Nos. 18-1323, 18-1460

IN THE

Supreme Court of the United States

JUNE MEDICAL SERVICES L.L.C., *et al.*,

Petitioners,

v.

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

Respondent.

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

Cross-Petitioner,

v.

JUNE MEDICAL SERVICES L.L.C., *et al.*,

Cross-Respondents.

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

BRIEF OF MEDICAL STAFF PROFESSIONALS AS *AMICI CURIAE* IN SUPPORT OF JUNE MEDICAL SERVICES L.L.C., *ET AL.*

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Interest of *Amici Curiae*[1]

Amici are healthcare practitioners, managers, and consultants. They have served on credentialing committees and acted as hospital trustees and chief medical officers. *Amici* submit this brief to provide the Court with a correct understanding of how admitting privileges are granted and why they present significant barriers that abortion providers, by the very nature of their practice, are unable to meet.

Nancy J. Auer, M.D., is a retired emergency physician who served as Director of Emergency Services, Chief of Medical Staff, Vice President of Medical Affairs, and Chief Medical Officer for Swedish Health Systems in Seattle. In these roles, Dr. Auer oversaw medical staff credentialing. She is Past Chair of the Board of Trustees of Swedish and served on the Medical Affairs Committee of the Board, which oversees credentialing of Swedish's five hospitals.

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[1] *Amici* certify that both parties have consented to the filing of this *amicus* brief. SUP. CT. R. 37.3(a). *Amici* also certify that no counsel for any party authored this brief in whole or in part, no party or party's counsel made a monetary contribution to fund its preparation or submission, and no person other than *Amici* or their counsel made such a monetary contribution. SUP. CT. R. 37.6.

Leslie Bishop served as Director of Medical Staff Services for many decades at hospitals in the Denver area. She is past President of the Colorado Association of Medical Staff Services. In October 2019, she was inducted into the National Association of Medical Staff Services ("NAMSS") Hall of Fame, an organization of 6,000 plus medical staff and credentialing services professionals.

Rick Bishop, M.D., has been chairperson of many credentials committees and is former Chief of Staff for a number of organizations in the Denver area. He is a family physician.

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Carol Cairns, CPMSM, CPCS, is a medical service manager who coordinated and directed medical staff services for Presence Saint Joseph Medical Center and Silver Cross Hospital in Illinois, serving on the Bylaws and Credentialing Committee. She founded PRO-CON, a consulting firm specializing in credentialing, privileging, medical staff organization operations, and survey preparation. She has written all six editions of *Verify and Comply: A Quick Reference*

Guide to Credentialing Standards, the third and fifth editions of *Core Privileges: A Practical Approach to Development and Implementation*, and *The Medical Staff's Guide to Overcoming Competence Assessment Challenges*.

David Dodge is founder, former President and CEO of PHT Services, Ltd., a South Carolina-based risk management services organization serving the state's not-for-profit hospitals and health care systems. Mr. Dodge oversaw individual assessments of hospital credentialing programs and directly supervised the credentialing of physicians associated with the organization's workers' compensation program.

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Linda Riggs, CPMSM, has over 20 years of progressive responsibility for hospital medical staff services, physician credentialing, regulatory compliance, and medical staff activities. She is Director of Medical Staff Services at Eisenhower Medical Center in California, overseeing medical staff services, including credentialing, bylaws, and accreditation compliance. Ms. Riggs previously was Director of Medical Staff Services at Desert Regional Medical Center and at John. F. Kennedy Memorial Hospital, both in California.

Todd Sagin, M.D., J.D., is a physician executive nationally recognized for his work with medical staffs on bylaws, strategic planning, and credentialing. He served on advisory panels to hospital accreditation organizations such as the Joint Commission, including a special panel advising on credentialing standards. Dr. Sagin is former VP & Chief Medical Officer of Temple University Health System. Currently, he is Medical Director of the LifeGuard Program, sponsored by the Foundation of the Pennsylvania Medical Society, which evaluates physician competency on behalf of state medical boards. He is board certified in family medicine and geriatrics.

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Mark Smith, M.D., M.B.A., FACS, a consultant with HG Healthcare Consultants, has expertise in peer review, ongoing and focused professional practice evaluation, deficient practitioner performance management, criteria-based privileging, low-volume practitioners, ED call, and external focused review. Dr. Smith has 25 years of clinical practice, including President of Medical Staff, Chief of Surgery, Chairman of Peer Review Committee, and Medical Director of Cardiac Surgery at Desert Regional Medical Center in California.

Michael Stauder, M.D., FACC, is Director of Cardiac Imaging and prior Chair of the Department of Internal Medicine at Heywood Hospital in Massachusetts. Dr. Stauder has overseen and coordinated the credentialing and clinical activities of general internists, internal medicine subspecialists, and hospitalists, and he is responsible for ongoing evaluation of department members through ongoing and focused professional practice evaluation. He is a member of the hospital's Medical Executive Committee.

Abigail Winkel, M.D., is Associate Professor, Vice Chair for Education and former Residency Program Director in the department of Obstetrics and Gynecology at the New York University School of Medicine. She oversees credentialing for residents and fellows and reviews privilege request forms for physicians trained at New York University Langone Medical Center.

Summary of Argument

In 2016, this Court declared unconstitutional Texas's H.B. 2, which required physicians to have admitting privileges within 30 miles of the clinics at which they provided abortions. Many signers of this brief filed an *amicus* brief in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) ("*WWH*"), explaining the purposes of hospital admitting privileges, how they are granted, and why abortion providers are unlikely to obtain or maintain admitting privileges. This Court relied on that brief in its decision. *Id.* at 2312.

