No. 13-51008

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES; PLANNED PARENTHOOD CENTER FOR CHOICE; PLANNED PARENTHOOD SEXUAL HEALTHCARE SERVICES; WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; SOUTHWESTERN WOMEN'S SURGERY CENTER; WEST SIDE CLINIC, INCORPORATED; ROUTH STREET WOMEN'S CLINIC; HOUSTON WOMEN'S CLINIC, each on behalf of itself, its patients and physicians; ALAN BRAID, M.D.; LAMAR ROBINSON, M.D.; PAMELA J. RICHTER, D.o., each on behalf of themselves and their patients; PLANNED PARENTHOOD WOMEN'S HEALTH CENTER,

Plaintiffs – Appellees

v.

ATTORNEY GENERAL GREGORY ABBOTT; DAVID LAKEY, M.D.; MARI ROBINSON, Executive Director of the Texas Medical Board,

Defendants – Appellant

On Appeal from the United States District Court for the Western District of Texas
(No. 13-862, Hon. Lee Yeakel)

Amicus Curiae Brief of
Alliance Defending Freedom, Bioethics Defense Fund, and Family Research Council
in Support of Defendants-Appellants and Reversal of District Court

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Defendants – Appellant

CERTIFICATE OF INTERESTED PERSONS

Pursuant to Fifth Circuit Rule 28.2.1, the undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees:

Planned Parenthood of Greater Texas Surgical Health Services

Planned Parenthood Center for Choice

Planned Parenthood Sexual Healthcare Services

Whole Women's Health

Austin Women's Health Center

Killeen Women's Health Center

Southwestern Women's Surgery Center

West Side Clinic, Inc.

Routh Street Women's Clinic

Houston Women's Clinic

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Other Interested Persons or Entities:

Amici are unaware of any other interested persons or entities.

***Amici**:*

Alliance Defending Freedom

American Association of Pro-Life Obstetricians & Gynecologists

Bioethics Defense Fund

Christian Medical Association

Catholic Medical Association

Family Research Council

Physicians for Life

National Association of Pro Life Nurses

The National Catholic Bioethics Center

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Amici have no parent corporations or stock of which a publicly held corporation can hold.

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Dated: November 29, 2013

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici curiae are national organizations whose members include attorneys, bioethicists, and concerned individuals who have a profound interest in protecting maternal health in their professional and personal roles.

Amici include the following organizations and individuals:

Alliance Defending Freedom ("ADF") is a non-profit public interest legal organization that provides strategic planning, training, funding, and direct litigation services to protect religious freedom, the sanctity of human life, and marriage and the family. Since its founding in 1994, Alliance Defending Freedom has played a role, either directly or indirectly, in many cases before the U.S. Supreme Court, as well as hundreds more in lower courts.

ADF is deeply concerned about the sanctity of human life, including the protection of the lives of women who choose to end the life of their unborn child. As a legal organization that often advises State legislators, ADF is also concerned about the tendency for abortion to distort the law, in this case erroneously

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[1] In accordance with FED. R. APP. P. 29, the parties have consented to the filing of this *amicus* brief. No party's counsel has authored the brief in whole or in part. No party or party's counsel has contributed money intended to fund preparing or submitting this brief. No person other than *amici*, their members, or their counsel has contributed money that was intended to fund preparing or submitting this brief.

[2] *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 116 (1973) *(*"the sensitive and emotional nature of the abortion controversy" provokes "vigorous opposing views" and inspires "deep and seemingly absolute convictions."); *Planned Parenthood v. Casey*, 505 U.S. at 850 (The practice of abortion has "profound moral and spiritual

curtailing the authority of State legislators to protect the health and safety of their citizens by ensuring appropriate emergency medical care for women who have chosen to end the lives of their unborn children. ADF and its allies, including more than 2,200 attorneys and numerous public interest law firms and other organizations, represent hundreds of thousands of Americans who believe strongly in these topics, and who have a right to express those views through this nation's political process.

Bioethics Defense Fund ("BDF") is a non-profit public interest legal and education organization whose attorneys collaborate with leading academics, medical doctors, and scientists to provide law and policy consultation, across the nation and abroad, based on the latest medical evidence and grounded in sound medical ethics that respect the dignity of the human person. BDF attorneys draft model legislation and engage in strategic litigation on issues involving abortion, biotechnology, and end of life issues, often in the context of conscience rights and the protections of the First Amendment. BDF attorneys engage in educational speaking engagements in the nation's leading law schools and medical schools, and serve as a resource for nationally syndicated writers.

BDF also files amicus briefs at all levels of state and federal courts, including amicus briefs filed in every Supreme Court case addressing abortion since its founding in 2005.

