Nos. 18-1323, 18-1460

In the Supreme Court of the United States

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

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

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

BRIEF OF ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENT–CROSS-PETITIONER

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INTERESTS OF THE *AMICUS CURIAE*[1]

Amicus curiae Association of American Physicians & Surgeons, Inc. ("AAPS") is a not-for-profit membership organization incorporated under the laws of Indiana and headquartered in Tucson, Arizona. AAPS members include thousands of physicians nationwide in all practices and specialties. AAPS was founded in 1943 to preserve the practice of private medicine, ethical medicine, and the patient-physician relationship. In addition to participating at the legislative and administrative levels in national, state, and local debates on health issues, AAPS also participates in litigation, both as a party and as an *amicus curiae*. AAPS *amicus* briefs have been cited by this Court. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000); *District of Columbia v. Heller*, 554 U.S. 570, 704 (2008) (Breyer, Stevens, Souter and Ginsburg, JJ., dissenting).

Based on the clinical and medical expertise of its physician members, *amicus* believes that abortion providers in Louisiana and throughout the nation should be subject to the same admitting-privilege requirements as other physicians who provide similar outpatient procedures in ambulatory surgical centers. These privileges will increase patient safety by ensuring continuity of care by competent physicians.

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[1] Under Rule 37.6, *amicus curiae* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amicus* and its counsel made a monetary contribution to the preparation or submission of this brief. The parties have consented to the filing of this brief.

SUMMARY OF THE ARGUMENT

This Court should affirm Louisiana's admitting-privileges requirement for abortion providers, which is identical to the rule governing physicians who perform outpatient surgery in ambulatory surgical centers. Rather than treating abortion providers in a discriminatory manner, Act 620 enhances patient care in Louisiana by bringing these providers into the same fold as other physicians who perform medical procedures in a clinic setting.

Admitting-privilege requirements create optimal conditions for high-quality care for those hospitalized after a medical procedure. Abortion, like other outpatient surgical procedures, sometimes results in patient hospitalization. Requiring abortion providers to maintain admitting privileges will improve communication between physicians in the transfer of patients to the hospital and allow them to participate in the care of their patients while in the hospital, in line with their ethical duty to ensure their patients' continuity of care. Admitting privileges also help ensure physicians are currently competent.

Abortion patients deserve the highest level of care both in and out of the hospital. The longstanding judgment of the medical community has been that admitting privileges enhance that care, especially in circumstances where an outpatient procedure carries risks of hospitalization and often uses anesthesia. Louisiana mandates that other physicians in similar situations maintain admitting privileges. The state should be entitled to require the same from those physicians who provide abortion services.

ARGUMENT

Admitting privileges by physicians who perform outpatient surgical procedures are necessary to ensure timely and high-quality treatment of complications which arise from those procedures. Communication and continuity of care—a recognized component of quality medical care—are enhanced when a competent treating physician maintains admitting privileges at a nearby hospital. *Amicus* urges this Court to find that a state's decision to require privileges by those who perform abortions is a proper component in protecting public health.

I. HOSPITAL ADMITTING PRIVILEGES INCREASE PATIENT SAFETY BY CREATING THE OPTIMAL CONDITIONS FOR HIGH-QUALITY HOSPITAL CARE THROUGH ENHANCED COMMUNICATION AND BETTER CONTINUITY IN THE PATIENT'S TREATMENT.

In *Whole Woman's Health v. Hellerstedt*, this Court affirmed that "the 'State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.'" 136 S. Ct. 2292, 2309 (2016) (quoting *Roe v. Wade*, 410 U.S. 113, 150 (1973)). The more robust record in this case shows that admitting-privilege requirements are a proven way to provide "maximum safety" for patients by creating the optimal conditions for high-quality care for those hospitalized after a procedure. Admitting privileges enhance the ability of physicians to communicate and participate in their patients' hospital care, which helps fulfill their ethical duty to the continuity of care of their patients.

A. Admitting privileges create the optimal conditions for communication in the patient transfer process, and Louisiana has long required them for physicians performing common surgeries.

Through a dual process known as *credentialing* and *privileging*, hospitals traditionally have granted currently competent physicians the privileges to admit and treat patients. The longstanding judgment of the medical community has been that maintaining hospital privileges improves communication at critical moments—both in the hospital-admissions process and during subsequent hospital care. In the context of this case, the patients of abortion providers will benefit by requiring those physicians to maintain privileges in the same way as other physicians who perform similar outpatient procedures in a clinic.

