116.

[14] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434, 435 tbl. 7 (2015). The rate of major complications across all abortion procedures, including medication and second-trimester abortions, is similarly low. *See* Upadhyay et al., 125 Obstetrics & Gynecology at 176 fig. 1, 181 (using 2009-2010 data from California and finding a 0.23 percent risk of abortion complications that might require hospital admission, surgery, or blood transfusion); *Safety and Quality of Abortion Care* 57 (in study of medication abortions in Iowa, rate of clinically significant adverse events (hospital admission, surgery, blood transfusion, emergency department treatment, or death) was less than 0.3 percent). The higher rates of hospitalization reported in some studies 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 et al., 92 Contraception at 434; *Safety and Quality of Abortion Care* 60.

on account of the procedure."[15] Similarly, the *June Medical Services* district court found 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."[16] There is no distinction to be made between this case and *Whole Woman's Health* regarding the findings related to the safety of abortion procedures. Nor has abortion become less safe since 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."[17]

II. 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 suggested that Act 620 supports women's health by promoting continuity of care or communication, or by preventing abandonment of patients.[18] These goals are not accomplished by an admitting privileges requirement. In the rare cases where women seek hospital care after an abortion, they are more likely to do so after returning home from the clinic, potentially far away from the hospital at which their clinician would be required to have admitting privileges

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[15] *Whole Woman's Health* v. *Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014).

[16] Pet. App. 209a, 210a.

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

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

under Act 620. Further, existing protocols call for effective planning and communication between outpatient clinicians and hospital providers, not an admitting privileges requirement, to ensure quality and consistency of care for the few patients 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.[19] 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;[20] in effect, 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.[21] This is especially

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[19] 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).

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

[21] *See Safety and Quality of Abortion Care* 116 ("Women traveling longer distances … were significantly more likely than

true for the approximately 30 percent of patients who obtain medication abortions,[22] in which the medication that completes the abortion is typically taken at home.[23]

B. Best Practices Call For Emergency Protocols And Effective Communication, Not Admitting Privileges Requirements

Modern medical practice emphasizes communication between physicians who specialize in inpatient or outpatient settings, which achieves continuity of care without regard to whether abortion providers have admitting privileges. Accepted medical practice requires a clinic to have a plan to provide prompt emergency services and (if needed) to transfer a patient to a

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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 that an abortion provider shall 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").

[22] Jones & Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Perspectives on Sexual & Reprod. Health 17, 24 tbl. 5 (Mar. 2017); Jatlaoui et al., 67 Morbidity & Mortality Weekly Rep. at 33 tbl. 11.

[23] *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).

nearby emergency facility if complications occur.[24] This practice ensures that, in the rare instance where a woman experiences an abortion-related complication and needs hospital-based care, she can be treated appropriately by a trained emergency-room clinician or the hospital's on-call specialist.[25] Hospital-based clinicians provide care without regard to whether the abortion provider has admitting privileges. Indeed, prior to the enactment of Act 620, Louisiana law 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.[26]

Transferring care from the abortion provider 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.[27] It is no longer the case that

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[24] 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.").

[25] *See* White et al., 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.").

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

[27] *See, e.g.*, ACOG, Comm. on Patient Safety & Quality Improvement, *Committee Opinion No. 657, The Obstetric and Gynecologic Hospitalist* (2016) (reaff'd 2017), https://bit.ly/2VC0hKv.

the same clinician necessarily provides both outpatient and hospital-based care; rather, hospitals increasingly rely on "hospitalists" who practice only in a hospital setting.[28] Even where a patient is transferred to the hospital at which her abortion provider has admitting privileges, the way hospitals structure their admitting processes makes it unlikely the abortion provider will actually admit the patient.[29] Instead, communication and collaboration between specialized healthcare providers achieves continuity of care.[30]

Both the *Whole Woman's Health* and *June Medical Services* district courts found that admitting privileges did not improve continuity of care. In *Whole Woman's Health*, the district court observed, "Evidence related to patient abandonment and potential improved continuity of care in emergency situations is weak in the face of the opposing evidence that such complications are exceedingly rare in Texas [and] nationwide…."[31] Similarly, the *June Medical Services* district court found, "Admitting privileges do little to advance and are not necessary for continuity of care…. Continuity of care can be accomplished by communicating with the physician to whom the patient's care is being turned

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[28] *Id.* at 2.

[29] *See, e.g.*, Upadhyay et al., 54 Health Servs. Research at 433-434 (describing case studies).

[30] *See id.* 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.").