In 2014, the State of Louisiana passed Act 620, enacting an admitting privileges requirement identical to Texas's law: a physician "performing or inducing an abortion shall have active admitting privileges at a hospital that is located not further than thirty miles from the location at which the abortion is performed or induced." La. Sess. Law. Serv. Act 620 (H.B. 388), § 1(A)(2)(a) ("Act 620" or the "admitting privileges requirement").[2] "'[A]ctive admitting privileges' means that the physician is a member in good standing of the medical staff of a hospital that is currently licensed by the [Department of Health and Hospitals], with the ability to admit a patient and to provide diagnostic and surgical services to such patient . . . ." *Id.* While Louisiana's alleged purpose was to promote women's health, the governor stated Act 620 would "build upon the work . . . done to make Louisiana the most pro-life

[2] Act 620 amended La. Rev. Stat. § 40:1299.35.2, recodified at § 40:1061.10.

state in the nation." ROA 10936-37; JA 582-85; Pet. App. ("App.") 195a.

Act 620—like Texas's unconstitutional law—will make it impossible for qualified physicians in Louisiana to provide abortion services in most cases, thus impeding women's health. *Amici* will explain how this requirement, which the Fifth Circuit mischaracterizes as simple, bars qualified physicians from practicing medicine in outpatient centers where the vast majority of abortions are performed.

Since this Court decided *WWH*, nothing has materially changed concerning the processes or requirements for obtaining hospital admitting privileges. As *Amici* demonstrated in 2016, admitting privileges are not a simple, straightforward evaluation of a physician's competence. Instead, a hospital's decision to grant admitting privileges requires a long process that evaluates physicians based on criteria primarily related to a hospital's interest in the care of hospital *inpatients*. At any point, a hospital may deny privileges based on numerous factors irrelevant to *outpatient* abortion providers.

To secure admitting privileges, a physician first must be recommended and approved for membership on a hospital's medical staff ("credentialing"). Only then is a physician granted authority to admit patients and perform specific procedures ("privileging"). Credentialing and privileging require physicians to meet pre-qualification criteria before hospitals even provide applications. Most outpatient providers never

have the opportunity to apply for credentials and privileges because they are barred by pre-qualification criteria.

As the United States District Court for the Middle District of Louisiana ("District Court") explained:

> [H]ospitals may deny privileges or decline to consider an application for privileges for myriad reasons unrelated to competency. Examples include the physician's expected usage of the hospital and intent to admit and treat patients there, the number of patients the physician has treated in the hospital in the recent past, the needs of the hospital, the mission of the hospital, or the business model of the hospital.

App. 172a. There is an inverse relationship between an abortion provider's expertise and his ability to obtain admitting privileges: the more he focuses on outpatient abortion procedures, the less frequently he will have occasion to perform the hospital-based procedures relevant to obtaining admitting privileges.

Even if an abortion provider does obtain admitting privileges, he likely will lose them, as he will be unable to meet ongoing review requirements due to the nature of his *outpatient* practice.

Admitting privileges requirements erect insurmountable burdens for most abortion providers. This is no less true in Louisiana than Texas.

Abortions are extraordinarily safe. One million abortions are performed nationwide each year, including 10,000 in Louisiana. App. 155a. Approximately 90 percent of abortions are performed during the first trimester and almost all are performed in outpatient settings. App. 209a. In Louisiana, complications resulting in emergency hospital transfers occurred "far less than [once] a year, or less than one per several thousand patients." App. 214a. This high degree of safety erects one of the greatest obstacles to abortion providers obtaining admitting privileges; they have little, if any, need to treat patients in hospitals because the procedure is so safe.

Act 620 would bar qualified abortion providers from performing abortions and reduce the number of abortion providers in Louisiana to a single clinic and physician. This directly contravenes the Act's stated purpose to protect women's health, and it would inflict greatest harm on poor women who have no alternatives. App. 155a. In short, Act 620 should be struck down as unconstitutional for the same reasons the Court found Texas's law unconstitutional.

Argument

The United States Court of Appeals for the Fifth Circuit ("Fifth Circuit") found Act 620 performed a "credentialing function" that "promote[d] the wellbeing of women seeking abortion." App. 39a. In reality, hospitals make credentialing and privileging decisions based on an array of factors, many of which are unrelated to competence or patient wellbeing. In-

stead, these factors are subjective and aimed at hospitals' missions and financial objectives.[3] At each stage in the credentialing and privileging process, these factors pose significant obstacles for abortion providers. While the Fifth Circuit tried to distinguish Louisiana's law from the Court's ruling in *WWH*, erroneously holding that admitting privileges perform a different function in Louisiana than Texas, the insurmountable barriers to abortion providers posed by such requirements do not vary by state. An admitting privileges requirement underscores a fundamental mismatch between a hospital's business practices and the nature of outpatient abortion care.

Further, the Fifth Circuit was incorrect in stating that "[a]lmost all Texas Hospitals required that for a doctor to maintain privileges there, he or she had to admit a minimum number of patients annually [but few] Louisiana hospitals make that demand." App. 2a. The records in both *WWH* and this case evidence that hospitals are unlikely to grant admitting privileges to outpatient providers who seldom admit patients; this simply runs afoul of hospitals' business models. *WWH*, 136 S. Ct. at 2312; App. 180a. As in Texas, patient minimums, along with other factors, will preclude Louisiana abortion providers from obtaining, much less maintaining, admitting privileges, imposing an unconstitutional burden on women seeking to access abortion services.

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[3] *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 Am. J.L. & Med. 173, 179-180 (1996); John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 Buff. L. Rev. 459, 469–471 (2005) ("*Beyond the Bylaws*").