Doctor Robert Marier—whose testimony as a hospital-administration expert in this case received "considerable weight"[2]—explained that admitting privileges improve patient care by enhancing communication between physicians in the transfer of patient information. JA 821. This is consistent with the approach of the Joint Commission, a national, non-profit organization that accredits "over 22,000 health care organizations and programs in the United States."[3] *See* Joint Commission Standards MS-17 (requiring a practitioner with privileges to perform a

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[2] *June Medical Services LLC v. Kliebert*, 250 F.Supp.3d 27 (M.D. La. 2017) (reprinted at Pet. App. 132a–279a, at 207a).

[3] *About us*, THE JOINT COMMISSION, https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx.

patient's medical history and required updates); MS-18 (placing patient-care coordination on practitioners with privileges); and MS-19 (urging coordination of "care, treatment, and services among the practitioners involved in a patient's care").[4]

Communication is key when hospitalizing a patient who has undergone an outpatient surgical procedure. As Judge Daniel Manion noted in *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, admitting privileges "expedite[] the admission process and avoid[] mis-communications between the patient and the hospital in situations where swift treatment is critical."[5] Dr. Marier testified to the limitations of written records: "How much can you write down? … [P]hysicians like to talk to the doctors who are caring for a patient to make sure they really understand it and not rely simply on a written document." JA 822. Indeed, "poor communication in medical practice turns out to be one of the most common causes of error" in transfers.[6] *See also Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d

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[4] All citations to standards are to JOINT COMMISSION RESOURCES, HOSPITAL ACCREDITATION STANDARDS (2016).

[5] 738 F.3d 786, 801 (2013) (Manion, J., concurring in part and in the judgment) (citing declarations). *See also* J. Studnicki, et al., *Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges*, 6 HEALTH SERV. RES. & MANAG. EPIDEM. 1, 7 (2019) (finding expedited inpatient admissions through an emergency room where patient was under care of a physician who was a frequent admitter).

[6] D.J. Solet, et al., *Lost in Translation: Challenges and Opportunities in Physician–to–Physician Communication During Patient Handoffs*, 80(12) ACAD. MED. 1094, 1097 (2005).

205, 219 (4th Cir. 2002) ("[C]ooperation and communication are essential to ensuring a high quality of patient care").

Improving communication is a laudable goal in the context of abortion, which is a common outpatient surgical procedure with nearly all abortions performed in an outpatient clinic, not a private physician's office or hospital.[7] As one *amicus* has explained, complications from abortion result in hundreds, if not thousands, of women being hospitalized each year, with abortion complication rates likely understated because few states mandate abortion-reporting and providers have no incentive to report complications.[8]

The National Abortion Federation has detailed in its 2018 *Clinical Policy Guidelines for Abortion Care* the serious complications that accompany abortion. These include perforation of the uterine wall—"one of the most serious immediate complications"—resulting in hemorrhaging that "can lead to significant morbidity" and, when it occurs in the second trimester, "even an asymptomatic perforation may warrant transfer to a hospital." NAF Guidelines at 54–55. Other complications include "[i]nfection,"

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[7] In 2017, over 862,000 abortions were performed in the U.S., with only 5% in physicians' offices and in hospitals. *See* R.K. Jones, et al., *Abortion Incidence and Service Availability in the United States, 2017*, GUTTMACHER INSTITUTE (2019).

[8] *See* Amici Br. of the Amer. Ctr. for Law & Justice and the Amer. Acad. of Med. Ethics, *June Medical Services LLC v. Gee*, 140 S. Ct. 35 (2019) (discussing prevalence of ambulance calls after abortion procedures and the medical risks of abortion).

"ectopic pregnancy," "[d]amage to organs including hysterectomy," and "[d]eath."[9] *Id.* at 3, 28.

Communication is critical in an abortion transfer because emergency rooms may need to contact on-call specialists for complications, and many hospitals have inadequate on-call coverage.[10] It is better to have available the physician who is familiar with both the patient's case and abortion complications. *See Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (noting that privileges help physicians to admit patients where "resources and facilities are familiar"). While privileges are not the "only way" to enhance communication, Dr. Marier testified that they are the "best way." JA 822.

Although abortion complications do not regularly require hospitalization, they undeniably require admission at unpredictable times and at rates similar to outpatient procedures performed at ambulatory surgical centers (ASCs). Like many states, Louisiana has long required every ASC physician to have admitting privileges at a local hospital (in addition to hospital transfer agreements). *See* La. Admin. Code § 48:4541 (2019); La. Admin. Code § 48:4535(E)(1) (2014). This is the same privileges requirement that Louisiana Act 620 places on abortion providers.

