No. 18-1460 (Vide 18-1323)

In the Supreme Court of the United States

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

Cross-Petitioner,

v.

JUNE MEDICAL SERVICES L.L.C., on behalf of its patients, physicians, and staff, d/b/a HOPE MEDICAL GROUP FOR WOMEN; JOHN DOE 1; JOHN DOE 2

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

BRIEF *AMICUS CURIAE* OF AMERICANS UNITED FOR LIFE IN SUPPORT OF CROSS-PETITIONER

CATHERINE GLENN FOSTER
RACHEL N. MORRISON
Counsel of Record
NATALIE M. HEJRAN
AMERICANS UNITED FOR LIFE
1150 Connecticut Ave NW
Suite 500
Washington, D.C. 20036
Rachel.Morrison@aul.org
(202) 741-4902

Counsel for Amicus Curiae

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INTEREST OF *AMICUS CURIAE*[1]

Amicus Americans United for Life (AUL) is the first and most active pro-life non-profit advocacy organization dedicated to advocating for comprehensive legal protections for human life from conception to natural death. Founded in 1971, before this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), AUL has nearly 50 years of experience relating to abortion jurisprudence. AUL attorneys are highly-regarded experts on the Constitution and legal issues touching on abortion and are often consulted on various bills, amendments, and ongoing litigation across the country. AUL has created comprehensive model legislation and works extensively with state legislators to enact constitutional pro-life laws, including model bills aimed at protecting the health and safety of women who choose abortion. See AUL, DEFENDING LIFE (2018 ed.) (state policy guide providing model bills that protect women's health). AUL has also documented more than 1,400 health and safety deficiencies and violations of state regulations at 227 abortion clinics in 32 states between 2008 and 2016. See AUL, UNSAFE: AMERICA'S ABORTION INDUSTRY ENDANGERS WOMEN (2018 ed.), https://aul.org/wp-content/uploads/2018/10/AUL-Unsafe-2018-Final-Proof.pdf.

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1 No party's counsel authored any part of this brief. No person other than *Amicus* and their counsel contributed money intended to fund the preparation or submission of this brief. Counsel for all parties received timely notice and have consented to the filing of this brief.

SUMMARY OF ARGUMENT

This *Amicus* Brief addresses the first question presented by Cross-Petitioner: whether "abortion providers [can] be presumed to have third-party standing to challenge health and safety regulations on behalf of their patients absent a 'close' relationship with their patients and a 'hindrance' to their patients' ability to sue on their own behalf." Specifically, *Amicus* focuses on the first prong regarding whether abortion clinics and doctors have a "close" relationship with their patients.

Louisiana abortion clinics have a long history of health and safety violations, and Louisiana abortion doctors have a long history of professional disciplinary actions and substandard medical care. This history reveals that not only do Louisiana abortion providers lack the kind of "close" relationship ordinarily required for third-party standing, but also that there is an inherent conflict of interest between abortion providers and their patients regarding state health and safety regulations. Therefore, Plaintiffs cannot be presumed to enjoy a "close" relationship with their patients when it comes to legal challenges brought against the very laws the State intends for the protection of their patients' health and safety, and they should not have third-party standing.

ARGUMENT

Plaintiffs do not have a "close" relationship with their patients and should not have third-party standing.

In *Singleton v. Wulff*, this Court concluded that "it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision." 428 U.S. 106, 118 (1976). Based on this generality, this Court and lower courts have assumed *carte blanche* that abortion providers have third-party standing on behalf of women seeking abortion without any meaningful, particularized analysis. Cf. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2322 (2016) (Thomas, J., dissenting) ("[A] plurality of this Court fashioned a blanket rule allowing third-party standing in abortion cases."). Considering abortion providers routinely challenge state health and safety regulations designed to protect their patients, this presumption is at odds with this Court's third-party standing doctrine requiring: (1) a "close" relationship between the third party and the person who possess the right, and (2) a "'hinderance' to the possessor's ability to protect his own interests." *Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004).

There is an inherent conflict of interest between abortion providers and their patients when it comes to state health and safety regulations. It is impossible for abortion clinics and doctors to share or represent the interests of their patients when they seek to *eliminate*

the very regulations designed to protect their patients' health and safety.

Abortion providers routinely bring legal challenges against state health and safety regulations, and Louisiana abortion clinics and doctors are no different.[2] These cases often involve the unsubstantiated claims that the health and safety regulations will close clinics or "force physicians in Louisiana to cease providing abortion services to women." *Okpalobi v. Foster*, 244 F.3d 405, 410 (5th Cir. 2001) (en banc). Yet despite these doomsday predictions, abortion clinics remain open and doctors continue to provide abortions when the regulations do go into effect. See, *e.g.*, *id.* at 410 (claiming that if Act 825 goes into effect, it will "eliminate abortions in Louisiana"); La. Rev. Stat. Ann. § 9:2800.12 (Act 825 currently in effect).