I. Hospital Requirements Deny Most Abortion Providers the Ability to Obtain Admitting Privileges

To obtain admitting privileges, a physician must apply for membership on a hospital's medical staff through the credentialing process and must request specific privileges that delineate exactly what the physician can do in the hospital, such as admitting patients, ordering tests, performing surgery, and prescribing medication. Credentialing and privileging usually occur simultaneously; however, a physician's privileges only are granted after approval for staff membership.

Although hospitals enjoy broad discretion, most hospitals utilize uniform standards established by The Joint Commission ("JC"), a national hospital accreditation organization. JC-accredited hospitals are "deemed" qualified to participate in Medicare and Medicaid, crucial sources of patients and funding. 42 U.S.C. 1395bb; 42 C.F.R. 488.5; JC, "Facts about federal deemed status and state recognition."[4] Hospitals obtain and maintain accreditation by demonstrating compliance with JC standards, detailed in lengthy manuals covering all areas of hospital operation, from

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[4] *Available at* https://www.jointcommission.org/facts_about_federal_deemed_status_and_state_recognition/ (last updated Dec. 13, 2018).

patient care to quality control to staff organization, among others.[5]

The JC's Accreditation Manual also establishes extensive standards for credentialing and privileging, which all JC-accredited hospitals must follow. *See* Accreditation Manual, "Medical Staff." The Fifth Circuit erroneously determined that obtaining admitting privileges at Texas hospitals involved materially significant obstacles absent from Louisiana hospitals. App. 2a-3a, 41a-42a. In reality, hospitals in Texas, Louisiana, and other states follow JC guidelines, which make it nearly impossible for abortion providers to obtain admitting privileges. Nationally, approximately 4,000 hospitals—or 70 percent—are JC accredited, including 166 of 207 Louisiana licensed hospitals and *all 13* hospitals in the record. Louisiana Department of Health, Health Standards Section, "New: Program Provider Directory Spreadsheets: Licensed Providers Spreadsheet;"[6] Quality Check, "Find a Gold Seal Health Care Organization."[7]

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[5] *See generally* JC, *Comprehensive Accreditation Manual for Hospitals 2019 Update 2* (effective Jan. 1, 2020) ("Accreditation Manual"). *Amici* hereinafter cite JC standards by number and "element of performance" ("EP"), *e . g.*, "MS.06.01.03, EP 3."

[6] *Available at* http://ldh.la.gov/index.cfm/page/3008 (last visited Nov. 28, 2019).

[7] *Available at* https://www.qualitycheck.org/search/?keyword=louisiana#keyword=louisiana&accreditationprogram=Hospital (last visited Nov. 28, 2019).

A. Threshold Requirements Preclude Abortion Providers from Obtaining Staff Membership Applications

For many hospitals, credentialing begins with a physician requesting the actual application, which allows hospitals to ensure physicians meet basic, threshold qualifications.[8] Hugh Greeley, *The Greeley Guide to Medical Staff Credentialing* 18 (1999) (*"Credentialing Guide*").

As a first step, hospitals will confirm they have the facilities the physician is seeking. Additionally, not all hospitals have capacity to handle outpatient providers admitting patients. For example, some small, rural hospitals transfer patients for treatment or are closed systems exclusively for hospitalists. JA 1144, 1255-56. One hospital located within 30 miles of Petitioner Hope Medical Group for Women ("Hope Clinic") refused Doe 1's request for an application, stating they could not accept any type of transfer. JA 712.

New Orleans East Hospital ("East Hospital") "screens" all application requests to preliminarily assess eligibility. ROA 9040. West Jefferson Medical Center ("West Jefferson"), Touro Infirmary ("Touro"), Woman's Hospital Baton Rouge ("Woman's Hospital"), and University Health Shreveport Medical ("University Health") forward all requests to the Medical Staff Office, Credentials Committee, Medical Executive

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[8] While many hospitals consider threshold requirements discussed *infra* before providing an application, others consider the same criteria at a later stage.

Committee, or similar committee and governing body to determine whether to release an application. ROA 9178-80, 9479, 10280-81, 10414.

At University Health, one of four qualifying hospitals within 30 miles of Hope Clinic, a physician cannot simply request an application; instead, the hospital *invites* applicants, who must be appointed faculty at Louisiana State University Health Sciences Center-Shreveport School of Medicine. ROA 9474. Doe 1 applied to the other three qualifying hospitals, but was not extended an invitation from University Health, which explained it "met with resistance" within the department regarding Doe 1's request for an application. JA 1145-46.

Another threshold criterion is the signature of a designated alternate (or "covering") physician willing to care for an applicant's patients when he is unavailable. The Record contains 13 hospitals' bylaws where the Doe physicians sought privileges. *Amici* considered 11 hospitals' bylaws,[9] nine of which required applicants to designate an alternate who already had admitting privileges at the hospital. ROA 9154, 9374, 9383, 9478, 9667, 10302, 10481, 10637, 10659-60, 10676. The other two hospitals also plainly considered this criteria. ROA 9250 (requiring doctor to "arrange a suitable alternative" when he cannot provide care), 10426 ("[t]he clinical privileges recommended . . . shall be based upon consideration of" the "availabil-

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[9] The other two hospitals' bylaws are part of the sealed record and are unavailable to *Amici*.

ity" of a covering physician). Abortion providers—especially in a state like Louisiana—often cannot find a designated alternate due to intense, widespread hostility to abortion. App. 183a-88a (discussing "climate" for abortion providers in Louisiana). Louisiana abortion clinics have been subject to protests and several dangerous attacks, while providers and their families have been victims of violent threats and harassment. *Id.* Does 3, 4, and 5 all testified about difficulty finding covering physicians because of animosity toward abortion. App. 143a, 178a, 244a, 252a. When Doe 5 asked a physician with whom Delta Clinic had a transfer agreement to be his covering physician at Woman's Hospital, the doctor refused, citing fear that anti-abortion protestors would threaten him or his family or protest outside his private practice. JA 1135. Doe 5 sought admitting privileges nonetheless, but his application remained pending several years later. App. 244a-45a.