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[9] The Louisiana Department of Health reports the rate of uterine perforation as "one out of every 500 abortions." LA DEP'T OF HEALTH AND HOSPITALS, *Women's Right to Know*, at 21.

[10] *See, e.g.*, A.S. O'Malley, et al., *Hospital Emergency On-Call Coverage: Is There A Doctor in the House*? 115 ISSUE BRIEF CTR. FOR STUDYING HEALTH SYS. CHANGE 1 (2007).

Dr. Marier testified that ASCs commonly provide minor surgeries, such as "endoscopies, upper or lower GI endoscopy, injections into the spinal cord often for relief of chronic pain, and ... orthopaedic procedures involving muscle compartments, fascia, [and] joints." JA 833. Other usual ASC surgeries include cataract removal, colonoscopies, and possibly even abortion.[11] The complication rate for procedures done at ASCs is 0.1%, which is lower than the (likely understated) complication rate of up to 0.5% for abortion.[12]

Nationwide regulations governing ASCs require complications to be addressed by more care than merely sending a patient to the emergency room via ambulance and transmitting her medical condition by telephone.[13] Abortion patients deserve no less. If an admitting-privileges requirement properly applies to ASCs, it can and should apply to abortion providers. This is especially true in Louisiana where, as the

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[11] Abortion is among the official list of reimbursable ASC Medicaid procedures. *See* 71 Fed. Reg. at 68233, 68277.

[12] *See* S.G. Boodman, *Popularity of Outpatient Surgery Centers Leads to Questions About Safety*, KAISER HEALTH NEWS (Dec. 18, 2014) (1 in 1,000 ASC patients requires hospital transfer due to complications); C.W. Ko, et al., *Serious Complications Within 30 Days of Screening and Surveillance Colonoscopy Are Uncommon*, 8 CLIN. GASTRO. & HEP. 166, 171–72 (2010) (colonoscopy complications in 2.01 per 1000 exams).

[13] *See* Amer. Assoc. for Accreditation of Ambulatory Surgery Facilities (AAASF), *Procedural Standards and Checklist for Accreditation of Ambulatory Facilities* (2018) (Standard 400.021.010 requires admitting privileges or a "written transfer agreement"; 300.000.020 requires patients transferred to a post-anesthetic care unit be "accompanied by a member of the anesthesia team who is knowledgeable about the patient").

state has explained, abortion clinics "have a history of serious health and safety problems, among other failures of legal compliance."[14]

While a different section of Louisiana regulations does exempt some office-based surgeries from the admitting-privileges requirement, *see* La. Admin. Code § 46:7305, Dr. Marier's trial report explained that those surgeries are excepted because they require little anesthesia and have fewer risks. ROA 11307−09. Those exemptions rightly do not apply to abortion which—as even the National Abortion Federation has acknowledged—anticipates the use of "[a]nxiolysis, analgesia, or anesthesia" to provide abortion patients with "the appropriate level of analgesia and sedation required for each patient's needs." *See* NAF Guidelines at 41. In his rebuttal trial report, Dr. Marier examined the anesthesia policy of an abortion clinic in this case and concluded its sedation combination of Valium, promethazine, and Ibuprofen would make standard abortion procedures qualify as "non-exempt" under state regulations even if they were done in a doctor's office. ROA 11409−10.

The Fifth Circuit properly found that "Louisiana was not attempting to target or single out abortion facilities. In fact, it was just the opposite—the purpose of the Act was to bring them 'into the same set of standards that apply to physicians providing similar types of services in [ASCs].'" Pet. App. 37a.

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[14] See Respondent's Br. in Opposition to Writ of Certiorari, p. 6, *June*, 140 S. Ct. 35.

B. Admitting privileges create the optimal conditions for continuity of care by fostering participation of physicians in the course of patient hospital treatment.

Requiring physicians to maintain admitting privileges enables them to better participate in the hospital treatment of their patients. Dr. Marier testified that, as a member of the hospital's medical staff, doctors with privileges can "see the patients, to review the records, to interact with … colleagues" and consultants. JA 821−22. This is important because "[t]hat's the way medicine is practiced in a hospital. Teams of people … bring to the bedside the expertise required to deal with a particular problem. And if you're a member of the medical staff, you can participate in that process." JA 822. This improves continuity of care because, for any problems in the outpatient setting, "the person who did the procedure is best positioned to … address the problem." JA 820.

