No. 18-1323

In The
Supreme Court of the United States

JUNE MEDICAL SERVICES, LLC, et al.,

Petitioners,

v.

DR. REBEKAH GEE, in her official capacity as Secretary of the Louisiana Department of Health and Hospitals,

Respondent.

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

AMICUS CURIAE BRIEF OF FORMER ABORTION PROVIDERS; THE NATIONAL ASSOCIATION OF CATHOLIC NURSES, U.S.A.; AND THE NATIONAL CATHOLIC BIOETHICS CENTER IN SUPPORT OF RESPONDENT

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CORPORATE DISCLOSURE STATEMENT

Amici National Association of Catholic Nurses, U.S.A. and the National Catholic Bioethics Center are nongovernmental corporate entities, and they have no parent corporations and no publicly held corporations hold 10% or more of their stock.

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STATEMENT OF INTEREST OF AMICI CURIAE

Both parties have given consent to file this Amicus Curiae brief. Counsel for Amici has prepared this brief supporting Respondents.[1]

Former abortion providers include Dr. Kathi Aultman (Florida); Carol Everett (Texas); Dr. Anthony Levatino (New Mexico); and Dr. Beverly McMillan (Mississippi). They know first-hand the physical and psychological risks of abortion and the need for doctors to have hospital admitting privileges. Their Affidavits are in the Appendices.

The National Association of Catholic Nurses, U.S.A. dates back to the 1930s and is a 501(c)(3) nonprofit organization and is dedicated to the highest ethical medical standards. The organization has a deep interest in ensuring women have good medical care and that they know the physical risks of abortion based on what the nurses have experienced and the extensive reliable scientific data. Amicus has members across the United States, including in Louisiana.

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[1] The parties were notified ten days prior to the due date of this brief of the intention to file. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Trinity Legal Center is a nonprofit corporation and is supported through private contributions of donors who have made the preparation and submission of this brief possible. No person other than Amici Curiae, their counsel, or donors to Trinity Legal Center made a monetary contribution to its preparation or submission. The parties have consented to this brief.

The National Catholic Bioethics Center (the Center) is a non-profit research and educational institute committed to applying the moral teachings of the Catholic Church to ethical issues arising in health care and the life sciences. It is committed to advocating for the human rights of all human beings, including women who made the tragic decision of having an abortion. The Center advises, educates, and advocates for ethical policies in the delivery of health care, and supports the highest standards of care for all persons. Not requiring admitting privileges for abortion providers is against every ethical standard of care for any human being, especially women who are at statistical risk from the abortion. The Center has deep concerns if such a provision is not mandated.

SUMMARY OF THE ARGUMENT

I.

Reliable scientific and medical studies confirm the physical and psychological risks of abortion. In the largest government study, the Report of the South Dakota Task Force reviewed the scientific studies and heard testimony from medical experts and post-abortive women. The Task Force concluded that there are serious physical and psychological consequences of abortion and women should be protected. In contrast, a 2018 study funded by abortion supporters and citing selective studies downplayed the risks. Abortion has both short-term and long-term consequences, and

therefore, the Louisiana Legislature was justified in protecting women.

II.

Surgical and medical abortions have potentially serious complications and the risk of death. H.B. 388 provides common sense health and safety regulations to protect women just as any other surgical out-patients have. Doctors having hospital admitting privileges prevent itinerant abortionists by providing continuity of care when complications occur. In addition, requiring hospital privileges supports this Court's assumption in *Roe* of a normal doctor-patient relationship. Therefore, the Court of Appeals' decision should be affirmed.

III.

This Court has long recognized that legislatures should be given broad deference in their findings and enactments. Because health issues are complex factual medical issues that involve policy, they are best left to the legislative branch of government. To protect women, the Louisiana Legislature provided for health and safety measures that are within this Court's established guidelines and tests. This is a legitimate and constitutional exercise of the State's interest in protecting women, and therefore, H.B. 388 should be upheld.

ARGUMENT

I. RELIABLE SCIENTIFIC DATA CONFIRMS THAT ABORTION CAUSES INCREASED RISKS OF PHYSICAL AND PSYCHOLOGICAL PROBLEMS, AND THEREFORE, THE STATE HAS A LEGITIMATE INTEREST IN PROTECTING WOMEN.

A. Objective Scientific Evidence Establishes the Negative Consequences of Abortion, and Therefore, the State Has a Compelling Interest to Protect Women.

In *Roe v. Wade*,[2] this Court did not have the advantage of the extensive reliable scientific and medical studies that are currently available on how abortion affects women both physically and psychologically. Now, forty-six years later, objective scientific evidence establishes the negative consequences of abortion.[3]

In the largest government study since *Roe*, the South Dakota Task Force held extensive hearings and heard from medical and scientific experts.[4] In creating the Task Force, the Legislature recognized that "there exists a need for special protection of the rights of such pregnant women, and that the State of South Dakota

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[2] 410 U.S. 113 (1973).

[3] Many studies are cited throughout sections I and II.

[4] Report of the South Dakota Task Force to Study Abortion (Dec. 2005), *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf.

has a compelling interest in providing such protection."[5]

After hearing evidence from medical experts and post-abortive women, the Task Force stated:

> The record reflects that abortion places women at increased risk of physical injury including the risk of: infection, fever, abdominal pain and cramping, bleeding, hemorrhage, blood transfusion with its subsequent risks, deep vein thrombosis, pulmonary or amniotic fluid embolism, injury to the cervix, vagina, uterus, Fallopian tubes and ovaries, bowel, bladder, and other internal organs, anesthesia complications (which are higher with general anesthesia), failure to remove all the contents of the uterus (leaving behind parts of the fetus/baby or placenta), need to repeat the surgery, possible hospitalization, risk of more surgery such as laparoscopy or exploratory laparotomy, possible hysterectomy (loss of the uterus and subsequent infertility), allergic reactions to medicines, mis-diagnosis of an intrauterine pregnancy with a tubal or abdominal pregnancy being present (which necessitates different treatment with medicines or more extensive surgery), possible molar pregnancy with the need for further treatment), emotional reactions (including but not limited to depression, guilt, relief, anxiety,

[5] *Id*. at 5.

