IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; and LENDOL L. DAVIS, M.D., on behalf of themselves and their patients,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 1:14-CV-284-LY
DAVID LAKEY, M.D., Commissioner of the Texas Department of State Health Services; and MARI ROBINSON, Executive Director of the Texas Medical Board, in their official capacities,	)	
Defendants.	)	

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In 1973, the U.S. Supreme Court held that the State of Texas could not ban abortion within its borders. Texas now seeks to do indirectly what, for forty years, it has been unable to do directly: eliminate access to safe and legal abortion services from most of the State. With the pretext of advancing women's health, Texas has enacted a pair of restrictions that single out abortion from all other medical procedures for the imposition of unreasonable requirements that will do nothing to enhance the health or safety of abortion patients and are impossible for most abortion providers to meet. Prior to the enactment of these requirements, there were 41 licensed facilities providing abortion services in Texas. As of September 1, 2014, there will be at most seven, clustered in four metropolitan areas in the eastern part of the State. There will not be a single licensed facility providing abortion services west or south of San Antonio.

The public health impact of the elimination of licensed abortion providers from the vast majority of the State will be nothing short of catastrophic. Texas has already seen a surge in illegal abortion in areas where licensed abortion facilities have closed. With the closure of the remaining facilities on September 1, 2014, the incidence of illegal abortion will increase substantially, leading to devastating consequences for women who cannot afford to travel long distances to access abortion care.

The evidence presented at trial has demonstrated, unequivocally, that the challenged restrictions on abortion impose an undue burden on women's ability to access safe and legal abortion services in Texas. Accordingly, Plaintiffs respectfully request that the Court declare these requirements to be unconstitutional and permanently enjoin their enforcement.

STATEMENT OF FACTS

I. The Testimony Given by Plaintiffs' Expert Witnesses Is Based on the Witnesses' Own Specialized Knowledge and Experience While the Testimony Given by Defendants' Expert Witnesses Is Based on Facts and Opinions Supplied by a Litigation Consultant with No Relevant Expertise.

Plaintiffs are challenging two provisions of Texas House Bill No. 2 ("the Act"), H.B. 2, 83rd Leg., 2nd Called Sess. (Tex. 2013): the "**admitting privileges requirement**," which provides, in relevant part, that "[a] physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced," Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin Code §§139.53(c), 139.56(a), and the "**ASC requirement**," which provides, in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40. The admitting privileges requirement is currently in effect. Any physician who violates this requirement commits a Class A misdemeanor offense. The physician is also subject to license revocation, and the abortion facility at which the physician provides abortion services is subject to license revocation. *See* Tex. Health & Safety Code § 171.0031; Tex. Occ. Code § 164.055(a); 25 Tex. Admin. Code § 139.32. The ASC requirement is scheduled to take effect on September 1, 2014. Failure to comply with it will give rise to criminal, civil, and administrative penalties, Tex. Health & Safety Code Ann. §§ 245.014 (criminal penalties), 245.015 (civil penalties), 245.017 (administrative penalties), and can result in the denial, suspension, probation, or revocation of an abortion facility license. Tex. Health & Safety Code Ann. § 245.012.

The evidence presented at trial demonstrates that these requirements target abortion providers for the imposition of unique regulatory burdens that are not imposed on any other health care providers in Texas, are inconsistent with accepted medical standards, impose costs that are far in excess of any potential benefits, and will dramatically reduce the number and geographic distribution of medical facilities in the State where women can access safe and legal abortion services.

This evidence includes the testimony of seven expert witnesses called by the Plaintiffs:

- **Anne Layne-Farrar, Ph.D.**, an economist who holds a Ph.D. from the University of Chicago and serves as a Vice President of Charles River Associates, a top economic consulting firm, with extensive experience conducting cost-benefit analysis of proposed regulations, Layne-Farrar Direct at ¶¶ 1-5; Tr. Vol. 1 (Rough) at 188:6-189:8; Ex. P-001;
- **Elizabeth Gray Raymond, M.D., M.P.H.**, a leading medical researcher in the field of reproductive health with over 25 years of experience designing, managing, and evaluating clinical trials and other scientific studies, Raymond Direct at ¶¶ 1-6; Tr. Vol. 1 (Rough) at 141:6-22; Ex. P-003;
- **Daniel Grossman, M.D.**, a board-certified obstetrician-gynecologist ("ob-gyn") who serves as Vice President for Research at Ibis Reproductive Health, Grossman Direct at ¶¶ 1-6; Ex. P-002;
- **Paul M. Fine, M.D.**, a board-certified ob-gyn who serves as Medical Director of Planned Parenthood Gulf Coast and several municipal police, fire, and Emergency Medical Services ("EMS") departments in Galveston County, Fine Direct at ¶¶ 1-3; Ex. P-006;

- **George W. Johannes, A.I.A.**, a licensed architect with extensive experience designing healthcare facilities, including ambulatory surgical centers ("ASCs"), Johannes Direct at ¶¶ 1-4; Tr. Vol. 1 (Rough) at 85:14-86:12; P-004;
- **Kristine Hopkins, Ph.D.**, a sociologist specializing in demography at the University of Texas at Austin, whose research focuses on women's reproductive health, Hopkins Direct at ¶¶ 1-4; Ex. P-005;
- **Lucila ("Lucy") Ceballos Felix**, a State-certified *promotora* with over 17 years of experience working as a community health educator in the Rio Grande Valley, Felix Direct at ¶¶ 1-5; Tr. Vol. 1 (Rough) at 118:2-23.