Many hospitals require physicians to maintain a primary residence and/or office within a certain distance from the hospital.[10] This requirement poses an onerous burden in rural states or states with few abortion providers, as physicians often travel significant distances to provide care. West Jefferson requires applicants to prove they have (or plan to establish) an

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[10] Of the 11 hospitals' bylaws reviewed, seven contain this requirement. ROA 9154, 9171, 9179, 9192, 9263, 9383, 9666, 10414, 10484, 10592-93, 10661. An eighth states, "[t]the following information is required to determine eligibility . . . Geographic location of office and residence (where applicable)." ROA 9479-80.

office within specific parishes. ROA 9150, 9179. Likewise, East Hospital requires applicants to have an office or residence within one hour or 50 miles of the hospital, and Minden Medical Center ("Minden") requires applicants to maintain an office or residence within 30 miles of the hospital. ROA 9041, 9263. Such requirements may pose insurmountable barriers for abortion providers who, while practicing at an abortion clinic 30 miles from a hospital, may live in another locale. The problem is compounded for abortion providers who practice at multiple clinics, perhaps on opposite sides of the state; in Louisiana, abortion clinics are clustered at the north and south of the state. Doe 2 lives in Bossier City, Louisiana, approximately 330 miles from Causeway Clinic, where he performed abortions before it closed. JA 379. Doe 5 travels nearly 82 miles between New Orleans and Baton Rouge to practice at Women's Clinic and Delta Clinic. JA 1134. The Fifth Circuit faulted Doe 5 for not pursuing privileges at three hospitals within 30 miles of Delta Clinic due to a lack of a designated alternate, but given Doe 5's residence and primary office in New Orleans, his applications likely would have been denied anyway because all three Baton Rouge hospitals require staff members to have offices located nearby. ROA 10414, 10592, 10661.

Other threshold requirements relate to a physician's specific area of practice and training. Many hospitals require physicians to hold specific board certifications in order to perform particular procedures, thus barring physicians from other specialties from even applying for the privilege. For instance, a hospital may require board certification in obstetrics and

gynecology to be granted the privilege to perform obstetrical or gynecological procedures, even though many family physicians and surgeons are trained to perform such procedures. Similarly, some hospitals require completion of a residency in the particular specialty for which the physician seeks privileges. East Hospital, Woman's Hospital, Baton Rouge General Hospital ("Baton Rouge General"), Willis-Knighton Bossier Health Center ("Willis-Knighton"), and University Health all require, with limited exceptions, applicants be board certified in their specialties. ROA 9035, 9475, 9667-68, 10414-15, 10610.

Doe 1's experience illustrates the barriers threshold requirements pose for abortion providers. Doe 1 has provided abortions for years, but has specialties in family and addiction medicine.[11] Doe 1 initially sought medical staff membership at University Hospital in family/sports medicine because he completed his residency there. JA 706-10. After his application was denied due to resistance to his abortion practice, he was instructed to contact the OB/GYN program, but the department head informed Doe 1 that admission was inappropriate for a family medicine doctor. *Id.* Doe 1 also applied for courtesy staff at Willis-Knighton, which has an addiction recovery center, but the hospital refused his application because he had not completed a residency in addiction medicine. JA 733, 735-36 (explaining that addiction medicine is a

[11] In 2013, Louisiana added a requirement that "[n]o person shall perform or induce an abortion unless that person . . . is currently enrolled in or has completed a residency in obstetrics and gynecology or family medicine." 2013 La. Sess. Law Serv. Act 259 (S.B. 90) (WEST).

new specialty with limited residency programs unavailable when Doe 1 completed residency).

Finally, hospitals often require that physicians commit to take on-call shifts, serve on committees, attend meetings, pay dues, and contribute to the hospital's financial and administrative health. Appointment to a particular category of medical staff is contingent upon the physician agreeing to fulfill the corresponding obligations. Eight of the hospitals reviewed require applicants to agree to provide emergency on-call coverage. ROA 9250, 9254, 9262, 9377, 9383, 9478-79, 9667, 9671, 10421-23, 10426, 10481-82, 10513, 10592, 10637.[12]

Threshold requirements will prevent most abortion providers from even having the opportunity to obtain or submit applications for staff membership, much less obtain admitting privileges, thus imposing an undue burden on women seeking abortion services. This is true in Louisiana no less than in Texas and other states.

B. Credentialing: Obtaining Appointment to the Medical Staff

An applicant who meets a hospital's threshold criteria will receive an application for medical staff mem-

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[12] One of the three hospitals' bylaws that did not mention this requirement were produced only in excerpted form, and require the performance of "obligations" and "responsibilities" that apparently are set forth in a part of the bylaws not in the record. ROA 10656-64.

bership through which the applicant requests membership in a particular staff category and specific clinical privileges. Credentialing and privileging involve complex, multi-step processes through which individuals and committees evaluate extensive documentation, verify information with outside sources, determine whether the applicant should be admitted to the medical staff, and delineate what privileges he should be permitted to exercise. MS.06.01.01, MS.06.01.03, MS.06.01.05. Information reviewed includes licensure and training, evidence of physical ability to perform, peer recommendation letters, and professional practice review data. *Id.* At numerous points, hospitals may seek additional information. While hospital bylaws may provide guidelines concerning review timeframes, the process often takes six months or longer; some applications, like those of many Louisiana abortion providers, languish for years without final action. App. 169a-171a. Here, *Amici* discuss the obstacles a highly competent abortion provider might encounter throughout the process.