Plaintiffs bring the current legal challenge against a backdrop of serious health and safety

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[2] See, *e.g.*, *Choice Inc. v. Greenstein*, 691 F.3d 710 (5th Cir. 2012) (Louisiana abortion clinics—Causeway Medical Clinic, Bossier City Medical Suite, Delta Clinic of Baton Rouge, Midtown Medical, and Women's Health Care Center—brought a legal challenge against a Louisiana law regulating abortion clinic licensing compliance standards.); *Okpalobi v. Foster*, 244 F.3d 405 (5th Cir. 2001) (en banc) (Louisiana abortion clinics and doctors—including Causeway Medical Suite, Bossier City Medical Suite, Hope Medical Group for Women, Delta Women's Clinic, Women's Health Clinic, Dr. Ifeanyi Charles Anthony Okpalobi, and Dr. A. James Whitmore, III—brought a legal challenge against a Louisiana law giving women a private tort remedy against abortion doctors for damages to both mother and unborn child during an abortion procedure.).

violations by Louisiana abortion clinics and professional disciplinary actions and substandard medical care by Louisiana abortion doctors. This history demonstrates that Plaintiffs do not have a "close" relationship with their patients and should not have third-party standing.[3]

A. Louisiana abortion clinics—including Plaintiff June Medical Services—have a long history of serious health and safety violations.

Louisiana abortion clinics have a slew of health and safety violations documented in Statements of Deficiencies (SOD) by the Louisiana Department of Health (LDH).[4] Below is a sampling of some of the more egregious violations reported by LDH for five Louisiana abortion clinics: June Medical Services, Delta Clinic of Baton Rouge, Women's Health Care Center, Bossier City Medical Suite, and Causeway Medical Clinic. The first three clinics are still operating, while the Bossier City and Causeway clinics closed soon after failing to report a rape of a minor and performing an abortion on a minor without judicial consent or parental notice, respectively.

June Medical Services. Plaintiff June Medical Services, doing business as Hope Medical Group for Women in Shreveport, is currently challenging

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[3] This Court need not overturn *Singleton v. Wulff* to conclude that Plaintiffs in this case do not have third-party standing.

[4] All of the LDH SODs cited in this Brief are public records received under Louisiana Public Records Law, La. Rev. Stat. Ann. 44:1 *et seq.*, and are on file with *Amicus*.

Louisiana's admitting privileges requirement in this case, as well as a host of other Louisiana health and safety regulations in other cases.[5] Despite June Medical's eagerness to have abortion health and safety regulations struck down, it has been cited for violating patient health and safety regulations, as well as failing to ensure proper physician credentialing and competency.

Substandard patient care.

- 2010: Immediate Jeopardy[6] situation identified for failing to monitor each abortion patient's level of consciousness, respiratory status, and cardiovascular status during abortion procedures for patients receiving

[5] See, *e.g.*, *June Medical Services v. Gee*, No. 18-1323 (U.S. petition for cert. filed Apr. 17, 2019) (challenging admitting privileges law); *June Medical Services v. Gee*, No. 17-404 (M.D. La. filed June 27, 2017) (challenging the entire out-patient abortion regulatory scheme, covering at least 26 abortion laws, including licensing, recordkeeping, and informed consent requirements); *June Medical Services v. Gee*, No. 16-444 (M.D. La. filed July 1, 2016) (challenging six 2016 health and safety laws, including board certification requirement).

[6] "Immediate Jeopardy" is a "situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death. . . . [It] is the most serious deficiency type, and carries the most serious sanctions . . . ." Ctrs. for Medicare & Medicaid Servs., State Operations Manual, Appendix Q—Core Guidelines for Determining Immediate Jeopardy (Mar. 6, 2019), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf.

administration of intravenous (IV) medications and inhalation gas agents.[7]

- 2010: Failure to monitor the amount or length of time the nitrous/oxygen gas was administered to abortion patients.[8]

- 2010: Failure to ensure that the physician performed and documented a physical examination on each abortion patient.[9]

- 2010: Failure to ensure that the physician verified a patient's menstrual, obstetrical, and medical history and questioned the patient about past complications with anesthesia prior to administering the anesthesia and performing the abortion.[10]

- 2012: Failure to ensure an abortion patient was medically stable upon discharge.[11]

- 2012: Failure to ensure all patients completed and signed consent forms for the abortion procedure conducted.[12]

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[7] LDH, SOD for Hope Medical Group for Women 4, 8–9 (Aug. 13, 2010). All future citations will refer to "Hope Medical Group for Women" as "Hope Medical."
[8] *Id.* at 8–12.
[9] *Id.* at 13.
[10] *Id.*
[11] LDH, SOD for Hope Medical 3 (July 25, 2012).
[12] *Id.* at 9.

Unsanitary, expired, missing, or improperly stored instruments, medications, and medical supplies.

