No. 15-274

# In the Supreme Court of the United States

WHOLE WOMAN'S HEALTH, et al., *Petitioners*,

v.

JOHN HELLERSTEDT, M.D., COMM'R, TEXAS DEP'T OF STATE HEALTH SERVICES, et al., *Respondents*.

*On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit*

## BRIEF *AMICI CURIAE* OF UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, TEXAS CATHOLIC CONFERENCE, NATIONAL ASSOCIATION OF EVANGELICALS, THE LUTHERAN CHURCH-MISSOURI SYNOD, THE ETHICS & RELIGIOUS LIBERTY COMMISSION OF THE SOUTHERN BAPTIST CONVENTION, AND THE SOUTHERN BAPTISTS OF TEXAS CONVENTION IN SUPPORT OF RESPONDENTS

ANTHONY R. PICARELLO, JR.*
JEFFREY HUNTER MOON
MICHAEL F. MOSES
United States Conference
of Catholic Bishops
3211 Fourth Street, N.E.
Washington, D.C. 20017
(202) 541-3300
apicarello@usccb.org

*Counsel of Record

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## INTEREST OF *AMICI*

The United States Conference of Catholic Bishops, Texas Catholic Conference, National Association of Evangelicals, the Lutheran Church-Missouri Synod, the Ethics & Religious Liberty Commission of the Southern Baptist Convention, and the Southern Baptists of Texas Convention unite here as *amici curiae* on behalf of the respondents.[1]

Individual statements of interest are provided in the Appendix to this Brief.

## SUMMARY OF ARGUMENT

For over four decades, commencing with *Roe* v. *Wade*, 410 U.S. 113 (1973), this Court has held that states may enforce standards relating to the qualifications of physicians who perform abortions and the conditions of facilities in which abortion is performed. *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), allows even greater regulation of abortion to protect maternal life and health than had been allowed in some prior cases. To hold that states may not enact measures like the Texas law challenged here would be a betrayal of over 40 years of precedent, including *Casey* and the concerns about *stare decisis*

[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* state that they authored this brief, in whole, and that no person or entity other than *amici* made a monetary contribution toward the preparation or submission of this brief. The parties have consented to the filing of this Brief. Their statements of consent are filed herewith.

and institutional integrity that are at the heart of that case.

Abortion providers should not be allowed to rely upon their own failure to comply with health and safety laws as a predicate for striking them down. To hold otherwise is to give the providers an effective veto over regulations that apply to them. Likewise, providers do not stand in the shoes of their patients when they resist regulations that promote patient health and safety.

There is ample evidence in this case that hospital admitting privileges and ambulatory surgical center requirements protect women's lives and health. Admitting privileges ensure physician competency and continuity of care, enhance inter-physician communication and complication management, and support doctors' ethical duty not to abandon their patients. These benefits are underscored by expert testimony in this case as well as the recommendations of a host of national medical associations.

Ambulatory surgical center requirements also benefit patients, as experts in this case testified. Perhaps the best indicia of the need for such requirements are the numerous citations meted out by the Texas Department of State Health Services to abortion clinics, including petitioner Whole Woman's Health. When such requirements are not enforced, abuses detrimental to women's lives and health arise.

## ARGUMENT

### I. Faithful Application of This Court's Precedents Requires Upholding Texas's Ambulatory Surgical Center and Admitting Privileges Requirements.

Under this Court's precedents, including *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), states may establish and enforce standards relating to the licensure and qualifications of doctors who perform abortions and to ensure the safety of women undergoing an abortion. The Texas hospital admitting privileges and ambulatory surgical center ("ASC") requirements challenged in this case are the type of maternal-health standards that this Court has upheld in prior cases. Under faithful application of this Court's precedents, the Texas law passes constitutional muster.

*Roe* was the first case to make explicit that, in regulating abortions, states have the authority to establish and enforce standards protecting maternal health:

> The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.
>
> * * *

> [A] State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

410 U.S. at 150, 163.

*Roe* authorized regulation to advance a woman's health after the first trimester, but permitted physician licensure requirements to be imposed *throughout* pregnancy. *Id.* at 165; *see also Connecticut* v. *Menillo*, 423 U.S. 9 (1975) (*per curiam* opinion upholding Connecticut law prohibiting abortions by non-physicians at any stage of pregnancy).[2]

Ten years after *Roe*, by an 8-1 vote, this Court upheld a Virginia law requiring that abortions after the first trimester be performed in an inpatient or outpatient surgical *hospital*. *Simopoulos* v. *Virginia*, 462 U.S. 506 (1983). The Court concluded that "the

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[2] *Casey* would ultimately reject the trimester framework, allowing maternal health regulation throughout pregnancy. 505 U.S. at 875-76, 878. Our point here is that even *prior* to *Casey* this Court allowed regulations pertaining to the qualifications of persons performing abortions to be applied throughout the course of pregnancy.