1. Medical Staff Categories Do Not Contemplate Outpatient Abortion Providers Seeking to Practice in Hospitals

Hospital staff membership is broken into various categories, corresponding to different expectations for hospital participation, numbers of patient encounters, privileges afforded, and more. While hospitals use differing terminology, membership on the "Active Staff" generally affords and/or demands the highest level of in-hospital autonomy and activity. Active Staff usually must meet a minimum number of an-

nual patient admissions or encounters, attend medical staff meetings, serve on committees, and regularly take emergency call. This ensures Active Staff are committed to and actively involved in hospital functions. Many hospitals have a second category, commonly called "Courtesy Staff," requiring fewer annual patient contacts and still allowing admitting privileges.[13] Other categories may include affiliate, consulting, senior, emeritus, or honorary staff; these generally do not afford active admitting privileges.[14]

Many Louisiana hospitals specify the minimum number of annual patient encounters required for Active Staff. East Hospital requires at least 12 patient contacts annually, University Health requires 20 or more, and Willis-Knighton requires at least *50*. ROA 9068, 9508, 9639-42. Ochsner requires new applicants to have at least 12 patient contacts within the first year to graduate from provisional to Active Staff. ROA 9376-77.

Because of these requirements, abortion providers might be considered for courtesy, not active, staff membership. However, at many Louisiana hospitals, Courtesy Staff only is available to physicians who are Active Staff at another hospital. ROA 9642, 10371.

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[13] Hospitals often limit the number of annual patient encounters Courtesy Staff may have before requiring Active Staff membership. ROA 9069-70, 9154-55, 9250, 9378, 9509.

[14] For example, Willis-Knighton offers consulting, honorary, and affiliate categories, which do not allow physicians to admit or independently treat patients. ROA 9643-45. *See also* ROA 10372, 10679-80.

Given the difficulty obtaining admitting privileges at *one* hospital, this alternative would be virtually impossible for abortion providers. In addition, even Courtesy Staff is foreclosed to abortion providers whose annual number of hospital transfers would be "far less than once per year." App. 212a-214a (plaintiff Hope Clinic's providers would have occasion to transfer *one or two patients per decade*).

In upholding Act 620, the Fifth Circuit wrongly relied upon the supposed absence of minimum admission requirements at Louisiana hospitals to distinguish Act 620's impact from Texas's law. App. 33a. The court suggests that Texas hospitals focus more on admission numbers, whereas Louisiana hospitals "have a competency requirement [whereby] [c]ompetency is evaluated either by requesting the doctor to provide information about recent admissions at any other hospital or by having a provisional admittance period during which the hospital can personally observe and evaluate him." *Id.* at 41a-42a. The Fifth Circuit fails to understand that demanding abortion providers supply information about recent admissions and/or be observed providing inpatient treatment erects an obstacle just as insurmountable as minimum admission rates because abortion providers rarely, if ever, admit patients to hospitals. All 11 Louisiana hospitals have one or more such requirements, except for one hospital, which only has a short excerpt of its bylaws available for review in the record.[15]

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[15] *See* ROA 9154, 9184, 9191-92, 9196-97; 9253-54, 9269, 9280-81; 9372, 9376-77, 9390-91; 9493-94, 9515-16; 9632-33, 9642, 9667, 9669, 9672, 9676, 9678, 9685-86, 9688-89, 9698, 9701-03,

2. Application Processes Prevent Abortion Providers from Complying with Act 620

Once a hospital receives a complete application, it verifies the contents with primary sources, including specialty boards, employers, and schools. The hospital also searches the National Practitioner Data Bank, performs background checks, and reviews peer recommendation letters. MS.06.01.05, EPs 2, 7; MS.06.01.03, Introduction and EPs 5, 6.[16] *See* ROA 9184, 9381, 10304, 10486, 10684. Woman's Hospital requires references from at least two physicians with "recent extensive experience . . . observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character." ROA 10419. Failure to verify information exposes a hospital to unlimited liability under theories of negligent credentialing, so a hospital may deny an application when a third party fails to submit requested documentation. *See Billeaudeau v. Opelousas Gen. Hosp. Auth.,* 218 So. 3d 513 (La. 2016).

9853-54; 10283, 10301, 10309-12, 10319; 10382, 10396, 10414, 10416, 10420-22, 10436, 10443; 10478, 10488, 10490, 10496-98, 10512, 10519, 10531; 10610, 10613, 10619, 10647, 10649; 10690, 10693, 10679. The record contains only excerpts of Laine Regional Medical Center's bylaws. ROA 10656-64.

[16] The JC Accreditation Manual lists certain items for review regarding privileging, but many items are examined during credentialing as well.

The application then moves through a series of individuals and committees who review the application, gather additional information, and pass along a recommendation to the next committee. Committee members also may interview applicants. If an applicant does not (or cannot) answer questions or the reviewing committee needs additional information, the application may be declared incomplete. *Credentialing Guide* at 105. A committee also may consider confidential reviews from staff members or colleagues, which may be tainted by "personal or economic bias." *Id.* For example, a staff surgeon may present an unfavorable review if the surgeon has an anti-abortion bias. Indeed, the District Court found "an abundance of evidence introduced . . . demonstrating that hospitals can and do deny privileges for reasons directly related to a physician's status as an abortion provider." App. 174a.

Each committee makes one of three assessments of an applicant: (1) recommend deferral; (2) favorable recommendation; or (3) negative recommendation. *Credentialing Guide* at 106. At any point, the hospital may determine an application is incomplete or ineligible, or decline to process an application further. *Id.* at 34. Because an "ineligibility" determination is not a denial based on incompetence or unprofessional conduct, it does not trigger the right to formal due process or appeal. *See* ROA 9259, 9262-63, 9480, 9682, 10458, 10612, 10619. The applicant may be entitled to appeal only if the final committee recommends denial. *Credentialing Guide* at 106.