- 2011: Failure to properly store and safeguard drugs and medication.[13]

- 2011: Failure to label the name or strength of stored medications and identify the patient's name, and the date and time the medication was prepared.[14]

- 2011: Failure to document date and time medications were compounded, properly store the medications, and identify the corresponding storage time limit.[15]

- 2012: Failure to properly handle sterile instruments and items, including placing opened sterile trays for future patients in procedure room while procedures were ongoing.[16]

- 2012: Failure to properly clean and disinfect instruments after use in patient procedures.[17]

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[13] LDH, SOD for Hope Medical 7–8 (May 27, 2011).
[14] *Id.*
[15] LDH, SOD for Hope Medical 4–5 (Aug. 30, 2011).
[16] SOD for Hope Medical 11 (July 25, 2012).
[17] *Id.*

Missing facility licenses; unlicensed or uncredentialed medical staff providing patient care.

- 2005: Failure to ensure the clinic's Controlled Dangerous Substance (CDS) license was up to date.[18]

- 2006: Failure to ensure physician had admitting privileges at a local hospital or a written transfer agreement with a physician with admitting privileges.[19]

- 2009: Failure to ensure that laboratory technicians dispensing medication were licensed to do so.[20]

- 2010: Failure to ensure qualifications, training, and competency of staff administering IV medications and analgesic gases to patients.[21]

- 2010: Failure to have a qualified professional monitor a patient during the initiation and administration of inhalation gas agents and after the administration of IV medications.[22]

- 2011, 2012: Failure to ensure nurse had the competency, skills, and knowledge to compound

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[18] LDH, SOD for Hope Medical 1–2 (Sept. 19, 2005).
[19] LDH, SOD for Hope Medical 1–2 (Oct. 4, 2006).
[20] LDH, SOD for Hope Medical 1–2 (Sept. 3, 2009).
[21] SOD for Hope Medical 2–3 (Aug. 13, 2010).
[22] *Id.* at 4–5.

medication used by physicians in paracervical blocks.[23]

Incomplete, inaccurate, and untimely patient medical records and state mandated reports.

- 2010, 2011: Failure to include an individualized, signed, and dated copy of the physician's standing orders in each patient's medical records.[24]

- 2011, 2017, 2018: Failure to timely submit Induced Termination of Pregnancy (ITOP) report with physician's signature and failure to submit reports for patients who had complications.[25]

Delta Clinic of Baton Rouge. Delta Clinic of Baton Rouge is still operating despite repeated violations of health and safety regulations.

Substandard patient care.

- 2009: Immediate Jeopardy situation identified for failing to follow standards of practice for administering conscience sedation by placing syringes in a non-sterile bag; failing to

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[23] SOD for Hope Medical 1 (Aug. 30, 2011); SOD for Hope Medical 2 (July 25, 2012).

[24] SOD for Hope Medical 13–14 (Aug 13, 2010); SOD for Hope Medical 7 (Aug. 30, 2011).

[25] SOD for Hope Medical 5–7 (May 27, 2011); LDH, SOD for Hope Medical 5–7 (June 7, 2017); LDH, SOD for Hope Medical 1–3 (Aug. 16, 2018).

document medication, time, and dose; failing to monitor cardiac status; and failing to document start and end times of abortion procedures.[26]

- 2019: Immediate Jeopardy situation identified for failing to have emergency IV fluids available for surgical abortion patient experiencing heavy bleeding, which led to the patient being transferred to the hospital where she underwent a hysterectomy and bilateral salpingectomy.[27]

- 2007: Failure to ensure that the physician performed and documented a physical examination on each abortion patient.[28]

- 2009: Failure to monitor level of consciousness, respiratory status, and cardiac status during abortion procedure for patients receiving conscious sedation.[29]

- 2009: Failure to counsel abortion patients individually and privately.[30]

- 2011: Failure to obtain written notarized parental consent before performing abortion on minor patient.[31]

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[26] LDH, SOD for Delta Clinic of Baton Rouge 6–9 (Dec. 7, 2009). All future citations will refer to "Delta Clinic of Baton Rouge" as "Delta Clinic."
[27] LDH, SOD for Delta Clinic 6–14 (Mar. 29, 2019).
[28] LDH, SOD for Delta Clinic 1–3 (Oct. 9, 2007).
[29] SOD for Delta Clinic 5, 14–17 (Dec. 7, 2009).
[30] *Id.* at 5, 20–22.
[31] LDH, SOD for Delta Clinic 5–7 (Feb. 3, 2011).

Unsanitary, expired, missing, or improperly stored instruments, medications, and medical supplies.