In this way, admitting privileges help physicians fulfill their ethical duties to ensure the continuity of care for patients transferred to a hospital. The American Medical Association (AMA) code of ethics recognizes patients' rights to continuity of care and to "expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making

alternative arrangements for care."[15] Dr. Marier explained that a doctor does not fulfill this ethical duty by sending a patient to the hospital "abandoned by the original provider, leaving the hospital staff to figure out … what's going on … without the benefit of all of the information" the doctor knows. JA 823–24.

In the context of abortion, states should be allowed to discourage a system where physicians travel from distant areas to perform procedures and then leave patients to fend for themselves by reporting to a local emergency department in case of a complication, with no chance for continuity of care.[16] Here, the district court identified this same remote-practice problem among the abortion providers who were parties to this case. *See* Pet. App. 173a (finding that Doe's 2 and 5 "travel significant distances from their respective homes to provide abortion services"). But instead of recognizing this as a potential ethics and safety issue for the state to resolve, the court used the fact as fodder to attack admitting privileges as non-competence-based. *See* Pet. App. 173a.

Further, the district court held that, in the context of abortion services, admitting privileges will not accomplish any of the objectives discussed earlier because many patients travel for abortion services

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[15] CODE OF MEDICAL ETHICS OF THE AM. MED. ASSOC., OPINION 1.1.3(i), https://www.ama-assn.org/system/files/2019-01/code-of-medical-ethics-chapter-1_0.pdf.

[16] *See, e.g.*, John H. Richardson, *The Abortion Ministry of Dr. Willie Parker*, ESQUIRE 152 (Sept. 1, 2014) (describing how one abortion provider "rushes around all the time, flying from Chicago to Philadelphia to Birmingham" to perform abortions).

and will not be admitted to an emergency department near the abortion provider's office. Pet. App. 218a. That is a *non sequitur*. As discussed, some women will need emergency transfer directly to a hospital due to abortion complications. Thus, the rationale remains valid for some—indeed, those most in acute need of continuity of care. And even those who are not direct transfers will benefit because privileges also ensure the competence of physicians, leading to better care.

C. The district court's findings undermine the longstanding, reasoned judgment of the medical community that admitting privileges help improve patient care.

The district court placed its own judgment over generations of medical practice that have affirmed the benefits of admitting privileges. It found privileges to be irrelevant to patient care because those who go to the emergency room "do not receive a lesser standard of care because their treating physician did not have admitting privileges." Pet. App. 216a. It found that privileges "do little to advance and are not necessary for continuity of care," Pet. App. 217a, and provide "no benefits to women and [are] an inapt remedy for a problem that does not exist," Pet. App. 215a. In this way, the district court erred by (1) holding the state to an unrealistic burden; (2) overlooking decades of consensus in the medical community for admitting-privilege requirements; and (3) undermining myriad laws and rules that rely on the efficacy of privileges.

First, the district court erred in requiring the state to prove a negative by proffering "evidence of any instance in which an admitting[-]privileges

requirement would have helped even one woman obtain better treatment." Pet. App. 215a. This partly led to the court's erroneous conclusion that privileges are "an inapt remedy for a problem that does not exist." Pet. App. 215a. Not only does that finding ignore the systemic benefits of privileges, but it improperly requires the state to wait until a health crisis erupts before officials can address it. *See Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 169 (4th Cir. 2000), *cert. denied*, 531 U.S. 1191 (2001) (noting "no requirement that a state refrain from regulating abortion facilities until a public-health problem manifests itself," and invoking precedent affirming "health measures that 'may be helpful' and 'can be useful'") (quoting *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 80–81 (1976)).

Second, the court ignored longstanding, near-unanimous support in the medical community for admitting privileges—a fact that began to change only when abortion providers started challenging privilege requirements. The American College of Obstetricians and Gynecologists (ACOG) still agrees (at least outside abortion practice) that admitting privileges help "assure the provision of high-quality patient care."[17] And courts have found for a century that admitting privileges "add[] an extra layer of

[17] *AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges*, https://www.aafp.org/about/policies/all/aafp-acog.html. *See also* Amicus Br. of Amer. Assoc. of Pro-Life Obstetricians and Gynecologists, *June*, 140 S. Ct. 35 (arguing that ACOG has become a pro-abortion activist organization).

protection for all of the patients,"[18] further "important state health objectives,"[19] and are "obviously beneficial to patients."[20] *See also supra* I.A and I.B; *Stenberg v. Carhart*, 530 U.S. 914, 958 (2000) (Kennedy, J., dissenting) (observing that the abortion provider lacked admitting privileges at any hospital).