> etc.) death of the woman, and risk of a living, injured baby.[6]

In addition, the Task Force heard evidence that there are long-term consequences of abortion including that abortion places women at increased risk of other long-term physical injury including placenta previa which necessitates a c-section and has higher rates of complications and pre-term birth in subsequent pregnancies.[7]

Sterility is also one of the long-term complications of abortion. It results from scarring due to an infection caused by the abortion or from the surgical procedure itself.[8]

The Task Force also heard extensive evidence from distinguished experts and post-abortive women of the psychological consequences of abortion.[9] After reviewing the lengthy materials and testimony, the Task Force found that "there is a substantial discrepancy between current medical and psychological information and the medical and psychological information conveyed

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[6] *Id*. at 48.

[7] *Id*.

[8] JOHN C. WILKE & BARBARA H. WILKE, ABORTION: QUESTIONS AND ANSWERS 162 (2003) (*citing* in chapter 21 the risk factors and scientific studies for each complication).

[9] Report of the South Dakota Task Force to Study Abortion 41-48 (Dec. 2005), *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf.

by abortion facilities (including Planned Parenthood of South Dakota) to their abortion patients."[10]

Citing the results of the four largest record-based studies in the world, the Task Force stated that these studies "have consistently revealed that women with a known history of abortion experience higher rates of mental health problems of various forms when compared to women without a known abortion history." The mental health consequences of abortion have included guilt, post-abortion anger and resentment, anxiety, posttraumatic stress disorder (PTSD), psychological numbing, depression, suicidal ideation, substance abuse, relationship problems, and parenting problems.[11]

Because of the well-documented, significant physical and psychological risks of abortion, the Louisiana Legislature enacted H.B. 388[12] to protect women considering an abortion. This is within its constitutional purview.

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[10] *Id*. at 41.

[11] *Id*. at 43-46 (*citing* studies).

[12] Act 620, recodified at LA. STAT. ANN. § 40:1061.10 [hereinafter H.B. 388].

B. Biased Studies That Downplay the Risks of Abortion Fail to Provide Women with the Scientific Evidence That Is Needed to Make an Informed Decision, and Therefore, Should Not Be Given Evidentiary Weight.

In 2018, the National Academy of Science (NAS) published a new report entitled "The Safety and Quality of Abortion Care in the United States," claiming that abortion is safe. However, the study was flawed in several respects. First, the report was "funded by abortion collaborators and organizations behind abortion expansion efforts."[13] This report was financed in part by individuals and groups that have possible profit motives and conflicts of interest including those by "Warren Buffett and the Packard Foundation which seeded the start-up of the abortion pill manufacturer, Danco Laboratories, LLC."[14] In addition, both the Packard Foundation and the Susan Thompson Buffett Foundation have given sizable grants to Planned Parenthood.[15] Abortionist Willie Parker and law professor Sara Rosenbaum, who is a vocal supporter of Planned Parenthood,

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[13] Novielli, *CONFLICT OF INTEREST: Study Claiming Abortion Is Safe Was Funded By Those Who Profit From It, and the Media Fails to Investigate* (Aug. 4, 2019), *available at* https://www.liveaction.org/news/profit-motive-study-claiming-abortion-safe/.

[14] *Id*. (listing the conflicts of interest and profit motive of each of the funders).

[15] Associate Professor Michael J. New and Dr. Donna Harrison, *New Report Misleads on the Health Risks of Abortion for Women* (Mar. 28, 2019), *available at* https://www.nationalreview.com/2018/03/abortion-safety-statistics-study-ignores-risks-women/.

served as consultants.[16] It is notable that "no pro-life researchers or scholars served as authors or consultants on this report."[17]

The NAS has had a history of conflicts of interest.[18] The NAS Guidebook warns of the dangers inherent to science when conflicts of interests are present.[19] This is "largely due to continued recruitment of scientists with financial interests in the field studied by committees on which they serve."[20]

The Center for Science in the Public Interest (CSPI) conducted one of the most comprehensive analyses of conflicts of interest within the NAS and concluded there were significant problems.[21] The report stated:

> Unfortunately, we found serious deficiencies in the NAS's committee-selection process that could jeopardize the quality of future NAS reports. The NAS has allowed numerous scientists (and others) with blatant conflicts of interest to sit on committees. Compounding

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[16] *Id*.

[17] *Id*.

[18] For a detailed explanation of the conflicts, *see* Affidavit of Dr. Priscilla Coleman, Appendix A.

[19] *Id.* (*quoting* the Guidebook).

[20] *Id.*

[21] *Id.*

> that problem, those conflicts of interest usually are not disclosed to the public.[22]

The problem of conflicts was certainly true with its 2018 report and raises questions as to the reliability of its findings on abortion. "Contracts between the NAS and several foundations with strong commitments to reproductive rights supported the undertaking and most of the committee members and reviewers of the document have ideological and/or financial ties to the abortion industry."[23]

Second, the report limited its analysis to studies that showed "abortion does not lead to either physical or psychological health problems."[24] One of the major shortcomings was the omission of the 2011 *British Journal of Psychology* meta-study on the mental-health effects of abortion. This important meta-study surveyed twenty-two published studies which combined data on 877,181 participants and presented a body of peer-reviewed research showing that abortion increases the likelihood of depression, anxiety, alcoholism, drug use, and suicide.[25]

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[22] *Id.* (*quoting* the CSPI report entitled "Are the National Academies Fair and Balanced?").

[23] *Id.* (listing the specific conflicts of individuals and funding organizations).

[24] Associate Professor Michael J. New and Dr. Donna Harrison, *New Report Misleads on the Health Risks of Abortion for Women* (Mar. 28, 2019), *available at* https://www.nationalreview.com/2018/03/abortion-safety-statistics-study-ignores-risks-women/.

[25] *Id*.

In the section of the 2018 NAS report concerning abortion and women's mental health, "the authors ignored the majority of published scientific studies, focusing nearly exclusively on the seriously flawed Turnaway Study (Biggs, 2016) and two literature reviews produced by professional organizations."[26] In contrast, "an extensive 40-year history of peer-reviewed research has definitively shown that when specific physical, demographic, psychological, and situational factors are present, women are at an elevated risk for post-abortion mental health problems."[27] Based on this history of scientific data, Louisiana has a legitimate interest in protecting women.