- 2019: Immediate Jeopardy situation identified when clinic did not have IV fluids available to stabilize patient who had surgical abortion complications and experienced heavy bleeding.[32]

- 2009: Failure to follow manufacturer's guidelines and properly decontaminate vaginal probes between patient use.[33]

- 2009: Failure to ensure single use IV fluid was used only once.[34]

- 2009: Failure to ensure pre-written, pre-signed prescriptions were patient-specific.[35]

- 2009: Failure to maintain aseptic technique for syringes.[36]

- 2017: Failure to properly sterilize medical equipment.[37]

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[32] SOD for Delta Clinic 6–14 (Mar. 29, 2019).
[33] SOD for Delta Clinic 34 (Dec. 7, 2009).
[34] *Id.* at 34–35, 39–40.
[35] *Id.* at 40–41.
[36] *Id.* at 9–11.
[37] LDH, SOD for Delta Clinic 37–41 (Jan. 25, 2017).

- 2009, 2013, 2018: Failure to ensure medical supplies and medications were not expired.[38]

- 2018: Failure to label and date syringes filled with lidocaine and epinephrine.[39]

- 2019: Failure to maintain sufficient supply of unexpired emergency medication for treating complications.[40]

Missing facility licenses; unlicensed or uncredentialed medical staff providing patient care.

- 2004: Failure to ensure physician had admitting privileges at a local hospital or a written transfer agreement with a physician with admitting privileges.[41]

- 2018: Failure of nurse to obtain physician's order before administering medications and biologicals.[42]

Incomplete, inaccurate, and untimely patient medical records and state mandated reports.

- 2009, 2018: Failure to document name, time, route, dose, and/or rate of administration of

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[38] SOD for Delta Clinic 29–30 (Dec. 7, 2009); LDH, SOD for Delta Clinic 1 (Jan. 9, 2013); LDH, SOD for Delta Clinic 37–38 (July 13, 2018).
[39] SOD for Delta Clinic 32–34 (July 13, 2018).
[40] SOD for Delta Clinic 14–16 (Mar. 29, 2019).
[41] LDH, SOD for Delta Clinic 1–2 (May 27, 2004).
[42] SOD for Delta Clinic 5–17, 43–51 (July 13, 2018).

conscience sedation medication and drugs for patients receiving paracervical blocks in patients' medical records.[43]

- 2009, 2011: Failure to follow mandatory reporting laws for carnal knowledge, incest, and rape of minors.[44]

- 2014: Failure to maintain accurate medical records on the correct age of the alleged father of the unborn child of a minor patient.[45]

- 2017, 2018: Failure to timely submit ITOP reports signed by physician.[46]

Women's Health Care Center. Women's Health Care Center, currently operating in New Orleans, has received numerous health and safety deficiencies.

Substandard patient care.

- 2004: Failure to follow up with patients regarding potential problems resulting from

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[43] SOD for Delta Clinic 11–14 (Dec. 7, 2009); SOD for Delta Clinic 22–29, 39–43 (July 13, 2018).
[44] SOD for Delta Clinic 9, 18–20 (Dec. 7, 2009); SOD for Delta Clinic 2–5 (Feb. 3, 2011).
[45] LDH, SOD for Delta Clinic 3–4 (Apr. 1, 2014).
[46] SOD for Delta Clinic 10–14, 26–31 (Jan. 25, 2017); LDH, SOD for Delta Clinic 4–6, 10–12 (June 20, 2017); LDH, SOD for Delta Clinic 1–2 (July 11, 2018); SOD for Delta Clinic 30–31 (July 13, 2018).

the use of an unsanitary instrument during abortion procedure.[47]

- 2013: Failure to ensure a patient, referring physician, or performing physician signed informed consent form for an abortion procedure.[48]

- 2015: Failure to document complication of a patient who experienced heavy vaginal bleeding eight days after her chemical abortion, was picked up by a clinic staff member and brought to the clinic, and was then subsequently transported by clinic staff to the hospital.[49]

- 2018: Failure to inform persons inquiring about abortion of Louisiana's website containing informed consent information about abortion—including abortion options and alternatives—during initial contact as required by law.[50]

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[47] LDH, SOD for Women's Health Care Center 2, 6–7 (Aug. 5, 2004).
[48] LDH, SOD for Women's Health Care Center 1–2 (Nov. 7, 2013).
[49] LDH, SOD for Women's Health Care Center 5–7 (Sept. 2, 2015).
[50] LDH, SOD for Women's Health Care Center 2–7 (June 19, 2018).

Unsanitary, expired, missing, or improperly stored instruments, medications, and medical supplies.

- 2004: Failure to properly sterilize surgical equipment and instruments, including instruments used to enter the uterine cavity.[51]

- 2015: Failure to disinfect abdominal ultrasound probe.[52]

Missing facility licenses; unlicensed or uncredentialed medical staff providing patient care.