[31] *Lakey*, 46 F. Supp. 3d at 685.

over."[32] The striking similarity of the district court findings demonstrates that there is no material difference between the admitting privileges requirement in *Whole Woman's Health* and the requirement at issue here.

III. ADMITTING PRIVILEGES SERVE NO RELEVANT CREDENTIALING FUNCTION AND CLINICIANS ARE FREQUENTLY DENIED PRIVILEGES FOR REASONS UNRELATED TO THEIR COMPETENCY

The Fifth Circuit suggested that Act 620 promotes women's health by serving a credentialing, or qualifying, function.[33] But the process of obtaining admitting privileges is specific to a hospital-based practice and the business of operating a hospital—it has nothing to do with whether a clinician is qualified to perform abortions on an outpatient basis.[34] As this Court held in *Whole Woman's Health*, "[t]he admitting-privileges requirement does not serve any *relevant* credentialing function"[35] because a clinician's meeting 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. For example, some academic hospitals will only allow admitting privileges for clinicians who qualify for and ac-

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[32] Pet. App. 217a.

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

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

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

cept faculty appointments.[36] Hospitals may also decline to grant admitting privileges to outpatient providers to disincentivize competitors.[37] 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. Abortion providers will not meet such requirements because abortion is a safe, typically outpatient procedure rarely resulting in hospitalization.[38] The Fifth Circuit attempted to contrast the instant case with *Whole Woman's Health* based on the frequency with which Louisiana hospitals' bylaws required applicants to admit a minimum number of patients relative to Texas hospitals.[39] Looking at this factor in isolation ignores the broader overall context—both through bylaws and in practice, hospitals retain extensive discretion over privileges decisions, and hospital-based track

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[36] *Id.* at 2312 (citing amici curiae brief of ACOG and other medical associations).

[37] *See, e.g.*, Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction, 83 Fed. Reg. 47,686, 47,693 (proposed Sept. 20, 2018) (proposing to remove the federal requirement that ASCs participating in Medicare have a transfer agreement or admitting privileges that meet certain requirements because hospitals have denied admitting privileges to ASC physicians due to competition reasons, and "the requirements are creating an administrative barrier to efficient ASC operations without any improvement in patient care or safety").

[38] *See, e.g.*, White et al., 92 Contraception at 35.

[39] Pet. App. 2a-3a; *Id.* 41a.

records and the hospital's business needs are often determinative.[40]

In *Whole Woman's Health*, the Fifth Circuit credited evidence that clinicians had been denied privileges for reasons unrelated to their competency.[41] In *June Medical Services*, the district court found that privileges were denied to—or would be revoked from—the plaintiff doctors because of (i) business reasons (no need for "a satellite primary care physician"); (ii) requirements that a provider 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.[42] The plaintiff doctors' practice of providing abortions also negatively impacted their candidacy for privileges.[43] No Louisiana law prohibits discrimination against abortion providers and, in fact, one Louisiana statute immunizes 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

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[40] Even the Fifth Circuit's explanation of Louisiana hospitals' "competency requirement" is about hospital performance, not competency to perform abortions. *See id.* at 41a (hospitals require "information about recent admissions at any other hospital or … a provisional admittance period during which the hospital can personally observe and evaluate him").

[41] *Whole Woman's Health* v. *Cole*, 790 F.3d 563, 596 (5th Cir. 2015).

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

[43] *Id.* 173a-178a.

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."[44]

Requiring hospital admitting privileges for abortion providers is as irrelevant to promoting the well-being of Louisiana women as it was for Texas women. There is no basis to treat this case differently from *Whole Woman's Health* on grounds related to the privileges processes in the respective states.

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

Admitting privileges requirements for abortion providers unnecessarily impede women's access to timely and quality abortion care.[45] The district court found that enforcing Louisiana's admitting privileges requirement would likely leave one physician at one clinic in the state to perform abortions, and estimated that 70 percent of would-be patients would not be able to obtain an abortion in Louisiana (approximately 55 percent if two physicians could provide abortions, a possible, but less likely, scenario).[46] There would be no clinician providing abortions between 17 weeks' and 21 weeks, six days' gestation.[47] Act 620 would increase the strain on already pressed resources—even without

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

[45] *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.").

[46] Pet. App. 255a-257a.

[47] *Id.* 260a.

this law, the number of clinics providing abortion in Louisiana has been decreasing and the majority of Louisiana women of reproductive age live in a county without an abortion provider.[48] Further, the average distance patients would need to travel to obtain an abortion would significantly increase under Act 620.[49] 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 nearly one-third of Texas's clinics closed, there was a noticeable increase in the proportion of abortions performed in the second trimester compared to the prior twelve-month period.[50] Delays in obtaining an abortion can compromise health. Abortion should be performed as early as possible[51] because, although abortion procedures are among the saf-

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[48] Guttmacher Inst., *State Facts About Abortion: Louisiana* 2 (2018).

