No. 18-1460

In the Supreme Court of the United States

DR. REBEKAH GEE, in her official capacity as Secretary of the 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,
Cross-Respondents.

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

AMICI CURIAE BRIEF OF WHOLE WOMAN'S HEALTH AND WHOLE WOMAN'S HEALTH ALLIANCE SUPPORTING CROSS-RESPONDENTS' STANDING

LINDA C. GOLDSTEIN
Counsel of Record
SAMANTHA ROSA
ALYSSA CLARK
DECHERT LLP
1095 Avenue of the Americas
New York, NY 10036
(212) 698-3500
linda.goldstein@dechert.com

BENJAMIN MCANANEY
DECHERT LLP
Cira Centre
2929 Arch Street
Philadelphia, PA 19104
(215) 994-2000

JONATHAN TAM
DECHERT LLP
1 Bush Street
Suite 1600
San Francisco, CA 94104
(415) 262-4500

Counsel for Amici Curiae

December 2, 2019

TABLE OF CONTENTS

TABLE OF CONTENTS
(continued)

TABLE OF AUTHORITIES

CASES **PAGE**

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

OTHER AUTHORITIES

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

INTERESTS OF *AMICI*

Whole Woman's Health ("WWH") and Whole Woman's Health Alliance ("WWHA") submit this *amicus curiae* brief in support of the standing of June Medical Services, LLC and other Cross-Respondents to challenge Louisiana's Act 620.[1]

WWH is comprised of a consortium of healthcare companies that operate abortion clinics in Maryland, Minnesota, Texas, and Virginia. WWHA is an independent nonprofit organization that receives management services from WWH and operates abortion clinics in Indiana, Texas, and Virginia.

For almost two decades, it has been WWH's mission to provide high-quality reproductive health care services, including abortion services. WWH's abortion care is multi-faceted, consisting of first-rate medicine for a patient's body and mind, and compassionate, supportive care for her heart and spirit. WWHA works strategically to end the stigma around abortion through providing a full spectrum of abortion care services, education, training, and advocacy.

---

[1] Under Supreme Court Rule 37.6, *Amici* affirm that no counsel for a party authored this *amici curiae* brief in whole or in part, and no person other than *Amici* and their counsel has made a monetary contribution to the preparation or submission of this brief. The parties have filed blanket consents to *amicus curiae* briefs.

Amici are well situated to explain why Cross-Respondents have standing to challenge Louisiana's law because they themselves have used third-party standing many times, including to challenge a Texas law that included an identical mandate for physician admitting privileges. On April 2, 2014, WWH challenged H.B.2, a sweeping measure that imposed numerous restrictions on access to abortion in Texas, most notably that doctors who provide abortion services must obtain admitting privileges at local hospitals. WWH and other clinics challenged this law because it required them to comply with an unconstitutional regulation and compromised patients' access to abortion care. Specifically, the admitting-privileges requirement dramatically reduced the number and geographic distribution of medical facilities where women could access a safe abortion, and overwhelmed the few remaining facilities with increased demand, with no discernible medical benefit. This Court struck down H.B.2 on June 27, 2016, concluding that the statute created barriers to safe and legal abortion that offered no medical benefit and unduly burdened women's rights to access abortion services in violation of the 14th Amendment to the United States Constitution. *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016).

WWHA, like WWH, has also zealously advocated on its patients' behalf by relying upon third-party standing to challenge laws restricting a woman's access to an abortion. For example, in *Whole Woman's Health Alliance* v. *Hill*, WWHA challenged an Indiana

licensing law that had prevented it from providing medication abortion care in an underserved region of the State. 937 F.3d 864 (7th Cir. 2019). Likewise, in *Falls Church Medical Center, LLC* v. *Oliver*, WWHA sought relief from a wide range of restrictions. __ F. Supp. 3d __, No. 3:18cv428, 2019 WL 4794529 (E.D. Va. Sept. 30, 2019).

In all of those cases, *Amici* responsibly represented the interests of patients who, because of the structural, societal, and personal burdens addressed below, often do not litigate on their own behalf. *Amici*, as providers of the abortion services their patients need, had the expertise and experience to represent their interests, and ably did so.

Amici's interest in this litigation springs from their deep-rooted commitment to providing excellent care for their patients, who find it difficult or even impossible to advocate for their rights on their own. Providers such as *Amici* are fully aligned with the interests of their patients when they challenge laws that unconstitutionally restrict access to abortion care.

SUMMARY OF ARGUMENT

For almost 50 years, this Court and the lower federal courts have held that abortion providers who suffer an "injury in fact"—as Cross-Respondents unquestionably do here—have standing to enforce the constitutional rights of their patients. These cases recognized that the relationship between a patient

and her abortion provider is a paradigm of why the third-party standing doctrine allows one injured party to enforce the rights of another:

(i) Patients and their providers inescapably share a "close relationship" when it comes to protecting patients' rights of access to abortion care because patients obtain that care through the services that providers offer. Thus, plaintiffs' exercise of their constitutional rights "is inextricably bound up with the activity" of the providers. *Singleton* v. *Wulff*, 428 U.S. 106, 114–15 (1976) (plurality).

(ii) The brief timespan for any individual woman's need for abortion services, the profound stigma associated with seeking an abortion in the first place, and the personal struggles that many women face at that time in their lives, all mean that abortion patients face unique hurdles to bringing lawsuits on their own behalf.