Following a positive recommendation, the application is submitted to the hospital governing board,

which makes a final decision about appointment, reappointment, and privileges. *Credentialing Guide* at 22; MS.06.01.07, EP 8. The board may approve, reject, or return the application for further investigation; a rejected applicant may be afforded a hearing or appeal. *See* ROA 10458, 10625.

Each step in the process may take one to two months, with the entire process taking upwards of six months *after* the application is complete. Some Louisiana hospitals have suggested review timeframes, but these are guidelines not requirements. App. 169a-71a. Tulane, for example, expects, but does not require, applications to be processed within 150 days. *Id.* at 171a. After 150 days, the applicant must recomplete the verification process to ensure information remains accurate. *Id.* A hospital's failure to act may also result in the hospital considering the application withdrawn. *Id.* at 171a. Doe 6's East Jefferson application, submitted in September 2014, remained pending in April 2017, and the District Court considered it de facto denied. *Id.* at 247a.

C. Privileging: Determining Services a Physician May Provide

Upon appointing a physician to the medical staff, a hospital determines what services and procedures the physician may perform. Act 620 requires abortion providers to have privileges permitting them to admit patients and "provide diagnostic and surgical services." § 40:1061.10. Abortion providers, who otherwise practice in outpatient settings, often cannot fulfill requirements to obtain such privileges precisely because they do not treat patients in hospital settings.

Clinical privileges are granted so physicians can "provide care, treatment, and services" to hospital patients. MS.01.01.01, note to EP 15; *Credentialing Guide* at 181. Admitting privileges constitute one privilege, allowing a physician to place a patient in the hospital under that physician's care. A physician rarely is granted just "admitting privileges" because he also must be authorized to provide care to a patient. MS.06.01.05.

As with credentialing, the privileging process is informed by medical staff bylaws and policies addressing how a hospital will verify an applicant's demonstrated, current competence in the specific procedures and activities the applicant seeks. MS.01.01.01, EP 14; MS.06.01.05, Introduction; EPs 2, 8, 10; *Credentialing Guide* at 181. *See also* MS.06.01.03, Introduction. This can be difficult, if not impossible, for abortion providers who rarely, if ever, treat patients in hospitals.

Almost all first trimester abortions, which account for approximately 90 percent of all abortions, occur in outpatient settings. App. 209a. While abortion providers easily can demonstrate current competence in the outpatient procedures they regularly perform, they likely do not have recent experience in the procedures hospitals demand.

1. Core Privileging

Hospitals traditionally granted privileges on a procedure by procedure basis as dictated by physicians' experience, expertise, and need. Today, hospitals have responded to the increasing complexity of privileging with a "core privileging" approach that groups multiple privileges for related procedures and activities into a single "core" privilege. "Core" privileges—for example, in obstetrics, gynecology, or family medicine—encompass the "clinical activities that any appropriately trained physician [in that specialty] would be competent to perform." *Credentialing Guide* at 183. *See* ROA 9653-53, 10392, 10429, 10432. Rather than tailoring privileges to a physician's specific experience and need, a hospital requires a physician to demonstrate competence in a more extensive list of "core" skills and procedures, erecting yet another obstacle for many abortion providers who rarely, if ever, treat patients in a hospital and may not have regular occasion to perform these "core" inpatient procedures.

2. Clinical Data Requirements

Hospitals require applicants to provide clinical data, particularly from hospital care, to demonstrate competence. MS.06.01.03, Introduction and Rationale; MS.06.01.05. Hospitals will not consider privilege requests unless applicants provide "clinical data demonstrating the number and type(s) of clinical activities . . . performed." *Credentialing Guide* at 181-82; MS.06.01.05, EP 10. Willis-Knighton requested that Does 1 and 2 "submit data on hospital admissions, patient management and consultations of patients in the past 12 months in a hospital." App. 179a.

Because of the nature of their outpatient practices, neither doctor had the necessary inpatient data. *Id.* For physicians who work primarily in outpatient settings and spend little, if any, time in hospitals, these requirements are impossible to meet.

Such data not only must demonstrate an applicant's competence in the procedures for which he seeks privileges, it also must evidence "*recent* direct or indirect experience" related to the privileges. *Credentialing Guide* at 183 (emphasis added). Such experience must relate to procedures performed in a hospital setting, which has nothing to do with a physician's competence in the *outpatient* procedures he performs on a daily basis. *Id.* Abortion providers perform sufficient *outpatient* procedures to demonstrate recent competency in those procedures, but they are unlikely to demonstrate the requisite number of *inpatient* procedures given the outpatient nature of their practices. Because it would be impossible for a physician who only practices outpatient medicine to show he has performed any recent procedures in a hospital, he is unlikely to be granted privileges.

Petitioner abortion providers rarely, if ever, need to transfer their patients to hospitals following abortions as "[s]erious complications requiring transfer directly from the clinic to a hospital are extremely rare." App. 210a. Over 23 years, only four Hope Clinic patients required transfer to a hospital. *Id.* at 212a-213a. Between 2009 and mid-2014, only two of 4,000 or more Bossier patients, and one of 10,000 or more Causeway patients required transfer. *Id.* at 213a. From 2009 to mid-2014, only two of Doe 2's 6,000 plus patients required transfer. *Id.* Doe 5 has performed

thousands of abortions, but has never transferred a patient to a hospital. *Id.* at 214a. Only two of Doe 6's thousands of patients have required transfer. *Id.* Accordingly, the District Court found, an abortion provider will likely have "far less than [one transfer] a year, or less than one per several thousand patients." *Id.*

As this Court concluded in *WWH,* "[i]n a word, doctors would be unable to maintain admitting privileges or obtain those privileges for the future, because the fact that abortions are so safe meant that providers were unlikely to have any patients to admit." *WWH*, 136 S. Ct. at 2312. Equally in Louisiana, abortion providers simply do not have the inpatient clinical data to meet hospitals' requirements precisely because abortion is safe and only extraordinarily rarely requires hospital treatment.