State necessarily has considerable discretion in determining standards for the licensing of medical facilities." *Id*. at 516. Justice O'Connor concurred in part and concurred in the judgment. *Id*. at 519. Foreshadowing this Court's decision in *Casey*, she rejected the notion that the constitutional validity of the Virginia law was "contingent in any way on the trimester in which [the abortion] is performed." *Id*. at 520. She also concluded that the requirement was "not an undue burden." *Id*. The Texas law challenged in the present case does not require that abortions be performed in an inpatient or outpatient hospital, but only in a facility that meets the requirements of an ambulatory surgical center.

*Casey* did nothing to upset this Court's conclusion in *Roe*, *Menillo* and *Simopoulos*, that states could adopt and enforce standards relating to physician qualifications and clinic safety. Quite the contrary, seven justices in *Casey* concluded that this Court's earlier decisions had too severely and improperly *restricted* the power of states to promote women's health in the regulation of abortion. 505 U.S., at 871-78, 881-87 (O'Connor, Kennedy, & Souter, JJ.); *id*. at 944 (Rehnquist, C.J., joined by White, Scalia, and Thomas, JJ.) (concurring in the judgment in part, dissenting in part). The justices who wrote the joint opinion in *Casey* concluded that this Court's earlier decisions had gone "too far" in striking down regulations that "in no real sense deprived women of the ultimate decision" whether to have an abortion. *Id*. at 875. They rejected *Roe*'s trimester framework, holding that "the State has [a] legitimate interest[] from the outset of the pregnancy in protecting the health of the woman," and rejected strict scrutiny in

favor of a more lenient undue burden standard. *Id.* at 876-78. Under *Casey*, therefore, states have greater latitude to advance the interest in maternal health than had been allowed in the two decades following *Roe*.

*Casey* also rejected the claim that abortion regulations create an undue burden simply by making it more difficult or expensive to obtain an abortion. "The fact that a law which serves a valid purpose, one not designed to strike at the right [to choose whether to have an abortion], . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Id.* at 874.

The authors of the joint opinion repeatedly declined to say whether *Roe* was correct in deciding that states constitutionally may not ban abortion before viability.[3] Instead, the justices who joined that opinion provided a detailed explanation of why, in their view, *stare decisis* and concern for institutional integrity required continued adherence to *Roe*'s viability rule. 505 U.S. at 854-69. Four other justices voted to overrule *Roe* in

[3] 505 U.S. at 871 ("We do not need to say whether each of us, had we been Members of the Court when the valuation of the state interest came before it as an original matter, would have concluded, as the *Roe* Court did, that its weight is insufficient to justify a ban on abortions prior to viability. . . . The matter is not before us in the first instance"); *id.* ("the immediate question is not the soundness of *Roe*'s resolution of the issue, but the precedential force that must be accorded to its holding"); *id.* at 853 ("the reservations any of us may have in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of *stare decisis*").

its entirety. *Id.* at 944 (Rehnquist, C.J., joined by White, Scalia, and Thomas, JJ.). Thus, in *Casey* seven justices voted to allow greater state regulation of abortion, while a differently constituted five-justice majority declined to overrule *Roe*'s viability rule—with three of those five justices relying on *stare decisis* rather than an independent judgment that the viability rule was correct.

As a majority of this Court would later describe it, the joint opinion in *Casey* "struck a balance," and this balance was "central to its holding." *Gonzales* v. *Carhart*, 550 U.S. 124, 146 (2007). States could not *ban* abortion before viability, but they could *regulate* abortion throughout pregnancy to further the interest in protecting women's health and promoting unborn human life, and they could do so with greater legislative discretion than allowed by some of this Court's earlier cases.

After *Casey*, however, abortion providers continued to challenge regulations designed to protect women's health and promote unborn human life with a frequency and vigor that might lead a neutral observer to conclude, mistakenly, that *Casey* had nothing to say on these subjects.[4] When presented with such

[4] *See*, *e.g.*, *Planned Parenthood* v. *Commissioner*, 64 F.Supp.3d 1235 (S.D. Ind. 2014) (safety requirements); *Stuart* v. *Camnitz*, 774 F.3d 238 (4th Cir. 2014) (ultrasound); *Planned Parenthood* v. *DeWine*, 64 F.Supp.3d 1060 (S.D. Ohio 2014) (RU-486); *Planned Parenthood* v. *Strange*, 33 F.Supp.3d 1330 (M.D. Ala. 2014) (admitting privileges); *Planned Parenthood* v. *Humble*, 753 F.3d 905 (9th Cir. 2014) (RU-486); *Comprehensive Health* v. *Templeton*, 954 F.Supp.2d 1205 (D. Kan. 2013) (informed consent); *Planned Parenthood* v. *Daugaard*, 799 F.Supp.2d 1048 (D. S.D. 2011) (same); *Planned Parenthood* v. *Heineman*, 724

challenges, this Court remained steadfast in holding that states have the authority to regulate physicians and facilities that provide abortion. *Gonzales*, 550 U.S. at 157 ("[T]he State has legitimate concern for maintaining high standards of professional conduct in the practice of medicine. . . . Under our precedents it is clear the State has a significant role to play in regulating the medical profession.") (internal quotation marks omitted); *see also Mazurek* v. *Armstrong*, 520 U.S. 968 (1997) (*per curiam* opinion upholding Montana law prohibiting abortions by non-physicians).

