Nos. 18-1323, 18-1460

IN THE

Supreme Court of the United States

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

v.

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

&

REBEKAH GEE, SECRETARY, LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS, PETITIONER,

V.

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

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

BRIEF OF AFRICAN AMERICAN PRO-LIFE ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF REBEKAH GEE

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INTEREST OF *AMICI CURIAE*[1]

Amici African American pro-life organizations believe that every person's life has value, whether that person is an unborn child or a mother seeking an abortion. Black women are the primary recipients of abortion services in Louisiana. Louisiana's Act 620 helps to protect the lives of mothers—especially black women—who seek abortions in the state.

Ryan Bomberger, Chief Creative Officer, The Radiance Foundation is a non-profit, educational organization established to affirm that every human life has purpose. Through ad campaigns, multimedia presentations, community outreaches, and citizen journalism, Radiance illuminates the intrinsic value we all possess. We motivate people to peacefully and positively affect the world around them. We work on a local and national level to advance a culture of life that rejects abortion, promotes adoption, celebrates intact married families, and protects the free speech that makes this messaging possible.

Dr. Alveda King, Executive Director, Civil Rights for The Unborn seeks to reach Black Americans and the general population with the truth about the harmful impact of abortion and its by-products. Alveda grew up in the civil rights movement led by her uncle, Rev. Dr. Martin Luther King, Jr. and

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[1] The parties have consented in writing to the filing of this brief, and their letters of consent have been filed with the Clerk. No party's counsel authored this brief in whole or in part, and no person or entity other than *amici* or their counsel made a monetary contribution intended to fund its preparation or submission.

uses her God-given talents and abilities to glorify God and uphold the sanctity of life from the womb to the tomb.

Dean Nelson, Chairman, The Douglass Leadership Institute advocates righteousness, justice, liberty, and virtue. Our mission is to educate, equip, and empower faith-based leaders to embrace and apply biblical principles to life and in the marketplace. Our strategic pillar, to empower black faith-based leaders to impact the marketplace, specifically highlights the disproportionate impact that abortion has had in the African American community.

Catherine Davis, President, The Restoration Project is a non-profit organization dedicated to rebuilding families, promoting the sanctity of life, and providing related educational materials, in order to transform American public policy and culture's impact on Black life. We work with pastors, ministry leaders, and organizations to restore a culture of uprightness, evenhandedness, and virtue.

Walter & Lori Hoye, The Issues4Life Foundation is a non-profit organization that targets and works directly with Black American leaders nationwide to strengthen their stand against abortion on demand. Our mission is to end abortion by raising awareness of the impact of abortion and the biblically immoral implementation of unethical biotechnology in Black America. Issues4Life is committed to protecting both the civil and human rights of the child in the womb by recognizing the inherent dignity and inalienable rights of all members of the human family, so that in law and in practice every life is valued from

the womb to the tomb. We understand that without life, nothing matters.

Troy Rolling, Chairman, Frederick Douglass Foundation is a national education and public policy organization with local chapters across the United States that brings the sanctity of free market and limited government ideas to bear on the hardest problems facing our nation. We are a collection of proactive individuals committed to developing innovative and new approaches to today's problems with the assistance of elected officials, scholars from universities and colleges, and community activists.

Day Gardner, President, The National Black Pro-Life Union serves as a clearing house to coordinate the flow of communications among African American pro-life groups and individuals in order to better network and combine resources. Headquartered in Washington, DC, we are committed to working with pro-life members of the U.S. House and Senate to expand protections for unborn children.

Rev. Brian & Rev. Denise Walker, Founders, Everlasting Light Ministries is a ministry dedicated to healing abortion and miscarriage wounds through our Rich in Mercy program. Brian and Denise desire to share the hope, forgiveness, and mercy of Jesus Christ, which they received, with anyone who has lost children by abortion or miscarriage.

Stacy Washington, Co-Chairman, Project 21 is a black leadership network that highlights the diversity of black opinion on public policy. Participants in Project 21 activities are black professionals in business, politics, the clergy, the media, and academia and can be found nationwide. They share a common goal of making America a better

place for blacks—and all Americans—to live and work, and pursue this goal through opinion editorials, media appearances, speeches, and policy panels as well as advising policymakers at the national, state and local levels. Its "Blueprint for a Better Deal for Black America" contains policy recommendations for removing barriers blocking blacks from reaching their full potential.

SUMMARY OF ARGUMENT

I. The struggle for racial equality is not over. The black community experiences a disproportionate share of abortions, often from doctors that do not have the same credentials as those who perform other forms of surgery. Until Act 620, Louisiana's abortion clinics were exempt from the admitting privileges requirement that applies to other outpatient and ambulatory surgical centers in the state. This disparity is significant to black women, who make up the majority of abortion clinic patients and thus bear most of the known risks of abortion in Louisiana. These known risks are life-threatening to mothers.

The record in this case shows that Act 620 serves the State's interest in promoting women's health by requiring that abortion providers employ competent, credentialed physicians—just like similarly situated medical clinics. As Congress and medical bodies have recognized, the peer review involved in granting admitting privileges performs a valuable credentialing function. It ensures that the physician who will perform an invasive, high-volume procedure has undergone the same verifications of surgical ability, education, training, practice record, and criminal history as physicians at other outpatient clinics. It also ensures that an abortion provider's

malpractice or other misconduct reports appear in the National Practitioner Data Bank so that medical offices can cross-check doctors' records and avoid hiring unsafe or unqualified practitioners. Act 620 further protects a mother's health by ensuring that the doctor who performed the abortion can maintain continuity of care in the event of an emergency that requires her hospitalization.

Thus, Act 620 confers a substantial medical benefit that justifies any minimal burden the requirement may impose on the right upheld in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992).