Third, although the report mentions that there is evidence linking induced abortion to premature births, it downplays the risk.[28] Forty-nine studies "have demonstrated a statistically significant increase in premature births or low-birth-weight risk in women who had prior induced abortions."[29]

Women who are considering an abortion need accurate information concerning the short-term and

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[26] Affidavit of Dr. Priscilla Coleman, Appendix A (providing a detailed explanation of the Turnaway Study and the APA Task Force Report).

[27] *Id*. (detailing the studies demonstrating the mental health risks to women having an abortion).

[28] Associate Professor Michael J. New and Dr. Donna Harrison, *New Report Misleads on the Health Risks of Abortion for Women* (Mar. 28, 2019), *available at* https://www.nationalreview.com/2018/03/abortion-safety-statistics-study-ignores-risks-women/.

[29] *Id*.

long-term risks of abortion. As this Court recognized in *Casey*, the state has a legitimate interest in ensuring that women have truthful, non-misleading information about the nature of the abortion procedure and the attendant physical and psychological health risks. The 2018 NAS report is at a minimum misleading due to its flaws and should not be given weight.

II. WOMEN CONSIDERING AN ABORTION DESERVE SAFETY PROTECTIONS DUE TO THE POTENTIALLY SERIOUS COMPLICATIONS, AND THEREFORE, THE LOUISIANA LEGISLATURE WAS JUSTIFIED IN ENACTING H.B. 388.

It is well documented that there are risks and complications of surgical and medical abortions. Therefore, the State of Louisiana has a legitimate and constitutional right to protect women. Requiring that abortionists have hospital privileges is a practical way to ensure women's health when complications arise and provide the continuity of care that does not create an undue burden on the abortion decision.

A. H.B. 388 Is Necessary Because of the Documented Physical Risks and Potentially Fatal Complications of Abortions.

Surgical Abortions

There are a variety of physical complications that can occur with an abortion.[30] Some of the immediate physical complications include cervical injuries and perforated uterus, acute or chronic pain, organ or system failures, cerebrovascular diseases, circulatory diseases, disseminated intravascular coagulation, amniotic fluid embolism, pulmonary embolism, and adult respiratory distress syndrome, various infections such as septic abortion, acute renal failure from septic abortion, autoimmune disease, endometritis, genital tract infection, pelvic inflammatory disease, and bacterial vaginosis.[31]

The risk of physical complications can occur at any stage of pregnancy,[32] and therefore, the protections

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[30] Thomas W. Strahan Memorial Library, *Physical Effects of Abortion*, *available at* http://abortionrisks.org/index.php?title=Physical_Effects_of_Abortion.

[31] *See* Affidavit of Dr. Kathi Aultman, Appendix C (providing a complete list of risks for both suction curettage abortions up to 12-14 weeks and D&E abortions for 13-24 weeks). There is also a negative impact on later pregnancies such as infertility, ectopic pregnancy, placenta previa, subsequent miscarriages, premature birth, or low birth weight, and various cancer risks such as breast cancer. *See generally* Thomas W. Strahan Memorial Library, *Physical Effects of Abortion*, *available at* http://abortionrisks.org/index.php?title=Physical_Effects_of_Abortion (confirming both immediate complications and the negative impact on later pregnancies).

[32] *See* Reardon & Coleman, *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004*, *available at* https://www.

provided in H.B. 388 are necessary for a woman's health. Based on the reliable scientific evidence, however, the physical risks are fewer in earlier stages of pregnancy.[33] The Louisiana Woman's Right to Know Booklet warns: "The risk of complications for the woman increases with advancing gestational age."[34]

Mortality rates are significantly greater the later the abortion.[35] This is confirmed by record linkage studies in Finland, Denmark, and the United States which clearly demonstrate that abortion is associated with significantly higher mortality rates.[36] Furthermore,

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researchgate.net/publication/230768961_Short_and_long_term_mortality_rates_associated_with_first_pregnancy_outcome_Population_register_based_study_for_Denmark_1980-2004.

[33] La. Dep't of Health, *A Woman's Right to Know Booklet*, *available at* http://www.ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf.

[34] *Id*. at 20; *see also* Tex. Dep't of State Health Services (DSHS) at 8, *available at* https://hhs.texas.gov/sites/default/files/documents/services/health/women-children/womans-right-to-know.pdf (stating "You have a greater risk of dying from the abortion procedure and having serious complications the further along you are in your pregnancy").

[35] Tex. Dep't of State Health Services (DSHS) at 8, *available at* https://hhs.texas.gov/sites/default/files/documents/services/health/women-children/womans-right-to-know.pdf (the booklet was produced by the DSHS after extensive hearings by the medical board and based on the scientific evidence and citing large-scale studies).

[36] *See, e.g.*, Reardon & Coleman, *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004* (Aug. 2012), *available at* https://www.researchgate.net/publication/230768961_Short_and_long_term_mortality_rates_associated_with_first_pregnancy_outcome_Population_register_based_study_for_Denmark_1980-2004;

the reliable scientific evidence demonstrates that "each additional abortion is associated with an even higher death rate."[37] Louisiana's goal to protect women's health is constitutional because it is based on reliable scientific evidence and the State's legitimate interest.

In *Roe*, this Court acknowledged the state's right to regulate abortion to protect women's health when the risk of death associated with abortion is greater than the risk of death associated with childbirth.[38] In 1973, the *Roe* Court believed that the risk of death associated with abortion arose after the first trimester.[39] Scientific studies now confirm that childbirth is safer than abortion whether in the early or late stages of pregnancy.[40] The incontrovertible evidence based on

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M. Gissler ET AL., *Injury Deaths, Suicides and Homicides Associated with Pregnancy, Finland 1987-2000*, 15 EUR. J. PUB. HEALTH 459 (2005); M. Gissler ET AL., *Suicides After Pregnancy in Finland, 1987-94: Register Linkage Study*, 33 BRIT. MED. J. 1431 (1996).

[37] Elliot Institute, *Abortions Increase Risk of Maternal Death: New Study*, *available at* http://afterabortion.org/2012/multiple-abortions-increase-risk-of-maternal-death-new-study/ (stating "Women who had two abortions were 114% more likely to die during the period examined, and women who had three or more abortions had a 192% increased risk of death").

[38] Roe v. Wade, 410 U.S. 113, 149 (1973).