Amici's experiences in the clinic and in the courts confirm that these twin pillars of third-party standing are as valid for abortion providers today as they were nearly 50 years ago. For example, when Texas enacted H.B.2, a law that (among other things) required physicians providing abortions to have hospital admitting privileges, the law shuttered clinic doors across the state. The enactment of H.B.2 affected WWH's patients and providers alike, because it

caused the immediate closures of many abortion clinics and led to longer waiting times at the remaining clinics. WWH's patients relied upon WWH's efforts to eliminate a barrier to their access to abortion services and re-open clinic doors. The ensuing invalidation of H.B.2 benefitted both WWH's patients (who did not have to wait as long for their clinic appointments or travel as far to them) and their providers (who were no longer held to an unconstitutional and medically unnecessary admitting-privileges requirement).

Amici also observe that abortion stigma is an omnipresent concern for many of their patients. Their clinics in many parts of the country are plagued by protestors at their doors, terrorizing patients as they come and go. Patients' questions during counseling routinely betray their fears that others will learn that they have had an abortion: "Do I have to tell my OB/GYN that I had an abortion?" "Will my doctor be able to tell that I had an abortion?" Some women tell their counselors they fear being disowned or hurt by their own families if they were to learn of their abortions. One patient told her WWHA physician that a protestor called her church after seeing the church's name on her car's bumper sticker, knowing that her church could shame or intimidate her for exercising her right to choose an abortion.

In light of this entrenched stigma, it is understandable that few women wish to publicly identify themselves as abortion patients by putting their names to lawsuits challenging abortion laws. Most of

Amici's patients are not even aware of the web of legal restrictions that may force local clinics to close their doors. Nor do they have the time, money, and expertise needed to pursue the kind of complex and lengthy litigation that can keep those doors open. And, since *Amici*'s abortion patients have only a matter of weeks to seek the redress that would allow them to access abortion care, they often could not themselves realize a personal benefit from pursuing lengthy litigation.

Providers such as *Amici*, however, can identify the connection between unconstitutional laws and diminished patient access, and can muster the resources to challenge those laws on their patients' behalf. They maintain a direct stake in pursuing the case to a successful conclusion throughout its duration. This Court is witness to the efficacy and zeal that providers such as *Amici* bring to the representation of their patients. Louisiana's assertion that providers do not establish personal bonds to their patients is both irrelevant to third-party standing, for reasons addressed in the Brief of Federal Courts Scholars as *Amici Curiae* in Support of Petitioners, and belied by *Amici*'s own experience of providing a full range of medical and emotional support for their patients.

Abortion patients have been relying upon abortion providers such as *Amici* to protect their rights for decades. Indeed, the last time this Court considered a constitutional challenge brought by a woman asserting her own constitutional right to an abortion without

the participation of her provider was in 1981.[2] If providers such as *Amici* are no longer permitted to enforce the constitutional rights of their patients, those patients' voices will likely go unheard and their rights un-vindicated. Such a draconian result is not warranted by the record in this case, where Cross-Respondents have been vigorous advocates on their patients' behalf, or in the many cases where *Amici* and other providers have successfully advocated for their own patients. *See, e.g., Whole Woman's Health*, 136 S. Ct. 2292. Louisiana's assault on the longstanding practice of third-party standing for abortion providers proffers a purported solution for an imaginary problem and should be rejected.

ARGUMENT

Third-party standing arises when (i) there is an injury in fact to the third-party who is asserting a right, (ii) the party asserting the right has a close relationship with the person who holds the right, and (iii) the person who holds the right faces some obstacle to protecting her own interests. *Powers* v. *Ohio*, 499 U.S. 400, 411 (1991). "Injury in fact" to a third-party establishes the "constitutional" requirement of Article III standing. *Kowalski* v. *Tesmer*, 543 U.S. 125, 129 n.2 (2004). Once "injury in fact" is established—as it indisputably was here—courts consider the "additional" and "prudential" aspects of third-party standing, *i.e.*, whether there is a "close relationship" with

---

[2] *See H. L.* v. *Matheson*, 450 U.S. 398 (1981).

the person holding the right and "hindrance" to enforcing it. *Id.* at 130. In the abortion context, this Court has repeatedly recognized that healthcare providers satisfy the prudential requirements of third-party standing, and may assert the constitutional rights of women seeking access to abortion care. *See, e.g.*, *Doe* v. *Bolton*, 410 U.S. 179, 188 (1973); *Singleton*, 428 U.S. at 113–17 (plurality); *Planned Parenthood of Cent. Mo.* v. *Danforth*, 428 U.S. 52, 62 (1976); *City of Akron* v. *Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 440 n.30 (1983), *overruled on other grounds by Planned Parenthood of Se. Pennsylvania* v. *Casey*, 505 U.S. 833 (1992).[3]

---

[3] So, too, have all of the Courts of Appeals that have considered the issue. *See*, *e.g.*, *Planned Parenthood of N. New England* v. *Heed*, 390 F.3d 53, 56 n.2 (1st Cir. 2004), *vacated on other grounds sub nom.*, *Ayotte* v. *Planned Parenthood of N. New England*, 546 U.S. 320 (2006); *Am. Coll. of Obstetricians & Gynecologists, Penn. Section* v. *Thornburgh*, 737 F.2d 283, 290 n.6 (3d Cir. 1984), *aff'd sub nom. Thornburgh* v. *Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986); *Greenville Women's Clinic* v. *Bryant*, 222 F.3d 157, 194 n.16 (4th Cir. 2000); *Planned Parenthood of Greater Texas Surgical Health Servs.* v. *Abbott*, 748 F.3d 583, 589 (5th Cir. 2014); *Planned Parenthood Ass'n of Cincinnati, Inc.* v. *City of Cincinnati*, 822 F.2d 1390, 1394–96 (6th Cir. 1987); *Planned Parenthood of Wisconsin, Inc.* v. *Schimel*, 806 F.3d 908, 910–11 (7th Cir. 2015); *Comprehensive Health of Planned Parenthood Great Plains* v. *Hawley*, 903 F.3d 750, 757 n.7 (8th Cir. 2018); *Planned Parenthood of Idaho, Inc.* v. *Wasden*, 376 F.3d 908, 916–18 (9th Cir. 2004); *Planned Parenthood of Rocky Mountains Servs.* v. *Owens*, 287 F.3d 910 (10th Cir. 2002); *Planned Parenthood Ass'n of Atlanta Area, Inc.* v. *Miller*, 934 F.2d 1462, 1465 n.2 (11th Cir. 1991).