II. The court below should not have assumed that abortion providers in this case have standing. Anonymous abortion providers do not share their patients' interest in the accountability that comes with mandatory admitting privileges. Plaintiffs seek to escape the oversight that admitting privileges provide. But their patients—especially African American women—have an interest in ensuring that their healthcare needs are met by competent physicians who can provide continuity of care. This disconnect between the interests of women seeking abortions, and the abortion providers who assert third-party standing to block the state's commonsense safety regulations, shows that they lack the "close" relationship necessary to establish third-party standing. *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004).

ARGUMENT

I. Louisiana's Act 620 Advances the State's Interest in Women's Health by Bringing Outpatient Abortion Clinics Into Conformity With Preexisting Law.

Louisiana passed Act 620, La. Stat. § 40:1061.10, to "promote women's health ... by ensuring a higher level of physician competence and by requiring continuity of care." App. 35a. Trial testimony established that Act 620 advanced both goals. First, "the credentialing process that leads to a physician being granted those [admitting] privileges provides the assurance ... that they be competent and with the required training." JA 839. Second, the admitting privileges requirement also ensures that abortion clinic patients will receive continuity of care in the event of complications "by enabling the physician to care for the patient in the hospital, not just in the clinic." *Id.*

This Court has consistently reaffirmed that these are proper objectives: "The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Whole Women's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016), *as revised* (June 27, 2016), ("*WWH*") (quoting *Roe v. Wade*, 410 U.S. 113, 150 (1973)). Indeed, to decide whether a law imposes an undue burden on abortion, courts must "consider the burdens a law imposes on abortion access together with the benefits those laws confer." *WWH*, 136 S. Ct. at 2309.

The court of appeals did just that. It recognized that Louisiana's Act 620 "brings the requirements regarding outpatient abortion clinics into conformity

with the preexisting requirement that physicians at ambulatory surgical centers ('ASCs') must have privileges at a hospital within the community." App. 36a (citing 48 LA. ADMIN. CODE § 4535(E)(1)). The court of appeals then weighed the benefits of this equal treatment against Plaintiffs' asserted burdens.

This Court has held that "state and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007). And although courts must not "place dispositive weight" on legislative findings, courts "must review legislative 'factfinding under a deferential standard.' " *WWH*, 136 S. Ct. at 2310 (quoting *Gonzalez*, 550 U.S., at 165).

Unlike in *WWH*, where "nothing in Texas' record evidence" "show[ed] that, compared to prior law …, the new law advanced Texas' legitimate interest in protecting women's health," 136 S. Ct. at 2311, the record here demonstrates that Act 620 benefits women's health.

Act 620 is premised on the sound legislative judgment that an admitting privileges requirement protects the health—and could even save the lives—of women who experience complications from abortion. The requirement reduces the health risks of abortion, either before an emergency arises, through the accountability of a hospital peer-review board that could screen out an unqualified doctor from performing abortions, or after an emergency that requires hospitalization. As the primary recipient of abortion services in the state of Louisiana, black women share the State's interest in ensuring abortion providers meet hospital credentialing requirements and can provide appropriate continuity of care.

A. Louisiana's interest in women's health furthers racial equality, because black women obtain most abortions and thus face the most health risks from abortion, in Louisiana and nationwide.

1. Louisiana's population is 32.7 percent black,[2] but black women obtained 61.2 percent of the abortions performed in Louisiana in 2018 (4,958 of 8,097 abortions).[3] This is consistent with an enormous national racial disparity in abortion rates. According to the Centers for Disease Control, "black women had the highest abortion rate (25.1 abortions per 1,000 women aged 15–44 years) and ratio (401 abortions per 1,000 live births)" of any racial group in the United States.[4] *See Box v. Planned Parenthood of Ind. & Ky., Inc.*, 139 S. Ct. 1780, 1791 (2019) (Thomas, J., concurring) (describing rate of abortions for black mothers as 3.5 times higher than for white mothers). The record in this case established that two-thirds of women who have had an abortion in Louisiana are black. JA 497. This disproportionate abortion rate approaches what some civil rights leaders have called

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[2] *QuickFacts Louisiana*, U.S. Census Bureau (July 1, 2018), https://www.census.gov/quickfacts/fact/table/LA/PST045218.

[3] *Induced Terminations of Pregnancy by Weeks of Gestation, Race, Age, and Marital Status Reported Occurring in Louisiana, 2018*, La. Bureau of Vital Recs. and Stats, http://ldh.la.gov/assets/oph/Center-RS/vitalrec/leers/ITOP/ITOP_Reports/Ap18_T21.pdf, at 1.

[4] *Abortion Surveillance – United States, 2016*, U.S. Dep't of Health and Human Services, Centers for Disease Control and Prevention, (Nov. 29, 2019), https://www.cdc.gov/mmwr/volumes/68/ss/pdfs/ss6811a1-H.pdf.

"race suicide." [5] Indeed, famed African American voting rights and anti-poverty activist Fannie Lou Hamer denounced abortion as "genocide" in her 1971 speech, "Is It Too Late?"[6]

2. Documented health and safety violations at abortion clinics risk the lives and health of their patients—especially black women. These clinics are managed by physicians who are not accountable to hospital credentialing and admitting review boards—peer-review bodies that monitor physicians who perform other types of surgery in Louisiana.

The legislature in Louisiana considered the "balance of risks" of permitting physicians who lack admitting privileges to perform abortions. *Gonzales*, 550 U.S. at 166. It decided that requiring physicians who perform abortions to maintain admitting privileges would improve the safety of the procedure. App. 37a.

This Court in *WWH* credited evidence that complications from abortion rarely occur "on the spot" at a clinic. 136 S. Ct. at 2311. The Court reasoned that admitting privileges would not promote women's health in those circumstances because "if a patient needs a hospital in the day or week following her abortion, she will likely seek medical attention at the hospital nearest her home." *Id*.

