Nos. 18-1323 and 18-1460

In The Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., on Behalf of Its Patients, Physicians, and Staff, d/b/a HOPE MEDICAL GROUP FOR WOMEN; JOHN DOE 1; JOHN DOE 2,

Petitioners-Cross-Respondents,

v.

DR. REBEKAH GEE, in Her Official Capacity as Secretary of the Louisiana Department of Health and Hospitals,

Respondent-Cross-Petitioner.

On Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF *AMICI CURIAE* HOLLY ALVARADO, RANA BARAR, JULIE BINDEMAN, DANIELLE CAMPOAMOR, AISLINN CANARR, J.C., STEPHANIE GOODELL, AMY IRVIN, AMBER KEPPERLING, KIMBERLY O'BRIEN AND AMANDA WILLIAMS IN SUPPORT OF PETITIONERS-CROSS-RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici curiae are women who have had abortions. They believe the deeply personal stories of their abortions, and of the dedicated support of their physicians who have given effect to their right to abortion in the face of enormous barriers to the women's own assertion of that right, are representative of countless women throughout this country.[1]

It is estimated that one in four American women have had or will have an abortion. The continuing, sometimes violent debate over abortion has led many to fear even to mention their abortions, let alone to bring a lawsuit to vindicate their constitutional rights. These women are proud members of our communities whose liberty the Constitution protects. They are our loved ones, our mothers, our wives, our daughters, our co-workers, our neighbors, and our friends from all walks of life. But the right of women to have an abortion is threatened by the Fifth Circuit's decision below and by Louisiana's untimely argument to disregard long-settled rules of standing.

Amici strongly believe their right to access an abortion, and to have their physicians assert that right against governmental interference, as in La. Rev. Stat. § 40:1061.10 ("Act 620"), is crucial to their and every

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[1] The parties gave written consent to file this brief. No party or party's counsel authored this brief in whole or in part or made a monetary contribution to fund its preparation or submission. No one other than *amici* and their counsel made a monetary contribution to its preparation or submission.

woman's ability to define her existence, determine her future, achieve her dreams and aspirations, and be an equal participant in our society. It is a key component of the constitutional right to liberty, and central to a woman's autonomy, dignity, and decisions concerning her family. *Amici*'s exercise of this fundamental liberty, with the vital assistance of their providers, has enabled them to set the direction of their lives. It has allowed *amici* to have children, if they chose to do so, when they were able to provide a safe and supportive home.

Amici submit this brief in support of Petitioners-Cross-Respondents ("Petitioners"), the reversal of the Fifth Circuit's decision, and every woman's right to choose an abortion without undue burdens on her ability to effectuate her choice. This Court should strike down Act 620, which is identical to the Texas law this Court found unconstitutional in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). Act 620 was proposed because of that Texas statute's "tremendous success in closing abortion clinics and restricting abortion access in Texas." J.A. 586. The restrictions in Act 620 would close all but one of Louisiana's abortion clinics and leave just one doctor able to provide abortion care in the entire state. But the restrictions are unnecessary to the claimed purpose of safeguarding women's health. Women's fundamental liberty rights, and principles of standing and *stare decisis*, should not be undone merely because the composition of the Court has changed.

SUMMARY OF ARGUMENT

Access to abortion, generally provided by dedicated clinics and physicians, enables women to make choices central to their personal dignity and autonomy, and to define their own concept of existence.

Point I addresses this Court's recognition that the right to abortion is a fundamental liberty protected by the Constitution. This Court has explained that the ability of women to participate equally in the social and economic life of this nation is facilitated by their ability to control their reproductive lives. It has rejected historical generalizations about "typically female 'tendencies' " or the "inherent" nature of women as a basis for "constraints on an individual's opportunity." *United States v. Virginia*, 518 U.S. 515, 533, 541 (1996).

Point II presents *amici*'s own stories, including their profound relief and gratitude for their ability to terminate a pregnancy they could not or did not wish to carry to term. *Amici* are conscientious, moral, and caring people. They are valued members of communities large and small which have benefitted from *amici*'s fulfillment of their aspirations. *Amici* have deeply valued their ability to take necessary steps to save their lives, to address severe lethal fetal anomalies, to choose to pursue their life's work, or to decide when they were ready to have children.

Point III addresses the critical nature of long-recognized principles of standing to the enforcement of the constitutional right to abortion. There are

enormous hindrances to a woman vindicating her right to abortion in court. A woman making an abortion decision must pursue an often difficult process to obtain access, sometimes complicated by risks to her own life or severe fetal anomalies. She may be fearful of loss of privacy, and retaliation, which could affect her family and employment. Most do not have the resources to devote years, continuing long after their pregnancies, to litigating against government lawyers funded by taxpayer dollars. Physicians who have dedicated their practices to providing safe, respectful reproductive health care to patients, including *amici*, are best positioned to endure years of litigation. There is no conflict of interest over admitting privileges because complications are rare and when they arise, women are admitted to the hospital regardless of whether their provider had admitting privileges there.