The National Abortion Federation itself used to advise abortion patients to use a doctor who "'[i]n the case of emergency' can 'admit patients to a nearby hospital.'" *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583, 595 (5th Cir. 2014) (quoting NAF, *Having an Abortion? Your Guide to Good Care* (2000)). And in 2004, ACOG and the AMA agreed with the "core principle" that "[p]hysicians performing office-based surgery must have admitting privileges at a nearby hospital," or a transfer agreement with another physician or a nearby hospital.[21]

Third, the district court's conclusions undermine state and federal rules that rely on the efficacy of admitting privileges. This reliance has persisted for generations and been affirmed repeatedly until

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[18] *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 801 (2013) (Manion, J., concurring in part and in the judgment).

[19] *Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989).

[20] *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 317 F.3d 357, 363 (4th Cir. 2002).

[21] *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 928 & n.3 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545 (2016) (Manion, J., dissenting) (quoting statement).

abortion advocates brought these recent challenges. A sampling of these myriad rules illustrates the point.

States regularly rely on admitting-privilege requirements to assure high-quality care in various medical programs. For instance, New York links admitting privileges to its Preferred Physicians and Children Program (PPAC) and also to abortion services;[22] Illinois links them to maternal and child health programs;[23] New Jersey links them to its "Healthstart" program for children and mothers;[24] California links them to primary care clinics;[25] and Arkansas links them to physicians in primary care case-management programs.[26]

Federal law long had paired ASC participation in Medicare to hospital admitting privileges to "ensure that patients have immediate access to needed

[22] *See* 18 NYCRR 533.7 (requiring that participating physicians have "current admitting privileges"); 10 NYCRR 756.4 (requiring in centers related to "abortion services" that operators ensure "at least one physician has admitting privileges at a hospital in order to ensure the necessary back-up for care").

[23] *See* 89 Ill. Adm. Code 140.924.

[24] N.J.A.C. 10:52-3.13 (requiring that pediatricians demonstrate their "knowledge of pediatrics" either through "board certification … or by hospital admitting privileges in pediatrics").

[25] 22 Cal. Code of Reg. § 75027 (requiring at least one staff member to have privileges to ensure needed hospital services").

[26] *See,* Arkansas Medicaid Primary Care Case Management Program Manual (2017), ¶ 171.120, 7-1-05.

emergency or medical treatment in a hospital."[27] 47 Fed. Reg. 34082, 34086 (Aug. 5, 1982). Further, health maintenance organizations must ensure their primary care physicians have admitting privileges to at least one hospital that serves "the area from which the physicians draw [their] enrollees."[28] And with the goal of "[i]mproving health status among underserved populations," clinicians at federal health center programs "should obtain admitting privileges and hospital staff membership at their referral hospital(s) so health center patients can be followed by health center clinicians."[29]

In sum, when a state requires abortion providers to maintain local hospital admitting privileges, it taps into a long-proven process that creates the optimal conditions for hospital care and is required by other physicians performing similarly risky procedures. The district court erred by finding otherwise, and this Court should affirm the Fifth Circuit's decision upholding Louisiana's privileges requirement.

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[27] 47 Fed. Reg. 34082, 34086 (Aug. 5, 1982). In a controversial move, Medicare recently removed requirements for privileges and emergency transfer agreements from its ASC provisions (42 C.F.R. § 416.41) due to concerns about hospital competition. *See* 84 Fed. Reg. 51732-01 (Sept. 30, 2019). The change noted, "ASCs are not precluded from obtaining hospital transfer agreements or hospital physician admitting privileges when possible." *Id.*

[28] Health Maintenance Organization (HMO)/CMP Manual, CMS Pub 75, § 2300, 2301.1 (2019).

[29] BUREAU OF PRIMARY HEALTH CARE, PIN 98-23, *Health Center Program Expectations*, August 17, 1998, at 13, 15. That requirement continues today. Elayne J. Heisler, *Federal Health Centers: An Overview*, CONG. RES. SVC., May 19, 2017, at 5.

II. ADMITTING PRIVILEGES HELP ENSURE CURRENT PHYSICIAN COMPETENCE BECAUSE HOSPITALS ARE SKILLED IN VETTING FITNESS AND HAVE A STRONG INCENTIVE TO CAREFULLY VERIFY QUALIFICATIONS.

Credentialing is the process of "verifying qualifications to ensure current competence to grant privileges," while privileging is the process of "authorizing a specific scope of practice for patient care based on credentials and performance."[30] Not only does the admitting-privileges process enhance patient care, as discussed earlier, but it also helps ensure physicians are currently competent.