But many "on the spot" complications from abortion have harmed women, especially black

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[5] Donald T. Critchlow, INTENDED CONSEQUENCES: BIRTH CONTROL, ABORTION, AND THE FEDERAL GOVERNMENT IN MODERN AMERICA 142 (Oxford Press 1999).

[6] Kay Mills, THIS LITTLE LIGHT OF MINE: THE LIFE OF FANNIE LOU HAMER 274 (University Press of Kentucky 2007).

women, and even resulted in their deaths at abortion clinics.

Indeed, Louisiana was one of several states that adopted its admitting privileges laws "in the wake of the Kermit Gosnell scandal, in which a physician who ran an abortion clinic in Philadelphia was convicted for the first-degree murder of three infants who were born alive and for the manslaughter of a patient. Gosnell had not been actively supervised by state or local authorities or by his peers ...." *Id.* at 2343–44 (Alito, J., dissenting) (footnotes omitted).

The Gosnell Grand Jury report recounted the risks of abortion to women, especially women of color, from doctors who are not appropriately supervised by their peers. The Grand Jury found that in Gosnell's abortion clinic, "white women were attended to by a doctor[,] and black women were pawned off on clueless untrained staffers."[7]

"A nineteen-year-old girl was held for several hours after Gosnell punctured her uterus. As a result of the delay, she fell into shock from blood loss, and had to undergo a hysterectomy." [8] A 41-year-old refugee named Karnamaya Mongar received sedatives from Gosnell's staff until she "simply stopped breathing" and was unable to be revived even after Gosnell's staff called paramedics to transport

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[7] Conor Friedersdorft, *Why Dr. Kermit Gosnell's Trial Should Be a Front-Page Story*, The Atlantic (Apr. 12, 2015), http://www.theatlantic.com/national/archive/2013/04/why-dr-kermit-gosnells-trial-should-be-afront-page-story/274944/.

[8] Grand Jury Rpt., *In re Cnty. Investigating Grand Jury XXIII*, NO. 0009901-2008, 2011 WL 711902, at 6 (1st Jud. Dist. Pa. Jan. 14, 2011), https://cdn.cnsnews.com/documents/Gosnell,%20Grand%20Jury%20Report.pdf.

her to a hospital. Mongar was declared brain dead the following day.[9]

A decade before Gosnell's criminal investigation, Semika Shaw, a 22-year-old black woman, called the clinic complaining of heavy bleeding the day after an abortion at Gosnell's clinic, but the clinic failed to tell her to return to the clinic or seek emergency care. She died of internal bleeding and sepsis three days later because her uterus had been punctured by the abortion.[10]

These women of color faced "complications requiring hospitalization" that did not "occur in the days after the abortion," but "on the spot." *WWH*, 136 S. Ct. at 2311.

The fact that black women received substandard care from Gosnell was calculated. Testimony before the Grand Jury found that "white patients often did not have to wait in the same dirty rooms as black and Asian clients."[11] One former unlicensed, untrained employee testified that Gosnell

> didn't mind you medicating your African American girls, your Indian girl, but if you had a white girl from the suburbs, oh, you better not medicate her. You better wait until he go in and talk to her first.

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[9] *Id*. at 7.

[10] Marie McCullough, *W. Phila. Abortion Doctor Had Problems 38 Years Ago*, The Phila. Inq. (Feb. 25, 2010), http://www.inquirer.com/philly/news/year-in-review/20100225_W__Phila_abortion_doctor_had_problems_38_years_ago.html?c=r.

[11] Grand Jury Rpt., *supra* n.8, 2011 WL 711902, at 62.

> And one day I said something to him and he was like, that's the way of the world.[12]

And the Grand Jury observed that when "something went wrong during a procedure—and it inevitably did, given Gosnell's careless techniques and gross disregard for patient safety—he avoided seeking help."[13] These vile crimes went unreported, the Grand Jury concluded, "because the women in question were poor and of color."[14] When the FBI finally raided Gosnell's clinic in 2010, they found

> blood on the floor. A stench of urine filled the air.... Semi-conscious women scheduled for abortions were moaning in the waiting room or the recovery room, where they sat on dirty recliners covered with blood-stained blankets.[15]

3. Gosnell's clinic is far from alone. Like Gosnell's clinic, Louisiana abortion clinics primarily serve minority women. JA 497. Like Gosnell's clinic, Louisiana's clinics have a history of serious health and safety violations. When considering Act 620, the Louisiana legislature heard testimony regarding the "history of health and safety violations by Louisiana abortion clinics." App. 197a; *see also* App. 4a ("Testimony also established numerous health and safety violations by Louisiana abortion clinics."). This

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[12] *Id*. at 62.

[13] *Id*. at 71.

[14] *Id*. at 13.

[15] *Id*. at 20.

included "horrifying" "testimony of unsanitary conditions and protection of rapists." App. 38a n.56.

A former Louisiana abortion worker, Shelley Guillory, was quoted describing these "horrible" conditions in the Delta Clinic of Baton Rouge:

> [I]t was filthy. You still had blood splattered from, I mean, weeks of procedures ago that were still on the wall. This building was not cleaned on a daily basis. It wasn't even cleaned on a monthly basis. Our buildings got cleaned when we knew the state was coming in.

This Louisiana clinic is owned by the same individual who had formerly employed Gosnell.[16]

On March 15, 2019, that same Louisiana clinic was forced to call 911 to rush a woman to a nearby hospital because her abortion caused profuse bleeding, but the clinic lacked necessary emergency supplies to treat her, such as IV fluids, according to a Louisiana Department of Health report.[17] The patient required a total abdominal hysterectomy and removal of both fallopian tubes.[18]

Affidavits from former clinic employees demonstrate that these Gosnell-like conditions are part of a long-term pattern in Louisiana. As one

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[16] Sarah Terzo, *Former Abortion Worker: Conditions Were 'Horrendous' But Inspectors Asked No Questions*, LiveAction (Jan. 4, 2018), https://www.liveaction.org/news/abortion-worker-horrendous-inspectors-questions/.