[39] *Id*. (stating "that abortion in early pregnancy, that is, prior to the end of the first trimester, although not without its risk, is now relatively safe").

[40] *See* Saunders & Novick, *Study Confirms Childbirth Is Safer for Women Than Abortion* (Sept. 13, 2012), *available at* http://www.lifenews.com/2012/09/13/study-confirms-childbirth-is-safer-for-women-than-abortion/. A study in Denmark of almost half a million women complements similar data from Chile and Ireland

record linkage studies from Finland, Denmark, and the United States provides reliable scientific evidence that the risk of death to women is higher than childbirth at *all stages*, including within the first 180 days after a first trimester abortion.[41] Therefore, under *Roe*'s reasoning and the current scientific evidence, the state has a right to enact health and safety regulations.

In addition, because the psychological consequences of abortion can lead to physical harm, it is important to have continuity of care by the attending physician who understands what transpired during the abortion and the consequences after the abortion. It is well recognized that some women experience sadness, grief, and feelings of loss following an abortion and that it can lead to clinically significant psychological disorders such as depression and anxiety.[42]

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that confirms legalizing abortion does not decrease maternal mortality rates. *Id.*

[41] Reardon & Coleman, *Short and Long Term Mortality Rates Associated with First Pregnancy Outcome: Population Register Based Study for Denmark 1980-2004* (Aug. 2012), *available at* https://www.researchgate.net/publication/230768961_Short_and_long_term_mortality_rates_associated_with_first_pregnancy_outcome_Population_register_based_study_for_Denmark_1980-2004. Dr. Reardon asserts that any claims to the contrary are due to reviewers specifically excluding record linkage studies to promote the myth of abortion safety. Reardon, *Rebuttal of Raymond and Grimes*, 79(3) LINACRE Q. 259-60 (Aug. 2012) (criticizing studies that do not use linkage studies).

[42] The principle has been recognized by this Court, various state departments of health, and the American Psychiatric Association. For example, Gonzales v. Carhart, 550 U.S. 124, 159 (2007);

These negative psychological effects of abortion can lead to negative physical consequences such as alcohol and substance abuse.[43] Scientific studies have shown that abortion is "significantly linked to behavioral changes such as promiscuity, smoking, drug abuse, and eating disorders which all contribute to increased risks of health problems."[44] The scientific studies also demonstrate that women who have multiple abortions face a much greater risk of experiencing these complications.[45] Thus, many have advocated that there needs to be appropriate screening.[46]

La. Dep't of Health, *A Woman's Right to Know Booklet* at 21, *available at* http://www.ldh.la.gov/assets/oph/Center-PHCH/Center-PH/familyplanning/WmnsRghtToKnow.pdf; Tex. Dep't of Health, *A Woman's Right to Know Booklet* at 8, *available at* https://hhs.texas.gov/sites/default/files/documents/services/health/women-children/womans-right-to-know.pdf; American Psychiatric Association, *APA Abortion Report* (2008), *available at* http://www.abortionrisks.org/index.php?title=APA_Abortion_Report#Others_Recommending_Screening_and_Doctor.27s_Obligation.

[43] Elliot Institute, *Abortion Risks: A List of Major Physical Complications Related to Abortion* (*citing* reliable scientific studies), *available at* http://afterabortion.org/1999/abortion-risks-a-list-of-major-physical-complications-related-to-abortion/.

[44] *Id*.

[45] *Id*.

[46] For example, *see* American Psychiatric Association, *APA Abortion Report* (2008), *available at* http://www.abortionrisks.org/index.php?title=APA_Abortion_Report#Others_Recommending_Screening_and_Doctor.27s_Obligation (recommending screening); Gallagher, *Without Pre-Abortion Screening Abortion Endangers Women's Health* (Apr. 27, 2004), *available at* http://www.lifenews.com/2004/04/27/nat-478/ (discussing Dr. Reardon's call for screening based on 63 medical studies).

Abortion is a short-term solution with long-term physical and psychological consequences that may begin immediately, but can last for years.[47] The courts have recognized what the post-abortive women have experienced. For example, in *Women's Medical Center of Northwest Houston v. Bell*,[48] the Court of Appeals for the Fifth Circuit concluded that "abortion is almost always a negative experience for the patient. . . ."[49] In 2007, this Court recognized that "it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained"[50] and recognized that "[s]evere depression and loss of esteem can follow."[51]

Medical Abortions (RU-486)

Medical abortions, such as the RU-486 regimen, pose a substantial risk to the physical health of women including severe complications and the risk of death. The scientific studies demonstrate a substantially higher risk of death from infection than surgical abortions or childbirth. There is also a high failure rate of

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[47] *See generally* Schlueter, *40th Anniversary of Roe v. Wade: Reflections Past, Present and Future*, 40 OHIO NO. U. L. REV. 105 (2013) (*citing* women's affidavits); MELINDA TANKARD REIST, GIVING SORROW WORDS: WOMEN'S STORIES OF GRIEF AFTER ABORTION 10 (2000) ("A woman never forgets a pregnancy and the baby that might have been").

[48] 248 F.3d 411 (5th Cir. 2001).

[49] *Id.* at 418.

[50] Gonzales v. Carhart, 550 U.S. 124, 159 (2007).

[51] *Id.*

the drug requiring additional surgeries and medical care. Therefore, the protections of H.B. 388 are necessary to protect women.

Both the FDA[52] and Danco, the drug manufacturer,[53] have acknowledged that RU-486 poses health risks for women. The Mifeprex drug label acknowledges that "[n]early all of the women who receive Mifeprex and misoprostol [the RU-486 regimen] will report adverse reactions, and many can be expected to report more than one such reaction."[54]

The Congressional Staff Report on RU-486 cited FDA findings concerning the physical risks to women taking the RU-486 regimen.[55] These included: "abdominal pain; uterine cramping; nausea; headache; vomiting; diarrhea; dizziness; fatigue; back pain; uterine hemorrhage; fever; viral infections; vaginitis; rigors (chills/shaking); dyspepsia; insomnia; asthenia; leg pain; anxiety; anemia; leucorrhea; sinusitis;

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[52] Congressional Staff Report, *The FDA and RU-486: Lowering the Standard for Women's Health*, prepared for the Chairman of the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, at 30 (Oct. 2006) (*citing* FDA findings and reporting adverse reactions).