Family Research Council ("FRC") is a non-profit organization located in Washington, D.C., that exists to develop and analyze governmental policies that affect the family. FRC is committed to strengthening traditional families in America and advocates continuously on behalf of policies designed to accomplish that goal. FRC contends that because many women who undergo an abortion experience unexpected emotional and physical harms that can result in the need for emergency care, State governments are permitted to regulate pursuant to the principles established under *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

SUMMARY OF THE ARGUMENT

Throughout this case, Planned Parenthood has painted an incomplete picture about the government's interests in regulating abortion, a surgical or drug-induced procedure that carries significant health risks. As the Supreme Court has repeatedly recognized, abortion raises profound moral questions on which American society has not come to a consensus.[2] But a plurality of moral opinions is irrelevant to the

[2] *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 116 (1973) *(*"the sensitive and emotional nature of the abortion controversy" provokes "vigorous opposing views" and inspires "deep and seemingly absolute convictions."); *Planned Parenthood v. Casey*, 505 U.S. at 850 (The practice of abortion has "profound moral and spiritual implications," and "men and women of good conscience can disagree" about those implications and can find abortion "offensive to [their] most basic principles of morality."). Indeed, "there are common and respectable reasons for opposing it." *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993). Further, as recognized by Justice Scalia, there are "those who share an abiding moral or religious conviction (or, for that matter, simply a biological appreciation) that

credible, peer-reviewed medical literature establishing that Texas has a legitimate interest in ensuring that physicians terminating pregnancies are able to carefully attend to the woman's health both during and after an elective abortion by having admitting privileges at a hospital within 30 miles of the location of the abortion (the "admitting privileges requirement").

In Section I, *amici* show that Texas House Bill (HB) 2 is a legitimate regulation designed to protect women's health which can be negatively impacted by both the risks inherent to abortion in any facility, and especially the risks that arise from abortions performed in facilities that have a poor record of meeting health and safety standards. In Section II, *amici* set forth the legal principles supporting the Texas legislature's legitimate interests.

ARGUMENT

I. The High Rate of Pregnancy Terminations Performed in Abortion Facilities and Their Poor Record of Meeting Safety Standards Gives Texas a Legitimate Interest in Requiring Admitting Privileges to Protect Women's Health

A. Background on Abortion in Texas

In 2008 alone, well over 80,000 abortions took place within the borders of Texas. Guttmacher Institute, STATE FACTS ABOUT ABORTION: TEXAS, *available at* http://www.guttmacher.org/pubs/ sfaa/texas.html. The vast majority of the known

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abortion is the taking of a human life." *Hill v. Colorado*, 530 U.S. 703, 763 (2000) (Scalia, J., dissenting).

elective abortions – 91.5 percent – were performed in abortion facilities rather than hospitals or ambulatory surgical centers according to 2006 data, the most recent year for which information was available from the Texas Department of State Health Services, http://www.dshs.state.tx.us/chs/vstat/latest/nabort.shtm.

1. Risks of abortion

Planned Parenthood's representation of abortion as an essentially risk-free undertaking is contrary to widely available, scientifically sound scholarly research. Abortion is a surgical procedure that carries significantly increased risks to the women who request it. The serious long-term health risks were made clear in a peer-reviewed abstract of abortion-related health studies over the first thirty years of legalized abortion, J.M. Thorp, Jr., M.D.,[3] et al., *Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OB/GYN SURVEY 67 (2003) ("the OGS Review"). The OGS Review evaluated over sixty international studies that included more than one million women. The prestigious and well-credentialed investigators reviewing the mountain of data concluded that induced abortion is associated with significantly increased risks of

[3] Dr. Thorp was an expert for the State in this litigation. *See* State Defendants' Trial Brief, at Exh. 4, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-cv-862 (Oct. 15, 2013).

the following long-term physical and psychological health conditions: serious mental health disorders/suicide, placenta previa, preterm birth, and breast cancer.[4]

The numerous documented short-term risks associated with induced abortion are dire. The Texas "A Woman's Right to Know" booklet ("WRTK Booklet"), which the State requires that all women resorting to abortion receive,[5] documents many of the risks, including: death, incomplete abortion (fetal body parts left in the woman), hemorrhage (profuse or uncontrolled bleeding), allergic reaction, respiratory problems, infection, uterine perforation or rupture, cervical laceration, and injury to the bowel or bladder. The WRTK Booklet states that emergency treatment may include, but is not limited to, surgery including hysterectomy, medical treatment, and blood transfusion. The WRTK Booklet directs women to seek emergency care if any of the following occurs: heavy bleeding (2 or more pads/hour), severe or uncontrolled pain, fever, difficulty breathing or shortness of

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[4] A summary of the OGS Review findings as presented to the U.S. Supreme Court in an amicus brief filed by BDF on behalf of Dr. Thorp can be found at http://www.bdfund.org/uploads/file_637.pdf. The OGS Review also concluded that induced abortion did *not* result in increased risk of the following: infertility, miscarriage, or tubal or ectopic pregnancy.