[17] *Statement of Deficiencies and Plan of Correction, Delta Clinic of Baton Rouge, Inc*, Louisiana Department of Health 6–7 (Mar. 29, 2019), https://prolifelouisiana.org/wp-content/uploads/2019/07/3-21-Delta.pdf.

[18] *Id*. at 12.

former employee said, "There was also dried up blood on the floor, in the old recliners in the recovery room, and rust on the insides of the surgical trays."[19] This clinic has continued performing abortions without a physician with admitting privileges while operation of Act 620 has been stayed by this Court.[20]

4. Gosnell's clinic is not isolated in another respect: women in Louisiana and nationwide have also suffered and died from dangerous complications "on the spot." *WWH*, 136 S. Ct. at 2311. These are circumstances in which continuity of care could make the difference between life and death, and which would often have been avoided in a peer-review regime. *See infra* pp. 20–29.

Sheila Hebert, a 27-year-old woman from Louisiana, went to the Delta Women's Clinic in Baton Rouge for an abortion on June 5, 1984. Hebert suffered from asthma, and shortly after the abortion, she complained to clinic staff that she had chest pains and could not breathe. She lost consciousness. By the time emergency personnel got to her, she was "cool" and "blue." She was taken to a nearby hospital, where she died.[21]

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[19] Decl. of Lisa Teegarden, July 21, 1999, at 3, https://abortiondocs.org/wp-content/uploads/2013/05/Delta-Clinic-Baton-Rouge-LA-Witness-Affidavit-July-1999.pdf.

[20] Elizabeth Crisp, *Louisiana Case Could Provide Insight into How New Supreme Court will handle abortion*, The Advocate (Apr. 17, 2019), https://www.theadvocate.com/baton_rouge/news/politics/article_b79266c8-611c-11e9-97b6-a7462063b735.html.

[21] Pet. for Damages, *Mr. & Mrs. Doe ex rel. Minor A v. Richardson Glidden, M.D., et al*, No. 289518, at 2 (19th Judicial Dist. Ct., East Baton Rouge Parish).

Tonya Reaves, a 24-year-old black woman from Illinois, died during a cervical dilation and evacuation abortion procedure at a Planned Parenthood abortion clinic in Chicago. The abortionist, Mandy Gittler, performed surgery in Reaves' womb three times because of unexpected bleeding from the first procedure before calling an ambulance. Gittler did not have admitting privileges at the nearby hospital where Reaves was transferred and did not accompany her. Instead, she called the hospital and talked to multiple residents while trying to explain Reaves' complications. While the initial abortion procedure began just before 1 p.m., the hospital did not discover the cause of her bleeding until 10:12 p.m.[22] A board certified doctor in Obstetrics/Gynecology who reviewed Reaves' treatment concluded "that a reasonable and meritorious malpractice action exists against Planned Parenthood and Dr. M. Gittler."[23]

LaKisha Wilson, a 22-year-old woman from Ohio, died in 2014 in Cleveland due to complications from an abortion.[24] Wilson suffered cardiac arrest during

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[22] Deposition of Mandy Gittler, M.D., Aug. 22, 2013, at 127–129, 136–37, *Jones v. Planned Parenthood*, No. 2013 L 000076 (Cir. Ct. of Cook Cnty., Ill.), http://operationrescue.org/pdfs/Deposition%20of%20Mandy%20Gittler,%20M.D..pdf; *see also* Janet Morana, *Questions Still Linger Five Years After Tonya Reaves Was Killed By Abortion*, The Daily Caller (July 20, 2017), https://dailycaller.com/2017/07/20/questions-still-linger-five-years-after-tonya-reaves-was-killed-by-abortion/.

[23] Report of Expert Witness filed in support of Complaint*, Jones v. Planned Parenthood* (Cir. Ct. of Cook Cnty., Ill., Jan. 3, 2013) (No. 20013 L 0076).

[24] Christopher Harris, Cuyahoga County Medical Examiner's Office, http://operationrescue.org/pdfs/MedicalExaminerState

the abortion procedure, but the clinic waited thirty minutes after the abortion started to call 911 for her to be admitted to a nearby hospital. The emergency call transcript indicates that the abortion clinic staff described Wilson as "not breathing at all" by the time they called 911.[25] If Wilson's physician had admitting privileges, this critical delay could have been avoided.

Sherika Mayo, a 23-year-old black woman from Georgia, died in 2008 from complications that arose during an abortion. According to a subsequent public reprimand from the state Board of Medical Examiners, Mayo's cervix and intestine were lacerated and her uterus was perforated by the abortion procedure, which resulted in cardiac arrest while she was in the recovery room at the outpatient clinic.[26] A board-appointed peer reviewer evaluated Mayo's death and treatment and documented that her abortion doctor committed three violations of the minimum standard of care for an abortion. If the physician who performed Mayo's abortion had been required to maintain admitting privileges, peer review might have ensured that he met those minimum standards of care—before treating Mayo.

Keisha Marie Atkins, 23, died in New Mexico in 2017 from a disseminated intravascular

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ment-05302014.pdf ("Cause: … cardiopulmonary arrest immediately following elective abortion of intrauterine pregnancy").

[25] Computer Aided Dispatch Transcript, Event Chronology E14022619http://operationrescue.org/pdfs/CAD%20Event%20Chronology-Preterm-03212014.pdf.