A. The privileging process helps ensure the current competence of physicians.

Before physicians were regulated through state licensure rules and professional organizations (starting in the late 1800s), boards of trustees at private voluntary hospitals were using practice privileges as a way to ensure current physician competence.[31] In the twentieth century, when

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[30] American Academy of Family Physicians (AAFP), *Hospital Credentialing and Privileging FAQs*, https://bit.ly/2EbWld1.

[31] In contrast to deplorable conditions at public *almshouses* in the nineteenth century, charitable hospitals provided higher-quality care, with bylaws and directors with authority to "grant[] the privilege of practicing the healing arts in such institutions." *W. Coast Hosp. Ass'n v. Hoare*, 64 So. 2d 293, 298 (Fla. 1953). *See also* C.E. Rosenberg, *From Almshouse to Hospital: The Shaping of Philadelphia General Hospital*, 60(1) MILBANK MEMORIAL FUND QUARTERLY, HEALTH & SOCIETY 108, 110 (1982).

hospitals became more professional,[32] organizations were formed to approve and improve hospital programs, always with an eye on maintaining physician quality. For instance, as early as 1919, the American College of Surgeons adopted a "minimum standard" for hospitals that required those physicians "privileged to practice in the hospital" to be "competent in their respective fields" and "worthy in character and in matters of professional ethics."[33]

The primary focus of admitting privileges has always been a physician's *current* competence.[34] Dr. Marier testified that the process of privileging "thoroughly vet[s] the qualifications of an individual … to ensure that the physicians are competent to provide the services that are in question." JA 818. The process is carried out according to each hospital's bylaws. JA 876. According to Dr. Marier, granting privileges may not be the "only way" to ensure current physician competency, but it is the "primary way" of doing so today. JA 818.

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[32] *See* C.E. Rosenberg, *The Origins of the American Hospital System*, 55(1) BULL. N.Y. ACAD. MED. 10, 20 (1979).

[33] L. Davis, FELLOWSHIP OF SURGEONS: A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS 479 (1960).

[34] *See Green v. City of St. Petersburg*, 17 So. 2d 517, 518 (Fla. 1944) (noting credentialing rules "establish and uphold the high standard of the hospital … to insure those entering the hospital for treatment that they will secure skillful service"). Privileges also help hospitals form a "self-governing medical staff." C.C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1074 (1984). *See also* Joint Commission Standard GL-9 (defining "credentialing"); GL-23 (noting different kinds of medical staff).

The district court expressed concern that "no state or federal statute … defines or sets uniform standards," and that privileging rules are "set by each hospital's by-laws" and may "vary from hospital to hospital." Pet. App. 168a−169a. But the court failed to recognize the influence of the Joint Commission, whose accreditation is sought by most hospitals to qualify for funding from Medicare and Medicaid.[35] As one of Petitioner's *amici* has demonstrated: because most hospitals follow the Joint Commission Standards—"including 166 of 207 Louisiana licensed hospitals and *all* 13 hospitals in the record"—there is a strong normative standard for privileges followed by "70 percent" of the hospitals nationwide.[36]

The Joint Commission Standards detail the scrutiny involved in the privileging of medical staff. Standards MS-23, 25, and 26 confirm the process is "designed to collect, verify, and evaluate data relevant to a practitioner's professional performance," and allows "an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities." Indeed, "[r]igorous scrutiny of a doctor's education and qualifications precedes" any grant of privileges.[37] As Dr. Marier testified, hospital committees perform

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[35] *See* 42 U.S.C. 1395bb, 42 C.F.R. 488.5 (setting out requirements of national accreditation to participate in Medicare and Medicaid).

[36] Amicus Br. of Medical Staff Professionals, p. 12, *June*, 140 S. Ct. 35.

[37] C. Quinn, *Procedural Due Process Rights of Physicians Applying for Hospital Staff Privileges*, 17 LOY. U. CHI. L.J. 453, 454 (1986).

the credentialing process by reviewing a doctor's "training and experience," "subspecialty training," "practice over the years," and "disciplinary matters," to assess physician competency beyond their initial licensing and periodic license renewal.[38] JA 817–18.

Based on this assessment, physicians are then "privileged" to provide delineated care to patients at the hospital. *See* Standard GL-33. *Clinical privileges* refers to specific care a physician may provide to patients at the hospital. *See* Standards MS-9 (medical staff must have "specific clinical privileges to provide care, treatment, and services authorized through the [privileging] processes"); MS-18 ("Practitioners have privileges that correspond to the care, treatment and services needed."). Dr. Marier testified to this distinction, stating that "[clinical] privileging is for a specific surgical procedure based on that person's experience and qualifications." JA 871.