[53] *See* Danco's MIFEPREX™ Label, *available at* http://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.htm.

[54] *Id*. (stating adverse reactions include abdominal pain, uterine cramping, nausea, vomiting, diarrhea, pelvic pain, fainting, headache, dizziness, and asthenia).

[55] Congressional Staff Report, *The FDA and RU-486: Lowering the Standard for Women's Health*, prepared for the Chairman of the House Subcommittee on Criminal Justice, Drug Policy and Human Resources, at 30 (Oct. 2006).

syncope; endrometritis/salpingitis/pelvic inflammatory disease; decrease in hemoglobin greater than 2 g/dL; pelvic pain; and fainting."[56]

Furthermore, the FDA's Medical Officer's review indicated that, "[m]ore than one adverse event was reported for most patients. . . . Approximately 23% of the adverse events in each gestational age group were judged to be severe."[57] The Congressional Staff Report calls these "startling adverse effects."[58]

The Report also expressed concern about "the incredibly high failure rate of the drug."[59] The FDA knew the failure rate was averaging 14.6% in the U.S. trial testing of the drug through 63 days gestation. The findings revealed that 27% had ongoing pregnancies, 43% had incomplete abortions, 10% requested and had surgical terminations, and the remaining 20% of patients had surgical terminations performed because of medical indications directly related to the medical procedure.[60]

The Congressional Staff Report stated the "best" outcome was where the pregnancies were less than or equal to 49 days, but there was still a 7.9% failure rate of RU-486 requiring surgical intervention.[61] The

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[56] *Id*.

[57] *Id*.

[58] *Id*. (stating these startling adverse effects were known by the FDA during the RU-486 NDA review process).

[59] *Id*.

[60] *Id*.

[61] *Id*.

Report warned that as "the gestational age increases, the failure rate of RU-486 increases rapidly. . . ."[62] This is why the "off label" use for increased gestational age of RU-486 was not approved. The Report surmised that: "By any objective standard, a failure rate approaching eight percent and requiring subsequent surgical intervention as the 'best' outcome is a dismal result."[63]

Therefore, the Congressional Staff Report concluded that: "The integrity of the FDA in the approval and monitoring of RU-486 has been substandard and necessitates the withdrawal of this dangerous and fatal product before more women suffer the known and anticipated consequences or fatalities."[64] It further concluded: "RU-486 is a hazardous drug for women, its unusual approval demonstrates a lower standard of care for women, and its withdrawal from the market is justified and necessary to protect the public's health."[65]

In 2011, the FDA issued a report on the post-marketing events of RU-486.[66] The FDA reported that there were 2,207 adverse events (complications) in the

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[62] *Id*. (stating increased to "17% in the 50-56 days gestation group, and 23% in the 57-63 days gestation group.").

[63] *Id*.

[64] *Id*. at 40.

[65] *Id*.

[66] Food and Drug Administration, *Mifepristone U.S. Post-marketing Adverse Events Summary Through 04/30/2011* (July 2011), *available at* https://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM263353.pdf.

United States related to the use of RU-486, including hemorrhaging, blood loss requiring transfusions, serious infections, and death.[67] Among the 2,207 adverse events there were 14 deaths, 612 hospitalizations, 58 ectopic pregnancies, 339 blood transfusions, and 256 infections (including 48 "severe infections").[68]

In its 2015 pronouncement concerning RU-486, the FDA warned about sepsis infection and recommended that "healthcare practitioners have a high index of suspicion for serious infection and sepsis. . . ."[69] Women who have taken RU-486 and "develop stomach pain or discomfort, or have weakness, nausea, vomiting or diarrhea with or without fever . . . " may have an indication that sepsis is present.[70] Because sepsis is a potentially life-threatening complication and can damage organs and cause them to fail, the FDA warns that "immediate treatment with antibiotics that includes coverage of anaerobic bacteria such as *Clostridium sordellii*" should be initiated.[71]

In analyzing the scientific literature, medical researchers have concluded that there are increased

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[67] *Id*.

[68] *Id*.

[69] Food and Drug Administration, *Mifeprex (mifepristone) Information* (07/17/2015), *available at* http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm.

[70] *Id*.

[71] *Id*.

physical risks with the RU-486 regimen.[72] They also report that "Mifepristone abortion has 10 times more risk of death from infection than surgical abortion and 50 times more risk of death from infection compared to childbirth."[73]

The protections provided in H.B. 388 are necessary and important to protect women when these severe complications occur. Abortionists need hospital privileges for access to emergency care when there are physical complications.[74] Women must have truthful and accurate information about the risks and understand that emergency treatment may be needed and know how to access it.[75] Continuity of care is important for both current and future pregnancies.

B. The Requirement That Doctors Have Privileges at Local Hospitals Is Implicitly Good for Women and Provides Continuity of Their Care When Complications Arise.

At least fourteen states have adopted laws that require abortionists to have admitting privileges at a

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[72] Shuping, Harrison, Gacek, *Medical Abortion with Mifepristone (RU-486) Compared to Surgical Abortion* (Apr. 16, 2007), *available at* http://www.lifeissues.net/writers/shu/shu_06mifepristone_ru486.html.

[73] *Id*. (citations omitted).

[74] *See* Affidavits of Dr. Kathi Aultman, Appendix C; and, Dr. Anthony Levatino, Appendix D.

[75] *See* Affidavits of Dr. Kathi Aultman, Appendix C; and, Dr. Anthony Levatino, Appendix D.

nearby hospital.[76] Generally, when a doctor has admitting privileges, the doctor can transfer a patient to a local hospital if complications arise during or after an abortion and can provide the continuity of care that is needed.[77]

H.B. 388 requires that abortionists have admitting privileges at local hospitals within thirty miles from the place of the abortion.[78] These laws are intended to raise the standard and quality of care for women seeking abortions, and protects their health and welfare.[79]

A physician having local hospital privileges is critical for several reasons. First, hospital privileges help ensure qualified and competent doctors work at the hospital.[80] This is because:

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[76] *See* ALA. CODE § 26-23E-4; ARIZ. REV. STAT. § 36-449.03; ARK. CODE ANN. § 20-16-1504; FLA. STAT. § 390.012; IND. CODE § 16-34-2-4.5; KAN. STAT. ANN. § 65-4a09; LA. STAT. ANN. § 40:1061.10; MISS. CODE ANN. § 41-75-1; MO. REV. STAT. § 188.080; N.D. CENT. CODE § 14-02.1-04; OKLA. STAT. tit. 63, § 1-748; TENN. CODE ANN. § 39-15-202; TEX. HEALTH & SAFETY CODE ANN. § 171.0031; WIS. STAT. § 253.095.

