Nos. 18-1323, 18-1460

IN THE

Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., ET AL.,
Petitioners,

v.

REBEKAH GEE, SECRETARY,
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,
Respondent.

REBEKAH GEE, SECRETARY,
LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS,
Cross-Petitioner,

v.

JUNE MEDICAL SERVICES L.L.C., ET AL.,
Cross-Respondents.

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

BRIEF OF PLANNED PARENTHOOD FEDERATION OF AMERICA, NATIONAL ABORTION FEDERATION, PHYSICIANS FOR REPRODUCTIVE HEALTH, AND ABORTION CARE NETWORK AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE[1]

Planned Parenthood Federation of America (PPFA), the National Abortion Federation (NAF), Physicians for Reproductive Health (PRH), the Abortion Care Network (ACN), and their members provide reproductive healthcare and education nationwide, including to patients in Louisiana. They submit this amici curiae brief in support of Petitioners in case number 18-1323 and Respondents in case number 18-1460.

PPFA is the largest provider of reproductive health services in the United States. For over one hundred years, Planned Parenthood has advocated for access to health services, provided informed reproductive health education, and offered comprehensive reproductive care. One in five women in the United States has chosen Planned Parenthood's expert care at least once.

NAF is the professional association of abortion providers. NAF's mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care. NAF members include individuals, private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physician's offices, and hospitals.

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

PRH is a doctor-led non-profit whose mission is to assure meaningful access to comprehensive reproductive healthcare, including abortion. Since its founding in 1992, PRH has been comprised of a network of nationally recognized medical experts in abortion, contraception, and healthcare access.

ACN is the national membership association for community-based independent abortion care clinics, which collectively provide the majority of abortion care in the United States, serving three out of every five people who has an abortion. By supporting independent clinics, ACN works to ensure that every person can access dignified, expert abortion care.

These organizations' members know first-hand that admitting privileges laws like Louisiana's Act 620 are counterproductive. The stories they share in this brief reveal what abortion care is actually like in America: Providers across the country deliver high-quality, compassionate abortion care to patients they are committed to serving.

INTRODUCTION AND SUMMARY OF ARGUMENT

Louisiana's admitting privileges law is unconstitutional for the same reason Texas's identical law was unconstitutional: It imposes significant burdens on patients seeking abortion care with no countervailing benefit. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

Louisiana can defend Act 620 only by misrepresenting the realities of abortion care and by challenging decades of precedent recognizing doctors' standing to assert the rights of their patients. Louisiana's defense of its admitting privileges law and its attack on third-party standing are both rife with mischaracterizations about physicians who provide abortion—in particular, their interests and commitment to their patients. The state impugns their motives, and the court of appeals questioned their good faith. Amici submit this brief to correct those mischaracterizations.

This brief conveys first-hand accounts from healthcare professionals who provide abortion care.[2] Providers describe—in their own words—why they provide abortion and their extensive efforts to obtain admitting privileges so they can comply with the laws that impose that medically irrelevant requirement.

The narratives in this brief highlight two central points:

I. Medical professionals who provide abortion are highly qualified and committed to protecting their patients' wellbeing. They choose to provide that care because they know that abortion is among "the most intimate and personal choices a person may make in

[2] The narratives come from interviews conducted by amici counsel. Each provider reviewed and approved his or her narrative. The opinions expressed are the providers' own and are not necessarily shared by the institutions for which they work. Patients have also consented to the use of their quotes.

a lifetime, choices central to personal dignity and autonomy, [and] central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992). Patient welfare motivates their decision to provide abortion in the first place—they recognize that if they do not provide this care, patients will lose access. The idea that the interests of these physicians and clinicians are at odds with the interests of the patients they serve is untethered from reality. To the contrary, the compassionate, patient-centered care they provide fosters a close relationship between them and their patients.

II. Physicians show their commitment to their patients by going to great lengths to satisfy state regulations, including admitting privileges requirements. That requirement does not further the purported state interest in ensuring that physicians are competent—other state regulations, and clinics' own rigorous protocols, already guarantee that only qualified clinicians treat patients. And contrary to the court of appeals' contention, physicians' inability to obtain or maintain admitting privileges is not due to a lack of effort. Instead, forces beyond physicians' control stand between them and privileges: political interference, abortion stigma, hospitals' business motives, and other reasons having nothing to do with patient wellbeing.