ARGUMENT

I. ACCESS TO ABORTION IS A FUNDAMENTAL LIBERTY PROTECTED BY THE CONSTITUTION

Just three years ago, in *Whole Woman's Health*, this Court reaffirmed the importance of safeguarding women's access to abortion providers from "'[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion.'" 136 S. Ct. at 2309 (quoting *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 878 (1992)). The Court concluded that an admitting privileges

requirement identical to Act 620 is an unconstitutional undue burden because it does not "confer[] medical benefits sufficient to justify the burdens upon access" it imposes. *Id*. at 2300.

This Court's landmark decision in *Roe v. Wade*, 410 U.S. 113 (1973), recognized that the right to abortion is a fundamental liberty protected by the Constitution. This holding is grounded on precedent respecting "bodily integrity" and "liberty in defining the capacity of women to act in society, and to make reproductive decisions." *Casey*, 505 U.S. at 857, 860. *Roe* rejected persistent stereotypes about women's ability to make decisions about their reproductive lives. It acknowledged that "maternity, or additional offspring, may force upon the woman a distressful life and future." 410 U.S. at 153.

As this Court later explained in *Casey*, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." 505 U.S. at 856.

> [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.
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> * * *
>
> Her suffering is too intimate and personal for the State to insist, without more, upon its own

> vision of the woman's role, however dominant that vision has been in the course of our history and our culture.

Id. at 852.

This Court has recognized that neither the Justices of the Court, nor theologians, nor Americans as a whole agree on the spiritual implications of abortion, or when life begins. In these circumstances, it is the responsibility and prerogative of human dignity to rely on one's conscience in deciding whether to have an abortion. *Id.* at 850-51. "The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Id.* at 852. The "Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood." *Id.* at 849.

Since *Casey*, this Court has reiterated that an individual's right to "shape [her] destiny" encompasses the right to personal choice regarding reproduction, marriage, and the safeguarding and stability of existing and future children, families, and relationships. Such personal choices are "central to individual dignity and autonomy." *Obergefell v. Hodges*, 135 S. Ct. 2584, 2594, 2599-600 (2015). Protecting women's right to make these choices "vindicate[s] precepts of liberty and equality." *Id.* at 2603-04.

The factual and legal predicates for this liberty interest are no less urgent or compelling today. The Constitution guarantees that a woman not be deprived of her right to control her reproductive life, shape her

destiny, and make the most intimate and personal choice of whether to carry a pregnancy to term. Her ability to access abortion cannot be unduly burdened by State law.

II. ACCESS TO ABORTION IS ESSENTIAL FOR WOMEN TO BE EQUAL PARTICIPANTS IN SOCIETY

Amici are grateful that they were able to access an abortion, and that clinics and physicians have asserted their rights. They have come forward so that women who choose abortion and depend on the advocacy of clinics and physicians are not strangers to the Court.

A. Holly Alvarado

Holly's single mother raised her to be grateful for the opportunities this country provides. The September 11, 2001 attacks inspired her to want to serve and defend this country. Five years later, at 19, she enlisted in the Air Force. Holly was tough and respected. In early 2009, she received deployment orders to Iraq. She was eager to join the fight.

Two weeks before deploying, however, while stationed in North Dakota, Holly felt a wave of nausea, and realized she was pregnant. She knew she would be unable to deploy if she did not have an abortion. Holly panicked, because she also knew the military would not provide the abortion.

Holly called North Dakota's only abortion clinic. But it could not treat her before her deployment. It referred her to a clinic 325 miles away, in St. Paul, Minnesota. That clinic could not see her for three days. Holly had to drive five hours to get there. When she arrived, she was greeted by angry protestors, who taunted and condemned her. Holly was astonished, because she knew none of the protestors would help her if the child was born. A clinic escort led her inside, and comforted her. The clinic explained her options, including to pursue adoption or get child support.

Minnesota law required a 24-hour waiting period before Holly could have the abortion. But the clinic's first opening was another three days away. Holly did not have enough money for a room or a hot meal. She had to sleep in her car for the three nights, eating saltines and drinking Gatorade.

When Holly returned to the clinic, the staff treated her with respect and compassion. She feels strongly that it was not important whether her doctor had admitting privileges. Because Holly's military insurance did not cover the abortion, she maxed out her credit card to pay for it and put the rest on her debit card, nearly exhausting her savings. After buying gas for her 325-mile drive back to North Dakota, Holly had $15 left.

Despite that, Holly remembers feeling a massive weight had been lifted off her shoulders. She believes the care she received may have saved her life, because

if it was not available she would have tried to end the pregnancy on her own.

Three days later, Holly was sent to Texas for predeployment training. She spent most of the next year in Afghanistan (instead of Iraq), working in the Joint Defense Operation Command, which secured American bases and investigated mortar attacks. On the advice of a colleague, Holly kept her abortion secret. After maintaining that silence for years, because of her concern about the reaction, Holly now talks freely about her experience, to save other women from the burden of feeling shame or alone. Holly has earned a degree in public health, met her husband, and works in organ donation supporting families making end of life decisions.