The testimony given by these witnesses is based on their own specialized knowledge and experience in their respective fields. It is credible and reliable in all respects.

The evidence at trial also included testimony by five expert witnesses called by Defendants: Mayra Jimenez Thompson, M.D., an ob-gyn; James Anderson, M.D., a physician specializing in family practice and emergency medicine; Deborah Kitz, Ph.D., a healthcare consultant; Peter Uhlenberg, Ph.D., a retired sociologist and demographer; and Todd Giberson, an IT professional employed by the State Attorney General's Office ("OAG"). The testimony of four of these five witnesses (Drs. Thompson, Anderson, Kitz, and Uhlenberg) was drafted by Vincent Rue, Ph.D., a litigation consultant with no medical background engaged by OAG. Each of the four witnesses initially denied the scope of Mr. Rue's involvement, *see, e.g.* Tr. Vol. 4 (Rough) at 95:20-21 ("As far as I know, I have not discussed with Dr. Rue the substance of the case or the opinions."), but ultimately conceded that Rue drafted substantive portions of their testimony after being confronted by their email correspondence with him.

For example, Dr. Thompson initially denied that Dr. Rue contributed substantively to her testimony. Tr. Vol. 3 (Rough) at 7:13-9 ("Q: Dr. Thompson, isn't it true that Vincent Rue took the lead in drafting your expert report in this case? A. No. Q. Isn't it true that you sent Dr. Rue certain materials that you wanted him to include in the expert report, and he declined to include those materials? A. No."); *see also* Tr. Vol. 3 (Rough) at 18:1-14, 19:17-23. However, an email sent from Dr. Rue to Dr. Thompson on the day before Defendants' rebuttal expert reports were due shows that Dr. Rue drafted Dr. Thompson's rebuttal to Dr. Grossman's expert report before Dr. Thompson had ever seen Dr. Grossman's expert report. Tr. Vol. 3 (Rough) at 16:4-17:19; Exs. P-211-212. Further, an email from Dr. Rue to Dr. Thompson at 4:21 a.m. on the day that Defendants' rebuttal expert reports were due attached a copy of Dr. Thompson's rebuttal expert report and stated: "I tried to use as much of your material as I could, but time ran out." Tr. Vol. 3 (Rough) at 19:17-22; Ex. P-213. Dr. Thompson admitted that the opinions she offered in her written direct testimony were the same as the ones contained in her rebuttal expert report. Tr. Vol. 3 (Rough) at 5:9-12.

Dr. Anderson was more candid: he testified that he wrote his direct testimony as a "team" with Dr. Rue, Tr. Vol. 3 (Rough) at 48:10-17, 52:19-53:5, 59:22-60:11, 62:8-63:4, and that Dr. Rue was allowed to "overrule" Dr. Anderson's own judgment about whether to offer an opinion, Tr. Vol. 3 (Rough) at 52:3-18, Ex. P-216.[1]

[1] Also, an "exhibit" to Dr. Anderson's written direct testimony that had been created by Dr. Rue was not included as part of Dr. Anderson's submission to the Court; its removal was apparently done without the knowledge of Dr. Anderson, who said "[i]t's supposed to be attached" and "the fact that it's not there is a surprise to me." Tr. Vol. 3 (Rough) at 59:11-59:21, 60:22-25; 61:23-62:7. This raises serious questions about how else Dr. Anderson's testimony may have been altered after he signed off on it and whether the direct testimony submitted to the Court is a complete and accurate reflection of his views, as he testified it was. *See, e.g.*, Tr. Vol. 3 (Rough) at 45:9-11 (Q. The statements that you're making here on direct testimony are yours and yours alone, correct? A. Correct.").

During her deposition, Dr. Kitz denied that anyone contributed to the writing of her expert report. Tr. Vol. 4 (Rough) at 22:22-23:2 ("Q: And at your deposition you were asked: Did anyone else contribute to writing your report? Do you recall that? A. Yes. Q. And you responded no? A. Correct."); *see* Kitz Dep. Tr. 28:14-25. But after being confronted with the relevant documents, Dr. Kitz admitted that Dr. Rue developed her testimony based on a series of bullet points she had written, Tr. Vol. 4 (Rough) at 23:25-24:5, Ex. P-218, and that he added information to subsequent drafts that Dr. Kitz had not written, including a rebuttal of an expert report which, at that point, Dr. Kitz had not read, Tr. Vol. 4 (Rough) at 24:19-25:16; 26:23-29:2, Exs. P-219-220, P-222-223.