ARGUMENT

I. The Qualified Professionals Who Provide Abortion Care Are Committed To Advancing Their Patients' Best Interests.

Being an abortion provider takes determination. It takes years of medical training. It takes contending with a raft of uniquely onerous and medically irrelevant restrictions. And it takes dedication to persevere in the face of hostility, harassment, and sometimes much worse.[3] Medical professionals choose to provide abortion because they believe that access to competent, compassionate abortion care is vital to their patients' wellbeing, autonomy, and dignity.

In providing that care, clinicians forge close bonds with their patients. Those connections—and the gratitude of their patients—motivate providers to continue their work and advocate for their patients even beyond the clinical setting.

A. Providers are dedicated to protecting patients' health, wellbeing, and dignity.

Clinicians take different paths to abortion care, but they all recognize that care is critical to their patients' ability to control their destinies. *See Casey*, 505 U.S. at 856 ("The ability of women to participate equally in the economic and social life of the Nation

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[3] *See* Joe Stumpe & Monica Davey, *Abortion Doctor Shot to Death in Kansas Church*, N.Y. Times (May 31, 2009), https://tinyurl.com/y8e24byb.

has been facilitated by their ability to control their reproductive lives."). They provide abortion care, even though it often comes at great personal cost, because their patients need it.

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Sarah Wallett, M.D., M.P.H.

Dr. Wallett completed her residency and a two-year family planning fellowship at the University of Michigan. She has provided abortion care and other gynecological services in Tennessee, Kentucky, and Michigan.

I was raised in a Christian home in Lexington, South Carolina. My family went to church regularly, and I was taught from childhood that it was my duty to help people in need and leave the world a better place than I found it. The compassion and empathy I learned from my Christian faith are fundamental to my work.

The patients I see every day are so clearly people in need—and the medical care I provide them is both life-changing and, in many circumstances, life-saving. Throughout my medical training and residency, I saw that women needing abortions were ostracized and shamed by medical professionals who did not want to participate in their abortion care. This treatment was antithetical to the lessons from my faith upbringing and my own ethos of how medical professionals should treat their patients. I wanted to be a doctor who would offer these women the care they needed without judgment and stigma.

Physicians who provide abortion care confront many challenges—we face discrimination and hostility from protestors, other medical professionals, and even sometimes our own families. We worry that our children will be harmed because of our commitment to caring for our patients. But I continue providing because I know that access to abortion is so important for women and their families. I'm lucky enough to leave work every day and know that I made a difference: I helped my patients take agency over their own lives so they could live the life they want. That's really powerful. It's a true privilege that my patients trust me to be a part of that.

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Bhavik Kumar, M.D., M.P.H.

Dr. Kumar provides abortion, gynecological, and primary care in Texas. He attended medical school at Texas Tech University and completed his residency in family medicine at Montefiore Medical Center in New York.

I view my purpose in life as helping other people, and that is why I went into medicine in the first place. But I didn't know that I necessarily wanted to provide abortions as part of my practice. Instead, that realization came to me over time.

Growing up in Texas, I saw first-hand what happens when teenagers lack access to accurate and comprehensive sex education: unwanted pregnancies. Then, in medical school, I got involved with Medical

Students for Choice and learned more about abortion—that it is a remarkably safe procedure, and that there is a real shortage of providers, particularly in the South and Midwest. I came to realize that abortion care was something that I needed to provide, especially since I wanted to practice medicine in Texas. I knew I would have the most impact on improving the lives of my patients if I stepped up and provided a service that was in short-supply in my home state. Abortion care is simply where my services are needed the most.

Every day I face barriers in providing this care to my patients: I am harassed by protestors outside my clinic, I have to give my patients a state brochure riddled with inaccuracies, and I'm forced to show ultrasound images to patients regardless of their wishes. But every day, I also meet patients who affirm why I do this work. I know that I am making an impact on their lives, helping them to access the care that they need to live the lives that they want. I take real pride in being a small but important part of my patients' lives, helping them and supporting them as they navigate what can sometimes be a difficult process.

My patients' stories are what drives me. People are always going to need access to abortion. Things happen. And I am trained and have the skills to provide this care. I feel like I have a duty to provide abortion care at this point. Given the dire need for additional abortion providers, it would be unethical for me to stop doing this work. My patients need me.

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Yashica Robinson, M.D.

Dr. Robinson is a board-certified obstetrician-gynecologist (OB-GYN) who provides abortion, in addition to routine obstetric and gynecological services, in Alabama. She attended medical school at Morehouse School of Medicine and completed her residency at the University of Alabama at Birmingham.

As a mother and a physician, abortion care is deeply personal. I carry both of these identities with me as I care for women and honor their decisions to become parents or to terminate their pregnancies.