[5] "Women's Right to Know" laws are in effect in twenty-five states: AL, AZ, AR, GA, ID, IN, KS, KY, LA, MI, MN, MS, MO, NE, ND, OH, OK, PA, SC, SD, TX, UT, VA, WV, and WI. These laws require abortion providers to provide a pamphlet that informs the woman of fetal development, medical risks and abortion alternatives, accompanied by a reflection period. Seven additional states require informed consent with no reflection period: AK, CA, CT, FL, ME, NV, and RI. *Informed Consent Laws: Protecting a Woman's Right to Know*, AUL DEFENDING LIFE 2013, *available at* http://www.aul.org/wp-content/uploads/2013/04/Abortion-2_Informed-Consent.pdf.

breath, chest pain, or disorientation. *See* Texas Department of Health, A WOMAN'S RIGHT TO KNOW, http://www.dshs.state.tx.us/wrtk/.

2. Abortion-facility regulation in Texas

Based on these significant risks to women's health and the special moral considerations unique to abortion, Texas regulates abortions and abortion facilities separately from other outpatient surgical facilities. *See* TEX. ADMIN. CODE § 139.1 *et seq.* The State defines abortion facilities as facilities that perform abortions, excluding licensed hospitals, ambulatory surgical centers, and physician offices that perform 50 or fewer abortions per year. Texas law also requires abortion facilities to be licensed, *see id.* at § 139.1-139.2, and to maintain a quality assurance program implemented by a quality assurance committee, *see id.* at § 139.8. Abortion facilities are to be fully inspected on-site, unannounced, at least once per year, *see id.* at § 139.31. Texas maintains an extensive array of regulations on abortion facilities that address numerous facets of operations, including personnel, records, physical and environmental requirements, infection control standards, disclosure requirements, patient rights and education, emergency and discharge services, and reporting requirements. *See, e.g.*, *id.* at § 139.41 *et seq.* Notably, *even before* the Legislature enacted H.B. 2, the rules required facilities to either have a physician with admitting privileges at a local hospital or, at the very least, a working arrangement with an outside physician who had those privileges to

ensure that facilities could provide for patient care when hospitalization becomes necessary. *See id.* at § 139.56.

3. Abortion facilities' poor record of patient care

Texas's experience has raised concerns about whether abortion facilities are, as a general matter, providing adequate care to their patients. Several recent episodes stand out as raising the sorts of concerns that are relevant to the issues in this case. Recent inspections of Texas abortion facilities have highlighted numerous deficiencies, including: lack of staff training; lack of sterilization; lack of medical personnel; lack of emergency medication and procedures; expired credentials, equipment, and medication; not following what emergency procedures there were; lack of recordkeeping on an otherwise-documented emergency; lack of follow-up with patients; a hole in the middle of an abortion room; another hole that "had the likelihood to allow rodents to enter the facility" and "puncture the sterilization" supplies; "numerous rusty spots" on a suction machine which had "the likelihood to cause infection"; a total lack of proper medication dispensation; a disconnected defibrillator cable and lack of staff knowledge about how to use it; unidentified liquids in operating rooms; the use of "ineffective"-strength sterilization solution; and abortions outside the gestational range. *See* Texas DSHS Statements of Deficiencies and Plans of Correction with various dates from 2011-

2013 , *available at* http://www.lifenews.com/2013/10/28/texas-abortion-chain-running-filthy-clinics-rusty-blood-stains-on-suction-machines/.

When questioned, one employee said it was just too expensive to maintain a sanitary environment: "The functional check is more expensive and the facilities do not want to pay for the functional check." *Id.* In short, the facilities "failed to provide a safe environment for patients and staff." *Id.* And at another facility, there was no hand washing and no one in charge of medical decisions, and employees were observed handling tissue and bodily fluids, and drawing up medications and sterilizing instruments at the same time, without washing hands or wearing gloves. *See* Texas DSHS Statement of Deficiencies and Plan of Correction (5/23/2013), *available at* http://prolifeaction.org/docs/2013/2013-05-23AlamoWomens.pdf.