*Gonzales* emphasized that it is not the Judiciary's role to second-guess state regulatory judgments, even in the face of conflicting medical opinions. "Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." 550 U.S. at 164; *see id.* at 163 ("The Court has given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.").[5]

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F.Supp.2d 1025 (D. Neb. 2010) (same); *Planned Parenthood* v. *Rounds*, 686 F.3d 889 (8th Cir. 2012) (same).

[5] *Gonzales*'s reaffirmation of legislative competence, and the importance of judicial restraint, was prudent. A legislature or administrative agency can respond quickly to new information in medicine and changes in medical practice. Once such issues are made the subject of a constitutional decision, however, there is no advancing or retreating from that decision short of further litigation to overrule or limit it. To bar states from adopting admitting privileges and ambulatory surgical center requirements as a matter of constitutional law would make this Court precisely the sort of *ex officio* medical board that it has said it is not.

*See also Mazurek*, 520 U.S. at 973 (legislatures have "broad latitude to decide that particular functions may be performed only by licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others"), quoting *Casey*, 505 U.S. at 885. This Court has rejected the invitation to sit as "the country's *ex offficio* medical board." *Gonzales*, 550 U.S. at 163-64, quoting *Webster* v. *Reproductive Health Services*, 492 U.S. 490, 518-19 (1989) (plurality opinion).

Adherence to *Roe*, *Menillo*, *Simopoulos*, *Casey*, *Mazurek*, and *Gonzales*, and to the institutional and *stare decisis* interests that were dispositive in *Casey*, leads invariably to the conclusion that the Texas laws challenged here are constitutional. As this Court has said for over four decades, states may adopt and enforce requirements with respect to physicians and facilities that perform abortions just as it may for doctors and facilities that perform any medical procedure. The Texas legislature's decision to require hospital admitting privileges and compliance with other health and safety standards is entirely within its competence, and that decision would be entitled to deference *even if* there were medical uncertainty about it. *E.g.*, *Gonzales*, 550 U.S. at 163-64, 166-67. To hold that states may not enact such measures would require the rejection of over 40 years of case law. Such a move would be a betrayal of *Casey* in particular, for it would be contrary to the concerns about *stare decisis* and institutional integrity that are at the heart of that case.

The petitioners are therefore in a dilemma. If *stare decisis* is the animating principle that underlies the

viability rule, as the joint opinion in *Casey* concluded, then the same considerations of *stare decisis* require upholding the maternal-health laws challenged in this case. On the other hand, if *stare decisis* is insufficient reason to uphold the laws challenged here, then it must be asked whether continued adherence to the viability rule is justified. If the petitioners upset one side of the balance achieved in *Casey*, they necessarily upset the other. Put another way, *Casey* cannot be said to have struck a balance if *stare decisis* requires continued recognition of the viability rule but nothing else. That is not a balance, but a return to the strict scrutiny that seven justices of this Court rejected in *Casey*.

## II. There Is Ample Evidence of Harm to Women Justifying the Texas Laws Challenged Here.

This case follows a familiar pattern. First, a state passes a law protecting the health and safety of women undergoing abortion. Then abortion providers, of their own choosing, refuse to devote the resources to comply. Instead, they fund litigation to overturn the law, claiming: (a) their clinics are out of compliance and therefore will have to close; and (b) closure of the clinics will unduly burden the right of women to choose an abortion.

This is entirely backwards, and for two reasons.

*First*, abortion providers should not be able to assert their own refusal or inability to comply with state health and safety laws as a predicate for striking down these laws. To allow that is to give the providers a veto over any regulations that apply to them.

*Gonzales*, 550 U.S. at 166-67 (noting the impropriety of giving abortion providers such a veto); *see Greenville Women's Clinic* v. *Bryant*, 222 F.3d 157, 171 (4th Cir. 2000) (concluding that it would "irrationally hamstring the State's effort to raise the standard of care in certain abortion clinics" were the court to accede to the argument that the clinics' "performance falls so far below appropriate norms" as to necessitate an expensive upgrade of their practice).

*Second*, with regard to health and safety standards, the interests of abortion providers and patients do not coincide and, to some extent, are adverse. Providers have a direct economic interest in avoiding the time and expense needed to comply with health and safety standards. Patients, on the other hand, have an obvious interest in their own safety and in not having their health compromised by any procedure. The premise that abortion providers stand in the shoes of their patients is flawed when, as here, they challenge laws that protect their patients' health and safety. "[I]n no other area of medicine [than abortion] may a doctor bring a suit on behalf of a patient solely because the doctor finds a safety regulation cumbersome. Where state regulation imposes on doctors measures designed to improve patient safety, doctor-patient interests may diverge." *Planned Parenthood of Wisconsin* v. *Schimel*, 806 F.3d 908, 924 (7th Cir. 2015) (Manion, J., dissenting).