B. Rana Barar

In 2015, when Rana learned she was pregnant for the third time, she was 40 and had two children. She and her husband had not planned to have more children. He had scheduled his vasectomy.

Rana decided to have an abortion. Her husband supported her. The children they already loved were their priority. Rana knew her 10-year-old daughter would need a lot of attention in middle school, because she had learning challenges. Rana's son was a high school freshman. She wanted to have time for him during his last years at home.

Rana lived in California, which has relatively few burdens on abortion access. But she faced obstacles her husband did not have for his vasectomy, even though the vasectomy permanently ends fertility and has a longer recovery period.

Rana was not concerned whether her doctor had admitting privileges. Rana had spent years studying abortion care and interviewed more than 1,000 women. Not one raised admitting privileges as a matter of concern. Rana knew that admitting privileges are not necessary to assure the health and safety of the women. Vacuum aspiration is a simple procedure that is used routinely for miscarriage management as well as abortions.

Rana's abortion was performed in her doctor's office. The recovery was easy. She and her husband ran errands on the way home.

Rana believes laws that restrict women's access to abortion are demeaning and disempowering. She thinks laws making abortion more difficult maintain misogynistic and paternalistic ideas about women's role in society.

Her experience in abortion research has convinced her that clinics and doctors are ideal litigants to challenge abortion restrictions because of their intimate knowledge of what abortion patients go through and what they need and want.

C. Julie Bindeman

Julie, a clinical psychologist, grew up in Washington, D.C. She earned her undergraduate degree from Bard College and her doctoral degree from George Washington University.

Julie and her husband wanted two or three children. They were delighted when she gave birth to their son. In 2009, when Julie arrived at the second trimester of her second pregnancy, she began informing people and making plans for the arrival of another child. But her 20-week anatomy scan revealed a severe problem with the fetus's brain formation. The maternal fetal medicine specialist and several other professionals explained there was a significant possibility the fetus would not survive to term. In the best-case scenario, the baby would never exceed the development of a two-month-old with no ability to walk, crawl, or communicate.

After much deliberation with their doctors, family members and Rabbi, Julie and her husband decided to terminate the pregnancy. Julie wanted an in-clinic surgical abortion, but it was not available in Washington, D.C., where she lived. Dr. George Tiller, the medical director of a women's health clinic in Kansas that provided abortions, had recently been murdered. Doctors in the Washington, D.C. area, fearing for their own lives, suspended their abortion practices for women more than 20 weeks pregnant.

Julie considered traveling to New Jersey, but it would have been difficult to make last minute travel

and childcare arrangements. She was also afraid of travelling to another state where she knew no one and had no support system if there were complications.

The only way to have an abortion locally was to have an induction abortion, which requires terminating the pregnancy and then labor and delivery. That was not the abortion procedure Julie felt was best for her. Instead of a short outpatient procedure, Julie had to spend several days at a hospital. She had to endure the physical and emotional pain of the very traumatic experience of labor and delivery for a fetus that could not survive.

A few months later, Julie became pregnant again. At 18 weeks, doctors noticed the same developmental problems in the fetus's brain. Julie and her husband decided to terminate the pregnancy. This time, Julie was able to have a surgical abortion locally because she had been pregnant for less than 20 weeks. Her doctor scheduled the procedure quickly. Julie was discharged the same day. Julie could not have handled bringing a lawsuit to obtain an abortion had that been necessary while enduring the devastation and heartbreak of the severe fetal anomaly.

Julie believes that if she carried either of these pregnancies to term, the stress of caring for the child—if it survived—would have forced her to become socially isolated, put a strain on her marriage, and made her oldest child suffer. She thinks the government and the courts should not intrude on her very personal decisions, and could not possibly know what is best for

her. Julie subsequently carried two pregnancies to term and delivered two healthy children.

Julie believes her doctors provided compassionate expert care when she terminated her pregnancies, and made her best interests their priority. She remembers feeling inspired and comforted when one of her doctors told her she was making the right decision. Another doctor, a practicing Catholic, attended her induced labor and delivery with compassion and care, and was able to see this was the right choice for her patient, even if it might differ from her personal beliefs.

D. Danielle Campoamor

Danielle Campoamor, a mother of two, is an editor and writer about women's reproductive health, mental health, and domestic violence. She was raised in a religious family in Anchorage, Alaska. Her father was active in the church where she attended Sunday school. She was taught to be anti-abortion, at home and at school.

But Danielle's devout father violently abused his wife and children. After a particularly savage beating, when their pastor's only advice to Danielle's mother was to pray, Danielle left the church.

When Danielle became pregnant unexpectedly in 2011, she reflected on her relationship with her boyfriend. He never hit her, but he was verbally abusive and their relationship had grown toxic. She knew this was not a healthy environment in which to raise a

child. And her boyfriend made it clear he was not interested in being a parent with her.