The features of the provider-patient relationship that this Court has relied upon for decades to hold that abortion providers could assert the constitutional rights of their patients have not changed since *Doe* v. *Bolton* was decided in 1973. The "closeness of the relationship" between healthcare providers who administer abortions and their patients is "patent." *Singleton*, 428 U.S. at 117. An abortion patient may be hindered from asserting her own rights "by a desire to protect the very privacy of her decision from the publicity of a court suit." *Id.* An abortion patient still presents a unique "imminent mootness" problem, because "after the maturing of the decision to undergo an abortion, her right thereto will have been irrevocably lost." *Id.*

Relying on these aspects of the provider-patient relationship, this Court has observed that there "seems little loss in terms of effective advocacy" from allowing a physician to assert the patient's right. *Id.* at 118. Healthcare providers are "uniquely qualified, by virtue of [their] confidential, professional relationship with [their patients], to litigate the constitutionality of the State's interference with, or discrimination against, the abortion decision." *Id.* at 107.

Amici's experience as both providers and litigants demonstrates that the reasons why abortion providers were first held to satisfy the elements of third-party standing remain valid today. There is no cause to abandon the historical application of third-party standing principles to abortion providers.

I. *AMICI*'S EXPERIENCES MANIFEST THE CLOSE RELATIONSHIP BETWEEN PROVIDERS AND THEIR PATIENTS IN CHALLENGING THE CONSTITUTIONALITY OF LAWS THAT RESTRICT ACCESS TO ABORTION SERVICES

A plaintiff has a "close relationship" with the third party whose constitutional rights are being enforced where the interests of the two are "concomitant," *i.e.*, where the third-party's rights "would be 'diluted or adversely affected'" if the constitutional challenge were to fail. *Craig* v. *Boren*, 429 U.S. 190, 195 (1976). That is plainly the case for abortion providers, for enforcement of laws like Louisiana's Act 620 that require providers to maintain hospital admitting privileges "'would result indirectly in the violation of third parties' rights.'" *Id.* (citing *Warth* v. *Seldin*, 422 U.S. 490, 510 (1975)); *Kowalski*, 543 U.S. at 126. Indeed, *Amici*'s experience confirms that the constitutional rights of patients to abortion care without undue burden, and the ability of providers to pursue their profession without unreasonable regulation, rise and fall together.

Louisiana's Act 620, like H.B.2, mandates that physicians submit themselves to an arbitrary and subjective application process in which the state delegates decision-making authority to local hospitals. Applying for admitting privileges is a lengthy and arbitrary process that requires time and effort, and ultimately depends on a subjective evaluation by the hospital staff

on the business needs of the hospital. *Whole Woman's Health*, 136 S. Ct. at 2312–13 (observing that certain *amicus* briefs set forth "without dispute other common prerequisites to obtaining admitting privileges that have nothing to do with ability to perform medical procedures" such as whether the applicant will accept faculty appointments). Failure to comply leaves providers subject to stark criminal penalties and licensure revocation. In Louisiana, as in Texas, notwithstanding extensive good faith efforts by abortion providers to comply with the hospital admitting-privileges requirement, most could not. If Act 620 were to go into effect, abortion clinics will be shut down.

Amici have first-hand experience with the challenges inherent in obtaining admitting privileges, including the lack of standard requirements across hospitals, the lack of a connection of those requirements to health or safety concerns, and the impact of social opprobrium on the decision whether to grant or deny that status. When Texas enacted H.B.2, WWH's Corporate Vice President, Andrea Ferrigno, was tasked with making sure its physicians were in compliance with the law requiring them to procure hospital admitting privileges. In her experience, the statute adversely affected providers by requiring them to submit applications for admitting privileges that had no practical application in the abortion context.[4]

---

[4] All statements attributed to *Amici* staff are drawn from interviews that *Amici's* counsel conducted in connection with the preparation of this brief.

For example, the process for gaining admitting privileges, which varied from hospital to hospital, generally required the collection of irrelevant documentation from the doctors' past practice, and often demanded evidence of recent hospital admissions—evidence that most WWH doctors lacked because their patients rarely required hospital admissions. As another example, many hospitals also required, as a condition to maintain admitting privileges, a minimum level of patient admissions to the hospital on a yearly basis. Again, as abortions are extremely safe and are generally performed on an outpatient basis, without resulting in hospital admissions, many WWH physicians were unable to commit to submitting patients for future hospitalizations. *See June Medical Servs. LLC* v. *Kliebert*, 250 F. Supp. 3d 27, 50 (M.D. La. 2017) ("Because, by all accounts, abortion complications are rare, an abortion provider is unlikely to have a consistent need to admit patients."), *rev'd sub nom. June Med. Servs. L.L.C.* v. *Gee*, 905 F.3d 787 (5th Cir. 2018), *cert. granted*, 140 S. Ct. 35 (2019).