3. Ongoing Clinical Data and Review Requirements

The demand for information about hospital procedures does not end with the initial grant of privileges. Once privileges are granted, hospitals review the ongoing exercise of those privileges to confirm physicians' competency through Focused Professional Practice Evaluation ("FPPE"). MS.08.01.01; Introductions to MS.06.01.01, MS.06.01.05. In addition to reviewing medical records and discussing performance with staff members, FPPE includes direct observation of a physician's medical techniques or "proctoring." *Id.*

Several Louisiana hospitals require newly appointed physicians to undergo FPPE, including conducting a minimum number of proctored procedures

during the first 12 to 24 months of appointment. Willis-Knighton requires evaluation of a physician's "exercise of . . . clinical privileges" within the first two months of appointment, and Touro requires FPPE involving a minimum number of procedures, which may include clinical proctoring. ROA 9685-86, 10280, 10310. *See also* ROA 3164-65, 9191-92, 9376. For an abortion provider, who likely only would provide care at a hospital under very rare emergency circumstances, securing a proctor quickly enough to observe the procedure so that it counts for FPPE would be extremely difficult.

At many hospitals, physicians must relinquish privileges or are deemed to voluntarily resign them if they fail to complete the required number of proctored cases. *See* ROA 2865, 3164-65. Thus, a primarily outpatient abortion provider who obtains admitting privileges likely will lose said privileges as he would have little need to treat patients at the hospital. *See* App. 214a.

The Fifth Circuit erroneously portrayed proctoring requirements as Louisiana's alternative to Texas's minimum patient admissions requirements. App. 41a-42a. In the context of abortion providers, proctoring requirements are tantamount to minimum admissions requirements because abortion providers practicing exclusively in outpatient settings would very rarely have enough hospital inpatient encounters to meet FPPE requirements. *Id.* at 214a. The rarity of hospital transfers—"far less than [one] a year, or less than one per several thousand patients"—underscores the practical impossibility. *Id.* Indeed, "Louisiana physicians, even were they able to obtain admitting

privileges, would rarely if ever have an occasion to use them." *Id.*

II. The Discretionary Nature of the Credentialing and Privileging Process Creates Opportunities to Deny Abortion Providers Privileges on Grounds Other Than Competence

Historically, hospital boards, relying on recommendations by medical staff, "rubber-stamped" privileges applications, but "the board today plays a constant, active role in . . . [the] credentialing process" and retains discretionary power to make privileging decisions on bases unrelated to competence. *Credentialing Guide* at 22-23. Hospital bylaws intended to protect a hospital's mission or economic well-being may be used to deny privileges. Coupled with the ambiguity and subjective nature of credentialing and privileging, bylaws afford hospitals significant leeway to withhold privileges from abortion providers, completely unrelated to competence.

A. Denial Based on Hospital Mission

One reason for denying medical staff membership and privileges is a physician's inability to support a hospital's mission. University Hospital only extends applications to physicians with faculty appointments at the Louisiana State University Health Sciences Center-Shreveport School of Medicine. ROA 9474.

Hospitals with religious affiliations require physicians to comply with religious and ethical directives. Does 2 and 5 testified that hospitals affiliated with the

Catholic Church will not grant privileges to physicians who primarily perform abortions. ROA 6486-87, 9925. The Fifth Circuit incorrectly stated that such religious missions could not possibly bar outpatient abortion providers because Doe 3 holds admitting privileges at Christus Shumpert Hospital ("Christus"), a Catholic hospital. App. 42a-43a. The court claimed Doe 2 failed to make a good faith effort to obtain privileges by not applying to Christus. *Id.* The Fifth Circuit failed to recognize that Doe 3 obtained privileges *despite* his abortion practice because he maintains an "active general OB/GYN practice, where he delivers babies and routinely performs gynecological surgeries . . . ." and "regularly admits patients to the hospital as part of his private OB/GYN practice, not because of his work at Hope Clinic." *Id.* at 163a-164a. It is highly unlikely that Doe 2, who does not have a OB/GYN practice, would be granted privileges at Christus. In fact, Doe 2's practice is comparable to Doe 1's practice, in that both focus on abortion services, and Doe 1 was denied privileges at Christus. *Id.* at 222a-224a.

Secular hospitals also may be unwilling to subject themselves to negative attention that often follows abortion providers. University Heath refused an invitation to Doe 1 because he worked at Hope Clinic. *Id.* at 220a-21a. Doe 2 also was told University Health was worried about the controversial nature of abortions (his courtesy privileges only allow him to consult, not admit patients). ROA 6463-70. Doe 5 used to be on the medical staff at an Alexandria hospital, but protests started outside the hospital within three months of him performing abortions at Women's and Delta Clinics. ROA 9918, 9927-28. The hospital told

him to stop performing abortions or stop working at the hospital. *Id.* Delta Clinic's administrator stated that protestors, who regularly congregate outside the clinic, also threatened to protest outside the Baton Rouge hospital where they believed Doe 5 applied for privileges, intending to discourage the hospital from granting privileges. ROA 9917-18. Protestors sent threatening letters to the hospital, and previously, were escorted out of its offices due to disruptive conduct. *Id.*

B. Denial Based on Economic Impact

So-called economic credentialing also may provide reason for denying privileges because of the significant impact credentialing has on hospital finances. Robin Locke Nagele, et al., *Economic Credentialing* (2004) at ix. Traditional sources of hospital income are threatened by increases in ambulatory surgical centers, specialty hospitals, and physicians offering diagnostic tests in outpatient offices. Hospitals must keep "medical staffs committed to practicing in the inpatient setting while curbing the revenue drain . . . ." *Id.* at xiii.