Because Danielle lived in Washington, a state with few abortion restrictions, and had a job that did not penalize her for taking a day off, and a car and health insurance, she was free from the burdens that many other women face. Her physician put her in control of the process, asking whether she wanted to look at the ultrasound and confirming she wanted to go through with the abortion. But she was in no position to bring a lawsuit had she needed to do so to safeguard the right to an abortion.

The hardest part of the process came months later, when Danielle started informing friends and family members. Her father said she was a whore and a monster. Others called her a murderer, and told her she was going to hell. Devastated, Danielle fell into a depression. She began to drink. With the help of a therapist, she eventually got past the feelings of shame caused by the negative reactions to her abortion.

Now, almost a decade later, Danielle is raising two happy, healthy children with a loving, supportive partner. She believes this would not have been possible had she been forced to carry her first pregnancy to term.

Danielle never cared whether her doctor had admitting privileges at a local hospital and would not want anyone to claim she felt differently. She believes doctors who work in reproductive health feel the call to do that work, despite the physical and verbal attacks on some providers, because they want to help

women. She is grateful to the doctors and clinics who pursue challenges to burdensome and unnecessary abortion restrictions.

E. Aislinn Canarr

Aislinn Canarr got pregnant unexpectedly in September 2001, just before her sophomore year at Wheaton College. She was not in a serious relationship. Raised by a single mother, she knew immediately she wanted an abortion. She did not have the emotional stability she felt was needed to raise a child. And having a child at that time would have prevented her from continuing her education.

Aislinn feels lucky she had a supportive family, lived in a state with minimal restrictions on abortion, and was referred to a Planned Parenthood clinic not far from her college.

Aislinn was not ashamed to get an abortion. She told her family she was pregnant as soon as she found out. Although her family supported her decision, she would not have had the resources to sue the State had that been required to obtain an abortion.

Aislinn eventually married the man with whom she got pregnant. But she believes their relationship would not have continued had she not had the abortion. Ten years after the abortion, they had a son together.

Aislinn is confident the abortion was the right decision for her. It allowed her to finish school, mature,

enter a long-term relationship, achieve financial stability, recover from addiction, and become a mother when she was able to be the parent she wanted to be.

Aislinn deplores Act 620 and similar legislation because they are not medically necessary, and treat women as if they cannot make decisions for themselves. Aislinn's primary concerns in choosing an abortion provider were proximity and timeliness. She was not concerned whether her trained, credentialed physician had admitting privileges at a nearby hospital. Aislinn believes clinics and doctors are better-positioned than she is to challenge such non-medically based laws. Doctors and clinics have far more knowledge about the impact of such laws, having seen thousands of patients in her situation, and are able to represent the collective voice of women seeking abortions.

F. J.C.

J.C. grew up in Washington. She earned a medical degree from Tulane University School of Medicine, is presently a fourth-year resident in obstetrics and gynecology at the University of Hawaii, and will soon start a fellowship in family planning at the University of Washington.

In 2012, during her first year at medical school, J.C. discovered she was pregnant. She knew that if she remained pregnant, she could not continue medical school and achieve her professional goals.

When J.C. called to make an appointment at a clinic, however, she learned about Louisiana's mandatory waiting period, which required her to make two in-person appointments at least 24 hours apart before she could have the medication abortion. This was challenging, because she was a full-time medical student and had to miss class twice during a busy time when exams were approaching. J.C. was also surprised and disappointed to learn her insurance would not cover the abortion. Her boyfriend, now husband, paid for it. Had he not done so, it would have been difficult for her to raise the funds she needed. She did not have her own income and did not want to involve her family.

The clinic took excellent care of J.C. She had never felt such compassion in a healthcare setting before. This experience changed her life. She became deeply involved with local organizations to ensure abortion access remained a reality.

J.C. did not ask whether her doctor had admitting privileges at a nearby hospital. As a medical student, she knew it was unnecessary and irrelevant to providing safe abortion care.

J.C. remembers waking up on the morning after her abortion with an overwhelming sense of relief and gratitude. She was relieved she would be able to plan her life and make her own decisions about her future. But she felt she could not share her abortion experience with anyone at her medical school, because of the stigma surrounding family planning and abortion. In her four years at medical school there was only one

lecture that even mentioned family planning or contraceptives.

As an obstetrics and gynecology physician, J.C. can attest that every abortion provider she has worked with prioritizes the patient's health and best interests. She knows that abortion providers take their special relationships with their patients very seriously and feel a calling to provide women with the best possible care. Ever since her own abortion experience, her goal has been to provide compassionate care and make sure that all patients have autonomy over their own bodies.

G. Stephanie Goodell

Stephanie feels lucky to have lived in a state that places few burdens on a woman's access to abortion. In her case, it made the difference between life and death.