I know that women will have pregnancies that end in different ways: some women will give birth to a much-wanted baby, some will suffer a miscarriage, and some will determine they do not want to have a child at that time and decide to obtain an abortion. I understand the complexity that goes into making these choices. I became pregnant when I was in high school. Because of my fear and lack of resources, I didn't confide in my mother or grandmother until it was too late to have an abortion. I love my children with all my heart, but everyone should be able to make this decision for themselves.

It's my job and my privilege to be there for all of these women, and to provide them with the care that they need at that particular point in their journey. I have never questioned whether providing abortion care should be part of my obstetrics practice. It's part of the spectrum of services women should be able to access.

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These accounts echo those of other physicians, who are driven by their conscience to provide the life-changing care their patients need.

- Dr. Lisa Perriera, who provides care in Pennsylvania: "I remember in medical school thinking about the shortage of physicians providing abortion in this country and the impact that has on women's ability to access this critical procedure. That convinced me that I needed to learn how to provide abortion care. It is so fulfilling to be able to offer a service that patients are so appreciative to receive, that allows them to decide they want to finish their college degree or to not bring a fifth child into the world when they are already struggling to make ends meet with four."[4]

- Dr. Shanthi Ramesh, who provides care in Virginia: "The ability to help a patient to change the trajectory of her life is extremely uncommon in medicine. Our patients are able to finish school, leave an abusive partner, or be a better parent to a special-needs child because of the care that we provide. That is really affirming—knowing the positive impact we have

[4] The majority of patients who obtain abortions have given birth before. *See* Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Institute 7 (2016), https://tinyurl.com/yyzkwj4b (noting that, in 2014, 59% of abortion patients had at least one previous birth, and one third had two or more births).

on our patients' lives sustains me through all of the challenges in this line of work."

- Dr. Douglas Laube, who has served as President of the American College of Obstetricians and Gynecologists and who currently provides care in Wisconsin: "I see this as an issue of women's self-determination. I want to protect a woman's ability to define for herself what her life is going to be. What motivates me is my patients' welfare."

B. Physicians form close and meaningful relationships with their patients.

Physicians' deep commitment to their patients translates into meaningful and often lasting connections with them. Louisiana portrays physicians who provide abortion as callous toward, and even at odds with, their patients' best interests. That could not be further from the truth, as both providers and patients attest below.

These physicians support patients in making a most intimate decision at what is, for some, a very difficult moment in their lives. The decision to have an abortion implicates many dimensions of a person's life, including her physical health and psychological wellbeing, relationships to partners, financial security, and goals for herself and her family. "All these are factors the woman and her responsible physician necessarily will consider in consultation." *Roe v. Wade*, 410 U.S. 113, 153 (1973).

Conversations with patients are a critical part of each visit, as Helen Weems, a provider in Montana, describes:

> I sit down with the patient and I ask them, 'how is it for you to be here today?' Then I wait. After a pause, patients will tell me for fifteen or twenty minutes about why they're here, how they're doing, and the thought that's gone into their decision. People feel comfortable sharing their stories with us because everyone involved in their care treats them with the utmost respect and kindness.

Julie Jenkins, a nurse practitioner who provides abortions in Maine, concurs, noting the "strong connection that patients form with the entire team at the clinic. From the education team, to the clinician who provides the abortion, to the nurses in the recovery room, every member of the team is deeply committed to supporting our patients in the most compassionate, understanding, and patient-centered manner possible."

Dr. Lisa Harris describes how these interactions lead to close—and oftentimes lasting—connections with her patients.

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Lisa Harris, M.D., Ph.D.

Dr. Harris is a practicing OB-GYN, Professor of Obstetrics and Gynecology, and Associate Chair of the

Department of Obstetrics and Gynecology at the University of Michigan. She attended medical school at Harvard University.

There is nothing more spiritually and emotionally important to me than being able to accompany my patients when they need me the most. For me, providing abortion care as part of my OB-GYN practice is a matter of conscience. It's my job, and my duty, to be there for patients when others don't want to be. I often think to myself, if I don't do this work, who will?

Abortion is the model for person-centered care that I aspire to in all other aspects of my practice. For many of my patients and their loved ones, the first medical setting in which they've been treated with compassion and respect is the health center where they seek abortion care. Because of the many structural barriers that our patients face in obtaining abortion care, my staff and colleagues and I end up getting to know the day-to-day details of our patients' lives as we make every effort to get them the care that they need. I can't tell you the number of times that we've fit a patient into the schedule or arranged our day to accommodate a woman so that she can get home in time to meet her children at the bus stop after school, or so that she doesn't have to miss a day of work. This kind of patient-centered care and genuine interest in accommodating all of the needs of our patients, in a really holistic way, is how medicine should be practiced in all settings, but often isn't.