Moreover, the fact that WWH's doctors performed abortions itself limited their ability to get admitting privileges. Many hospitals and practitioners did not want to be affiliated with a physician who performed abortions, and they declined admitting privileges on that basis alone. *Whole Woman's Health* v. *Lakey*, 46 F. Supp. 3d 673, 685 (W.D. Tex. 2014) ("[D]octors in Texas have been denied privileges for reasons not related to clinical competency."), *aff'd in part, vacated in part, rev'd in part sub nom. Whole*

Woman's Health v. *Cole*, 790 F.3d 598 (5th Cir. 2015), *rev'd and remanded sub nom. Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016); *Whole Woman's Health* v. *Cole*, 790 F.3d 563, 596 n.44 (5th Cir. 2015) ("Plaintiffs state that the hospital denied Dr. Richter admitting privileges because she was an abortion provider."), *rev'd and remanded sub nom. Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016). The same was true for the Dr. Does in this case. JA 708–09.

Further, as *Amici* witnessed in Texas, there is no regulated procedure or standard for a denial of an application for admitting procedures. Hospitals need not provide an explanation for a denial, nor are they even required to acknowledge an application was received. Thus, WWH repeatedly found its physicians' applications ignored in Texas, which effectively operated as a denial. It is a subjective process that depends on bylaws and practices that vary from hospital to hospital. Thus, a physician must repeatedly jump through hoops to comply with the various regulations at each hospital, which are often not relevant for outpatient providers. As WWH's Corporate Vice President described the process in Texas, they are "near-impossible" to satisfy notwithstanding the outstanding track records of WWH physicians.

The impact of the admitting-privileges requirement on WWH's doctors in Texas was severe. Those who could not meet the requirements were effectively blocked from their medical practice. Some doctors

were forced to change practice area or to relocate to states with less burdensome regulations. Others felt compelled to retire. WWH, for its part, struggled to recruit new physicians, and it, like many abortion care providers in Texas, had to close clinics.

Ultimately, the number of facilities providing abortion services in Texas went from a pre-regulation level of forty to about twenty. *Whole Woman's Health*, 136 S. Ct. at 2312. As a result, providers' ability to provide high-quality, patient centered care was significantly undermined. *See, e.g., id.* at 2318 ("Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities. Patients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered."). In Texas, *Amici*'s clinics that were able to stay open struggled to meet the growing demands of patients from shuttered clinics who traveled to seek services at operating clinics. Doctors and staff were forced to work long shifts or turn patients away as a result. As Sean Mehl, the previous clinic manager for WWH in San Antonio (now working as WWHA's Charlottesville clinic manager), explains, the impact was "heartbreaking."

Admitting-privileges requirements clearly impact both physicians and the patients they care for. Some physicians are blocked from continuing to provide abortion care, while for the remaining physicians, their ability to provide their patients with the best

possible care, consistent with their professional and ethical obligations, is seriously undermined. In Texas, WWH's physicians remained focused on providing the best care and attention possible under H.B.2's regime, but their patients were often frustrated by the long delays in getting appointments, which could affect their treatment options. The requirement challenged the physicians' ability to provide not just access to medical care, but what *Amici* insist on for their patients: "*good* access" to care. That access was compromised by the longer waiting times and more crowded facilities that *Amici*'s patients had to endure.

In sum, the adoption of an admitting-privileges requirement for abortion providers in Texas affected the constitutional rights of *Amici*'s patients. And WWH's success in challenging that admitting-privileges requirement helped to restore the rights that H.B.2 had unduly burdened: "A suit by clinics and doctors seeking injunctive relief is more feasible and if successful gives the women what they want. If the clinics and doctors win, the patients win." *Schimel*, 806 F.3d at 910–11. *Amici*'s experience demonstrates that patients' constitutional rights are inextricably bound up with their providers' interests when the latter challenge laws that purport to regulate how they provide abortion services.

II. *AMICI* HAVE WITNESSED THE SERIOUS IMPEDIMENTS THAT PREVENT THEIR PATIENTS FROM ENFORCING THEIR OWN CONSTITUTIONAL RIGHTS

Third-party standing is warranted where the person who holds a particular right faces some obstacle preventing her from protecting her own interests. *Kowalski*, 543 U.S. at 130. In the context of abortion regulations, significant obstacles can impede a woman from championing her own interests. *Singleton*, 428 U.S. at 117. Indeed, for abortion regulations that target provider conduct, third-party standing is particularly important because providers often are better positioned to litigate those claims than their patients.

A. Stigma Against Abortion Is Pervasive and Affects Patients' Conduct

One of the most significant impediments to a patient's willingness and ability to challenge laws like Act 620 is the stigma and the negative backlash a woman may expect to face when she publicizes, through litigation, her choice to seek an abortion. *See id.* ("[S]he may be chilled from such assertion by a desire to protect the very privacy of her decision from the publicity of a court suit."). Notwithstanding the efforts, and even the successes, of *Amici* and others in combating stigma, this is still a stubbornly pervasive problem.

The record in this case illustrates why so many women, particularly in Southern, rural, or less-affluent areas, fear social stigma (or worse) for exercising their constitutional rights. For example, Hope Clinic in Shreveport, Louisiana has been the subject of three violent attacks: once by a man wielding a sledgehammer; once by an arsonist who threw a Molotov cocktail at the clinic; and once by having a hole drilled through the wall and butyric acid poured through it. JA 1142; JA 1253; JA 112. Some clinics require on site security. JA 112.