- 2012: Failure to provide nursing services under the direction of a registered nurse (RN) because the facility did not employ an RN.[53]

- 2010, 2015: Failure to properly evaluate licensed medical personnel and non-licensed staff for competency.[54]

- 2018: Failure to ensure the clinic medical director who procured/ordered a controlled dangerous substance had a current CDS license.[55]

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[51] SOD for Women's Health Care Center 2–6 (Aug. 5, 2004).
[52] SOD for Women's Health Care Center 11–13 (Sept. 2, 2015).
[53] LDH, SOD for Women's Health Care Center 1–2 (Nov. 14, 2012).
[54] LDH, SOD for Women's Health Care Center 5 (Oct. 19, 2010); SOD for Women's Health Care Center 3–4 (Sept. 2, 2015).
[55] SOD for Women's Health Care Center 8–10 (June 19, 2018).

Incomplete, inaccurate, and untimely patient medical records and state mandated reports.

- 2004: Failure to document medications administered and post-operative care in patients' medical records.[56]

- 2010, 2013, 2016: Failure to timely submit ITOP reports signed by physician, and failure to ensure reports contained accurate information.[57]

- 2015: Failure to document patient communication, complications, transport to hospital, or hospital admittance in patient medical records.[58]

Leroy Brinkley. Leroy Brinkley, who operates both Delta Clinic of Baton Rouge and Women's Health Care Center, and as well as other clinics in the past and in other states, has a history of reportedly unscrupulous business practices.

For example, Brinkley was held personally liable for Delta Clinic's $337,000 fine for violating the Federal Controlled Substances Act after the clinic failed to pay. See *United States v. Clinical Leasing Service, Inc.*, 982 F.2d 900 (5th Cir. 1992). He also employed the infamous Dr. Kermit Gosnell as an

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[56] LDH, SOD for Women's Health Care Center 3–5 (Apr. 8, 2004).
[57] SOD for Women's Health Care Center 2 (Oct. 19, 2010); LDH, SOD for Women's Health Care Center 4–5 (Nov. 7, 2013); LDH, SOD for Women's Health Care Center 4–8 (Sept. 12, 2016).
[58] SOD for Women's Health Care Center 5–6 (Sept. 2, 2015).

independent contractor at his Delaware clinic, Atlantic Women's Medical Services.[59] Brinkley would send women whom the Delaware clinic could not help (presumably because they were seeking a late-term abortion) across state lines to Gosnell's clinic in Pennsylvania.[60] Gosnell's clinic was "convicted for the first-degree murder of three infants who were born alive and for the manslaughter of a patient." *Hellerstedt*, 136 S. Ct. at 2343 (Alito, J., dissenting). When Brinkley was subpoenaed for Gosnell's patient files, he was only able to produce three files and could not explain what happened to the rest.[61]

Bossier City Medical Suite. Bossier City Medical was located in Bossier City, Louisiana until the clinic's abrupt closure on April 1, 2017, two months after LDH reported that the clinic failed to report a rape of a minor. About a month after the clinic closed, all of the patient files were destroyed by the clinic's former principal. Declaration of Roneal Martin, *Gee v. Bossier City Medical Suite*, No. 18-00369 (E.D. Tex. July 3, 2018).

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[59] Testimony of Leroy Brinkley, *In re Cnty. Investigating Grand Jury XXIII*, No. 000-9901-2010, at 9 (First Jud. Dist. of Pa. Ct. Com. Pl. Nov. 4, 2010).
[60] *Id.* at 42.
[61] *Id.* at 19–20.

Substandard patient care.

- 2009: Failure to assess patients who had been administered narcotic medications prior to their abortion procedure.[62]

Unsanitary, expired, missing, or improperly stored instruments, medications, and medical supplies.

- 2004: Failure to ensure medications were not expired.[63]

- 2004: Failure to ensure clinic was supplied with emergency medications.[64]

- 2009: Failure to maintain sanitary environment by keeping a suction bottle for "special procedures" in a biohazard bag inside a trash can, storing an open jug of distilled water next to disinfection spray, and allowing rust and dirt to build up on the metal of procedure beds.[65]

- 2017: Failure to ensure proper sterilization of surgical instruments.[66]

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[62] LDH, SOD for Bossier City Medical Suite 1 (July 2, 2009). All future citations will refer to "Bossier City Medical Suite" as "Bossier City."
[63] LDH, SOD for Bossier City 6 (Jan. 20, 2004).
[64] *Id*. at 7.
[65] SOD for Bossier City 1–3 (July 2, 2009).
[66] LDH, SOD for Bossier City 13–16 (Feb. 1, 2017).

Missing facility licenses and patient care by unlicensed or uncredentialed medical staff.

- 2004: Failure to have site-specific CDS license and Drug Enforcement Administration registration needed to order drugs.[67]

- 2007: Failure to ensure nurse administering IV medications received in-service training, completed formalized training course, and received signed physician statement to administer medications to patients.[68]

Incomplete, inaccurate, and untimely patient medical records and state mandated reports.