The petitioners are thus in the awkward position of arguing that health and safety standards with which they do not comply, standards adopted to protect the health and safety of their patients, will have the opposite effect by driving noncompliant providers out of business. Only in cases involving abortion are such

self-serving claims taken seriously. *Id*. at 923 ("[N]o reasonable patient considering a medical procedure known to result in complications—potentially even death—would regard state measures designed to minimize those risks as an imposition on her constitutional rights.").

Federal courts of appeals and medical experts recognize that ASC and hospital admitting privilege requirements protect the health and safety of women. We consider these requirements in turn.

### A. Hospital Admitting Privileges

Petitioners claim that "[t]he admitting-privileges requirement provides *no health benefit* to abortion patients." Pet. Br. 19 (emphasis added). This is demonstrably false. As the Fifth Circuit concluded, admitting privileges ensure physician competency and continuity of care, enhance inter-physician communication and complication management, and support the ethical duty not to abandon patients. *Planned Parenthood of Greater Texas Surgical Health Services* v. *Abbott*, 748 F.3d 583, 592 (5th Cir. 2014). As courts have noted, these interests are "obvious" and the state has "undoubted authority" to further them by requiring admitting privileges.[6]

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[6] *Greenville Women's Clinic* v. *Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 363 (4th Cir. 2002) (admitting privileges requirement is "obviously beneficial to patients" undergoing an abortion); *Women's Health Center* v. *Webster*, 871 F.2d 1377, 1381 (8th 1989) (finding "no difficulty" in concluding that hospital admitting privileges requirement protects the health of patients experiencing complications from an abortion, and that the state has "undoubted authority" to enact such a

Medical experts recognize that abortion patients benefit from having physicians with hospital admitting privileges. One benefit is credentialing. Experts in this case testified that the admitting privileges requirement "assures peer-review of abortion providers by requiring them to be credentialed . . . , thereby protecting patients from less than qualified providers." *Whole Woman's Health* v. *Cole*, 790 F.3d 563, 579 (5th Cir. 2015) (quoting testimony); *see also* J.A. 866 (Testimony of James Anderson, M.D.) (noting that plaintiffs' experts in this case "discount the long-standing value of hospital credentialing and privileging and provide no reasonable or objective alternative method to evaluate a physician's credentials and competency").

Another benefit is the avoidance of delays in transfer in the event of a complication. J.A. 851 (Testimony of Mayra Jimenez Thompson, M.D.); *see also* J.A. 868 (Testimony of James Anderson, M.D.) (hospital admitting privileges "reduce[] communication errors and costly time delays and thus improve[] patient safety and clinical outcomes"); J.A. 897 ("Another major benefit of requiring abortion providers to have local hospital admitting privileges is that this minimizes time delays in the treatment of critical conditions"). Such delays are not inconsequential. A delay of "as little as one hour, can mean the difference between life and death" for a patient experiencing a post-abortion complication. J.A. 899 (Testimony of James Anderson, M.D.); *see* J.A.

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requirement); *see also Schimel*, 806 F.3d at 930 (Manion, J., dissenting) (admitting privileges requirement "beyond a doubt" protects the health and safety of women undergoing an abortion).

865 (admitting privileges "will . . . improve the postoperative management of serious post-abortion complications").[7]

In a prior facial challenge to Texas's hospital admitting privileges requirement, medical experts offered similar testimony. *Planned Parenthood of Greater Texas Surgical Health Services* v. *Abbott*, 748 F.3d at 595 (referencing expert testimony that an admitting privileges requirement would lead to greater continuity of care, increase quality of care, and reduce risks from complications), cited in *Whole Woman's Health* v. *Cole*, 790 F.3d at 579 n.19. Even medical experts testifying *on behalf of abortion providers* have acknowledged that admitting privileges increase patient safety. *Shimel*, 806 F.3d at 927 n.2 (Manion, J., dissenting) ("plaintiffs' own expert and the court-appointed expert testified that admitting privileges are beneficial because they make abortions safer").

Medical associations of all stripes agree. In 2003, the American College of Surgeons issued a statement that reflects a consensus in the surgical community on "a set of 10 core principles that states should examine when moving to regulate office-based procedures."[8]

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[7] Abortion providers have claimed for years that informed consent requirements *cause* unjustifiable delay. Yet in this case they challenge a law that, if they will only comply with it, *prevents* delay by facilitating the prompt transfer of a patient (and relevant information about that patient) in the event of a complication requiring hospitalization. It seems the providers are perfectly willing to tolerate delay, even at risk to their patients' health, if it means avoiding regulation.