Moreover, so much of what we do as abortion caregivers is restorative, reparative work for patients who have been judged and abandoned on their path to us.

We have patients who have been told by their prior doctors that they are going to hell if they get an abortion, and who then have to walk through a gauntlet of protestors on their way into our health center. So part of our job is comforting them, and making sure that they know that they will not be judged or abandoned by our staff. And because of the stigmatization of abortion, it's especially important to me that my patients know that I view them as a person, and that I'm able to connect with them on a human level and learn something important about their lives and what matters most to them during our time together.

My relationships with my patients and their loved ones do not end at the conclusion of their visit. If a patient has any questions after her procedure or needs any follow-up, I'm available to her—I've given my cell phone number to patients and their family members so they can call me directly at any time. My patients also regularly reach out to me to express their gratitude for the skilled and compassionate care that they received. I get "thank you" notes more often from patients for whom I've provided abortion care than from patients I've cared for in other contexts. I think they reach out because they are so grateful that they were able to obtain the care and compassion that they needed from someone who prioritized their well-being. In response to an opinion piece I recently published in *The New York Times*,[5] a few patients from as many as 14 and 15 years ago reached out to me with expressions of appreciation for the care they received years ago. I was so humbled and touched—it's

[5] Lisa H. Harris, Opinion, *My Day as an Abortion Care Provider*, N.Y. Times (Oct. 22, 2019), https://tinyurl.com/y4rg5us7.

a real testament to the impact of this care, and the depth of feelings and relationships that can grow from it.

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Dr. Ghazaleh Moayedi, a provider in Texas, agrees that abortion care is the model of patient-centered medical care: "The people we care for often say in their evaluation surveys that they were treated with more kindness, compassion, and respect at our office than in any other doctor's visit they've ever had." Dr. Laube recounts that his health center "regularly receives handwritten notes from patients who describe their visits as their most positive experience with the healthcare system, thanking us for providing a warm environment where everyone cares about their wellbeing and never rushes them. They tell us they feel seen, heard, and respected as individuals." Dr. Julia McDonald, a family medicine physician who provides abortions in Maine, also notes that she and her colleagues "are constantly getting letters from patients who are so grateful for the compassionate abortion care they received." Likewise, in the words of one Planned Parenthood patient:

> My experience was exceptional. I felt comfortable, welcome, safe, respected, but most importantly [the staff] gave me the confidence and tools to make my own decision. I was by myself throughout this journey, but the kind and knowledgeable staff did not make me feel alone. We cracked jokes, they educated me, but most importantly they gave me hope. For me, Planned Parenthood was a lifesaver.

These patients do not just send thank you notes—many are compelled by their experience to begin volunteering or even working for the health centers that helped them. As one patient said: "Planned Parenthood fought for me when I needed them, and I will continue to fight for them in every way I can." The idea that an abortion patient's relationship with her provider ends the moment she walks out the door is sheer fiction.

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Some physicians are so motivated to serve the needs of patients that they travel out of state to provide abortion care to underserved areas. Dr. Meera Shah, a family medicine physician, explains why she travels from New York to Indiana:

> If I'm not there, the center won't open and there are fifteen patients on the schedule who will not get the care they need. It is not easy, but I do it because I believe that people should be able to decide what is best for them and their families and should have agency over their own bodies.

Dr. Fred Hopkins, who travels from his home state of California to provide care in Arkansas, agrees: "It can be so hard for people to find a doctor to take care of them. I travel to Arkansas so that everyone can have access to excellent care, no matter where they live." Dr. Chava Kahn also travels to provide care in regions of the country with limited access. As she explains, that doesn't prevent her from connecting with her patients.

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Dr. Chava Kahn, M.D., M.P.H.

After finishing medical school at Albert Einstein College of Medicine, Dr. Kahn completed a family planning fellowship at the University of Michigan.

After my fellowship, I worked for a number of years in academic medicine providing full-spectrum obstetrics, delivering babies and performing gynecological services. A few years in, I decided I needed to cut back and be home more for my children. When I thought about the most meaningful part of my work—what I didn't want to give up—it was abortion care. The work is so needed and so important.

Now I travel to a state in the South twice a month to provide abortion care. The travel isn't fun, and it isn't easy on me or my family. Every time I get into an Uber headed to the clinic or walk past protesters, I worry about my safety. But I do it anyway because making the trip means patients are able to get the care they need.