- 2004: Failure to maintain records of prescription drugs dispensed to patients.[69]

- 2017: Failure to timely submit ITOP reports with physician signature.[70]

- 2017: Failure to report rape of minor child to proper authorities.[71]

Causeway Medical Clinic. Causeway Medical Clinic was located in Metairie until its abrupt closure on February 10, 2016, less than three months after

[67] SOD for Bossier City 7 (Jan. 20, 2004).
[68] LDH, SOD for Bossier City 1–2 (Aug. 27, 2007).
[69] SOD for Bossier City 6–7 (Jan. 20, 2004).
[70] SOD for Bossier City 6–11 (Feb. 1, 2017).
[71] *Id.* at 6–7, 11–13.

LDH reported that the clinic performed an abortion on a minor without parental consent or judicial notice.

Substandard patient care.

- 2009: Immediate Jeopardy situation identified for failure to monitor rate of IV sedation, level of consciousness, respiratory status, and cardiovascular status during patients' abortion procedure.[72]

- 2011: Failure to ask minor patients the age of the alleged father of the minor's unborn child or whether sexual contact had been consensual or forced—information necessary to comply with mandatory state reporting of "abuse of minors as it relates to carnal knowledge, incest, and rape of minors."[73]

- 2012, 2015: Failure to obtain parental consent or judicial bypass before performing an abortion on a minor.[74]

- 2014: Failure to document patient's vital signs during post-procedure recovery or at time of discharge.[75]

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[72] LDH, SOD for Causeway Medical Clinic 3–9 (July 2, 2009). All future citations will refer to "Causeway Medical Clinic" as "Causeway."
[73] LDH, SOD for Causeway 2–5 (Jan. 27, 2011).
[74] LDH, SOD for Causeway 2–5 (May 15, 2012); LDH, SOD for Causeway 10–15 (Nov. 30, 2015).
[75] LDH, SOD for Causeway 2–4 (May 28, 2014).

- 2015: Failure to investigate a complaint and grievance of a mother whose minor daughter had an abortion without parental consent or judicial bypass.[76]

Unsanitary, expired, missing, or improperly stored instruments, medications, and medical supplies.

- 2009: Failure to have reversal agent for sedation in emergency medical and supply box.[77]

- 2009: Failure to maintain a clean environment to prevent possibility of cross-contamination between patients and/or staff.[78]

- 2009, 2012: Failure to ensure medications were not expired.[79]

- 2011: Failure to ensure vaginal ultrasound transducer was properly disinfected and sanitized between patient use.[80]

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[76] SOD for Causeway 10–13 (Nov. 30, 2015).
[77] SOD for Causeway 10, 12 (July 2, 2009).
[78] *Id*. at 19.
[79] *Id.* at 22; SOD for Causeway 6–7 (May 15, 2012).
[80] SOD for Causeway 14–15 (Jan. 27, 2011).

Missing facility licenses; unlicensed or uncredentialed medical staff providing patient care.

- 2009: Failure to ensure abortion clinic was inspected and approved annually by the Office of Public Health.[81]

- 2009, 2015: Failure to obtain physician's order before administering medications.[82]

- 2009: Failure to have qualified staff administer IV sedation.[83]

- 2011, 2015: Failure to determine physicians' specific privileges at clinic, privilege qualifications, license restrictions, or evidence of prior malpractice claims or settlements.[84]

Incomplete, inaccurate, and untimely patient medical records and state mandated reports.

- 2009: Failure to accurately document in patients' medical records the rate of IV sedation, level of consciences, cardiac status, and respiratory status throughout stay until discharge.[85]

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[81] SOD for Causeway 1 (July 2, 2009).
[82] *Id.* at 21–22; SOD for Causeway 5–8 (Nov. 30, 2015).
[83] SOD for Causeway 15–16 (July 2, 2009).
[84] SOD for Causeway 8 (Jan. 27, 2011); SOD for Causeway 2–4 (Nov. 30, 2015).
[85] SOD for Causeway 2–9 (July 2, 2009).

- 2013: Failure to record correct age of the alleged father of the unborn child of a minor patient.[86]

All of the clinic violations reported in the LDH Statement of Deficiencies demonstrate that Louisiana abortion clinics do not share the same interests as their patients when it comes to health and safety, and as such cannot have the necessary "close" relationship for third-party standing.

B. Louisiana abortion doctors have a long history of professional disciplinary actions and substandard medical care.

In Louisiana abortion doctors have received numerous professional disciplinary actions by the Louisiana State Board of Medical Examiners ("Board"). These actions reveal that past and current abortion doctors have engaged in unprofessional and unethical behavior, and substandard medical care of their patients.[87] Five of these abortion doctors—some of whom have been involved in legal challenges against Louisiana health and safety laws—are discussed below.

Dr. Adrian J. Coleman. Dr. Coleman was an abortion doctor at the Delta Clinic. In 2008 and 2009, his operative vaginal delivery privileges and his clinical privileges were suspended at two medical

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[86] LDH, SOD for Causeway 1–3 (May 30, 2013).