Some Texas abortion facilities were evidently prepared to continue performing abortions after the enforcement date of H.B. 2. *See* Emergency Application to Vacate Stay, at 2, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13A452 (Nov. 12, 2013) (noting that "in just the few short days since the injunction was lifted, over one-third of the facilities providing abortions in Texas have been forced to stop providing that care," meaning that plaintiffs admit that nearly two-thirds of the facilities continued to perform abortions). On the other hand, while the plaintiffs have averred very few details about their operations, many of the doctors who conduct abortions at plaintiffs'

facilities apparently do not have admitting privileges. *See* Plaintiffs' Complaint, at ¶¶ 9-21, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-cv-862 (Sept. 27, 2013). The plaintiffs' business model may be more profitable, but it provides less personalized patient care. The plaintiffs have not explained how far away these doctors reside from the facilities or how often they make themselves available to patients. It is incumbent on the plaintiffs to provide fuller details about precisely how their businesses work in this regard. But it is apparent that those doctors are not available to patients, on an emergency basis, should complications or the need for follow-up care arise. When one of these facilities' patients needs emergency care at a hospital, she apparently must deal with other doctors who do not have access to her medical chart and thus do not know what kind of care she has received that has generated the medical emergency.

4. H.B. 2

The Legislature passed H.B. 2 against this backdrop, with the overarching purpose of strengthening existing health-and-safety regulations for women.

H.B. 2, *inter alia*, adds TEX. HEALTH & SAFETY CODE § 171.0031, altering the existing requirement regarding doctors' privileges at local hospitals so that contracting with an outside doctor is now no longer sufficient. Now all doctors performing abortions on pregnant women must be able to admit those women to a

hospital in the event of complications. More particularly, H.B. 2 Section 2 requires that an aborting physician must, on the date the abortion is performed or induced, "have active admitting privileges at a hospital that is located not further than 30 miles from the location [of the abortion]; and provides obstetrical or gynecological health care services," and further, provide the pregnant woman with contact information for the physician or another medical employee of the facility with access to the woman's relevant medical records, available 24 hours a day, as well as the name and telephone number of the nearest hospital to the woman's home. To enforce this requirement, the Act exposes abortion-facility physicians to criminal liability. *See id.*

The Act is thus designed to ensure that an abortion patient has access to a doctor familiar with her particular case at every possible step of the recovery process.

a. The Act's benefits to patients

Admitting privileges promote both the physical and emotional well-being of patients, and may be necessary in emergency circumstances if doctors are to provide an acceptable level of care.

When the abortion physician has admitting and treating privileges at a local hospital, he or she is more likely to effectively manage patient complications by providing continuity of care. If the abortion doctor is not involved in the

admission, by contrast, the facility's failure to timely convey information about the woman's medical history can create time delays contrary to her best interest. Likewise, many hospitals have inadequate on-call coverage by OB/GYNs. *See, e.g.*, Center for Studying Health System Change, *Hospital Emergency On-Call Coverage: Is There A Doctor in the House?* (November 2007), http://www.hschange.com/CONTENT/956/. In sum, admitting privileges are necessary to prevent doctors from abandoning their patients if complications arise and emergency follow-up intervention is necessary.

B. H.B. 2 Is a Common-Sense Medical Regulation and a Constitutional Exercise of Texas' Legitimate Interest in Women's Health

1. Facial challenges are disfavored attacks on state attempts to protect women and children through abortion regulation

"Litigants in the federal courts can attack the constitutionality of legislative enactments in two ways: they can bring a facial challenge to the law, alleging that it is unconstitutional in all of its applications, or they can bring an as-applied challenge, alleging that the law is unconstitutional as applied to the particular facts that their case presents." Marc E. Isserles, *Overcoming Overbreadth: Facial Challenges and the Valid Rule Requirement*, 48 AM. U.L. REV. 359, 361 (1998).

In the abortion context, the Supreme Court in *Gonzales v. Carhart* employed the presumption in favor of as-applied challenges to help shape the appropriate standard for determining whether there was a constitutional violation. *Gonzales v.*

Carhart, 550 U.S. 124, 167 (2007). Writing for the majority, Justice Kennedy rejected the challenge to the partial-birth abortion ban, citing, among other things, the presumption in favor of as-applied challenges. *Id.* Rather than focus on remedy, which was not at issue, the Court concluded that "facial attacks should not [be] entertained in the first instance." *Id.* Instead, the Court indicated that the preference for as-applied challenges meant that only a woman, or potentially her doctor, facing a specific health risk could challenge the statute. *See generally Richmond Med. Ctr. for Women v. Herring*, 570 F.3d 165, 180 (4th Cir. 2009) (holding that a doctor could not challenge a Virginia abortion statute following *Gonzales* because "[h]e has not indicated that he has any particular patient in mind, nor any discrete factual circumstance that is detailed by medical records or other similarly concrete evidence").