[26] *In The Matter Of Tyrone Mallory, M.D.*, No. 20090033, State of Georgia Comp. State Bd. of Med. Exam., Jan. 8, 2009, https://abortiondocs.org/wp-content/uploads/2012/10/Tyrone-Malloy-Public-Reprimand-Jan-8-20092.pdf.

coagulopathy, a life-threatening blood clotting problem likely brought on by septic shock because of the abortion, according to her autopsy report.[27] The report noted that Atkins was at the abortion clinic when she complained of shortness of breath and her oxygen saturation dropped below baseline. Clinic staff called 911 asking for an ambulance, but the ambulance was cancelled before it arrived with a note from the ambulance operator that the patient "was being treated and prepared for transport," indicating that staff may have caused further delay while attempting to treat the patient.[28] Although she was eventually transferred to a nearby hospital, she may have survived if her physician had been able to admit her more quickly.

Antonesha Ross, an 18-year-old black woman, died in 2009 in Illinois from complications resulting from severe pneumonia that should have prevented the clinic she visited from performing an abortion.[29] After the abortion, Ross coughed up blood and fluid, prompting clinic employees to call an ambulance—40 minutes later. Although paramedics treated her at the clinic and transported her to a nearby hospital, she

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[27] Rebecca Asch-Kendrick & Lauren D. Dvorscak, *Keisha Atkins Rpt. Of Findings*, Office of the Medical Investigator, UNM Health Sciences Center, No. 2017-00704, https://abortiondocs.org/wp-content/uploads/2017/08/Autopsy-Report-Keisha-Atkins.pdf.

[28] AFD EMS Report, Incident No. F170009348, (accessed Dec. 16, 2019), http://www.operationrescue.org/wp-content/uploads/2017/08/522-Lomas-EMS-report.pdf.

[29] Nara Schoenberg, *Abortion Clinic Closes, Avoids Fine After Fatality*, Chicago Tribune (Apr. 13, 2015), https://www.chicagotribune.com/investigations/ct-abortion-death-met-20150216-story.html.

was pronounced dead in the emergency room. When the State investigated the clinic that performed her abortion, it found 15 violations of state health and safety regulations, including 28 vials of expired medication on the anesthesia cart, frozen dinners stored in a biohazard refrigerator that also held fetal tissue, and a failure to specify the medical or psychiatric conditions that should have made a patient like Ross ineligible for surgery. Had Ross's abortion doctor been required to maintain admitting privileges, that requirement could have saved her life. The hospital's peer-review of Ross's doctor could have alerted authorities of the unsafe conditions and lack of protocols at the clinic that were only discovered after her death. Those conditions contributed to Ross receiving an abortion when she was too sick for the procedure, which ultimately lead to her death.

These gruesome deaths are part of a long history involving unqualified and uncredentialed abortion providers disproportionately harming black women. Psychologist Harvey Karman, who was not a trained physician, joined Gosnell in what was called the "super coil" abortion method experiment in 1972.[30] Of the 15 African American impoverished women involved in this grotesque experiment, "9 had complications," "3 of the 9 sustained major complications," and two women "required major surgery" (including a "total abdominal hysterectomy").[31]

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[30] McCullough, *supra* n.10.

[31] Judith P. Bourne, Gary S. Berger, Richard J. Haber, Carl W. Tyler, Louis Keith, Kristine Knisely, & Jack Zackler, *Medical Complications From Induced Abortion by the Super Coil Method*,

5. As discussed *infra* at pages 19–29, an admitting privileges requirement could have ameliorated these horrors and saved the lives of these women. The Gosnell Grand Jury ultimately recommended that abortion clinics should be "held to the same standards as all other outpatient procedure centers," and that "[r]eports about individual doctors should be cross-checked against reports about the medical offices where they have worked, and vice versa."[32]

That is what Louisiana sought to do in Act 620: it required doctors at abortion clinics to maintain admitting privileges just like doctors who practice at other ambulatory surgical centers. By requiring admitting privileges, it also created a means for reports about individual doctors to be checked against a national database—for the benefit of all patients, of all races, equally.

B. Act 620's admitting privileges requirement ensures that physicians are credentialed and equipped to provide continuity of care.

At trial, Louisiana's expert witness testified that the hospital credentialing and privileging process is the "*primary* way of determining [physician] competency." JA 818 (emphasis added). The process is so effective that it "is used by hospitals and other by other large provider organizations, insurance companies, for instance." *Id*. Plaintiffs' expert also agreed "that admitting privileges can serve the function of providing an evaluation mechanism for

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89 Health Serv. Rep. 40, at 41 (1974), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1616242/.

[32] Grand Jury Rpt., *supra* n.8, 2011 WL 711902, at 16–17.

physician competency generally" and that the peer-review component of reviewing doctor's application for privileges "might uncover things that would reveal competence or incompetence." JA 1091. Indeed, "hospitals have strong incentives to award staff privileges only to those physicians who have proven to be capable and knowledgeable professionals." Kurt Erskine, *Square Pegs and Round Holes: Antitrust Law and the Privileging Decision*, 44 U. Kan. L. Rev. 399, 401 (1996). A Hospital's "Medicare participation and other certifications depend on completing the credentialing process" for its medical staff, including physicians who can admit patients. Sean Ryan, *Negligent Credentialing: A Cause of Action for Hospital Peer Review Decisions*, 59 How. L.J. 413, 419 (2016). This is no accident, but the deliberate product of national healthcare policy.

1. Admitting privileges requirements are a widely recognized, congressionally sanctioned means of protecting all patients.

1. In response to nationwide concerns about medical malpractice, Congress found that "[t]here is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance" and that "[t]his nationwide problem can be remedied through effective professional peer review." 42 U.S.C. §§ 11101(2)–(3).

But peer review faced a legal obstacle: "participants in the peer review process risked being sued by physicians seeking monetary damages from

adverse actions" regarding admitting privileges. Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 Seton Hall L. Rev. 1179, 1194 (2006).