Standards MS-27 and 28 explain that privileging allows a hospital to assess basic matters, such as whether the applicant is who she claims to be, whether her medical license is current, and whether she has maintained competence to perform the requested privileges. Standards MS-29 through 32 explain that, in deciding which privileges to grant, a hospital engages in a "clearly defined procedure" that considers sources such as the National Practitioner Data Bank, a physician's own health records, any clinical data bearing on the physician's performance

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[38] *See also* J. Lowy, *Board Certification as Prerequisite for Hospital Staff Privileges*, AMA J. MED. ETHICS, April 2005 (review also includes residency training and clinical experience).

record, and peer recommendations. These are fact-intensive inquiries, and hospitals that do it poorly open themselves to liability and lawsuits.[39]

But the district court found that only state licensing and disciplinary boards—not privileges—help ensure competency. Pet. App. 272a. In making this finding in error, the court missed two key points. First, although licensure laws set a state's minimal threshold to enter medical practice,[40] they are limited in their ability to ensure *current* competence. Second, the credentialing and privileging process—redone every two to three years—is a continuing source of critical data for state licensing and disciplinary boards. *See Miller v. Huron Reg'l Med. Ctr.*, 936 F.3d 841, 844 (8th Cir. 2019) (explaining how state licensing boards have access to data collected through avenues such as the privileging process).

B. The district court's findings undermine the longstanding medical judgment that admitting privileges help ensure current physician competence.

Abortion providers are doctors of obstetrics and gynecology (OB/GYN), which is regarded as a surgical

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[39] *See, e.g., Billeaudeau v. Opelousas General Hospital Authority,* 218 So.3d 513 (La. 2016) (finding hospitals are unprotected by Louisiana's medical malpractice cap if they are liable for negligent credentialing of emergency-room personnel). *See also Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007) (collecting related liability cases from twenty-seven states).

[40] *See* Note, *Right of Corporation to Practice Medicine*, 48 YALE L.J. 346, 348 (1938).

specialty.[41] Louisiana's Act 620 requires abortion providers to "have active admitting privileges at a hospital" that "provides obstetrical or gynecological health care services" and "is located not further than thirty miles" from the abortion location. La. R.S. § 40:1299.35.2. The Act closes the "regulatory gap" that had merely required abortion clinics to have "one physician present who has admitting privileges or has a written transfer agreement with a physician[] who has admitting privileges at a local hospital to facilitate emergency care." La. Admin. Code § 48:4407(A)(3) (2003). By closing this gap, the Act now ensures the current competence of every abortion provider in Louisiana by requiring that their qualifications to perform abortions be regularly vetted by a hospital with OB/GYN expertise.

At trial, Petitioners—purporting to rely on a similar decision by this Court[42]—convinced the

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[41] American College of Surgeons, *What are the surgical specialties?*, https://www.facs.org/education/resources/medical-students/faq/specialties (identifying OB/GYN as one of the surgical specialties and noting that its specialists are trained "to provide medical and surgical care for the pregnant patient").

[42] Petitioners and their *amici* argue this Court decided the admitting-privileges issue once for all time in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). *See, e.g.,* Amicus Br. for the Amer. Bar Assoc., pp. 14–15, *June*, 140 S. Ct. 35. But even their most pointed arguments acknowledge that this Court's ruling about a Texas law did not decide the issue for every state. *See* Br. for Petitioners, p. 25, *June*, 140 S. Ct. 35 (recognizing their theory is based on a perceived "suggestion" that this Court did not "expect" other states to be able to balance interests differently). Here, the Fifth Circuit showed that a more robust trial record in this case with different state benefits and detriments did justify a different result. *See* Pet. App. 38a–39a.

district court that Louisiana's admitting-privileges requirement is not sufficiently tied to competence and that it engenders anti-abortion discrimination because hospitals can consider "non-competence-based" factors in their privileging decisions. Pet. App. 171a–194a, 272a. The district court concluded that privileges "do not serve 'any relevant credentialing function'; that state licensing and discipline are the [only] means of ensuring physician competency; and that "[h]ospitals grant privileges to physicians to promote the smooth functioning of the hospital, or to serve other goals or priorities of the particular hospital." Pet. App. 272a. These findings are inconsistent with the long-held accepted judgments of the medical community about the benefits of admitting privileges. In particular, the court failed to apprehend that the factors that underlie the privileging decision work together to assess the primary focus of current physician competence.