I care for my patients in a compassionate way. I don't just walk in, do a procedure, and leave. In this line of work, it's all about the patient connections. You treat every patient as a human being and hear their stories. You learn so much about each patient: how far they've driven that day; why they've come in; where their kids are now. Our patients face so many obstacles to get to the clinic in the first place, and then they have to walk through a line of protesters. I make sure that when they get inside, I'm warm and accepting of

them, and that they know I'm a provider they can talk to. There aren't many opportunities in medicine where you're able to support your patients as they take agency over their own lives, and I get to do that multiple times a day.

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Providers' connection with their patients not only motivates them to continue providing care, it also drives them to stand up for patients outside of the clinical setting. In Dr. Lisa Perriera's words, "My job is to be my patients' voice when they aren't comfortable speaking themselves." Dr. Colleen McNicholas feels the same way.

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Dr. Colleen McNicholas, D.O., M.S.

Dr. McNicholas completed a residency and fellowship in OB-GYN at Washington University in St. Louis School of Medicine. She was previously an Associate Professor in the Department of Obstetrics and Gynecology at Washington University School of Medicine and currently provides abortion care in Missouri, Kansas, Illinois, and Oklahoma.

People often ask why I provide abortion care and why I advocate for my patients, despite the seemingly endless obstacles. My answer is always the same: Because I have the opportunity—the privilege, really—to interact with patients at such a critical time in their lives and to witness how abortion access changes their lives for the better.

As in any field of medicine, it isn't the quantity, but quality, of time spent with patients that matters. It's being there for them with true sincerity and empathy. There are very few opportunities in medicine for physicians to have such an intimate interaction with patients and provide care that affects them so profoundly. Technically, the procedure for most is simple to perform, but it can be life changing for patients. An abortion gives patients the chance to get back to life, to reimagine what their lives are, could be, or should be. Some of the most meaningful connections I have had with patients have come while providing abortion care, granting me a small part in the self-empowerment of my patients on their way to futures they see for themselves.

For many, a completed abortion brings great relief and immense gratitude. There are hugs, and tears, and so many "thank yous." Patients send letters of gratitude sometimes years later, sharing pictures of the babies they've had when they were ready to have them, stories of their journey to advocacy, and sometimes my favorite, a copy of their diploma—all symbols of the dreams they were able to achieve because they could access abortion care.

These experiences stay with me. They are why I not only provide abortion care, but also advocate for abortion access. Whether it is in print, in legislative halls, or courtrooms, I am committed to serving the needs of my patients.

The law should not force individual patients to share their private stories in court or anywhere else. People decide to obtain abortions because parenting

is not right for them at that moment, whether that's because of financial insecurity, health and wellness concerns, care-giving responsibilities, or needing to finish their education. Our patients are doing the best they can despite the intersecting challenges of their lives. They often aren't aware of the various laws that limit access to abortion, and even if they were, they shouldn't have to take on the additional responsibility of filing a lawsuit. But for physicians like me, laws restricting access are always front of mind, and we see the impact they have on our patients. We should be able to stand up for our patients and against those restrictions.

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Providers strive to support their patients any way they can, both inside and outside the clinical setting. Indeed, many would like to develop longer-term clinical relationships with their abortion patients by offering full-scope OB-GYN care. But as Dr. McNicholas knows, unjustified state regulations sometimes prevent them from doing so: "Any perception that this is an abbreviated relationship is a consequence of how we've been forced to practice by regulation." Targeted regulations of abortion providers and the stigma accompanying them often force physicians to silo abortion care. Dr. Wallet explains that it is her "impossible dream" to be able to provide abortion care as part of an OB-GYN practice: "But when I started practicing in Kentucky, I learned that I had to make a choice: I couldn't continue providing full-scope OB-GYN care at the hospital where I was working and also provide abortions. And I knew that the patients who needed me the most were those who needed abortions."

In states without those restrictions, abortion practice can be seamlessly woven into full-spectrum healthcare, as done by Dr. McDonald (Maine) and Dr. Shah (New York). Jessica Dieseldorff, a nurse practitioner who provides abortion care in California, reports:

> Patients who come in for an abortion often end up getting other health services from us, like setting up a birth control method. And, of course, some of our abortion patients are preexisting patients of Planned Parenthood. Because of California's progressive laws, we're able to integrate abortion as part of routine healthcare, which is really gratifying.

These stories about physicians' and clinicians' unflagging commitment to their patients' wellbeing are typical. The relationship between provider and patient is one of trust, compassion, and care.

II. Physicians Strive In Good Faith To Obtain Admitting Privileges, But Are Stymied For Medically Irrelevant Reasons Beyond Their Control.