As Justice Kennedy explained, "the proper means to consider exceptions [to the law] is by as-applied challenge" which he defined as those involving "discrete and well-defined instances [when] a particular condition has or is likely to occur in which the procedure prohibited by the Act must be used." *Gonzales*, 550 U.S. at 167. "In an as-applied challenge the nature of the medical risk can be better quantified and balanced than in a facial attack." *Id.*

The law strongly favors as-applied challenges on the grounds that they are more consistent with the goals of resolving concrete disputes and deferring as

much as possible to the legislative process. *See Wash. State Grange v. Wash. State Republican Party*, 128 S. Ct. 1184, 1190–91 (2008) (discussing the preference for as-applied challenges to facial challenges); David L. Franklin, *Facial Challenges, Legislative Purpose, and the Commerce Clause*, 92 IOWA L. REV. 41, 55–56 (2006) ("The Court has explained that the act of striking down a statute on its face stands in tension with several traditional components of the federal judicial role, including a preference for resolving concrete disputes rather than abstract or speculative questions, a deference to legislative judgments, and a reluctance to resort to the 'strong medicine' of constitutional invalidation unless absolutely necessary."); David H. Gans, *Strategic Facial Challenges*, 85 B.U.L. REV. 1333, 1348 (2005) ("As-applied adjudication, of course, carries with it important benefits. . . . [I]t ensures that courts do not make uncertain speculations about how a law operates outside of the facts generated by the controversy before it."). Facial challenges, in contrast, should be used sparingly and only in exceptional circumstances. *See Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328–30 (2006) (discussing the Court's preference for as-applied challenges); Richard H. Fallon, Jr., *As-Applied and Facial Challenges and Third-Party Standing*, 113 HARV. L. REV. 1321, 1321 (2000) ("Traditional thinking has long held that the normal if not exclusive mode of constitutional adjudication involves an as-applied challenge . . . ."); Marc E. Isserles, *Overcoming Overbreadth: Facial Challenges and the Valid*

Rule Requirement, 48 AM. U.L. REV. 359, 361 (1998) ("As the Supreme Court has made clear on numerous occasions, facial challenges are appropriate, if at all, only in exceptional circumstances."). Perhaps the best-known formulation of this idea was the Supreme Court's statement in *United States v. Salerno* that a "facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully" and will only succeed if a litigant can "establish that no set of circumstances exists under which the Act would be valid." 481 U.S. 739, 745 (1987).

2. Courts support State interests to regulate abortion

As far back as *Roe v. Wade*, 410 U.S. 113, 162-64 (1973), the Supreme Court has recognized two state interests: the "important interest" in protecting a pregnant woman's health, as well as "still another important and legitimate interest in protecting the potentiality of human life." Thus, a State may "proscribe abortion [after viability], except when it is necessary to preserve the life or health of the mother." *Id.*

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the Court rejected *Roe*'s trimester framework, imposing instead a bifurcated pre-viability/post-viability framework and applying a newly adopted "undue burden" standard (on abortion *patients*, not abortion *physicians*) to gauge the constitutionality of abortion restrictions. Further, the Court reaffirmed *Roe*'s

holding that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.* at 878-79 (quoting *Roe*, 410 U.S. at 164-65). Under *Casey*, "a statute which, while furthering the interest in potential life or some other valid state interest, ha[d] the effect of placing a substantial obstacle in the path of a woman's choice [could] not be considered a permissible means of serving its legitimate ends." *Casey*, 505 U.S. at 877.

Finally in *Gonzales v. Carhart*, 550 U.S. 124 (2007), the Supreme Court rejected Planned Parenthood and abortionist Leroy Carhart's challenges to the Partial-Birth Abortion Ban Act based on, among other things, concerns about the medical profession: "The Act's stated purposes are protecting innocent human life from a brutal and inhumane procedure and protecting the medical community's ethics and reputation. The government undoubtedly 'has an interest in protecting the integrity and ethics of the medical profession.'" *Id.* at 128 (citing *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

The Court declined to accept the invitation to revisit the scope of the constitutionally required "health" exception, stating that it assumed that the Act would be unconstitutional "if it subjected women to significant health risks." Here, however, "whether the Act creates significant health risks for women has been a

contested factual question." *Id.* at 161. In view of this "documented medical disagreement," the Court concluded, "[t]he question becomes whether the Act can stand when this medical uncertainty persists. The Court's precedents instruct that the Act *can survive this facial attack*." *Id.* at 163 (emphasis supplied).

Abortion jurisprudence, Justice Kennedy suggested, had *distorted* the usual deference afforded legislative determinations. "Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." *Id.* at 164. The lower courts' interpretations of *Stenberg v. Carhart*, 530 U.S. 914 (2000), "to leave no margin of error for legislatures to act in the face of medical uncertainty" operated as a kind of judicial "zero tolerance policy" for legitimate abortion regulations. "This is too exacting a standard to impose on the legislative power . . . to regulate the medical profession," the Court concluded. *Id.* at 166.