[8] American College of Surgeons, *Statement on Patient Safety Principles for Office-based Surgery Utilizing Moderate*

These principles, *unanimously* agreed to by over 30 medical groups—including the American Medical Association, the American College of Obstetricians and Gynecologists, and the American Society for Reproductive Medicine—provide that "[p]hysicians performing office-based surgery must have admitting privileges at a nearby hospital" or similar arrangement.[9] Even the National Abortion Federation ("NAF"), a professional association of abortion providers, has recommended that "[i]n the case of emergency, the doctor should be able to admit patients to a nearby hospital (*no more than 20 minutes away*)."[10] This requirement, proposed by the abortion industry's own trade association, is more rigorous than Texas's requirement that the doctor have admitting

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*Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia,* Bulletin of the American College of Surgeons, vol. 89, no. 4 (Apr. 2004), https://www.facs.org/about-acs/statements/46-office-based-surgery, quoted in *Planned Parenthood of Wisconsin* v. *Van Hollen*, 738 F.3d 786, 800 & n.1 (7th Cir. 2013) (Manion, J., concurring in part and in the judgment).

[9] *Id*. (Core Principle #4).

[10] National Abortion Federation, *Having an Abortion? Your Guide to Good Care* (2000) (emphasis added), http://web.archive.org/web/20000619200916/http://www.prochoice.org/pregnant/goodcare.htm, quoted in *Van Hollen*, 738 F.3d at 801 (Manion, J., concurring in part and in the judgment). National standards promulgated by NAF are intended by it to "serve as a useful resource for . . . state agencies charged with safeguarding the public's health." National Abortion Federation, *Standards for Abortion Care* (1998), quoted in *Greenville Women's Clinic* v. *Bryant*, 222 F.3d at 168. A witness for abortion clinics in South Carolina testified that NAF standards are "a distillate of extensive experience by highly trained and experienced [abortion] providers." 222 F.3d at 168.

privileges within *30 miles* of the abortion clinic (NAF's requirement for a hospital 20 minutes away is not satisfied by a requirement of 30 miles away unless one maintained an average speed of 90 miles or higher the entire distance to the hospital).

Complications necessitating transfer to a hospital are not infrequent. In the prior facial challenge to the Texas hospital admitting privileges law, "Planned Parenthood conceded that at least 210 women in Texas annually must be hospitalized after seeking an abortion." *Planned Parenthood of Greater Texas Surgical Health Services* v. *Abbott*, 748 F.3d at 595. The actual number of hospitalizations may be much higher. J.A. 844 (Testimony of Mayra Jimenez Thompson, M.D.) (noting that "serious complications and death from abortion are underreported"); J.A. 870-72 (Testimony of James Anderson, M.D.) (noting that physicians are often called upon to treat complications from abortions in the emergency room, but that the complication rate from abortion is generally underreported, owing in part to reticence on the part of the patient or physician to report the abortion); *see* Cheryl Sullenger, *Nearly 1,000 Texas Women Hospitalized Every Year after Botched Abortions* (Apr. 22, 2014), www.lifenews.com/2014/04/22/nearly-1000-texas-women-hospitalized-every-year-after-botched-abortions/.

Complications from abortion can be serious. Immediate complications include hemorrhage, retained tissue, infection, uterine perforation, cervical laceration, and immediate psychiatric morbidity. ANGELA LANFRANCHI, M.D., IAN GENTLES, M.D., & ELIZABETH RING-CASSIDY, M.D., COMPLICATIONS: ABORTION'S IMPACT ON WOMEN 96 (2013). It is

estimated that, in the United States, "at least 45,000 women a year experience physical complications" from abortion. *Id*. at 97.[11] There are also long-term complications, such as placenta previa and pre-term delivery in subsequent pregnancies. John J. Thorpe, Jr., M.D., et al., *Long Term Physical and Psychological Consequences of Induced Abortion: Review of the Evidence*, 58 OBSTETRICAL & GYNECOLOGICAL SURVEY 67, 70-72, 75 (2002); *see also* Brent Rooney & Byron C. Calhoun, M.D., *Induced Abortion and Risk of Later Premature Births*, 8 J. AM. PHYSICIANS & SURGEONS 46 (2003) (identifying 49 studies that have demonstrated a statistically significant increase in premature births or low birth weight in subsequent pregnancies in women with prior induced abortion).

Under these circumstances, there is ample justification for requiring doctors performing abortions to have hospital admitting privileges.

### B. Ambulatory Surgical Center Requirements

The petitioners "made no effort to narrow their challenge to any particular standards of the ASC

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[11] A comparison with maternal mortality associated with childbirth would not make these figures any less significant. Even if such a comparison were relevant, which it is not, petitioners' extravagant claim (Pet. Br. 16) that a woman is 100 times more likely to die from carrying a pregnancy to term than from having an abortion is not credible. *See* Byron Calhoun, M.D., *The Maternal Mortality Myth in the Context of Legalized Abortion*, 80 LINACRE QUARTERLY 264 (2013) (stating that "there is no credible scientific evidence" to support the claim that childbirth is 14 [let alone 100] times more likely to result in maternal death than abortion).