Providers' commitment to their patients' welfare leads them to go to great lengths to comply with state regulations, even when they are medically unnecessary. Admitting privileges laws are a paradigmatic example of an unjustified requirement, but one that providers nonetheless make every effort to satisfy.

Louisiana contends that such laws are needed because clinics do not check physicians' credentials or

qualifications, and that "the process for obtaining admitting privileges serves to vet physician competency." Conditional Cross Petition 12-13, 4. Neither assertion is true.[6] As explained below, physicians are already thoroughly vetted. And hospitals deny physicians admitting privileges for reasons having nothing to do with these providers' qualifications and no matter how hard physicians try to acquire them.

Lori Williams elaborates on the methodical care she and her staff take to ensure that physicians meet the highest possible standards.

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Lori Williams, M.S.N., A.P.R.N.

Ms. Williams is the clinical director and nurse practitioner at Little Rock Family Planning Services (LRFP), which, like the Plaintiff clinic, is a member of NAF. She is responsible, among other things, for supervising staff and ensuring that LRFP complies with all laws, regulations, and internal policies.

Our physicians usually come to us through a referral, either through NAF or other physicians we work with. We always talk with their past colleagues and employers to make sure there are no concerns about their past medical practice.

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[6] Nor do admitting privileges ensure that patients receive continuity of care in the exceedingly rare instances of emergencies. *See, e.g.*, Brief for Amici Curiae American College of Obstetricians and Gynecologists et al. in Support of Petitioners (No. 18-1323) (Dec. 2, 2019).

An extraordinary amount of work then goes into onboarding a new physician. It starts with obtaining a state license, if the physician doesn't already have one. I cannot begin to explain how rigorous the licensure process is for Arkansas and Louisiana (I've done both). We also have to submit an application for malpractice insurance, which reviews any possible previous malpractice cases. And there are other regulatory applications, like for the federal Drug Enforcement Administration. The application processes collectively have an extraordinary scope of review, including rigorous checks of physicians' background and references that speak to the quality of their care.

On top of that, new physicians are always trained and regularly supervised to ensure they are proficient in all relevant procedures. And all practitioners are subject to oversight, including by the State of Arkansas, which conducts unannounced inspections multiple times a year. NAF also routinely sends at least two clinicians to spend several days observing our physicians and each type of patient care. They review our protocols and examine our records—all to be sure that we comply with NAF's rigorous guidelines and standards. And they follow up to ensure we meet our goals.

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As Ms. Williams explains, clinics are not solely responsible for ensuring that physicians are competent. Existing state processes (including physician and clinic licensing requirements), combined with clinics' additional protocols, are more than enough to guarantee that abortion care is safely provided, and that any

shortfalls are promptly addressed. *See Doe v. Bolton*, 410 U.S. 179, 199 (1973) ("If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment."); *Roe v. Wade*, 410 U.S. 113, 166 (1973) ("If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available."); *see, e.g.*, La. Rev. Stat. § 40:1061.10(A)(1) (physician licensure); *id.* §§ 40:2175.4, 40:2175.6 (facility licensure); *id.* § 40:2175.6(D), (F) (on-site inspections); *id.* § 40:2175.6(G) (facility license revocation).

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There is no need for any further vetting of physicians' qualifications to determine whether they are qualified to provide abortion care in an out-patient setting. Even if there were, admitting privileges requirements would not meet it.

Physicians providing abortion care jump through every hoop to obtain (and maintain) privileges in states that require privileges, but they are stymied for reasons having nothing to do with the quality of their care or their competence to provide it. Their persistent, good-faith efforts are frustrated by forces beyond their control. Sometimes the obstacles are prerequisites, like guaranteeing a certain number of admissions per year, which "have nothing to do with ability to perform medical procedures." *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312 (2016). Often opposition to abortion prevents physicians from obtaining or maintaining privileges, no matter how qualified they are. Sometimes it is both, as Dr. David

Eisenberg experienced when he attempted to satisfy a Missouri law that requires, among other things, abortion providers to have admitting privileges at a nearby hospital.

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David Eisenberg, M.D., M.P.H.

Dr. Eisenberg is a board-certified OB-GYN. He is Director of Benign Gynecology at Barnes Jewish Hospital and Associate Professor in the Department of Obstetrics and Gynecology at Washington University in St. Louis School of Medicine.

I am able to maintain admitting privileges at a hospital in St. Louis because that is where my OB-GYN practice is and where I teach. But I also wanted to provide abortion care at Planned Parenthood health centers in Joplin and Springfield to prevent patients from those towns from having to make the over 200-mile one-way trip from these cities to access care at our health center. And they have to make this lengthy trip twice to comply with the state's 72-hour waiting-period law. But I could not obtain privileges at any of the hospitals near Joplin or Springfield, as the law required.