Amici have also witnessed the relentless targeting of their patients and others associated with its clinics. In one example provided by a WWHA doctor in South Bend, Indiana, a protestor saw the name of a church on a patient's car bumper sticker and called the church to report that the patient was getting an abortion, publicizing her procedure to her great distress. Amy Hagstrom Miller, Founder, President, and CEO of *Amici*, recalls that anti-abortion activists' harassment campaign even caused construction crews to quit work on WWHA's South Bend Indiana clinic. Protestors have also scaled WWH's fences, blocked clients from entering the parking lots and even stopped patients from closing their cars' doors as they tried to

leave.[5] In April of this year, WWH's clinic in McAllen, Texas, was the target of an arson attack. *Id.*

Social science research confirms that fear of disclosing an abortion because of the associated stigma is widespread. According to one study of women who had abortions, two-thirds believed that other people would look down on them if they knew about the abortion and 58 percent felt that they could not tell their family and friends.[6] Of particular relevance here, concerns of stigma are heightened in the South, where there are "dominant tendencies of traditionalism and Christian religiosity."[7]

When a patient approaches an abortion clinic, she can expect to be verbally attacked by opponents of abortion. In 2018 alone, there were 3,038 reported incidents of obstruction, a 78 percent increase from 2017, resulting in heightened levels of intimidation for

---

[5] Kate Smith, *Violence Against Abortion Clinics Hit a Record High Last Year. Doctors Say It's Getting Worse*, CBS NEWS, Sept. 17, 2019, https://cbsn.ws/2OcxknK.

[6] K. Shellenberg & A. Tsui, *Correlates of perceived and internalized stigma among abortion patients in the USA: An exploration by race and Hispanic ethnicity*, 118(2) Int'l J. of Gynecology and Obstetrics S152–S159, S153–54 (2012) ("Shellenberg (2012)").

[7] Whitney Smith *et al.*, *Social Norms and Stigma Regarding Unintended Pregnancy and Pregnancy Decisions: A Qualitative Study of Young Women in Alabama,* Vol. 48(2):73–81, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, at 3 (June 2016).

patients.[8] As the district court below found, "each of Louisiana's five clinics experiences frequent demonstrations by anti-abortion activists." JA 112. Protestors use aggressive and demeaning tactics to intimidate patients and disrupt services; it has been reported that at abortion clinics, protestors cross property lines, uproot landscaping, rip apart fences, and block patients from entering parking lots.

The climate of fear created by extremist hate speech and violence intensifies the experience of protests and targeting tactics, such as flyer campaigns. In addition to the increased incidents of obstruction in 2018, there were also 21,252 incidents of online hate speech, 125 incidents of trespassing, 14 incidents of stalking, 13 incidents of burglary, and 15 assaults and batteries directed against abortion clinics and providers. National Abortion Federation (2018) at 1. In February 2018, anti-abortion protestors trespassed into the waiting room of an abortion hospital in Michigan to harass patients, and during their sentencing, they vowed to perpetrate more clinic invasions. *Id.* at 3. Anti-abortion protestors have even spread nails throughout clinic parking lots, damaging vehicles driven by patients and staff. *Id.* at 2. One "protestor used a bullhorn to threaten staff by stating 'I have a bullet with your name on it.' This protestor was also observed threatening patients as they entered the

---

[8] National Abortion Federation, *2018 Violence and Disruption Statistics* at 1 (2018) ("National Abortion Federation (2018)"), *available at* http://bit.ly/35VVnO1.

building." *Id.* And in Colorado Springs in 2015, a gunman held patients and staff hostage at a Planned Parenthood clinic, killing three people and injuring nine others.[9]

Abortion stigma has the effect of silencing women about their choice to have an abortion, thus deterring women from becoming litigants. Abortion stigma creates an "implicit rule of secrecy" in which women are expected to remain silent about their abortion or risk negative perception and discrimination.[10] As a result of abortion stigma, women may view their abortion to be socially unacceptable and anticipate negative judgment, "such as being labeled 'evil,' 'not normal' or 'murderer,' and expected overt discrimination."[11]

Women often express their concerns about stigma to *Amici*'s counselors and doctors when discussing their choice to have an abortion by asking questions such as "Do I have to tell my OB/GYN that I had an abortion?" "Will my doctor be able to tell that I had an abortion?" "Do you think I will go to hell?"

---

[9] National Abortion Federation, *Violence Statistics and History*, http://bit.ly/2sckGN5 (last visited Dec. 2, 2019).

[10] *See* Alison Norris, *Women's Health Issues, Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences* S49, at S50 (No. 3 2011) ("Norris (2011)").

[11] Franz Hanschmidt *et al.*, *Abortion Stigma: A Systematic Review,* Vol. 48(4):169–77, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, at 172 (Mar. 31, 2016) ("Hanschmidt (2016)").

"Will I get breast cancer?" "Or become infertile?" Patients' questions demonstrate their own internalized stigma as a result of anti-abortion propaganda and their fears of experiencing discrimination because of societal stigma. Anticipated negative judgment, or perceived stigma, is a major risk factor for reduced mental health, delays in seeking care, and impaired psychosocial function. Hanschmidt (2016) at 175. Perceived stigma has been cited as the main reason women keep their abortions a secret, which keeps women from "seeking and receiving social support." Norris (2011) at S50; *see also* Hanschmidt (2016) at 174.