Congress decided that hospital admitting privileges decisions provided essential professional peer-review and thus immunized privileging decisions from antitrust liability in the Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §§ 11101, *et seq.*; *see, e.g.*, *Austin v. McNamara*, 979 F.2d 728, 737 (9th Cir. 1992) (holding that hospital's suspension of physician's admitting privileges was "within the immunity conferred by § 11111(a)" of the HCQIA). [33] Congress also provided defendant hospitals attorneys' fees for frivolous suits by doctors over admitting privilege decisions. 42 U.S.C. § 11113.

In the same act, Congress created a tool for tracking misconduct and malpractice by physicians: The National Practitioners Databank (NPDB). This

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[33] In response to adverse admitting privileges decisions by hospitals that sought to reduce the risk of malpractice, many physicians launched antitrust lawsuits against those hospitals that denied them privileges, seeking treble damages. *See, e.g.*, *Crane v. Intermountain Health Care*, 637 F.2d 715 (10th Cir. 1981); *Harron v. United Hosp. Center*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976). To address this raft of antitrust suits, "Congress enacted the HCQIA to ... reset the priorities by putting the rights of patients to treatment by competent providers as judged by their peers above the rights of physicians to litigate their ability to compete." Patricia A. Sullivan & Jon M. Anderson, *The Health Care Debate: If Lack of Tort Reform Is Part of the Problem, Federalized Protection for Peer Review Needs to Be Part of the Solution*, 15 Roger Williams U. L. Rev. 41, 52–53 (2010).

database relies on hospital admitting privileges decisions as a source of data. Under the HCQIA, hospitals are required to submit adverse decisions to the NPDB. 42 U.S.C. § 1320a–7e; *see* 45 C.F.R. § 60.1.[34] "The Data Bank prevents a physician who applies … for clinical privileges from being able to hide disciplinary actions that have been taken against him." *Leal v. Sec'y, U.S. Dep't of Health & Human Servs.*, 620 F.3d 1280, 1283–84 (11th Cir. 2010). "NPDB reports are not available to the public but are available to state licensing boards and prospective employers." *Miller v. Huron Reg'l Med. Ctr.*, 936 F.3d 841, 844 (8th Cir. 2019).

2. Admitting privileges are not only favored by Congress but are an industry standard. Some commentators described admitting privileges as "the life-blood of any medical practice." Erskine, 44 U. Kan. L. Rev. at 400. As one healthcare expert said in a symposium in the *Wall Street Journal*, "the most important facts about doctors are: medical education, residency training, any fellowships, board certification in their relevant field (internal medicine, family physician, *etc.*), *at what hospitals they have admitting privileges*, how many years in practice."[35] The American Cancer Society recommends, "Pick a doctor who practices (has privileges) at a hospital that

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[34] NPDB Guidebook, U.S. Department of Health and Human Services (2018), https://www.npdb.hrsa.gov/guidebook/EClinicalPrivileges.jsp#DenialsRestrictions.

[35] *What Is the Biggest Mistake Patients Make When Picking a Primary-Care Doctor?*, Wall St. J. (Feb. 27, 2014), https://www.wsj.com/articles/primary-care-doctors-the-biggest-mistakes-people-make-searching-for-them-1393535876 (quoting Helen Darling, president and CEO of the National Business Group on Health) (emphasis added).

you're willing to use. Doctors can only send patients to hospitals where they have admitting privileges."[36]

Hundreds of outpatient health care providers across numerous medical specialties rationally advertise that their physicians maintain admitting privileges at nearby hospitals. [37]

In fact, a peer-reviewed study of physicians who perform abortions found that "[p]hysicians who hold hospital privileges are significantly more likely to be board certified and to be approved for Medicaid payment than their colleagues without privileges."[38]

It is thus unsurprising that existing Louisiana law requires doctors who provide outpatient surgery to maintain admitting privileges at a nearby hospital. LA. STAT. § 40:2131 *et seq.*; 48 LA. ADMIN. CODE § 4535(E)(1). Prior to Act 620, Louisiana law treated abortion doctors in outpatient clinics differently from other doctors. Act 620 simply "applies the same standard to abortion providers that currently exist[s] for patients undergoing similar procedures in ambulatory surgery centers." JA 905. This logic follows the principles this Court has long recognized:

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[36] American Cancer Society, *Choosing a Doctor and a Hospital*, (Feb. 26, 2016), https://www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/choosing-a-doctor-and-a-hospital.html.

[37] As of 12/28/2019, Google returned 903 results that contain the phrase, "our physicians have admitting privileges," https://tinyurl.com/sdu6amy.

[38] James Studnicki, Tessa Longbons, John W. Fisher, Donna J. Harrison, Ingrid Skop, & Sharon J. MacKinnon, *Doctors Who Perform Abortions: Their Characteristics and Patterns of Holding and Using Hospital Privileges*, Health Servs. Research & Manag. Epidemiology (Apr. 15, 2019), https://journals.sagepub.com/doi/full/10.1177/2333392819841211.

"The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Gonzales*, 550 U.S. at 163.

3. The record in this case bolsters the prudence of Congress's and Louisiana's judgment. Louisiana's "hospitals perform more rigorous and intense background checks than do the [abortion] clinics." App. 35a. "[H]ospitals verify an applicant's surgical ability, training, education, experience, practice record, and criminal history" through peer-review "by a board of multiple physicians." App. 36a n.53.

By contrast, abortion clinics do not perform background checks on medical staff and often make hiring decisions through a "committee of one." JA 249–50. Before Act 620, "abortion providers did not even have to have OB/GYN credentials." App. 36a n.53. In fact, abortion providers themselves testified that they hired a radiologist and an ophthalmologist to perform abortions, JA 249, even though those fields are unrelated to abortion.