Joplin has two hospitals close enough to our health center. The first one required all privileged physicians to reside and maintain an office within 15 minutes of the hospital. But I live in St. Louis, hundreds of miles away, so I would not qualify for privileges. Indeed, short of picking up my entire family and

moving to Joplin, there was no way I could ever satisfy this policy.

I couldn't obtain privileges at the second hospital in Joplin because it required that all privileged physicians use the hospital in a manner consistent with the Ethical and Religious Directives for Catholic Health Facilities. The Directives state that abortion is never permitted. Because I have a deeply held belief that providing women's healthcare requires that I provide comprehensive patient-centered care including abortion and I would only use the hospital to treat my abortion patients (if any such treatment was ever needed), I couldn't satisfy that policy.

In Springfield, there were also two hospitals within the law's geographic range. The first never even responded to my request for the hospital bylaws, despite multiple efforts to get ahold of them. And that hospital also adheres to the Directives, so I wouldn't have been able to obtain privileges there even if they had responded.

Things initially looked promising at the other hospital in Springfield. The staff said they were impressed with my resume and even told me about open positions in their practice groups. However, when I explained that I was not seeking full-time employment with the hospital but would instead provide outpatient care at Planned Parenthood, the hospital stopped responding to me. It was clear I could never meet the hospital's requirements anyway. The hospital requires physicians to complete a period of provisional status, during which the physician's work in the hospital is proctored by staff physicians. Because

abortion is extremely safe, I would not have enough—and probably not *any*—patients who need care in the hospital. The hospital also requires physicians to find another physician on staff to provide coverage for patients. But that is next to impossible due to the local community's hostility to abortion. I know because I reached out to a number of other physicians in the community, including one who previously served as our associate medical director in Springfield, and was told by all of them that while they supported access to abortion care and would treat any patients needing care, they could not be affiliated with me or Planned Parenthood because they felt it would hurt their clinical practice.

Since we couldn't provide abortion care in Joplin or Springfield, patients in those cities are unable to access care at health centers in their communities and must instead travel to access care. That is no small feat, especially for patients with limited resources. The travel delays them from accessing care—it means that some women are too far along in their pregnancies to access medication abortion and pushes others into the second trimester. It's incredibly frustrating to impose these kinds of unnecessary burdens on my patients.

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Dr. Wallett also faced obstacles obtaining and maintaining admitting privileges when she began providing care in Tennessee.

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Dr. Wallett (continued from Section I.A)

When I moved to Memphis to provide abortion care, a big worry was whether I would be able to satisfy the state's law requiring abortion providers to have admitting privileges. Thankfully, since I had been working as a generalist gynecologist at a hospital prior to the move, I had done a wide enough variety of procedures in the prior year to qualify on paper. But even then, persuading any hospital in Memphis to grant admitting privileges to a physician providing abortions took an enormous amount of leg work. The CEO of the Planned Parenthood affiliate met with all the hospital systems in Memphis, attempting to assuage their concerns about the backlash they would face if they were to grant me privileges. After much back and forth, finally one hospital agreed to give me limited-scope privileges so that I could begin work.

But there was a catch. They said that in order to keep my privileges, I would need to treat enough patients at the hospital. I tried really hard to find patients so that the hospital would not revoke my privileges. But working as a full-time abortion provider, I had no patients to admit because there were never any complications that warranted hospital care. The hospital also wanted me to perform specific procedures at the hospital, including a hysterectomy. As time went by, I hadn't found any patients that needed a hysterectomy. Those cases simply don't present in the largely young, healthy patients I see. I ended up resigning those privileges before they could be revoked because I knew I was never going to be able to meet the hospital's conditions for maintaining them.

I currently practice in Michigan, where admitting privileges are not required. But I have serious concerns about whether I'd ever be able to get admitting privileges again. On top of the general hostility towards abortion providers, I now have a gap where I haven't had any admitting privileges that I would need to justify on any future applications. I've also now provided exclusively reproductive healthcare and abortion for the past four years. As a result, I haven't performed the wide range of procedures most hospitals require for privileges. If providers like me are prevented from providing abortions because of admitting privileges laws, we run the risk that patients around the country will be unable to access abortions.

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These experiences are not unique. Molly Oakley-Rizzo recounts a Kansas clinic's painstaking efforts to obtain admitting privileges for its physicians.