Stephanie grew up in Virginia and Florida, went to school in North Carolina and Tennessee, and eventually settled in Massachusetts where she started trying to get pregnant at 39, shortly after she got married. She was still not pregnant when, at 42, she started going through early menopause. Her doctor advised her to find an egg donor. Around the same time, Stephanie divorced, but she stayed on the path to motherhood. She got pregnant twice, and had an early miscarriage both times. In 2017, she became pregnant for a third time and made it to 21.5 weeks. Then her water broke. Her doctor sent her to the hospital.

Stephanie was given her options: she could have an abortion or they could induce labor. The doctors explained there was little chance that labor would produce a healthy baby. Still, after eight years of trying to conceive, Stephanie was determined to hold her child at least once. She asked the doctors to induce.

Stephanie was in labor for three days when she began passing in and out of consciousness. Her vitals were plummeting. Her body was failing her. Finally, her doctors told her if they did not perform an abortion soon, she would not survive. Stephanie agreed and was rushed to an operating room.

As she recovered from the abortion, Stephanie continued to feel weak. Although she wanted to go home, doctors urged her to stay in the hospital. They ran tests and learned she had an infection. She took antibiotics, but her condition continued to deteriorate. The doctors told her the only way to survive would be to have a hysterectomy.

A post-operation biopsy revealed Stephanie had Placenta Accreta—her placenta had become deeply imbedded in her uterine wall. This serious, life-threatening disorder likely would have caused significant hemorrhaging had her labor continued. Had Stephanie been unable to get an abortion, her pregnancy would likely have killed her. Had she needed to sue to obtain the abortion, there is no way she could have done it.

Stephanie is deeply grateful to the more than 50 doctors, nurses, anesthesiologists, patient care

technicians and other hospital staff who cared for her. After she recovered, she went to work in the hospital's development office, which raises money to enable the hospital to continue to provide the high quality care she received.

H. Amy Irvin

Amy is intimately familiar with the way abortion access has changed over the last 20 years. When she had her first abortion in 1992, as a 21-year-old University of Cincinnati student, Ohio had few restrictions. When she had a second abortion 20 years later in Louisiana, she was shocked by the intrusive and burdensome requirements now placed on women seeking abortion, and appalled by the overcrowding it caused at the clinic where she was a patient.

Although Amy used a birth control pill in high school, she did not have the money to pay for it when she went to college. Amy held a part-time job and used most of her income to pay rent and buy art supplies for class. Like many college students without financial support from her family, Amy lived hand-to-mouth; she once went to a soup kitchen to feed herself. When Amy learned she was pregnant during an internship in Atlanta, Georgia, she knew immediately she needed an abortion. Raised by a single mother who worked multiple jobs to provide for the family, Amy wanted to finish college, have a career, and not repeat a childhood where her family worried about buying groceries or paying bills. Amy had no one in Atlanta to confide in

and felt strongly she should inform the father she was pregnant and wanted an abortion. So she returned to Ohio.

The journey was traumatizing. Amy ran out of money and gas somewhere in Kentucky, and had to ask a gas station attendant for money for gas to get to Cincinnati. She promised to pay for it on her return trip.

Amy did not inform her family or her college roommates she was pregnant. She had graduated third in her high school class, and was the first person in her family to go to college. She felt ashamed of how desperate her situation had become, and believed an unplanned pregnancy was inconsistent with expectations of her.

After informing the father, who already had a child and did not want another, Amy went back to Atlanta to resume her internship. Then she returned to Cincinnati for the abortion, because it was critical to her that she be at home in familiar surroundings and near her support network.

Amy paid for the abortion herself. She does not remember how she scraped the money together. Her mother would not have had it to give, and she would never have asked her father.

In 2012, Amy unexpectedly became pregnant for a second time. This time, she had finished her education, had a career, had been married and divorced, and was not struggling financially. But she decided that because the father struggled with substance abuse, she

was not prepared to be involved with him for the rest of her life. And having seen how difficult it was for her mother to be a single mother, she was not prepared to do that. The father, a regular churchgoer, was conflicted and ashamed, but supported her decision.

Amy's second abortion in New Orleans was different from her first. She lived across town from the clinic and had the support of nearby friends. She was able to have a medical abortion. But she was required to make two in-person appointments to satisfy a mandatory waiting period, and undergo a mandatory scripted ultrasound that Amy found so intrusive that she has tried to block it from memory. And the abortion clinic was so overcrowded, due to patients from Baton Rouge being redirected to New Orleans after their local clinic temporarily stopped seeing patients, that she had to wait all day to be seen. Hearing the women in the waiting room describe their long trips to get there, and concerns about how they were going to return home, brought back memories of Amy's first abortion. Amy's experience led her to work in abortion advocacy to help low-income women in Louisiana access abortions.

Amy believes doctors are best positioned to bring lawsuits challenging unnecessary regulations that restrict abortion access. Litigation is costly, time-consuming, and public, and she has never been in a position to bring such a lawsuit herself. In her experience, abortion providers are committed to the well-being of the women they serve. Many are old enough to retire but do not because they consider their work to be so important.