In response, hospital boards "assess[] (as a qualifying factor) the financial impact of accepting a physician onto a hospital's medical staff." *Id.* at xviii. *See also Beyond the Bylaws* at 470-474; Elizabeth A. Weeks, *The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members*, 36 J. Health L. 247, 252 (2003). Economic credentialing includes "medical staff development plans" specifying "optimal formula[s]" for staff num-

bers based on market conditions, infrastructure, resources, usage, staff profiles, and referral patterns. *Economic Credentialing* at 31-34.

East Hospital and University Hospital may decline staff membership and privileges if the applicant's services do not fit within the hospitals' plans. ROA 9037, 9477. Hospitals also may have closed staffs whereby hospitals decline to accept applications in a particular department. *See* ROA 9384, 9405, 10059; *Beyond the Bylaws* at 476-477.

Frequently, hospitals also request individual practice plans detailing any resources needed by an applicant, anticipated hospital time, admissions and referrals expectations, financial relationships with rival entities, and willingness to support hospital mission. *Economic Credentialing* at 47. A plan inconsistent with a hospital's goals may be disqualifying. *See ibid.*

Likewise, exclusive contracts may dictate that a single, private medical group is the exclusive provider of particular services. *Economic Credentialing* at 51; *Beyond the Bylaws* at 475-476. Only group members may apply for privileges to perform such services, and physicians who leave the group lose privileges and staff membership. *See* ROA 9688, 9695 ("To the extent that any such contract confers the exclusive right to perform specified services at the [Willis-Knighton] . . . no other person may exercise clinical privileges to perform the specified services while the contract is in effect."), 10300 ("an existing exclusive contract for a particular service [at Touro] prohibits the applicant from practicing in the requested capacity"). If an abortion provider had the requisite experience in an

area subject to an exclusive contract, he would be foreclosed from privileges.

Hospitals practicing economic credentialing have no reason to grant staff membership or privileges to abortion providers as they likely will not admit any patients due to the extraordinarily low rate of abortion complications. ROA 6794-95 (*e.g.,* Minden denied Doe 5 because it did not "need [] a satellite primary care physician"). An abortion provider will be less likely to help with committee work, coverage, or training; he offers no clear financial benefit to a hospital.

III. An Abortion Provider who is Granted Admitting Privileges Likely Will Lose Them

Notwithstanding the Fifth Circuit's statements to the contrary, Louisiana hospitals require patient admissions or encounters in the hospital to maintain privileges. *See supra* I.B.1. Doe 3 previously had privileges at LSU Medical Center (now University Hospital), but his privileges were not renewed because he had not admitted patients in many years. JA 1322 (Doe 3 explaining the Department Chairman told him that "the hospital had decided to remove doctors from the staff who had not admitted patients in many years.") The Hospital Chancellor explained that "the [JC] had required that all hospitals it had previously accredited not renew admitting privileges for doctors who had not admitted patients within a certain number of years." *Id.*

Even if an abortion provider obtains admitting privileges and graduates from provisional status, he likely will be unable to maintain privileges because of

ongoing monitoring requirements. These requirements expand the credentialing and privileging process from "a procedural, cyclical process in which practitioners are evaluated when privileges are initially granted, and every two years thereafter," to an Ongoing Professional Practice Evaluation ("OPPE") that re-evaluates the physician on continual basis. MS.06.01.01, Introduction; MS.08.01.03. During renewals, a hospital uses OPPE data to confirm a physician's current competence in the procedures for which he has privileges. Without sufficient OPPE data, a physician may be unable to renew his privileges.

OPPE requires a physician to have "had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested." ROA 9698, 9701. A physician with insufficient patient contacts may provide information from practice elsewhere, but the information must relate to the privileges held. *Id.* OPPE for an abortion provider with little or no inpatient practice may be impossible. The JC acknowledges that OPPE does "not fully address the issue of the low or no volume practitioner" with very limited data to review. JC FAQ "Ongoing Professional Practice Evaluation (OPPE) – Low Volume Practitioners – Data Use From Another Organization."[17]

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[17] *Available at* https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1987&StandardsFAQChapterId=74&ProgramId=5&ChapterId=74&IsFeatured=False&IsNew=False&Keyword= (last viewed Dec. 1, 2019).

As with FPPE, patient contacts reviewed during OPPE often must be observed by a qualified proctor, which creates the same obstacles given that abortion providers' contact with hospitals likely only will be in emergent settings. *See supra* I.C.3.

Abortion providers who obtain privileges likely will lose them due to hospital inpatient admission requirements, ongoing review requirements, and infrequent need to treat patients in hospital settings.

Conclusion

To obtain active admitting privileges at a hospital, as required by Act 620, an abortion provider must navigate the labyrinthine credentialing and privileging process that evaluates physicians based on many factors unrelated to their competence to perform the services they provide. The intricate and subjective process leaves abortion providers—generally outpatient physicians—in a "Catch-22": the more experienced the physician is in providing abortion services, the less likely he can demonstrate inpatient experience required for admitting privileges. Act 620 imposes a baseless, time-consuming exercise upon hospitals and abortion providers that fails to increase the quality care for women. If upheld, Act 620 will bar most qualified physicians from providing abortions, unconstitutionally burdening access to abortions.

For the foregoing reasons, the judgment of the Fifth Circuit should be reversed.

Respectfully submitted,

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