In so ruling, the Court affirmed once again that challenges to restrictions on abortion must play by the same juridical rules as constitutional challenges in other contexts. Notably, there has been no "as-applied" challenge brought to the federal Partial-Birth Abortion Act since *Gonzales* was decided over six years ago, belying the argument that a health exception was necessary as abortion advocates contended.

Moreover, the Supreme Court's precedents emphasize that the validity of laws regulating abortion depends on delicate balances that weigh the State's articulated interests along with a woman's liberty interests. *See Webster v. Reprod. Health Servs.*, 492 U.S. 490, 569 (1989); *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists,* 476 U.S. 747, 778 (1986) (Stevens, J., concurring).

In considering this balance, the Supreme Court has assessed the "interest in protecting fetal life" and "in preserving and protecting the health of the pregnant woman." *Casey,* 505 U.S. at 876. The Court has also considered such interests as "'express[ing] respect for the dignity of human life," *Gonzales*, 550 U.S. at 157; "protecting the integrity and ethics of the medical profession," *id.* at 157; ensuring that a woman makes her decision with "informed consent," *Casey,* 505 U.S. at 882; and encouraging a minor "to seek the help and advice of her parents," *Hodgson v. Minnesota,* 497 U.S. 417, 480 (1990) (Kennedy, J., concurring in the judgment in part and dissenting in part); *see Casey,* 497 U.S. at 899.

Importantly, in regard to *Casey,* Justice Kennedy wrote:

> [In *Casey*] [w]e held it was inappropriate for the Judicial Branch to provide an exhaustive list of State interests implicated by abortion. *Casey* is premised on the States having an important constitutional role in defining their interests in the abortion debate. It is only with this principle in mind that Nebraska's interests can be given proper weight. . . . States also have an interest in forbidding medical procedures which, in the State's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful, to life, including life in the human fetus. . . . A State may take measures to ensure the medical profession and its

> members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others.

Stenberg, 350 U.S. at 958-59 (Kennedy, J., dissenting) (citation omitted).

3. Other Federal Circuits agree that admitting privileges in the abortion context do not violate procedural due process

Three federal circuits agree that an admitting privileges provision of this sort does not violate procedural due process. The Ninth Circuit upheld a similar requirement in Arizona. In *Tucson Woman's Clinic v. Eden*, the court upheld a state law requiring physicians performing abortions to have admitting privileges at a local hospital. 379 F.3d 531 (9th Cir. 2004). There, the court made special note that judicial review should be "narrow" when a hospital denies a physician admitting privileges; the courts should defer to the specialized knowledge of hospital administrators in applying all the relevant criteria to their decision. *Id.* at 555-56. The court also explained that, "[b]ecause this is a facial constitutional challenge, plaintiffs must show that there are no circumstances under which the delegation could be applied constitutionally." *Id.* at 556 (citing *United States v. Salerno*, 481 U.S. 739, 745 (2004)). The plaintiffs there "ha[d] not submitted any evidence tending to show that any hospitals in [the State] will or do deny admitting privileges to physicians based on their status as abortion providers, or based on any other policies seeking to restrict the right to abortion." *Id.* The Court also noted that "Arizona law prohibits hospitals from violating procedural due process." *Id.*

In *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control* ("*Greenville II*"), the Fourth Circuit upheld a substantially similar law. 317 F.3d 357 (4th Cir. 2002). There, the South Carolina legislature passed a law that, among other things, required physicians to have admitting privileges at a local hospital that has OB/GYN services, and also required abortion facilities to make arrangements for consultation or referral services to certain specialties, to be available if needed. *See id.* at 360.

The abortion facilities, like the plaintiffs here, argued that those regulations "provide[] for the standardless delegation of licensing authority to third persons, in violation of the Due Process Clause." *Id.* at 361. The court there found that although the regulation "does not directly grant any veto power to third persons over the issuance of a license," it does require "that clinic doctors maintain certain admitting rights with local hospitals" as a "condition of licensure." *Id.* at 362. The court "reject[ed]" the abortion facilities' facial due-process challenge because the "possibility that the requirements will amount to a third-party veto power is so remote that, on a facial challenge, [the court could not] conclude that the statute denies the abortion clinics due process." *Id.* at 363 (citing *Whalen v. Roe*, 429 U.S.