I. Amber Kepperling

Amber is a married mother of a four-month-old son. When she became pregnant for the first time in 2016, she learned after 19 weeks that the fetus she was carrying had skeletal dysplasia and osteogenesis imperfecta, conditions that are incompatible with life.

Amber did not know Indiana barred abortions after 20 weeks. It would not have mattered. On the day the diagnosis was confirmed by a genetic specialist, Governor Pence signed a bill that prohibited abortions due to any fetal anomaly at any time. Amber's doctors expected an imminent miscarriage and advised waiting.

At 22 weeks, Amber began to leak amniotic fluid. Fearing an infection, she and her doctors started looking for ways to terminate the pregnancy. Amber and her husband wanted to induce labor so she could hold her baby, at least for a short time.

Because Indiana law did not permit abortion in Amber's circumstances, she contacted Northwestern Hospital in Illinois. They told her they would only perform a dilation and evacuation ("D&E"). The D&E was not covered by insurance. It would cost about $7,000; half had to be paid in advance. Amber and her husband did not have that.

While they were trying to decide what to do, additional testing revealed that Amber's amniotic sac had ruptured. Her doctor informed her this serious condition could be grounds for an emergency abortion in

Indiana. He would ask the ethics board, but only after the holiday weekend.

While they waited, Amber began to bleed, increasing the already high risk of infection, as well as death. Amber's doctor decided she needed an emergency C-section, which carried a higher risk of infertility than an induction or a D&E.

Amber cannot understand why Indiana law put her life and ability to bear children at risk. Fighting for her life, she was in no position to challenge those restrictions.

J. Kimberly O'Brien

Kimberly grew up in a conservative Catholic home in Louisiana. Like everyone she knew, she was opposed to abortion. She never imagined she would choose to have an abortion, until she learned the fetus she was carrying had multiple brain malformations.

When Kimberly was a law student at Tulane University, she met her husband, a student in Tulane's medical school. After his residency, they had a daughter.

Kimberly and her husband wanted a second child. In 2011, with the help of a fertility doctor, she became pregnant. During the 20-week anatomy scan, however, her doctor discovered the fetus had Dandy-Walker Syndrome, a congenital brain malformation. Kimberly was extremely upset. She sought second, third and fourth opinions. They all confirmed the initial diagnosis.

Kimberly remained determined to have the baby. Relying on her husband's professional network, they solicited as much information and guidance as they could. During additional medical testing, the fetus was diagnosed with another brain defect, agenesis of the corpus callosum. Her physicians agreed that even if the baby survived birth it would suffer severe disabilities. After many discussions, and with the support of her husband, Kimberly decided to have an abortion.

Kimberly's primary doctor explained she had the option of abortion or carrying to term. However, at 21 weeks, her time to end the pregnancy was running out. The doctor explained he was unable to perform the procedure because most New Orleans hospitals do not allow an abortion after 20 weeks. Another doctor suggested she go to a local clinic. Kimberly, already traumatized by the fetal anomalies, felt sick when she imagined having to endure the abuse from the aggressive protesters she saw every time she passed the clinic.

Aware her options were dwindling, Kimberly and her husband again tapped into his professional network. The closest provider they could find was a hospital in Houston, Texas, 350 miles away. They left their daughter with Kimberly's parents and drove the six hours together.

Kimberly's doctors in Houston were compassionate and supportive, but they were bound by Texas law to require Kimberly to listen to the fetal heartbeat and provide information about alternatives to abortion.

Kimberly was also required to make arrangements for the fetal remains. None of this served a medical purpose; Kimberly knew the true purpose was to shame and pressure her into changing her mind.

After Kimberly had been dilated, she learned the hospital's board had just decided, unbeknownst to the Obstetrics Department, to prohibit abortions at her stage of pregnancy unless her life was in danger. So Kimberly had to be wheeled out of the hospital to a clinic where a doctor could induce fetal demise, and then wheeled back to the hospital to complete the procedure.

Kimberly would make the same choice again. She believes it was the best course for her family, including her older daughter and second daughter she had a year later. The experience has opened her eyes to the reality of the difficult reproductive choices women have to make. She also realizes how fortunate she was compared to the many women who seek an abortion but do not have the means to travel, find childcare, or perform extensive research.

As a lawyer, Kimberly was better positioned than most pregnant women to challenge the legal obstacles to abortion care in court. But she knew that was not feasible. She was devastated, she needed the abortion immediately, and her days were consumed with tests, consultations, and research. She could not imagine the loss of privacy had she become a plaintiff and did not feel strong enough at that time to stand the abuse she would receive in a public legal battle. Kimberly

believes that doctors and clinics can bring challenges to these laws.

K. Amanda Williams

Amanda was a full-time college student at the University of Houston, working two part-time jobs, when she learned she was pregnant in 2009. She was living paycheck-to-paycheck, paying her rent with tips from waitressing. She had plans for her education and professional life she could not have pursued as a single parent. And she was in an unhealthy relationship with a partner who had severe mental health problems. The relationship ended immediately. A few years later, Amanda learned he committed suicide.