[49] 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).

[50] Grossman et al., *Change in Abortion Services After Implementation of a Restrictive Law in Texas*, 90 Contraception 496, 498-499 & tbl. 1 (2014).

[51] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 6, at 2.

est medical procedures, the associated rate of complications increases as the pregnancy progresses.[52]

Also in the months immediately preceding and following the implementation of H.B. 2's privileges requirement, the number of abortions reported in Texas declined by 13 percent, which researchers observed was a steeper drop "than that reported for both Texas and the nation in recent years."[53] Amici are concerned that this decline may indicate not a true reduction in the incidence of abortion, but rather, among other possibilities (such as obtaining care in another state), a rise in unsafe abortions, including potentially unsafe self-induced abortions. Data suggest that there is a relationship between restricted access and the use of unsafe means to end an unwanted pregnancy.[54]

For example, a statewide survey of Texas women in January 2015 found that women in populations most likely to be affected by additional clinic closures (because of already existing difficulties accessing reproductive healthcare) were the most familiar with self-induction, and researchers found cause to "suspect that

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

[53] Grossman et al., 90 Contraception at 499 tbl. 1, 500.

[54] *See* ACOG, *Committee Opinion No. 613*, *supra* note 6, at 1061 ("[H]istorical and contemporary data show that where abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy…."); Shah et al., *Access to Safe Abortion: Progress and Challenges Since the 1994 International Conference on Population and Development (ICPD)*, 90 Contraception S39, S40 (2014) (noting that "legal restrictions result in women self-inducing abortion or seeking it clandestinely"); Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 Contraception 73, 74 (2014) ("Evidence from other countries indicates that severely restricting abortion does not reduce its incidence—it simply makes unsafe abortion more common.").

abortion self-induction will increase as clinic-based care becomes more difficult to access."[55] In the instant case, the district court found that Louisiana women are facing the same risk as women in Texas: "[T]he reduction in availability of abortion would lead to an increase in self-performed, unlicensed and unsafe abortions."[56]

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.[57] They are also more likely than others to seek abortion care.[58] Women of color and poor women are also more likely to experience complications or deaths in attempting to carry a pregnancy to term.[59] In Louisiana specifically, most pa-

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[55] Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Texas Policy Evaluation Project Research Brief 2, 4 (2015).

[56] Pet. App. 274a.

[57] Parks & Peipert, *Eliminating Health Disparities in Unintended Pregnancy with Long-Acting Reversible Contraception (LARC)*, 214 Am. J. Obstetrics & Gynecology 681, 681-682 (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).

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

[59] Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, https://bit.ly/2K7Ans3 (visited May 20, 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* 2, 3 (2010); ACOG, Comm. on Health Care for Underserved Women, *Committee Opinion No. 649, Racial and Ethnic Disparities in*

tients seeking abortion are women of color[60] and have a lower median income and higher incidence of poverty than the Louisiana average.[61]

Women in these groups may also face unique challenges in obtaining an abortion that Act 620 could exacerbate.[62] 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),[63] and, in Louisiana, a fifth of working-age women live at or below the federal poverty line (a higher percentage than in Texas).[64] For young women or minors, increased travel

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

[60] Roberts et al., 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, 2017*, at 2 (2017), https://bit.ly/2w4bglv.

[61] Roberts et al., 91 Contraception at 371.

[62] *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 providers, and requirements for multiple appointments) are more burdensome for women who reside far from providers and/or have limited resources.").

[63] *See* 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).

[64] TalkPoverty, *Report of Louisiana 2018 Poverty Data*, https://bit.ly/2JKqFiO (visited May 20, 2019); TalkPoverty, *Report of Texas 2018 Poverty Data*, http://bit.ly/2WbkxH4 (visited May 20, 2019) (both relying on U.S. Census Bureau, American Community Survey, 2017 data).

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.[65] Creating more medically unnecessary obstacles to obtaining an abortion will harm these women even more.

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*: by impeding, if not outright preventing, access to safe, legal, evidence-based abortion care. Amici oppose laws that, in the absence of any valid medical justification, have this potentially devastating result.[66] 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.

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[65] *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).

[66] *See* ACOG, *College Statement of Policy, Abortion Policy*, *supra* note 6, at 2.

CONCLUSION

For the foregoing reasons, amici urge the court to grant the petition for a writ of certiorari and summarily reverse the decision below.

Respectfully submitted.

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