[ambulatory surgical center]" provision, but instead asked the lower courts to "invalidate the entire ASC requirement." *Whole Woman's Health* v. *Cole*, 790 F.3d at 579. As the Fifth Circuit noted, some of those requirement are "benign and inexpensive." *Id.* at 579 (noting, as an example, that the ASC standards require a soap dispenser at each hand washing facility). The petitioners offered expert testimony that the ASC construction requirements are "largely aimed at maintaining a sterile operating environment," which they claim (counter-intuitively) is not necessary for abortion. *Id.* at 578 n.17. Their experts also testified that abortion procedures do not require large operating rooms or the presence of nurses. *Id.*

Other experts disagreed. "Surgical abortion," Dr. Thompson testified, "is performed with instrumentation and is indeed an invasive surgical procedure. To the extent abortion is an invasive surgery and has complications including bleeding and infection, the safest operatory environment is a sterile one." J.A. 846. She testified that "abortion procedures should . . . be performed in an ASC where the higher standard of care is required so as to better protect the patient's health and safety." J.A. 850; *see* J.A. 851 ("[B]y requiring abortion facilities to conform to the minimum standards of ASCs, the Act addresses the specific needs of patients who may encounter serious abortion complications, not the best interests or convenience of the provider."); J.A. 852 ("By requiring abortion clinics to conform to the equivalent minimum standards of ASCs, the standard of abortion care is raised").

Dr. Anderson reached the same conclusion. J.A. 865 (testifying that the ASC requirements are

"reasonable and medically necessary to protect the health and safety of Texas women. . . . [I]t is my opinion that these regulations will . . . improve the quality of abortion care offered in abortion clinics"). By one estimate, some 27 states currently require abortion facilities to meet the structural standards of ASCs. J.A. 869-70 (Testimony of Dr. Anderson). Like the Fifth Circuit, other courts have upheld these or similar requirements for abortion clinics, finding that they "indisputably represent[] a reasonable attempt to further the health of abortion patients." *Greenville Women's Clinic* v. *Bryant*, 222 F.3d at 169.

Perhaps the best indicia of the need for ASC requirements in Texas are the numerous citations meted out by the Texas Department of State Health Services ("DSHS") based on its inspections of abortion clinics. In the last few years, at least four clinics operated by petitioner Whole Woman's Health have been cited by DSHS for deficiencies:

- Whole Woman's Heath of McAllen was cited for expired CPR training of staff, and failure to follow proper sterilization procedures.[12]

- Whole Woman's Health of Fort Worth was cited for expired equipment; expired, unlabeled, and unsecured medication; failure to follow proper procedures to ensure a sterile environment; and failure to ensure that all staff providing patient

[12] DSHS, Inspection Report of Oct. 18, 2013, based on survey completed Sept. 4, 2013, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_McAllen_09_04_2013.pdf.

care were currently certified in basic life support.[13]

• Whole Woman's Health of San Antonio was cited for failure to implement and enforce acceptable environmental controls in cleaning and preparing instruments for sterilization, and for related deficiencies.[14]

• Whole Woman's Health of Beaumont was cited for failure to provide a safe environment for patients and staff; for improperly storing sterilization solutions near a large hole in the cabinet flooring that "had the likelihood to allow rodents to enter the facility" and presenting a risk that "splintered wood edges could puncture the sterilization solutions"; for "numerous rusty spots on the suction machines used on the patient[s]"; for failure to implement procedures to follow up on patients with post-abortion complaints; and for failure to have EKG equipment ready and working in the event of an emergency. According to the report, a cardiac defibrillator was "out of paper and the cardiac cables were disconnected from the machine."

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[13] DSHS, Inspection Report of Apr. 12, 2011, based on survey completed Mar. 15, 2011, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_Fort_Worth_03_15_2011.pdf.

[14] DSHS, Inspection Report of Oct 15, 2013, based on survey completed Aug. 29, 2013, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_San_Antonio_08_29_2013.pdf.

> Inspectors also found expired drugs and unlabeled medication cups.[15]

This list, which is by no means exhaustive,[16] renders petitioners' complaints about ASC

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[15] DSHS, Inspection Report of Oct. 18, 2013 based on survey completed Oct. 3, 2013, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_Beaumont_10_03_2013.pdf.

This is not the first time Whole Woman's Health of Beaumont has been cited for deficiencies. In 2011, for example, the clinic was cited for "failure to ensure the staff was trained in [the] sterilization" of "surgical instruments," and "numerous rusty spots on the suction machine" used on patients. The facility also "failed to monitor the expiration dates on sterile supplies," kept "expired sterile supplies" in the supply closet, "failed to maintain the sterility of the surgical instruments," "failed to ensure staff was trained in CPR," "failed to have current emergency medication in the emergency crash cart," failed to have emergency airway management equipment, and failed to have currently-inspected fire extinguishers. DSHS, Inspection Report of Dec. 7, 2011, based on survey completed Nov. 17, 2011, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_Beaumont_11_17_2011.pdf.