One recent study of women who chose to publicly disclose that they have had an abortion found that more than half experienced harassment online or in person, 14 percent felt that they or their loved ones were in physical danger, and 47 percent reported experiencing mental or emotional stress, damage to their reputation, or other negative consequences due to sharing their story.[12] This was the case even among women who used an alias or revealed only their first names. *Id.*

Legislation such as Louisiana's Act 620, which specifically targets abortion clinics, itself perpetuates the stigma and shame surrounding abortions. "By setting abortion and those of us who provide it apart from

---

[12] ANSIRH, *Experiences of Harassment and Support after Sharing One's Personal Abortion Story Publicly*, Nov. 2019, at 2 http://bit.ly/2L6CBLG.

other medical procedures, these laws enhanced the stigma and secrecy women face when trying to access quality care. Instead of making abortion safer, the added restrictions insulted women's intelligence, chipped away at their dignity and dishonored their decision-making processes."[13] Indeed, levels of perceived stigma are higher among women who live in regions that enact more legislative hurdles to abortion. Shellenberg (2012) at S154.

There is no question that the social stigma surrounding abortion affects women's willingness to take public action to enforce their rights. Nearly two-thirds of the women whose private insurance would cover an abortion nonetheless chose to pay their expenses out of pocket. Norris (2011) at S50. They do so for fear of disclosing their abortion to their employers.[14]

As evidenced by the vanishingly small number of cases this Court has considered in the 43 years since *Singleton* was decided that were brought by abortion patients, very few women have opted to bring their own constitutional challenges to abortion restrictions since their providers were allowed to do so.[15] If women

---

[13] Amy Hagstrom Miller, *Keep Politicians Out of the Doctor's Office*, WASHINGTON POST Sept. 8, 2016, https://wapo.st/2XE25Fc.

[14] K. Cockrill & T.A. Weitz, *Abortion patients' perceptions of abortion regulation*, 20 Women's Health Issues, 12–19, 16 (2010).

15 Research reveals only five such cases, all decided in 1981 or earlier: *Beal* v. *Doe*, 432 U.S. 438 (1977); *Maher* v. *Roe*, 432

pursue litigation at all, they still rely on their providers, by serving as co-plaintiffs with them.[16] Given the overwhelming pressure to avoid public disclosure of their status as an abortion patient, it is not surprising that women have historically relied upon their providers to vindicate their constitutional rights.

Social science research and the experiences of *Amici* fully validate *Singleton*'s observation that women are indeed "chilled" from asserting their own rights "by a desire to protect the very privacy of her decision from the publicity of a court suit". *Singleton*, 428 U.S. at 117. Indeed, the persistent stigma of abortion, fomented by decades of anti-abortion violence and targeting of both abortion providers and their patients, means that the impediments to women enforcing their own constitutional rights are at least as great now as they were when this Court decided *Singleton*. Third-party standing is as necessary now as it was then, as women continue to rely upon their providers to defend their constitutional rights.

Allowing patients to file lawsuits under pseudonyms is not the answer. That has been an avenue

---

U.S. 464 (1977); *Poelker* v. *Doe*, 432 U.S. 519 (1977); *Bellotti* v. *Baird*, 443 U.S. 622 (1979); *H. L.* v. *Matheson*, 450 U.S. 398 (1981). The number of abortion cases brought to this Court by providers since *Singleton* was decided is significantly larger.

[16] *See Harris* v. *McRae*, 448 U.S. 297 (1980); *Williams* v. *Zbaraz*, 448 U.S. 358 (1980); *Hodgson* v. *Minnesota*, 497 U.S. 417 (1990); *Ohio* v. *Akron Ctr. for Reprod. Health*, 497 U.S. 502 (1990); *Leavitt* v. *Jane L.*, 518 U.S. 137 (1996).

openly available to women since *Roe* v. *Wade*, 410 U.S. 113 (1973), yet few have taken advantage of it. Patients would have to share their stories with everyone involved in the litigation, as well as through written discovery, deposition testimony, and trial testimony. Their ability to maintain privacy would inevitably erode, especially in smaller communities that have the least access to abortion services. The efforts of anti-abortion forces to unmask women seeking abortions, exemplified by the patient who was "outed" by a church bumper sticker on her car, means that "Doe" anonymity is not adequate protection.

B. Lengthy Litigation Cannot Remedy the Restrictions on Any Individual Patient's Rights of Access

The duration, demands, and scope of litigation are serious impediments to a patient enforcing her right of access to abortion. The *Whole Woman's Health* case is a recent example. Texas's H.B.2 was enacted in July 2013, but this Court did not issue its opinion invalidating the measure until June 2016. In the interim, WWH engaged in massive and costly amounts of discovery, briefing, and appeals. That three-year litigation period was, if anything, remarkably fast for the preparation and consideration of a case of such complexity. By comparison, the present case has been pending for five years. But while providers such as *Amici* and June Medical Services have the time to fight those legal battles, their patients do not.

A woman seeking to terminate a pregnancy has at best 11 weeks in which to seek a first-trimester abortion, assuming she becomes aware of the pregnancy within days of conception.[17] The result, as *Amici* have frequently seen, is that women have a short window in which to seek counseling, identify their options, find a healthcare provider, arrange travel and lodging for (in many states) two separate trips to a provider, and assemble funds to pay for it all. Many of *Amici*'s patients report that it is the most turbulent time in their lives, and *Amici's* staff observe that their patients' primary focus is on the hurdles they must scale to exercise their legal right to an abortion.