As Plaintiffs' expert admitted, "I think the laws that regulate the safety of medical care should apply to all patients for all procedures" "equally." JA 1086. Act 620 reflects the legislative judgment that everyone, including black women, should be able to expect this minimum marker of competence from an abortion provider: a doctor performing abortions should have admitting privileges at a nearby hospital.

2. The admitting privileges requirement enhances continuity of care.

Louisiana's expert witness testified that another purpose of hospital credentialing and privileging is "to enable continuity of care when patients are admitted

to the hospital." JA 817. As one of the Louisiana abortion doctors testified, "continuity of care" means that a doctor who is "responsible for the care of [a] patient" will continue to provide necessary care or will "make certain that another physician has the information they need to be able to care for that patient" if the initial doctor is "no longer able to provide that care." JA 213–14. Louisiana's expert testified that continuity of care is "best provided by a single person, who, in fact, cares for the patient across the continuum in whatever setting a patient might be at in a particular point in time." JA 819.

As testimony established, if there was a "problem during the procedure in the outpatient setting," "the details matter," "so the person who did the procedure is best positioned to" provide "the intervention needed to deal with it." JA 820. Especially in a surgical setting, "a lot of information … becomes part of the evaluation of the medical problem and so the person who's gathering that information" is "best able to provide the continuing care of that patient." JA 819. Ensuring that abortion clinics conform to Louisiana's admitting privileges requirement thus puts in charge the person "best able to provide the continuing care" of Louisiana mothers.

Ensuring continuity of care is a common-sense goal that some abortion providers already work to ensure through documentation. *Patient Portal User Guide*, Planned Parenthood (accessed Dec. 16, 2019), https://www.plannedparenthood.org/files/6114/0157/5267/Patient_Portal_overview_for_patients.pdf, at 6 ("Your portal account provides a Continuity of Care document that pulls information from your medical chart"); *see also Planned Parenthood of Arkansas & E. Oklahoma v. Jegley*, 864 F.3d 953, 960 n. 9 (8th Cir.

2017), *cert. denied*, 138 S. Ct. 2573 (2018), ("[W]e certainly see some benefit for patients where the State mandates continuity-of-care standards—especially in the face of known complications .... For instance, had the State merely mandated Planned Parenthood's existing continuity-of-care protocols, Planned Parenthood likely would not argue that these would be of no significant benefit to its patients.").

1. Ensuring continuity of care is especially important to black women, who continue to face disparities in healthcare quality. As the *New York Times* reported, "the Agency for Healthcare Research and Quality ... showed that 40 percent of the quality measures were still worse for blacks than whites."[39]

The lack of continuity of care for racial minorities explains part of this disparity. According to the National Academy of Sciences, "racial and ethnic minority patients are more likely to receive care in hospital clinics and other settings characterized by rapid staff turnover and lack of continuity of care providers. Under these circumstances, it is reasonable to assume that physician advocacy on behalf of patients will be less likely, either because the physician is less familiar with patients that he or she does not regularly treat, or because resource constraints … prevent physicians from meeting all patients' demands for services ...."[40]

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[39] Aaron E. Carroll, *Doctors and Racial Bias: Still a Long Way to Go*, N.Y. Times (Feb. 25, 2019), https://www.nytimes.com/2019/02/25/upshot/doctors-and-racial-bias-still-a-long-way-to-go.html.

[40] Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson, Eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities*

This means minority women are less likely to receive care from "a single person" who provides healthcare "across the continuum." JA 819. This disparity in continuity of care is deeply alarming: "increased continuity of care by doctors is associated with lower mortality rates."[41] A peer-reviewed meta-study of 22 observational articles showed that "patients across cultural boundaries appear to benefit from continuity of care with both generalist and specialist doctors."[42] Continuity of care can literally make the difference between life and death.

2. Abortion is a procedure known to have certain potential complications that many women of color have tragically endured disproportionately. JA 250. Indeed, Louisiana's legislature heard testimony that abortion carries the risk of serious complications that could require immediate hospitalization. App. 197a. **S**urgical abortions require a "regional anesthetic" involving four injections of lidocaine. JA 222. Complications include "risk of hemorrhage, risk of retained tissue, risk of incomplete abortion, risk of perforation," the most common of which is "risk of retained tissue." JA 126. As one abortionist testified, "one of the most common complications to occur is that we have an incomplete abortion" where "there are

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in Health Care, National Academies Press 154–55 (2003), https://www.ncbi.nlm.nih.gov/pubmed/25032386.

[41] Denis J. Pereira Gray, Kate Sidaway-Lee, Eleanor White, *et al*, *Continuity of Care With Doctors—a Matter of Life and Death? A Systematic Review of Continuity of Care and Mortality*, BMJ Open (June 28, 2018), https://bmjopen.bmj.com/content/8/6/e021161.

[42] *Id*.

some retained fragments of the placenta left in the pregnancy." JA 224.

Moreover, some known abortion risks, such as perforation of the uterus, could be life threatening if not properly treated—as Plaintiffs' staff testified. JA 128. The legislature heard testimony that women "who experience abortion complications frequently rely on the care of emergency room physicians, who often must call on the assistance of a specialist in obstetrics or gynecology." App. 197a. Plaintiffs' own expert admitted that not all emergency room physicians are competent to treat known complications from abortions. JA 1076. And whenever a physician has to hand-off a patient to someone else, "often information is lost." JA 819–20.

These risks are not hypothetical. Women have died from perforations, incomplete abortions, or cardiac arrest as a result of complications during the procedure. *See supra* pp. 7–18.