Whole Woman's Health of Beaumont was also cited for deficiencies based on a 2012 survey. DSHS, Inspection Report of Jan. 9, 2013, based on survey completed Dec. 19, 2012, www.texasallianceforlife.org/wp-content/uploads/imported/issues/hb2/DSHS_inspection_WWH_Beaumont_12_19_2012.pdf.

[16] *See Inspections Find Notorious Texas Abortion Chain Running Filthy Clinics, Despite New Safety Standards*, LifeSite News (Oct. 30, 2013) ("Whole Woman's Health, a chain of abortion centers spanning five cities in Texas, has been cited dozens of times over the past three years for health and safety violations. . . . During the most recent round of inspections, . . . inspectors found dangerous conditions at three of the company's five locations."), www.lifesitenews.com/news/inspections-find-notorious-texas-

requirements abstract by comparison. Are clinics that fail to maintain a sterile environment, that allow conditions conducive to rodents, that do not keep a cardiac defibrillator in working order, and that have been cited for these and many other deficiencies, in *any* position to argue that that *they* (and not their patients, who the state wishes to protect) are the victims in this case? The clinics, not the state, are the wrongdoers here.

The importance of ASC standards to patient safety is further underscored by considering what happens when they are not required or enforced. In 2013, Dr. Kermit Gosnell was convicted of three counts of first-degree murder of newborn infants and one count of involuntary manslaughter of 41-year-old Karnamaya Mongar, who died following an abortion by Dr. Gosnell.[17] The Grand Jury investigating him concluded that "[t]he abhorrent conditions and practices inside Gosnell's clinic are directly attributable to the Pennsylvania Health Department's refusal to treat abortion clinics as ambulatory surgical facilities." *In re County Investigating Grand Jury XXIII, Report of the Grand Jury*, Misc. No. 0009901-2008, p. 166 (Pa. Ct. Common Pleas, Crim. Trial Div.) (filed as a public record by order dated Jan. 14, 2011),

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abortion-chain-running-filthy-clinics-desp.

[17] Brady Dennis, *Jury Convicts Abortion Provider Kermit Gosnell of Murder*, WASH. POST (May 13, 2013), www.washingtonpost.com/national/health-science/2013/05/13/b4444bdc-bbda-11e2-97d4-a479289a31f9_story.html. Dr. Gosnell was also convicted of 21 felony counts of illegal late-term abortion and more than 200 counts of violating Pennsylvania's informed consent law. *Id.*

www.phila.gov/districtattorney/pdfs/grandjurywomensmedical.pdf.

Petitioners may think that the construction requirements of ASCs are irrelevant to patient safety, but the Grand Jury whose investigation led to Dr. Gosnell's indictment, trial and conviction plainly did not agree. As detailed in the Grand Jury report, after managing to open a locked emergency exit, emergency medical personnel "had to waste precious more minutes trying to maneuver through the narrow cramped hallways that could not accommodate a stretcher." *Id.* at 129. Ms. Mongar was declared dead at the hospital.[18]

In any event, as *Gonzales* makes clear (550 U.S. at 163-64, 166-67), it is not an appropriate role for courts to substitute their judgment for that of the state on matters of medical regulation on which experts disagree. Notably, petitioners in this case do "not argue that it is *impossible* for abortion providers to comply with the ASC requirement,[19] *only costly and difficult*." *Whole Woman's Health* v. *Cole*, 790 F.3d at 585 n.28 (emphasis added). But, as *Casey* concluded,

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[18] The problems in Pennsylvania are not unique to that state. *See* William Saletan, *The Back Alley: How the Politics of Abortion Protects Bad Clinics*, Pt. 8 (Feb. 25, 2011) (describing very serious maternal health complications, including some maternal deaths, as a result of abortions performed in clinics in Florida, Delaware, Illinois, Maryland, Massachusetts, and New Jersey), www.slate.com/articles/news_and_politics/the_back_alley/2011/02/the_next_gosnell.html.

[19] Many abortion clinics in Texas are already complying with the ASC requirement. *Whole Woman's Health* v. *Cole*, 790 F.3d at 578 & n.15.

"[t]he fact that a law which serves a valid purpose . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." 505 U.S. at 874.

Likewise, petitioners' complaint that a private leasing opportunity fell through due to hostility to abortion, *Whole Woman's Health* v. *Cole*, 790 F.3d at 578 n.15, or that poverty makes it difficult for some women to obtain an abortion, *id.* at 589, are not burdens imposed by the state.[20] *Casey* only forbids an undue burden by *the government* on the decision whether to have an abortion. The government "need not remove those [obstacles to abortion] not of its own creation." *Harris* v. *McRae*, 448 U.S. 297, 316 (1980) (upholding law limiting use of federal funds for abortion, noting that "financial constraints that restrict an indigent woman's ability to enjoy the full range of constitutionally protected freedom of choice are the product not of governmental restrictions on access to abortions, but rather of her indigency").