589, 601-02 (1997) (noting that a "remote possibility" is "not a sufficient reason for invalidating" a statute, on a facial challenge)).[6]

As in *Eden*, plaintiffs here "have submitted no evidence that any hospitals will exercise the authority delegated to them by [Texas] in an unconstitutional manner." *Id.* Public hospitals in Texas also must comply with due process. *See, e.g.*, *Woodbury v. McKinnon*, 447 F.2d 839, 842 (5th Cir. 1971). Hospitals receiving federal funds cannot discriminate against doctors in the extension of staffing or other privileges because they administer abortions off-site. *See* 42 U.S.C. §300a-7(c)(1)(B). All Texas hospitals are governed by the Texas Department of State Health Services' general regulations on admissions privileges, which the Department will be free to interpret and apply in its enforcement of H.B. 2 in the future. And hospitals have highly rationalized, self-imposed bylaws that further regulate the process. Accordingly, "plaintiffs cannot show on this record that there is 'no set of circumstances' in which the delegation will be constitutional." *Eden*, 379 F.3d at 556.

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[6] The Eighth Circuit also has upheld a similar requirement—albeit one that operated directly on doctors rather than on the clinic-licensing process. *See Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989) (rejecting nondelegation challenge to privilege requirement imposed on doctors). The Eighth Circuit did suggest that there might be a distinction for these purposes between enforcing the requirement directly on doctors, as the law did there, and making the requirement a condition of a clinic's license. *See id.* But no such distinction would be tenable. In both cases, the plaintiff's authority to operate would be contingent on obtaining privileges at a local hospital.

The weight of federal authority has found that admitting-privileges and similar requirements are constitutional exercises of a State's regulatory power. The provision here is no different, and plaintiffs are unlikely to succeed on the merits.

4. The admitting privileges provision does not violate substantive due process

Under Planned Parenthood's facial substantive-due-process challenge to H.B. 2, they must show, at the very least, that "in a large fraction of cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Planned Parenthood v. Casey,* 505 U.S. 833, 895 (1992) (opinion of the Court). The plaintiffs cannot satisfy this burden on the record before the Court.

a. Texas has a legitimate interest in requiring abortion doctors to obtain admitting privileges

While the Constitution protects a woman's right to an abortion, it also accommodates the "legitimate interests" of the state and federal governments "in protecting the health of the woman." *Gonzales v. Carhart*, 550 U.S. 124, 145 (2007) (quoting *Casey*, 505 U.S. at 846 (opinion of the Court)). Two recognized state interests are relevant here. The first is the government's "legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Simopolous v. Virginia*, 462 U.S. 506, 519 (1983) (quoting *Roe v. Wade*, 410 U.S. at 150). The second is

the government's separate interest in "regulating the medical profession." *Gonzales*, 550 U.S. at 157. States can "determin[e] standards" for medical facilities, including "licensing" requirements. *Simopoulos*, 462 U.S. at 516. And States are given "considerable discretion" to do so. *Id.*

The Texas Legislature enacted H.B. 2 to protect both public health and potential human life. The admitting privileges provision protects public health by "foster[ing] a woman's ability to seek consultation and treatment for complications directly from her physician" and by deterring "patient abandonment." Opinion at 5, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13-51008 (5th Cir. Oct. 31, 2013).

Notably, the National Abortion Federation seems to agree with the Texas Legislature's wisdom in enacting H.B. 2's admitting privileges provision, because it has counseled patients to "make sure" that their doctor is "able to admit patients to a nearby hospital (no more than 20 minutes away)." Defendants' Memorandum in Opposition to Emergency Application to Vacate Fifth Circuit's Stay Pending Appeal, at Ex. A 1–2, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13A452 (Nov. 12, 2013).

Planned Parenthood has no meaningful argument that H.B. 2 does not advance Texas' interests. The Fourth Circuit has called South Carolina's similar admitting-privilege requirement "obviously beneficial to patients." *Greenville II*,

317 F.3d at 363. The Eighth Circuit has called Missouri's requirement a "legitimate effort to ensure that abortion is 'as safe for the woman as normal childbirth at term . . . [and] is performed by medically competent personnel under conditions insuring maximum safety for the woman.'" *Women's Health Ctr. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989) (quoting *Connecticut v. Menillo*, 423 U.S. 9, 10 (1975)). And other states have adopted similar mandates. *See, e.g.*, N.D. SB2305 (approved Mar. 26, 2013); Miss. H.B. 1390 (approved Mar. 16, 2012).

The plaintiffs do not have a substantial argument that Texas' concerns are somehow illegitimate because of the existing requirement, in Texas law, that facilities at least contract with an outside physician who has staffing privileges. TEX. ADMIN. CODE § 139.56. That provision was insufficient because requiring facilities to contract with an outside physician does not solve the fundamental problem the Act was trying to solve; transfer of care is still fragmented care, and still increases the chance of time delays and miscommunication.