Amanda knew an abortion was the right decision for her. Had she remained pregnant, she would not have finished school. She would have brought a child into an unstable environment with one parent and few resources.

Amanda did not have the money to pay for the abortion. The stigma and shame of an abortion, especially in Texas, left Amanda feeling isolated and afraid to share her decision with others or ask her family for money. Amanda's partner eventually managed to borrow enough to pay for the abortion. She does not know how she would otherwise have paid. Amanda was a volunteer patient escort at a women's clinic in Houston, but she chose not to have her abortion there because she did not want anyone to know about it.

The staff and doctors at the clinic where she had her abortion were extremely patient and kind. No one pressured her to have the abortion. Amanda does not know whether the doctor had admitting privileges at a nearby hospital. It did not matter. She is grateful that many of the restrictions on abortion access that exist today, and deny women the dignity and compassion they deserve, did not exist at the time of her abortion.

Amanda now has a Master's degree in Social Work. She is Executive Director of the Lilith Fund, which supports women's right to make their own reproductive choices and helps women pay for abortions they cannot afford. The Fund is presently challenging Texas abortion regulations. As a full-time student with two jobs, no money, and a limited support network, Amanda cannot imagine having been able to bring a lawsuit herself.

III. *AMICI*'S EXPERIENCES DEMONSTRATE THAT LONG-SETTLED RULES OF STANDING ARE VITAL TO PROTECT THE FUNDAMENTAL RIGHT TO ABORTION.

Louisiana urges the Court to find that clinics and doctors do not have standing to challenge abortion restrictions, particularly when the restrictions purport to be "health and safety regulations." Conditional Cross-Petition at 17-21. As *amici*'s stories illustrate, Louisiana's effort to undo more than four decades of precedent, belatedly raised for the first time in its cross-petition for certiorari, lacks merit.

In *Singleton v. Wulff*, the Court held "it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision." 428 U.S. 106, 118 (1976). The Court found the relationship between an abortion provider and a woman seeking an abortion is "patent[ly]" close because "the physician is intimately involved" in the exercise of that right. *Id.* at 117. Patients face obstacles to litigation that, while "not insurmountable," are sufficient to satisfy the purpose of the exception to the general prudential rule. *Id*. The Court explained that patients are hindered from vindicating their rights because of concerns about privacy and stigma, and the imminent mootness associated with pregnancy.

Just three years ago, in *Whole Woman's Health*, the Court allowed "a group of abortion providers" to assert patients' rights to abortion. 136 S. Ct. at 2301. In fact, as Justice Thomas acknowledged in his dissent, this Court has uniformly "accepted doctors' and clinics' vicarious assertion of the constitutional rights of hypothetical patients." *Id.* at 2323.[2]

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[2] *See, e.g.*, *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 62 (1976) (physicians "clearly have standing" to challenge abortion law provision that required parental and spousal consent); *Webster v. Reprod. Health Servs*., 492 U.S. 490, 501 (1989) (addressing constitutional challenge to abortion restrictions brought by "five health professionals employed by the State and two nonprofit corporations" that provided abortions); *Hodgson v. Minnesota*, 497 U.S. 417, 429 (1990) (addressing constitutional challenge to parental notification law brought by doctors, clinics, pregnant minors, and the mother of a pregnant minor); *Casey*, 505 U.S. at 845

A. Abortion Providers Have a Close Relationship With Their Patients

Amici's stories demonstrate the enduring validity of the Court's holding in *Singleton* that physicians have a "patent[ly]" "close" relationship because they are "intimately involved" in the exercise of the right to abortion. 428 U.S. at 118. Ignoring this settled law and fact, Louisiana argues abortion providers do not have a "close" relationship with their patients because the "clinic is only a business" and the "doctors perform very brief procedures on drugged patients whom they never saw before and will never see again." Conditional Cross-Petition at 29. That is incorrect.

First, the Court has "uniformly permitted" businesses to assert the rights of those who, like *amici*, "seek access to their market or function." *Carey v. Population Servs., Int'l*, 431 U.S. 678, 684 (1977) (quoting *Craig v. Boren*, 429 U.S. 190, 195 (1976)) (collecting cases and holding that mail-order distributors of contraceptives had standing to assert the rights of potential customers).

(addressing constitutional challenge to abortion restrictions brought by "five abortion clinics and one physician representing himself as well as a class of physicians who provide abortion services"); *Stenberg v. Carhart*, 530 U.S. 914, 922 (2000) (addressing challenge to abortion restrictions brought by a physician); *Gonzales v. Carhart*, 550 U.S. 124, 133 (2007) (addressing challenge to abortion restrictions in consolidated cases, one brought by four physicians and the other by Planned Parenthood and the City of San Francisco).