First, the record here reflects the district court's focus on potential anti-abortion discrimination, Pet. App. 171a–194a, which led to its finding that "[t]here are ways in which the hospital staff's and/or the general public's hostility to abortion and abortion providers can be injected into the credentialing process." Pet. App. 177a. But the Fifth Circuit found the district court had strayed into clear error with this type of reasoning.[43] In addition, the district court

[43] The Fifth Circuit found the court had "erroneously factored into its substantial-burden analysis that Louisiana is a strongly anti-abortion state" due to "actions taken by Louisiana citizens and other previously enacted abortion regulations," which the "courts cannot consider." Pet. App. 48a.

failed to take into account the potential impact of existing federal anti-discrimination law.[44]

Second, the district court failed to see the obvious relation between competence and some of the relevant factors considered in a privileging decision. The court labeled certain factors as "non-competency based," including a plan by the physician "to provide services in the hospital"; a submission of "data on hospital admissions, patient management and consultations of patients in the past 12 months in a hospital"; and the need to admit patients to a hospital. Pet. App. 176a–181a. But these standards are related to competence,[45] and any potential discrepancies in individual privileging decisions can be challenged by

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[44] The district court did not consider the impact of the anti-discrimination federal Church Amendment (42 U.S.C. § 300a-7(c)(1)(B))—which the state placed into evidence, JA 914—because it had "no evidence" about whether hospitals in the state receive federal funds. Pet. App. 168a, 176a. Instead of taking judicial notice about funding or seeking evidence on this key point, the court concluded in error that hospitals in Louisiana had no legal detriments to discriminating against abortion providers and that state law condoned discrimination. *Id.*

[45] Joint Commission Standard MS-32 discourages criteria for privileging unrelated to patient care or physician competence by requiring that, if a hospital uses such criteria, it must provide evidence evaluating "the impact of resulting decisions on the quality of care, treatment, and services." *See also Sokol v. Akron Gen. Med. Ctr.*, 173 F.3d 1026, 1032 (6th Cir. 1999) (state law requires private hospitals to use reasonable, nondiscriminatory criteria in privileging decisions).

physicians in court, which rightly acts as a judicial check on arbitrary decision-making.[46]

Petitioners and their *amici* argue at length that requiring abortion providers to follow the same process as other physicians would require them to go through "exhaustive and futile efforts."[47] The faulty premise of their argument is that abortion providers cannot receive and retain admitting privileges in Louisiana or elsewhere. This finding is contradicted by the fact that abortion providers have retained— and continue today to obtain and retain— admitting privileges in Louisiana and throughout the nation.[48]

Another *amicus* supporting Petitioner has over-generalized the credentialing process in some hospitals, essentially arguing that abortion providers should not be "burdened" with the same rigorous scrutiny as other OB/GYN doctors.[49] That brief has overlooked a key fact: Act 620 is not so onerous as the discussed worst-case scenarios because the Act can be satisfied by a physician obtaining mere "courtesy"

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[46] *See Hospital Staff Privileges*, CAL. MED. 54−55 (1964). *See, e.g., Belmar v. Cipolla*, 475 A.2d 533, 538 (N.J. 1984) (courts can overturn privileging decisions inconsistent with the "public interest" or with a hospital's "health care mission").

[47] Amicus Br. of the Amer. Civil Liberties Union, pp. 25−31, *June*, 140 S. Ct. 35.

[48] *See* Studnicki, *supra*, at 7 (noting in a six-year study that 43 of 85 Florida abortion providers held privileges and only 32 of them had at least one admission during the study period). *See also* Pet. App. 163a, 165a (Doe 3 and Doe 5 have privileges here).

[49] *See generally* Amicus Br. of Medical Staff Professionals, *June*, 140 S. Ct. 35.

privileges at a hospital[50]—a reality that blunts most criticism directed at the process.

In sum, when a state requires physicians who perform certain procedures to maintain local hospital admitting privileges, it taps into a long-proven process that helps ensure current physician competence and optimal patient care. Indeed, by failing to hold abortion providers to the same standards as other doctors, a state would deny women who undergo abortion the same right to high-quality care provided to women undergoing other surgical procedures. The district court erred in finding otherwise. This Court should affirm the Fifth Circuit's decision that upheld Louisiana's admitting-privileges requirement.

CONCLUSION

For the foregoing reasons, the judgment below should be affirmed.

Respectfully submitted,

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[50] Dr. Marier testified that physicians could satisfy Act 620 by receiving "courtesy" privileges, depending on hospital bylaws. JA 831–32.