The particular way plaintiffs are currently doing business—and the counterintuitive, depersonalized, fly-by-night relationship it entails—cannot be the best means of fostering the well-being of abortion patients. And numerous other facilities in Texas, by demonstrating their ability to fulfill the requirements of H.B. 2, have already shown that this way is hardly inevitable. Nothing in the Constitution precluded the Legislature from deciding that the plaintiffs should

follow the same course. While the Supreme Court in *Roe v. Wade* recognized a right to abortion, it did not create a corresponding right of facilities to resist the sort of change to a more patient-focused approach that H.B. 2 entails.

To be sure, the medical profession may be in the midst of a debate about the best way to provide patient care. But the question for this Court is not whether a consensus has developed on these issues, and the Constitution does not require the government to accept the lowest common denominator in a debate of this sort. The Supreme Court has never held that an abortion regulation must be strictly "necessary" to be constitutional. To the contrary, the Court has expressly upheld health-related abortion- facility rules when they "may be helpful" and "can be useful" to advance the State's legitimate interests in a woman's health. *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 80, 81 (1976); *Casey*, 505 U.S. at 900-01; *City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.13 (1983).

In "areas where there is medical and scientific uncertainty," the U.S. Supreme Court "has given state and federal legislatures wide discretion to pass legislation" furthering their interests. *Gonzales*, 550 U.S. at 163. In fact, medical uncertainty can "provide[] a sufficient basis" to reject a facial challenge to an abortion regulation. *Id.* at 164. And deference to legislative judgment is at its highest when, as here, the regulation focuses on physician qualifications rather

than the patient directly. *See Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) (*per curiam*) (upholding a restriction on the performance of abortions to licensed physicians despite the respondents' contention "all health evidence contradicts the claim that there is any health basis for the law") (internal quotation marks omitted). Planned Parenthood cannot superimpose its own view of the proper standard of care on the state.

Pursuant to H.B. 2, all women may continue to choose an elective abortion, at a licensed facility with proper admitting privileges for its aborting physicians. In summary, the goal of promoting maternal health is compelling and lacks any purpose or effect to impose any obstacle on the abortion right that *Casey* reaffirmed.

b. H.B. 2 does not, in serving these interests, impose an undue burden on the woman's right to choose

Nor are the plaintiffs substantially likely to show that H.B. 2, notwithstanding its "obviously beneficial" enhancement of continuous patient care, *Greenville II*, 317 F.3d at 363, imposes an "undue burden" on a patient's "ultimate decision to terminate her pregnancy," *Gonzales*, 550 U.S. at 146. The plaintiffs would be able to establish an undue burden only if they could show that H.B. 2's "purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion." *Id.* (quoting *Casey*, 505 U.S. at 878). Particularly in light of the facial nature of the plaintiffs' challenge, other facilities' apparent current compliance

with the admitting-privileges requirement distinguishes this case markedly from the recent decision from the District Court in Mississippi. *See Jackson Women's Health Org. v. Currier*, 878 F. Supp. 2d 714, 715 (S.D. Miss. 2012) (noting that the plaintiff is the only abortion facility in Mississippi).

Even if the costs associated with travel to compliant clinics would impose some burden on patients, it is not, in light of the benefits of the admitting privileges provision, undue. Licensed facilities with credentialed and privileged providers are, quite simply, better and safer than seeking terminations at more convenient but substandard ones. The Sixth Circuit agreed in a context similar to the one here. In *Women's Medical Prof'l Corp. v. Baird*, Ohio law required an abortion facility to maintain a transfer agreement with a hospital in order to be licensed under state law. 438 F.3d 595, 598 (6th Cir. 2006). A facility that had closed as a result argued that the facility's "approximately 3,000 patients per year" would have to "travel further" to receive an abortion. *Id.* at 604. The Court held that this result did not create an "undue burden" for those women. Although closing the facility "may be burdensome for some of its potential patients, the fact that these women may have to travel farther to obtain an abortion does not constitute a substantial obstacle." *Id.* at 605. Likewise, "the fact that the clinic serves 3,000 women per year is insufficient in and of itself to establish" that the requirement "constitutes an undue burden." *Id.* This is so especially when the plaintiffs provide "no evidence

suggesting that a large fraction of these women would be unable to travel to other Ohio cities for an abortion." *Id.* The Supreme Court made a similar point in *Casey*. There, the district court had found that "for those women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to husbands, employers, and others, the 24-hour waiting period will be 'particularly burdensome.'" *Casey*, 505 U.S. at 886 (citations omitted). The Court held that although "[t]hese findings are troubling in some respects," they did "not" give rise to any finding of undue burden. *Id.*

CONCLUSION

For the reasons stated above, *amici* urge the Court to reverse the judgment of the district court.

Respectfully submitted this the 29th day of November, 2013.

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CERTIFICATE OF SERVICE

I hereby certify that on November 29th, 2013, I electronically filed the foregoing Amicus Curiae Brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the CM/ECF system. Participants in the case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

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