Likewise, Dr. Uhlenberg testified at his deposition that he had not discussed his opinions with Dr. Rue and never spoke with Dr. Rue about the substance of his report. Tr. Vol. 4 (Rough) at 94:8-95:21, 105:22-106:12. But on cross-examination at trial, Dr. Uhlenberg admitted that he had received "critical suggestions" from Dr. Rue about how to present an opinion, Tr. Vol. 4 (Rough) at 100:18-101:13, Ex. P-229, and that he included an opinion in his testimony at the behest of Dr. Rue that he himself had wished to omit, Tr. Vol. 4 (Rough) at 104:16-105:16, Ex. P-230.

Drs. Thompson, Anderson, and Uhlenberg also testified that they relied on various sources provided to them by Dr. Rue, some of which they did not review independently. Tr. Vol. 3 (Rough) at 20:5-20, 48:1-9, 54:4-24; 55:9-12; Tr. Vol. 4 (Rough) at 106:17-107:16; Exs. P-214, P-231.

Dr. Rue's involvement in developing substantive components of the direct testimony of these witnesses, and the witnesses' lack of veracity about Dr. Rue's involvement until confronted by documentary evidence, cast serious doubt on the testimony's credibility and reliability.

Accordingly, the Court should give little weight to the testimony of Drs. Thompson, Anderson, Kitz, and Uhlenberg in resolving disputed factual issues.

II. At the Time the ASC and Admitting Privileges Requirements Were Enacted, Existing Regulations Were Sufficient to Ensure the Health and Safety of Abortion Patients.

The ASC and admitting privileges requirements were not written on a blank slate. Prior to their enactment, Texas had in place numerous laws regulating the medical profession generally and abortion providers specifically. For example, under Texas law, all healthcare providers are required to meet accepted standards of medical care and are liable in tort if their failure to do so causes injury. *See generally* Tex. Civ. Prac. & Rem. Code Ann. §§ 74.001 – 74.507. Similarly, all physicians are required to practice medicine in an "acceptable professional manner consistent with public health and welfare" and are subject to disciplinary action by the Texas Medical Board for failure to do so. 22 Tex. Admin. Code § 190.8(1). Failure to practice in an acceptable professional manner consistent with public health and welfare expressly includes "failure to timely respond in person . . . when requested by emergency room or hospital staff." 22 Tex. Admin. Code § 190.8(1)(F).

Further, all healthcare facilities, other than hospitals and ASCs, that provide 50 or more abortion procedures on an annual basis must be licensed by the Texas Department of State Health Services ("DSHS" or the "Department") under chapter 139 of the Texas Administrative Code and meet the detailed standards set forth in that chapter. *See* 25 Tex. Admin. Code §§ 139.1 – 139.60. These standards include, *inter alia*, requirements concerning quality assurance ("QA"), 25 Tex. Admin. Code § 139.8; unannounced inspections, 25 Tex. Admin. Code § 139.31; policy development and review, 25 Tex. Admin. Code § 139.41; organizational structure, 25 Tex. Admin. Code § 139.42; orientation, training, and review of personnel, 25 Tex. Admin. Code § 139.44; qualifications of clinical and non-clinical staff, 25 Tex. Admin. Code §

139.46; physical environment, 25 Tex. Admin. Code § 139.48; infection control, 25 Tex. Admin. Code § 139.49; patient rights, 25 Tex. Admin. Code § 139.51; medical and clinical services, 25 Tex. Admin. Code § 139.53; health care services, 25 Tex. Admin. Code § 139.54; clinical records, 25 Tex. Admin. Code § 139.55; emergency services, 25 Tex. Admin. Code § 139.56; discharge and follow-up, 25 Tex. Admin. Code § 139.57; and anesthesia services, 25 Tex. Admin. Code § 139.59. In most respects, these standards are comparable to, or more stringent than, than minimum standards for ambulatory surgical centers ("ASCs") set forth in chapter 135 of the Texas Administrative Code. For example, whereas licensed abortion facilities must be inspected at least once annually,[2] 25 Tex. Admin. Code § 139.31(b)(1), ASCs need only be inspected once every three years, 25 Tex. Admin. Code § 135.21(a)(2). But the minimum standards for ASCs are more stringent in two respects: (1) they impose detailed requirements for new construction that abortion facilities are not currently required to meet, *see* 25 Tex. Admin. Code § 135.52; and they require the nursing staff to be much larger than at licensed abortion facilities, *compare* 25 Tex. Admin. Code § 135.15(a) *with* 25 Tex. Admin. Code § 139.46(3)(B). It is the construction and nursing requirements that form the basis of Plaintiffs' challenge.