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Molly Oakley-Rizzo

Ms. Oakley-Rizzo is the chief operating officer of Trust Women, a network of clinics with locations in multiple states, including one in Wichita, Kansas.

Our physicians made every effort to obtain privileges to comply with a Kansas law. They couldn't obtain them for multiple reasons.

Some hospitals would not grant privileges to our physicians unless we found doctors who already had privileges to be our backups. We couldn't find a single

backup. Even physicians who were sympathetic refused to publicly affiliate with an abortion clinic for fear of having their privileges revoked.

Other hospitals required the physician to be a member of the community, which our physicians could not satisfy since they all fly in from out of state. We tried to find in-state physicians to provide abortion care, but the murder of Dr. Tiller in Wichita in 2009 has made it impossible for us to recruit any in-state physicians.

The Catholic hospitals were also a non-starter: They told us they would never grant privileges to physicians who provide abortions.

Thankfully the admitting privileges law in Kansas was enjoined before it went into effect—if it had not been blocked, we wouldn't have been able to provide care to our patients.

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It can be particularly difficult for qualified physicians to secure privileges at state-supported hospitals, owing to opposition to abortion. Consider Dr. McNicholas's experience in Missouri, one of the states most hostile to abortion access.

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Dr. McNicholas (continued from Section I.B)

Although there is currently just one abortion clinic left in Missouri (in St. Louis), that wasn't always the case. Not long ago, I was also able to provide

abortion care in Columbia. I could do that because I had privileges at the nearby state-university hospital, which satisfied Missouri's admitting privileges law. But when anti-choice legislators realized I had those privileges, they held the university's funding hostage: They threatened that if the hospital didn't find a way to revoke my privileges, they would cut its funding. In response, the hospital decided to discontinue the class of privileges it had granted me.

The only remaining class of privileges available required that I contribute to the hospital's mission, such as by engaging in clinical practice. Because abortion care is so safe, it was incredibly unlikely I would ever engage in clinical practice at the hospital. I applied for those privileges anyway, making the case that I should be given privileges since I was the only abortion provider in the area and my services would benefit the community.

After my application was denied, I undertook a lengthy and unsuccessful appeal. The physicians and administrators on the appeals panel acknowledged that I was qualified and in fact an expert in my field. But they simply couldn't grant me privileges, even though they had no doubt about my competency.

I also tried to get privileges at the other hospital within the distance required by Missouri's law, but it required that I identify a backup provider with privileges. Clinic staff reached out to all the physicians they knew with privileges, but not one was willing to be my backup because hostility to abortion and retaliation against abortion is so pervasive in Missouri that they couldn't bear the risks of coming forward.

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As illustrated by the accounts in this brief, physicians don't, as the Fifth Circuit said, "largely s[it] on their hands" when it comes to satisfying states' medically unnecessary admitting privileges requirement. Pet. App. 41a. They actively pursue privileges. And their inability to obtain (or maintain) them has nothing to do with their good faith or their competency. Instead, factors entirely out of their control—namely, prerequisites that are not relevant to patient care, or hostility to abortion—can doom them to failure, no matter how hard they try. Nothing about this counterproductive exercise is "reasonably related to maternal health." *Roe*, 410 U.S. at 164.

Amicus Planned Parenthood knows all too well that Louisiana is not motivated by patient health. A Planned Parenthood affiliate has built a state-of-the-art facility in New Orleans to provide abortion care to patients in Louisiana, but the state has unconstitutionally refused—for three years running—to even act on its application for a license. *See Planned Parenthood Gulf Coast, Inc. v. Gee*, No. 18-176, slip op. at 4, 20-21 (M.D. La. May 23, 2018). Louisiana's intransigence is motivated solely by its desire to block access to abortion care.

The same is true of Act 620's admitting privileges requirement. Amici's experience confirms that admitting privileges laws play no meaningful role in ensuring that providers are qualified or in protecting patient health. All these laws do is shut out competent providers and deny patients the care they need.

Andrea Ferrigno, the corporate vice president of Whole Woman's Health, has seen firsthand the toll admitting privileges laws take:

> When Texas's law went into effect, our clinics shut down because our doctors could not get privileges, even though we tried our hardest. We had patients saying to us, "I'm here, I want this procedure, why can't you do it?" And we had to tell them there was nothing we could do. For those patients who could not travel to get an abortion elsewhere, their lives were completely changed. And even those who could travel were hurt in irreparable ways. These laws prevent and delay our patients from getting the care that they need. The despair and humiliation from that never goes away.

CONCLUSION

For these reasons, the decision of the court of appeals should be reversed.

Respectfully submitted,

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