[77] Shimabukuro, *Abortion, Hospital Admitting Privileges, and Whole Woman's Health v. Cole* (Sept. 25, 2015), *available at* https://www.fas.org/sgp/crs/misc/R44205.pdf (providing a report for the Congressional Research Service).

[78] TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1).

[79] *See* Whole Woman's Health v. Cole, 790 F.3d 563, 576 (5th Cir. 2015).

[80] *See* Affidavit of Dr. Kathi Aultman, Appendix C (discussing reasons why hospital privileges are so important and citing examples in her practice and as an emergency room doctor).

> The physicians on the hospital's credentialing committee investigate the applicant's background to determine the extent of his past medical training and performance, whether he is licensed and board certified, he carries malpractice insurance, and any other information that they believe is relevant.[81]

Second, physical complications can occur during or after an abortion that requires hospitalization.[82] For example, some reports claim that approximately 1,000 Texas women per year require hospitalization due to complications of the abortion.[83] Planned Parenthood's expert admitted at the trial concerning Texas H.B. 2 that annually at least 210 women went to the emergency room and some have "complications that require an Ob/Gyn specialist's treatment.[84]

Third, in many hospitals, specialists such as Ob/Gyns are not on call.[85] Relying on the comprehensive testimony and data by Dr. John Thorp, the Court of Appeals for the Fifth Circuit recognized the "lack of adequate on-call coverage by specialist physicians,

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[81] Neff, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 613-14 (1988).

[82] Affidavit of Carol Everett, Appendix B.

[83] Sullenger, *Nearly 1,000 Texas Women Hospitalized Every Year After Botched Abortions* (Apr. 22, 2014), *available at* http://www.lifenews.com/2014/04/22/nearly-1000-texas-women-hospitalized-every-year-after-botched-abortions/.

[84] Planned Parenthood v. Abbott, 748 F.3d 583, 595 (5th Cir. 2014).

[85] *Id*. at 592.

including Ob/Gyns."[86] Thus, the court concluded that "requiring abortion providers to obtain admitting privileges will reduce the delay in treatment and decrease health risks for abortion patients with critical complications."[87] Such safety measures are reasonable and protect women.

Fourth, an abortionist not having local hospital privileges is like an itinerant surgeon which the American College of Surgeons proscribes.[88] In states such as South Dakota, the abortionist is flown in from another state for the day to do abortions and flies home at the end of the day.[89] Therefore, if a woman has complications, "local doctors who are strangers to the patient and were in no way involved in the abortion procedure must see her."[90] This practice is not in the best interests of women.[91]

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[86] *Id*.

[87] *Id*.

[88] *See* American College of Surgeons, *Statement of Principles*, subsection F, *available at* https://www.facs.org/about-acs/statements/stonprin#anchor172291. For a practical application of this problem, *see* Affidavit of Dr. Kathi Aultman, Appendix C (describing the problem and drawing a contrast with surgical centers having this requirement because patient safety and care would be compromised).

[89] Report of the South Dakota Task Force at 18, *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf.

[90] *Id*.

[91] *See* Affidavit of Dr. Anthony Levatino, Appendix D (stating "This is clearly not in the best interest of the patient. For the health and safety of women, individuals performing an abortion should have hospital privileges.").

The American College of Surgeons has standards concerning the relationship of the surgeon to the patient and its proscription of what is called "itinerant surgery."[92] Part of the ethical responsibility of the surgeon is to "ensure appropriate continuity of care of the surgical patient."[93]

In Louisiana, if the abortionist does not have local hospital privileges, he or she would not be able to provide the continuity of care that is critically necessary when complications occur. This in essence is a de facto itinerant surgeon.[94]

In addition, it is important for a woman to have an ongoing relationship with her doctor as this Court assumed in *Roe* because complications can arise either immediately or over time. The scientific studies demonstrate that approximately ten percent of post-abortive women suffer from immediate complications.[95] Of this

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[92] Report of the South Dakota Task Force at 18, *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf. "Itinerant surgery involves the practice of a physician outside the physician's normal geographical area of practice to perform surgery where the physician is not personally involved in the original diagnosis or preparation of the patient and is not involved in follow-up care." *Id*. at n.5.

[93] *See* American College of Surgeons, *Statement of Principles*, subsection F, *available at* https://www.facs.org/about-acs/statements/stonprin#anchor172291.

[94] Affidavit of Carol Everett, Appendix B (stating that some of her abortionists lived some distance from their clinics and would move from clinic to clinic).

[95] Elliot Institute, *Abortion Risks: A List of Major Physical Complications Related to Abortion* (*citing* studies), *available at*

number, one-fifth or two percent were considered major complications.[96] Some complications take time to develop and will not be apparent for days, months or even years.[97]

The physical complications may have life-long consequences. For example, Jackie Bullard, who had an abortion, states that:

> Five days later, I went to the hospital with cramping, bleeding, and running a fever. I had a raging infection, and an emergency D & C was done to scrape out the baby parts that had been left inside of me. . . . After unsuccessful fertility treatments, a test revealed scar tissue damage from the complications of my incomplete abortion. When the doctor told me I could never have children, I was devastated. That day I knew I had taken the life of the only child I would ever carry.[98]

Therefore, when complications arise, it is not in the best interests of the woman to have local doctors who are "strangers" to the patient and were not

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http://afterabortion.org/1999/abortion-risks-a-list-of-major-physical-complications-related-to-abortion/.

[96] *Id*.

[97] *Id*. *See generally* JOHN C. WILKE & BARBARA H. WILKE, ABORTION: QUESTIONS AND ANSWERS 50 (2003) ("5 years is common, 10 or 20 not unusual"); Elliot Institute, *Abortion Complications*, *available at* http://afterabortion.org/1990/abortion-complications/ ("The best available data indicates that on average there is a five to ten year period of denial during which a woman who was traumatized by her abortion will repress her feelings.").