Second, contrary to Louisiana's assertion, *amici*'s stories show that patients make informed decisions about abortion and are not "drugged" when they see their providers. In fact, the district court found "[m]edication abortion requires no anesthesia or sedation" and "[v]irtually all surgical abortions require only mild or moderate sedation and/or local anesthesia." *June Med. Servs. LLC v. Kliebert*, 250 F. Supp. 3d 27, 61-62 (M.D. La. 2017).[3] *Amici* were not drugged when they saw their doctors, and many of them saw their doctors more than once. Furthermore, Louisiana ignores its own delay law, which requires at least two visits to physicians.

Thousands of women have trusted Petitioners and sought their care. Petitioners have endured "violence, threats of violence, harassment and danger" to help their patients. *Id.* at 51-53. Their vital work gives them insight into the broad range of experiences, desires, and concerns of women who seek abortions, and makes them eminently suitable and powerful defenders of their patients' rights.

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[3] In 2017, approximately 39% of abortions were medication abortions. Rachel K. Jones et al., Guttmacher Institute, *Abortion Incidence and Service Availability in the United States*, 2017 (2019), available at https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017.

B. *Amici* Were Hindered From Bringing Lawsuits to Assert Their Fundamental Right to Abortion

The Court has recognized that women who seek abortions face genuine obstacles to challenge abortion regulations.

First, many women seek abortions because of financial pressure or other demands that would make parenting or having an additional child difficult. They cannot afford the time and expense of litigation, let alone hire lawyers, address case strategy, or attend depositions and court hearings. Holly Alvarado would have found it impossible to litigate an abortion restriction while patrolling military bases in Afghanistan. Rana Barar terminated her pregnancy so she could dedicate more time to her children; challenging an abortion restriction would not have been possible. Amanda Williams, J.C. and Aislinn Canarr had abortions when they were students. None of them had the time or resources to pursue a case through the courts.

Second, many women, like Holly Alvarado and J.C., feel tremendous relief when the abortion is complete. They could not contemplate filing a lawsuit while pregnant, and seeking abortion care, and "possess[ed] little incentive to set in motion the arduous process needed to vindicate [their] own rights." *Powers v. Ohio*, 499 U.S. 400, 415 (1991).

Third, women's legitimate privacy and safety concerns pose a strong hindrance. Danielle Campoamor, who was verbally attacked when she revealed her

abortion, would have faced even more abuse had she been the plaintiff in an abortion rights case.

Fourth, women whose lives are in danger or face severe fetal anomalies are in no position to litigate. Julie Bindeman, Stephanie Goodell, and Amber Kepperling could not have initiated litigation while making complicated medical decisions, struggling to find a provider, and facing serious time constraints.

Women who have to confront undue burdens to obtain abortions should be able to rely on the doctors, who understand the burdens, to vindicate their rights.

C. *Amici* Strongly Believe the Providers Are Not Conflicted and Represent Their Patients' Interests in Ensuring Access to Compassionate, Respectful Abortion Care

Louisiana's argument that Petitioners have a conflict of interest with their patients is also mistaken. There is no conflict between doctors and patients on the issue of admitting privileges because the policy does not benefit patients; in the rare instances when complications occur, emergency rooms treat patients regardless of whether their doctors have privileges. Regulations, like Act 620, that impose unnecessary limits on doctors' ability to perform abortions, hurt women who seek to exercise their abortion rights. This Court has already held in *Whole Woman's Health* that "there was no significant health-related problem" that Texas's admitting privileges law "helped to cure." 136 S. Ct. at 2311. Louisiana's argument that its identical

Act 620 would benefit women is equally baseless. The opposite is true. By leaving Louisiana with only a single abortion provider, the law would make it even more difficult for women to access abortion.

Amber Kepperling was unable to get the procedure her doctors recommended because of the abortion restrictions in her native Indiana. Instead, she was forced into a dangerous emergency C-section. Her conflict of interest was not with her doctors, but with the legislators who unduly burdened her choices.

Julie Bindeman could not receive the care she needed because there are so few abortion providers, and some physicians suspended abortion care for women more than 20 weeks pregnant after a fellow provider was murdered for providing abortions. Her conflict was not with her doctors.

Holly Alvarado, who lived in a state with only one clinic, had to travel more than 300 miles to find a physician who could provide an abortion before she deployed. Desperate, she contemplated a self-induced abortion. She too had no conflict with her doctors.

Louisiana law prevented Kimberly O'Brien from receiving the care she and her doctors agreed was necessary. She had the resources to travel to another state for the procedure, but many in her position do not. Her conflict was with Louisiana law, not her doctor.

The compassionate, respectful treatment *amici* received from providers who put their patients' interests first, made strong impressions on J.C., who was

inspired to pursue a specialty in obstetrics and gynecology and become an abortion provider; Stephanie Goodell, who began working at the hospital; and Amy Irvin, who went to work to secure abortion access for low-income women. Far from being in conflict, they have joined forces with their providers to ensure that others receive the care they need.

Amici trust abortion providers to assert their rights in court because, unlike Louisiana, the providers have prioritized their patients' medical best interests.

CONCLUSION

The Court should reverse the Fifth Circuit's decision.

Respectfully submitted,

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