The legislation challenged in this case is a responsible exercise of the state's authority to protect the lives and health of women seeking an abortion. "Their lives," as amicus Texas Catholic Conference observed while the bills were being debated, "are just as precious as those destroyed in the act of abortion . . . . The state has a legitimate interest in ensuring

[20] Some of petitioners' claims in this regard border on the absurd. In this Court, for example, they complain that petitioner Sherwood Lynn is "past retirement age" and "unable to work at the [McAllen] clinic full-time." Pet. Br. 24. Clearly the state cannot be faulted for Dr. Lynn's age or the unwillingness of younger physicians to perform abortions.

the maximum level of safety for the woman subject to the [abortion] procedure and that there is a viable . . . plan for emergency care should complications such as hemorrhage, infection, uterine perforation, blood clots, cervical tears, or allergic reactions occur." Texas Catholic Conference, *Support HB 2 & SB 1*, at 1. That laudable legislative purpose and effect do not run afoul of the Constitution.

## CONCLUSION

The Texas law should be upheld in its entirety.

Respectfully submitted,

ANTHONY R. PICARELLO, JR.*
JEFFREY HUNTER MOON
MICHAEL F. MOSES
United States Conference
of Catholic Bishops
3211 Fourth Street, N.E.
Washington, D.C. 20017
apicarello@usccb.org
(202) 541-3300

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**Counsel of Record*

## **APPENDIX** (List of Amici)

1. The United States Conference of Catholic Bishops ("USCCB"). The USCCB is an assembly of the leadership of the Catholic Church in the United States. The USCCB seeks to unify, coordinate, encourage, promote, and carry on Catholic activities in the United States; to organize and conduct religious, charitable and social welfare work at home and abroad; to aid in education; to care for immigrants; and generally to further these goals through education, publication, and advocacy. To that end, the USCCB provides and promotes a wide range of spiritual, educational, and charitable services throughout the country and around the world. The USCCB advocates and promotes the Church's pastoral teaching in such diverse areas as education, family life, health care, social welfare, immigrant aid, poverty assistance, communications, human rights, and the sanctity and dignity of human life.

2. Texas Catholic Conference ("TCC"). The TCC is the public policy voice of the bishops of the state's 15 Roman Catholic dioceses. The Roman Catholic Bishops are the visible foundation of unity of the Catholic Church and ensure that Christ's mission endures among the Catholic community across the state. The Bishops direct the TCC to advocate on legislative, regulatory, and policy issues that relate to or affect the Church and its teachings. The TCC unites with the USCCB to promote and fulfill the purposes outlined in the USCCB's statement of interest. The issues presented here are of particular interest to the TCC because they relate directly to the pastoral

teachings of the church and to the sanctity and dignity of human life.

3. The National Association of Evangelicals ("NAE"). NAE is the largest network of evangelical churches, denominations, colleges, and independent ministries in the United States. It serves 40 member denominations, as well as numerous evangelical associations, missions, nonprofits, colleges, seminaries and independent churches. NAE serves as the collective voice of evangelical churches and other religious ministries. It believes that human life is sacred because made in the image of God, that civil government has no higher duty than to protect human life, and that duty is particularly applicable to the life of the unborn because they are helpless to protect themselves.

4. The Lutheran Church-Missouri Synod ("LCMS"). The LCMS, a Missouri nonprofit corporation, has 6,150 member congregations with 2,200,000 baptized members throughout the United States. The LCMS believes in the sanctity of human life, including "unborn children, whom God has woven together in their mother's wombs" (Psalm 139:13-16). The LCMS fully supports laws, such as the Texas laws in this case, that preserve and protect maternal life and health.

5. The Ethics & Religious Liberty Commission ("ERLC") of the Southern Baptist Convention. The ERLC is the moral concerns and public policy entity of the Southern Baptist Convention ("SBC"), the nation's largest Protestant denomination, with over 46,000 churches and 15.8 million members. The ERLC is charged by the SBC with addressing public policy

affecting such issues as the sanctity of human life, human flourishing, religious liberty, marriage and family, and ethics. The SBC has passed many theological and policy statements expressing our concerns about abortion and its impact on women. Both the baby and the mother are created in the image of God. Consequently, they both deserve utmost respect and care. Not only are human beings killed in an abortion, but the women who undergo abortion are often traumatized, and in some cases they even die. Women who make the choice to have an abortion should be assured that everything possible has been done to ensure their health and wellbeing during and afterward. Anything less belittles their value in the eyes of God and society.

6. The Southern Baptists of Texas Convention ("SBTC"). The SBTC is a fellowship of 2,541 Southern Baptist churches in Texas, representing approximately one million church members. SBTC supports the spiritual and physical wellbeing of all people, whom we believe to be created in the image of God and thus of great worth. Our churches have from our founding supported by resolution, benevolence, the conduct of family ministries, and the support of legislation, the holiness of all human lives, including those of children and mothers. In regard to the Texas law challenged here, we affirm that women who undergo a medical procedure, including abortion, should receive a consistently high level of care, ensured by state regulation and the state's role in maintaining the common good.