Even one of the abortionists in this case testified about abortion complications in which his admitting privileges ensured continuity of care: "I—we perforated the uterus and it was unsafe to continue with the abortion, so we transported the patient" to a nearby hospital. JA 216. He continued, "since I was on the staff, I went ahead and accompanied her and then I taught the residents" "what to do in that situation." *Id*. The same doctor also testified about a woman who had a placenta accrete, a condition that caused post-abortion bleeding severe enough to require her to be taken to a nearby hospital for a hysterectomy procedure. JA 218.

* * *

"Considerations of marginal safety, including the balance of risks, are within the legislative competence

when the regulation is rational and in pursuit of legitimate ends." *Gonzales*, 550 U.S. at 166. There should be no dispute that the health of the mother in a high-volume, invasive surgical procedure is a legitimate end, nor that admitting privileges requirements are rational. *See* App. 149a (granting Louisiana's motion for summary judgment that the admitting privileges requirement of Act 620 was "rationally related" to a legitimate state interest). Louisiana's legislature considered the marginal improvement in safety and the balance of risks to all women. As Representative Katrina Jackson, an African American woman, explained when introducing Act 620 in committee:

> This bill … says that you must have admitting privileges at a hospital, which means if something goes wrong from your surgical procedure, you can call the hospital or follow your patient to the hospital and make sure they receive proper care. And I think that's just a commonsense method that we've always used with physicians who are set up in surgical centers. There's no doubt that abortion clinics are set up for the primary purpose of performing abortions. And so this bill cleans up, what I think that we all thought that the ambulatory surgical rules did, is make sure that the safety of women is intact.

App. 37a n.54. Act 620 promotes women's health and racial equality alike by ensuring physicians who provide abortions can provide continuity of care in the event of a complication that requires hospitalization.

II. The Record Shows Plaintiff Abortion Providers Cannot Demonstrate Third-Party Standing, Because Their Interests Diverge From Those of Their Patients, Including Black Women.

"[T]his Court has held that the plaintiff generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Warth v. Seldin*, 422 U.S. 490, 499 (1975). Thus "a party seeking third-party standing" must "make two additional showings." *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004). "First, we have asked whether the party asserting the right has a close relationship with the person who possesses the right. Second, we have considered whether there is a hindrance to the possessor's ability to protect his own interests." *Id*. (citation omitted). The Plaintiffs in this case have not made either showing, so they should not be permitted to assert the rights of their patients—including the black women who bear the brunt of the risks of abortion.

The clear conflict of interest between abortion providers and the women who seek abortions destroys any presumption of a "close" relationship: abortion providers have a financial incentive to avoid the accountability and burden of maintaining admitting privileges, especially because a hospital's denial of admitting privileges could trigger an adverse report to the National Practitioner Data Bank. As Plaintiffs admit, "Non-administrative denials of admitting privileges are considered a stain on physicians' records. Physicians are required to disclose denials on future applications for privileges, and denials are entered into a national practitioner database that is posted online." Br. for Petitioners, *June Medical*

Services L.L.C. v. Rebekah Gee, No. 18-1323 at 41 n.7 (Nov. 25, 2019). Patients, on the other hand, would benefit from the transparency and accountability that flow from mandatory admitting privileges. It is thus not surprising that the Plaintiffs' seek to assert the rights of others, rather than their own rights.

1. The history of physicians' legal challenges to admitting privileges decisions also demonstrates the conflict of interest that undermines any showing of a close relationship. "Throughout most of this century, physicians have fought … in the political arena and at the level of individual hospitals" against peer-review admitting privileges regimes under the "not-so-hidden agenda of protecting physicians' professional independence and their incomes." James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review, Law & Contemp. Probs.*, Spring 1988, at 7, 24. In service of escaping peer review, "[c]reative lawyering engendered claims such as breach of contract for violating medical staff by-laws, tortious interference with business relations, violation of the Uniform Deceptive Trade Practices Act, breach of confidential relationship, conspiracy, defamation, deprivation of the right to practice a profession, intentional infliction of emotional distress and antitrust violations." Van Tassel, 36 Seton Hall L. Rev. at 1194.

That list of "creative lawyering" strategies now includes pleading constitutional claims "to vicariously vindicate the putative constitutional right of women seeking abortions." *WWH*, 136 S. Ct. at 2321 (Thomas, J., dissenting). Plaintiffs' real concern is not the burden they allege admitting privileges requirements impose on their patients, but the burden this imposes on their income.

2. Plaintiff abortion providers seek to assert the rights of their patients, because a challenge to Act 620 brought by abortion providers in their own interest would be subject to deferential judicial review. If the Plaintiffs' alleged an injury-in-fact to their own liberty or property, their claims would be subject to rational basis review. *See, e.g.*, *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 258 (1964) (applying rational basis review to a hotel's claim that the Civil Rights Act violated its Fifth Amendment rights). But challenging Act 620's admitting privileges requirement on behalf of their patients' putative substantive due process right to an abortion affords Plaintiffs' the advantage of heightened "undue burden" review. *Gonzales*, 550 U.S. at 146 (quoting *Casey*, 505 U.S. at 878 (joint opinion)).

This Court has established standards for third-party standing precisely to avoid this kind of gamesmanship. But for the Court's standing doctrines, "[a] medical malpractice attorney could assert an abstract, generalized challenge to tort reform statutes by asserting the rights of some hypothetical malpractice victim (or victims) who might sue." *Kowalski*, 543 U.S. at 134 n.5. That is analogous to what the Plaintiff abortionists seek to do here.

Minority women have an interest in receiving safe medical care from appropriately credentialled medical professionals. This interest conflicts with the Plaintiffs' interest in avoiding the accountability that comes with admitting privileges. The Court should deny Plaintiffs third-party standing.

CONCLUSION

The decision of the Fifth Circuit should be affirmed, or, in the alternative, Plaintiffs' suit should be dismissed for lack of standing and the decisions below should be vacated.

Respectfully submitted.

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