[98] Statement of Jackie Bullard, *available at* trinitylegal center.org.

involved in the abortion procedure. Itinerant surgery is proscribed. Thus, for the health and safety of women, H.B. 388 provides a reasonable requirement that an abortionist have local hospital privileges.

Because of the serious risks and complications of abortion, this Court should provide greater protection with *Casey*'s undue burden test and not use *Hellerstedt*'s[99] balancing of the benefits and burdens. As this Court explained in *Gonzales v. Carhart*, where the State has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to regulate abortion procedures in furtherance of its legitimate interest in regulating the medical profession.[100] H.B. 388's provision requiring admitting privileges regulates the medical profession and is not a substantial obstacle to the woman's exercise of the right to choose.[101]

C. Requiring Hospital Privileges Supports Roe's Assumption of a Normal Doctor-Patient Relationship.

Abortionists having hospital privileges would support this Court's assumption in *Roe* of a normal

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[99] Whole Woman's Health v. Hellerstedt, ___ U.S. ___, 136 S. Ct. 2292 (2016).

[100] Gonzales v. Carhart, 550 U.S. 124, 158 (2007).

[101] This Court stated in *Casey* that "Regulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose." Planned Parenthood v. Casey, 505 U.S. 833, 877 1992).

doctor-patient relationship by providing for a woman's continuity of care after the abortion. Women considering an abortion should be given the same continuity of care that any surgical patient currently has and would expect as part of a normal doctor-patient relationship.

In the abortion industry, normal doctor-patient relationships are not formed.[102] Generally, patients do not have continuity of care from the abortion provider, but patients are told if they have a problem to go to the nearest Emergency Room.[103] This is neither continuity of care nor a normal doctor-patient relationship.

At the heart of *Roe* is the assumption that the abortion decision should be made by a woman in consultation with her personal doctor.[104] In its decision, the *Roe* Court repeatedly referenced the assumption that the woman's decision would be made privately in consultation with her physician. Abortion practice, however, does not usually involve a normal doctor-patient relationship, nor is it a voluntary, informed private decision between a woman and her doctor.[105]

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[102] *See* Affidavits of Carol Everett, Appendix B; and, Dr. Kathi Aultman, Appendix C.

[103] *See* Affidavit of Dr. Kathi Aultman, Appendix C.

[104] *See* Roe v. Wade, 410 U.S. 113, 153 (1973) ("All these are factors the woman and her responsible physician necessarily will consider in consultation.").

[105] *See* Report of the South Dakota Task Force at 16-17, *available at* http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf (finding "no true physician-patient relationship").

Usually women do not see the abortionists until just before the procedure is performed.[106]

While the Court's opinion in *Roe* focused on the woman's initial decision to obtain an abortion, the underlying assumption that the attending physician would be involved – by parity of reasoning – the woman should have the benefit of counsel from her physician if complications should arise post-abortion.

For example, the physician who performed the abortion would normally be in the best position to assess the complication, based on his or her knowledge of the woman's condition and the procedures that either had been used, or not used, during the abortion. It would be potentially harmful to the woman to be admitted to a hospital post-abortion, and not have the advice and care of the physician who performed the abortion – a medical procedure which the *Roe* Court itself acknowledges can lead to complications.[107]

Documents are available on a clearinghouse website concerning abortionists' lack of continuing care, where there should have been an ongoing doctor-patient relationship, which would have helped and benefited the woman.[108] For example, abortionist James

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[106] *Id.* at 16 (finding the abortionist "sees the pregnant mother for the first time in the procedure room, only after the consent form has been signed and the woman has made her commitment to undergo the abortion").

[107] Roe v. Wade, 410 U.S. 113, 145-46 (1973).

[108] The website Abortion.Docs.org is a clearinghouse for information from across the nation. The searchable database has

Pendergraft, a Florida abortionist, sent a patient to the hospital for a potential uterine perforation, but he failed to tell the physicians at the hospital that he had already removed the baby's leg.[109] Because the hospital physician did not know this, he had to search the woman's uterus and then do X-rays and a CT scan to make sure he did not cause an infection by leaving the missing body part in her uterus. The Administrative Law Judge found that Pendergraft "breached the standard of care" which constituted medical malpractice.[110] This case illustrates the problem of not having the continuity of care from the attending physician.

H.B. 388 supports the belief that a woman should have the medical advice of her physician post-abortion. This is certainly consistent with *Roe*'s assumption that there would be an ongoing normal doctor-patient relationship. If the abortionist does not have admitting privileges where his patient must seek medical attention, then the information may be incomplete or limited to remote transmission of information as demonstrated in the Pendergraft case. This is a serious problem because "80 percent of serious medical errors involve miscommunication between caregivers when

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documents such as health code violations, abortion injuries, malpractice claims, disciplinary action, and criminal conduct.

[109] Dep't of Health, Board of Medicine v. Pendergraft, State of Florida Division of Administrative Hearings, DOH case No. 10-0208 (2010), *available at* http://abortiondocs.org/wp-content/uploads/2012/01/pendfinal012610.pdf.

[110] *Id*. at 20-21. Based on the findings, the Administrative Law Judge imposed a two-year suspension, followed by a three-year probation, and a fine of $20,000.00. *Id*. at 25.

patients are transferred or handed-off."[111] A woman should have the benefit of her attending physician's continuity of care so that any complications can be accurately and efficiently addressed.

There are serious and detrimental effects for women if H.B. 388 is not upheld.[112] This is because it would (1) keep the abortion doctor unaccountable to his patient and to the community in which he practices; (2) allow him to provide women with substandard medical care which places their lives in danger; and (3) would protect the doctor and harm the woman.

Abortion poses significant physical risks including death, and therefore, H.B. 388 enacted reasonable protections for women by providing a qualified doctor who can give continuity of care. H.B. 388's requirement for abortionists to have hospital privileges is necessary for the health and safety of women and supports this Court's assumption in *Roe* of a normal doctor-patient relationship. This Court has approved these health and safety laws.[113]

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[111] Planned Parenthood v. Abbott, 748 F.3d 583, 592 (5th Cir. 2014) (*citing* testimony of Dr. John Thorp referring to several significant studies).

[112] *See generally* Affidavits of Carol Everett, Appendix B; Dr. Kathi Aultman, Appendix C; and, Dr. Tony Levatino, Appendix D.