Most patients do not know why there are so few clinics in their state, or why they must wait so long for multiple appointments, or how a constitutional challenge might result in readier access. "If two of the four abortion clinics in the state close and a third shrinks by half, some women wanting an abortion may experience delay in obtaining, or even [may] be unable to obtain, an abortion yet not realize that the new law is likely to have been the cause. Those women are unlikely to sue." *Planned Parenthood of Wisconsin, Inc.* v. *Van Hollen*, 738 F.3d 786, 793–94 (7th Cir. 2013). They are particularly unlikely to sue in the crucial

---

[17] Management of First-Trimester Abortion, Vol. 143, PRACTICE BULLETIN: CLINICAL MANAGEMENT GUIDELINES FOR OBSTETRICIAN-GYNECOLOGISTS (Mar. 2014) http://bit.ly/33czFn8.

pre-enforcement stage, before the effects of an unconstitutional law have been felt. And even if they were aware of the possibility of litigation, serving as a plaintiff would require them to devote time to meetings with lawyers, reviewing documents, and attending court hearings, meaning still more travel, more time off from work, and more arrangements for child care.

Amici's staff report that, at this crucial juncture in her life, a patient stymied by restricted access to an abortion does not see litigation as way to fix her problem. And rightly so, because even if she were to launch a lawsuit, she herself could not benefit from it, since her own need for an abortion would inevitably expire long before her case could be decided.

Indeed, after a woman's own need for an abortion has passed, litigation becomes a pure burden with no direct benefit to her. Once a former patient no longer has a personal stake in the matter, she would often be laboring as a volunteer to protect the rights of *other* women, not her own. This turns standing doctrine on its head, for a former patient would have no "concrete interest" in the outcome of any case. *See Kowalski*, 523 U.S. at 136 (Article III standing requires "a sufficiently concrete interest in the outcome of the issue in dispute").

Nor could a patient make a meaningful contribution to the factual record needed to mount an effective constitutional challenge without procuring evidence and testimony from providers. In this case, for

example, patient plaintiffs would be unlikely to understand how legislation like H.B.2 or Act 620 restricts their access because the legislation regulates physician conduct, not patient conduct. Additionally, even if the physicians were not the plaintiffs, they would be crucial witnesses to the litigation and to demonstration of an undue burden on the right to abortion. Evidence from providers was essential to the showing that June Medical Services made here regarding physicians' inability to obtain and maintain admitting privileges. *See, e.g.*, JA 1044–45; JA 212; JA 257–59; JA 879–80; JA 1127–28; JA 1134–35; JA 1310–12. Without support from providers, patients would have been unlikely to have made the showing that WWH made in *Whole Woman's Health* about the effect admitting privileges had on the ability of clinics to remain operational. *Whole Woman's Health*, 136 S. Ct. at 2316 (noting the weighty record evidence on this point, including but not limited to, charts, expert testimony of physicians, and press releases from abortion clinics).

As a result, the women who are most affected by legislation like H.B.2 or Act 620 are unfortunately less than ideal representatives for litigating other women's constitutional rights. By contrast, providers such as *Amici* or June Medical Services have particular advantages that make them exceptional advocates for those rights. Their interests in the issue are ongoing and recurring, and they are willing and able to undertake the considerable demands of the process, as WWH proved in *Whole Woman's Health* and June

Medical Services has demonstrated here. Their doctors and staffers can assist in developing the factual record needed to challenge a state law under this Court's precedents. And perhaps most importantly, they are dedicated to protecting the rights of their patients, as demonstrated by their chosen career. Advocating for women's rights is a lifelong mission for *Amici*'s doctors and staff, and this, coupled with their personal stake in the outcome, assures effective advocacy when they litigate on behalf of their patients. Given the burdens of societal stigma weighing on patients, as well as the resources and expertise required to effectively litigate their rights on their own behalf, providers who have a personal stake in outcome of challenges to unlawful regulations are trustworthy representatives of their patients' rights. Both groups share a concomitant interest in maintaining access to abortion services.

III. *AMICI*'S RELATIONSHIPS WITH THEIR OWN PATIENTS BELIE LOUISIANA'S CHARACTERIZATION OF THE PROVIDER-PATIENT RELATIONSHIP

As described above in Section I, abortion providers have a "close" relationship with their patients for purposes of standing because enforcement of restrictions on providers' practices affects patients' constitutional rights.[18] That a patient's right to abortion

---

[18] Louisiana's argument that a purported conflict of interest precludes the requisite "close relationship" assumes that Louisiana wins on its merits argument—that admitting privilege laws

access can be affected through their medical providers' licensure demonstrates how closely their interests are intertwined. Ultimately, their relationship is unquestionably "close" given their unity of interests—both patients and providers want to assure access to safe, effective medical care—and the fact that enforcement of the law against providers impedes the constitutional rights of the patients.

Amici's doctors and staffers do establish an extraordinarily close relationship with their patients, far from what Louisiana claims to be circumscribed to a doctor performing "very brief procedures on drugged patients whom they never saw before and will never see again." Louisiana's Conditional Cross-Pet. at 29. While the procedure itself is often quite short in duration, duration is not the right test. Medical providers and staffers seek to connect with their patients to provide medical and emotional support systems from the moment a patient picks up the phone to call the clinic until she no longer needs clinical support.

A doctor-patient relationship is created anytime a physician serves a patient's needs, at which point a physician develops an ethical responsibility to place the patient's welfare above the physician's own

---

serve women's health. However, it is abortion providers such as *Amici* who are in the best position to litigate whether admitting privilege laws advance health, as they have experience with not only trying to comply with the laws, but can also demonstrate from experience that abortion care is extremely safe.

self-interest.[19] That relationship is often particularly deep in the context of abortion care, where the totality of services provided ranges from medical treatment to emotional support. And for *Amici*, the clinic's support function can, and does, extend as long as the patient requests it.