[87] All Board disciplinary reports are judicially noticeable public documents available on the Board's website: https://secure.pharmacy.la.gov/Lookup/LicenseLookup.aspx. See Fed. R. Evid. 201.

facilities, respectively—first after an infant died during a delivery he performed and second after he had an "unacceptably high number of absences from obstetrical deliveries, [did] not adequately evaluate and care for his patients in the labor and delivery unit, and fail[ed] to document his patient care adequately and accurately."[88] As a result, the Board placed Dr. Coleman's medical license on probation for three years in 2010 and prohibited him from performing all operative vaginal delivery procedures, a prohibition that would not be lifted until the Board determined that he was "competent to perform [surgical] procedures safely and in accordance with the prevailing standards of medical practice."[89] He passed away in 2011.

Dr. Ifeanyi Charles Anthony Okpalobi. Dr. Okpalobi was involved in multiple legal challenges to Louisiana abortion health and safety laws, including a Louisiana law that created a private tort remedy for women against abortion doctors for damages to both the mother and unborn child during an abortion procedure. See, *e.g.*, *Okpalobi*, 244 F.3d 405. During this legal challenge he was cited by the Board for failing to report multiple malpractice complaints and settlements.[90] His failure to report, in addition to allegations that he "demonstrated professional and/or medical incompetency by his inability to provide timely and appropriate care to his patients, including

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[88] *In the Matter of: Adrian Joseph Coleman*: No. 08-I-775, at 1 (La. Bd. Med. Exam'rs Mar. 15, 2010).
[89] *Id*. at 2–3.
[90] *In the Matter of: Ifeanyi Okpalobi*, No. 93-I-051-X (La. Bd. Med. Exam'rs Mar. 8, 1999).

but not limited to risk assessment, pre-natal and post-natal management, determination of uterine size and gestational age, and testing and evaluation related to abortion," resulted in a consent order by which Dr. Okpalobi agreed to have his medical license put on a three-year probationary period and to an indefinite prohibition on his obstetrical practice.[91] In 2012, Dr. Okpalobi was officially reprimanded for his repeated failures to meet Abortion Facility Licensing Standards and continued conduct that was indicative of a practice which "fail[ed] to satisfy the prevailing and usually accepted standards of medical practice."[92] He was required to receive Board approval for any intended medical practice.[93] He passed away in 2018.

Dr. A. James Whitmore, III. Dr. Whitmore was part of the same legal challenge as Dr. Okpalobi against the Louisiana abortion tort remedy law. See *Okpalobi*, 244 F.3d 405. Prior to this challenge, Dr. Whitmore was involved in two deliveries of children in which his diagnoses and treatments were inappropriate and resulted in the birth of one child brain damaged, the death of one other child, and an inappropriate Caesarean section.[94] About a decade later, while working at Delta Clinic, Dr. Whitmore used instruments that were rusty, cracked, and unsterile; single-use instruments on multiple patients; and a sterilization solution that was

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[91] *Id.*

[92] *In the Matter of: Ifeanyi Charles Okpalobi*, No. 10-I-033, at 1 (La. Bd. Med. Exam'rs May 9, 2012).

[93] *Id.* at 3.

[94] *In the Matter of: A. James Whitmore*, No. 92-A-001, at 1 (La. Bd. Med. Exam'rs May 21, 1992).

infrequently changed and often had pieces of tissue floating in it.[95] After a second trimester abortion he performed, the patient continued to have moderate bleeding, but the ambulance was not called until almost three hours later.[96] When the patient arrived in the emergency room, it was discovered that she had a perforated uterus, her uterine artery was lacerated, and it was necessary to perform a complete hysterectomy.[97] The Board found Dr. Whitmore guilty of unprofessional conduct and continuing or recurring medical practices which failed to satisfy accepted medical standards based on his "disregard of proper sanitary procedures, his rude and callous treatment of his patients, his refusal to answer their questions, and his tardy recognition of the seriousness of the condition of [a] patient [that] endanger[ed] her life."[98] Based on these actions, the Board had "grave reservations as to Dr. Whitmore's professional competency," and placed his medical license on immediate probation for an indefinite period.[99]

Dr. Victor Brown. Dr. Brown has received many disciplinary actions from the Board. In 1989, after allegedly writing and issuing prescriptions for controlled substances to five patients without legitimate medical justification, Dr. Brown entered into a consent order placing his medical license on probation for three years and prohibiting him for the

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[95] *In the Matter of: A. James Whitmore, III*, No. 00-A-021, at 2 (La. Bd. Med. Exam'rs Jan. 22, 2002).
[96] *Id*. at 3.
[97] *Id*.
[98] *Id*.
[99] *Id*.