[113] Planned Parenthood v. Casey, 505 U.S. 833, 878 (1992) (recognizing that "[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion").

III. THIS COURT HAS RECOGNIZED THAT BROAD DEFERENCE SHOULD BE GIVEN TO LEGISLATIVE FINDINGS AND ENACTMENTS, AND THEREFORE, THE COURT OF APPEALS' DECISION SHOULD BE AFFIRMED.

A. Health Issues Are Complex Issues That Are Fact Bound and Involve National and State Policy and Are Best Left to the Legislative Branches of Government.

For over a century prior to *Roe v. Wade*[114] and *Doe v. Bolton*,[115] health issues such as abortion were traditionally state issues.[116] This Court recognized, under what was later called the state's "police power," states could regulate "health laws of every description."[117] Furthermore, this Court gives deference to legislative judgments.[118]

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[114] 410 U.S. 113 (1973).

[115] 410 U.S. 179 (1973).

[116] Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 2 (1824).

[117] *Id*. at 203.

[118] Gonzales v. Carhart, 550 U.S. 124, 163 (2007) (stating state and federal legislatures have wide discretion to pass legislation where there is medical and scientific uncertainty); Turner Broadcasting System, Inc. v. F.C.C., 520 U.S. 180, 195 (1997) (stating substantial deference should be given because legislature is better equipped to amass and evaluate the vast amounts of data on legislative issues and out of respect for legislative authority); Dominion Hotel v. State of Arizona, 249 U.S. 265, 268 (1919) (stating deference due to legislative judgments has been repeatedly emphasized).

Since *Roe*, this Court has continued to recognize that states may make reasonable health and safety regulations that do not impose an undue burden for women.[119] In *Planned Parenthood v. Casey*, this Court recognized that because the State has a substantial interest in the life of the unborn child, the State may promulgate regulations that do not create an undue burden on the woman's right to decide.[120] In particular, regulations that are "designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden."[121] This Court recognized that "[a]s with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion."[122]

Furthermore, this Court has upheld health regulations that "are not efforts to sway or direct a woman's choice, but rather are efforts to enhance the deliberative quality of that decision or are neutral regulations on the health aspects of her decision."[123] The Louisiana Legislature did not attempt to sway a woman's decision but to protect her health once the decision is made.

As long as there is a "commonly used and generally accepted method" of abortion, there is not a

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[119] *See* Gonzales v. Carhart, 550 U.S. 124, 146 (2007); Planned Parenthood v. Casey, 505 U.S. 833, 876 (1992).

[120] Planned Parenthood v. Casey, 505 U.S. 833, 876 (1992).

[121] *Id*. at 877.

[122] *Id.* at 878.

[123] *Id*. at 917 (Stevens, J., concurring in part and dissenting in part) (providing examples of valid regulations).

"substantial obstacle to the abortion right."[124] Specifically, this Court stated in *Gonzales*[125] that "[c]onsiderations of marginal safety, including balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends."[126] H.B. 388's effort to protect the health and safety of women is a legitimate end as this Court has articulated.

As one federal court recognized: "Historically, laws regulating abortion have sought to further the state's interest in protecting the health and welfare of pregnant women. . . ."[127] In furtherance of its interest, the State of Louisiana passed H.B. 388 to protect pregnant women from the significant known risks and complications that can occur during and after an abortion. This is within the State's authority and competence, and therefore, should be given deference.

B. The H.B. 388 Provisions Are Within This Court's Constitutional Framework and Should Be Upheld.

Since *Casey*, the Louisiana Legislature has properly exercised its authority to protect women who are considering an abortion. For example, the Louisiana Legislature passed the State's Women's Right to Know

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[124] Gonzales v. Carhart, 550 U.S. 124, 165 (2007).

[125] 550 U.S. 124 (2007).

[126] *Id*. at 166.

[127] McCormack v. Hiedeman, 694 F.3d 1004, 1010 (9th Cir. 2012).

law[128] to inform "women while protecting their safety and the lives of unborn children in four specific ways."[129] To further this end, the Department of Health produced *A Woman's Right to Know Booklet*[130] to inform women of the gestational development of their baby and the known risks and complications of abortion and pregnancy. The Louisiana Legislature's enactment of H.B. 388 is another step to protect women by providing common sense safety laws for women considering an abortion just as any other surgical out-patient has.

Furthermore, legislative bodies, unlike courts, are able to hold hearings, review the scientific data, and enact or revise health and safety laws to keep pace with the scientific evidence.[131] If legislatures are not able to evaluate the evolving medical knowledge and

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[128] During the 2011 session, the Louisiana Legislature passed Act 411, the "Woman's Right to Know Act," LA. STAT. ANN. § 40:1061.17 (stating the legislative findings and purposes).

[129] Louisiana Dep't of Health, "Woman's Right to Know," *available at* http://www.ldh.la.gov/index.cfm/page/812.

[130] Louisiana is one of twenty-eight states that have *A Woman's Right to Know* law and booklets so that a woman will know the medical risks associated with abortion and have scientifically accurate medical facts about the development of her unborn child. *See A Woman's Right to Know: Casey-style Informed Consent Laws* (2018), *available at* http://www.nrlc.org/uploads/stateleg/WRTKFactSheet.pdf.

[131] *See* McCorvey v. Hill, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring but also writing the majority opinion for the panel). Judge Jones stated that she could not "conceive of any judicial forum in which McCorvey's evidence could be aired." *Id*. By constitutionalizing the issue, legislative bodies cannot meaningfully debate the scientific evidence and this has led to a "perverse result" which affects over a million women each year. *Id*.

scientific evidence, then it "leaves our nation in a position of willful blindness."[132] Thus, this Court correctly gives deference to legislative enactments and findings.

The Amici urge this Court to give deference to the Louisiana Legislature which enacted H.B. 388 to protect the health and safety of women once they have made the decision to have an abortion. H.B. 388's safety provisions are based on current, scientific evidence and do not create an undue burden on her decision to have an abortion, and therefore, should be upheld.

CONCLUSION

For the foregoing reasons, the requirements of H.B. 388 should be upheld and the decision of the United States Court of Appeals for the Fifth Circuit affirmed.

Respectfully submitted,

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[132] *Id*. at 853.