Amici start their relationships with their patients from the very first phone call, when women are frequently nervous, scared, and often uninformed. *Amici*'s clinic staff report that every employee is considered a patient advocate and every interaction with patients is part of their healthcare model. The relationship with patients involves counseling, educating, comforting, and helping the patient, and spans the entirety of communications and office visits—not just the interaction with the physician herself. Patients rely on *Amici* to assist with travel arrangements, funding, and scheduling of tertiary care. *Amici* parse through disinformation with the patients and assist in combatting the stigma that has been created in connection with abortion care. Every part of *Amici*'s interaction with the patient is crucial in establishing respect and trust.

Amici's doctors also report a strong emotional connection with their patients. For example, Dr. Joe Nelson, a physician in one of *Amici*'s Texas clinics, relates that his patients share "deeply personal stories"

---

[19] *See*, American Medical Association Code of Medical Ethics Opinion 1.1.1, http://bit.ly/2pYjFri (last visited Dec. 2, 2019).

with him that help him counsel them as they go through the process of abortion. His level of connection with his patients is such that they routinely tell him they have never felt such empathy and respect from a doctor before. Dr. Nelson meets with his clients for consultations as well as for medical procedures, and both interactions contribute to forming his close relationship with his patients. Likewise, Dr. Diane Horvath, another of *Amici*'s clinicians, explains that while the abortion procedure itself can often be brief, the doctors and patients establish their close relationship due to the totality of the medical services being provided. Patients demonstrate their gratitude through cards or, for *Amici*'s clinics that offer gynecological care, by returning for annual examinations.

Amici routinely provide counseling, medical care, and follow-up care to their patients. Due to the safe and minimally-invasive nature of aspiration abortions, there is usually no medical necessity for subsequent office visits, and patients are generally spared the inconvenience of travel to return to a clinic for re-evaluation. In the case of medication-based abortions, involving an initial administration of abortifacients at the office and a subsequent dose at a later time, *Amici* have established procedures for communicating with patients to schedule return visits to confirm the efficacy of the procedure. But given the hostility and intimidation present at abortion facilities, and the sometimes considerable distances that must be traveled to reach a clinic, it is understandable that some women may not return for subsequent care. *Amici*, like other

abortion care providers, offer post-procedural counseling in-person or by telephone, and continue to maintain close communication with many of their patients following their procedures.

Louisiana's suggestion that providers of abortion services lack strong personal bonds to their patients because the procedure they administer is brief, safe, and generally lacks the need for follow-up care is, for the reasons discussed in Section I, above, irrelevant to the standing inquiry. There is a "close relationship" between providers and their patients because the patients' constitutional rights are affected by their providers' compliance with Louisiana Act 620. Indeed, the very fact that Louisiana legislators appear to have sought to reduce the number of abortion clinics available to *patients* by imposing hospital admitting privileges on their *physicians* proves the point. *See* Brief for Petitioners at 8–9. Louisiana's surmise that there could be a "conflict of interest" between providers and patients on this issue is particularly absurd; *Amici*'s staff do not recall any patient or potential patient inquiring about hospital admitting privileges, and are not aware of any instance where a patient's care was compromised for lack of such privileges. And doctors and staff are ethically bound to place patient welfare above any real or hypothetical personal or business interests that may arise in the context of the services they provide.

The crux of the matter is that laws like Act 620 create hurdles to patients accessing and receiving safe

abortion care—whether by increasing distance, cost, or availability—and both patients and their doctors are motivated to make sure that abortion care remains accessible. Both patients and their medical providers seek the same outcome in this case—the invalidation of a law that blocks patients' access to abortion services by imposing unnecessary and burdensome regulations on their providers. Finding third-party standing and striking down Act 620 will advance both patients' and providers' shared interest in maintaining access to safe and legal abortion services.

Nearly 50 years of abortion-related litigation in this Court, including WWH's successful advocacy in *Whole Woman's Health*, demonstrates that providers are more than adequate representatives for their patients. *Amici*'s staff, like those in most abortion clinics, choose to do their work out of a strong sense of duty and in the interest of social justice. WWH's for-profit business has a tiny one percent profit margin. As WWH's Director of Clinical Services, Marva Sadler, puts it, "nobody gets rich doing this work." Abortion providers risk abuse and physical violence on a daily basis to make sure their patients have access to abortion services. Most patients, however, just want to return to their every-day lives. This makes abortion providers more than suitable representatives for those patients' right to abortion access. That is reflected in the experiences of *Amici*'s staffers, who report patients' gratitude for their advocacy, particularly when the *Whole Woman's Health* decision allowed WWH to keep its doors open and abortion available to them.

CONCLUSION

Based on the foregoing, *Amici* respectfully submits that the Court should deny Louisiana's challenge to third-party standing and conclude that abortion providers adequately represent the interests of their patients in this matter.

Respectfully submitted,

LINDA C. GOLDSTEIN
Counsel of Record
SAMANTHA ROSA
ALYSSA CLARK
DECHERT LLP
1095 Avenue of the Americas
New York, NY 10036
(212) 698-3500
linda.goldstein@dechert.com

BENJAMIN MCANANEY
DECHERT LLP
Cira Centre
2929 Arch Street
Philadelphia, PA 19104
(215) 994-2000

JONATHAN TAM
DECHERT LLP
1 Bush Street
Suite 1600
San Francisco, CA 94104
(415) 262-4500

Counsel for Amici Curiae

DECEMBER 2, 2019