duration of his medical career from prescribing, dispensing, or administering any Schedule II controlled substance.[100] In 1997, a medical center suspended his surgical/invasive/endoscopic clinical privileges after an investigation revealed that his definition, evaluation, and treatment of infertility were inconsistent and not in keeping with generally recognized medical standards since he performed dilation and curettage on almost every patient even when the procedure was not medically indicated or necessary.[101] Dr. Brown failed to report the loss of his privileges on three different medical license renewal applications, so when the Board discovered this in 2000, he agreed to a consent order placing his medical license on indefinite probation and a lifetime limitation on the practice of medicine in the field of obstetrics/gynecology.[102] Specifically, he was never again to perform any prenatal care in any and all surgical/invasive/endoscopic procedures, including dilations and curettages, dilations and evacuations, dilations and extractions, abortions, and vaginal or cesarean deliveries.[103] But in 2005, Dr. Brown violated the 2000 consent order by engaging in and practicing medicine he was not authorized to practice. His license was once again placed on indefinite probation and he was further restricted from performing cervical or vaginal biopsies and

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[100] *In the Matter of: Victor Brown*, No. 89-A-035, at 2 (La. Bd. Med. Exam'rs Dec. 8, 1989).
[101] *In the Matter of: Victor Brown*, No. 99-I-035, at 1 (La. Bd. Med. Exam'rs Mar. 24, 2000).
[102] *Id.* at 4.
[103] *Id.*

performing or interpreting ultrasounds of any kind.[104] In 2007, Dr. Brown's medical license was revoked and cancelled for violating the terms of the 2005 consent order, unprofessional conduct, and professional and medical incompetency when he gave prenatal care to an abortion patient by either giving the patient a prescription without first examining her or taking and interpreting an ultrasound and then prescribing the patient an abortifacient.[105]

Dr. Kevin Work. Dr. Work has received multiple disciplinary actions from the Board. In 2009, his medical license was placed on a one year probation after a hospital suspended his clinical privileges.[106] In 2014, after Dr. Work allowed staff to use his name and electronic signature, and engage in the practice of medicine, he agreed to a one year probation on his medical license and a requirement that the Board approve any future practice of medicine.[107] In 2016, after again allowing unlicensed staff members to practice medicine by performing ultrasounds and providing prenatal care at his clinic, Dr. Work agreed not practice medicine in *any* capacity for one year.[108] In 2017, his license was reinstated on a two-year

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[104] *In the Matter of: Victor Brown*, No. 01-I-037, at 3 (La. Bd. Med. Exam'rs Aug. 15, 2005).

[105] *In the Matter of: Victor Brown*, No. 06-A-021, at 2, 5 (La. Bd. Med. Exam'rs Sept. 17, 2007).

[106] *In the Matter of: Kevin Govan Work*, No. 08-I-774, at 1–2 (La. Bd. Med. Exam'rs Mar. 16, 2009).

[107] *In the Matter of: Kevin Govan Work*, No. 13-I-014, at 1–3 (La. Bd. Med. Exam'rs Oct. 17, 2014).

[108] *In the Matter of: Kevin Govan Work*, No. 15-A-009, at 3 (La. Bd. Med. Exam'rs Feb. 15, 2016).

probation requiring that he only engage in the practice of medicine as approved by the Board and in a non-solo practitioner setting.[109] In 2019, his medical license was suspended pending resolution of claims relating to practicing at an abortion clinic without prior Board approval.[110] As part of a consent order, he was officially reprimanded and placed on probation for two years with the same restrictions as in 2017, but with the addition that another physician be present any time he practices medicine and a covenant that, regardless of the status of his medical license, "he will not practice in the area of abortion care in the State of Louisiana" and "will not practice obstetrics in the State . . . other than diagnosing pregnancy and referring pregnant patients."[111] Dr. Work's medical license was reinstated without restriction on June 20, 2019.[112]

In sum, Louisiana abortion doctors' multiple professional disciplinary actions for substandard medical care and blatant disregard for their patients' health and safety—in addition to the numerous health and safety violations of Louisiana abortion clinics—demonstrate that abortion providers' interests are at odds with their patients' interests. As such, Plaintiffs do not have a "close" relationship with their patients and should not have third-party standing.

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[109] *In the Matter of: Kevin Govan Work*, No. 15-A-009, at 1–2 (La. Bd. Med. Exam'rs June 20, 2017).

[110] *In the Matter of: Kevin Govan Work*, No. 19-I-144 (La. Bd. Med. Exam'rs Feb. 26, 2019).

[111] *In the Matter of: Kevin Govan Work*, No. 2019-A-011, at 1–2 (La. Bd. Med. Exam'rs Apr. 15, 2019).

[112] *In the Matter of: Kevin Govan Work*, No. 2019-A-11 (La. Bd. Med. Exam'rs June 10, 2019).

CONCLUSION

If the Court grants the petition in No. 18-1323, it should grant the Conditional Cross-Petition.

Respectfully submitted,

CATHERINE GLENN FOSTER
RACHEL N. MORRISON
Counsel of Record
NATALIE M. HEJRAN
AMERICANS UNITED FOR LIFE
1150 Connecticut Ave NW,
Suite 500
Washington, D.C. 20036
Rachel.Morrison@aul.org
(202) 741-4902

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