Two requirements of Texas law that were in effect at the time of the Act's enactment are especially noteworthy. First, Texas law required that: "A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital. The facility shall ensure that the physicians who practice at the facility have admitting privileges or have a working arrangement with a

[2] A licensed abortion facility must also be inspected any time a complaint is made against it for violation of any applicable regulation, even if the complaint is made by an anti-abortion advocacy group. *See* 25 Tex. Admin. Code § 139.31(c). From January 2008 to June 2013, sixty-one complaint inspections were conducted at licensed abortion facilities in Texas, in addition to the annual licensure inspection of each facility. *See* Ex. P-014 at 5.

physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a) (2012). This requirement was superseded by the admitting privileges requirement challenged here. Second, Texas law required that "[a]n abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion." Tex. Health & Safety Code Ann. §171.004. This requirement remains in effect and is not challenged by Plaintiffs.

The record demonstrates that, at the time the ASC and admitting privileges requirements were enacted, existing regulations were sufficient to ensure the health and safety of abortion patients. In the five years leading up to the enactment of these requirements, only sixteen enforcement actions were taken against the State's more than three-dozen licensed abortion facilities, and these were primarily for alleged violations of recordkeeping and other administrative requirements. Layne-Farrar Direct at ¶ 26; Ex. P-014. None of these enforcement actions related to any serious health or safety risk. Layne-Farrar Direct at ¶ 26; Ex. P-014. Further, the Executive Director of the Texas Medical Board testified that, from her thirteen-year tenure at the Medical Board, which included service as Manger of Investigations and Enforcement Director, she could not identify a single instance in which a physician practicing at a licensed abortion facility engaged in conduct that posed a threat to public health or welfare that could not be adequately addressed through existing regulation. Tr. Vol. 4 (Rough) at 83:2-84:2. She further testified that she could not identify a single instance of an abortion provider failing to respond to a request by emergency room or hospital staff. Tr. Vol. 4 (Rough) at 81:2-82:18. In contrast, the Executive Director recalled vividly "a very high-profile case of a young child who died, I believe it was in a dental office, when anesthetic was used but the proper training and

equipment was not available." Tr. Vol. 4 (Rough) at 86:17-20. Dentists are not subject to an ASC or admitting privileges requirement under Texas law.

III. Abortion as Currently Practiced in the United States Is an Extremely Safe Procedure.

There are generally two methods of performing abortions in the United States: surgical abortion, which involves the use of medical instruments to evacuate the contents of the uterus; and medical abortion, which involves the administration of medications that cause the termination of a pregnancy. Raymond Direct at ¶ 11; Fine Direct at ¶¶ 7-15. Both types of abortion are extremely safe. Raymond Direct at ¶¶ 12-22; Fine Direct at ¶ 16; Grossman Direct at ¶¶ 36-39.

The mortality rate for legal induced abortion in the United States is quite low and has declined over time. Raymond Direct at ¶¶ 12-15. In 1973-1979, following the Supreme Court's decision in *Roe v. Wade*, the U.S. Centers for Disease Control and Prevention ("CDC") estimated this rate as 2.09 deaths per 100,000 procedures. *Id.* at ¶ 15. The risk subsequently dropped and has been stable at the current rate, of approximately 0.69 deaths per 100,000 legal abortions, for the past 30 years. *Id.* at ¶¶ 12-15.

To put this risk in context, it is important to consider that, nationwide, the risk of death from childbirth is roughly 14 times higher than the risk of death from abortion. *Id.* at 23; Tr. Vol. 1 (Rough) at 146:5-148:1. Texas' maternal mortality ratio is significantly higher than the national average, and in Texas, the risk of death from childbirth is roughly 100 times higher than the risk of death from abortion. Raymond Direct at ¶ 24 & Table 2; Tr. Vol. 1 (Rough) at 148:2-149:15.

Serious nonfatal complications from abortion are also rare and seldom require hospitalization. Dr. Raymond testified about nine different studies concerning abortion-related

morbidity. Raymond Direct at ¶¶ 17-22 & Table 1; Tr. Vol. 1 (Rough) at 141:23-145:6. Each of these studies was conducted independently of the others by different researchers at different times using patient data from different sources. Raymond Direct at ¶ 17. At least one of the studies had essentially complete follow up. *Id.* at ¶ 20; Tr. Vol. 1 (Rough) at 144:7-10. All of the studies reported a total complication rate of less than 4% and a rate of major complications requiring hospitalization of less than 0.5%. Raymond Direct at ¶¶ 17-22 & Table 1. Additional studies referenced in Dr. Grossman's testimony are also consistent with these findings. Grossman Direct at ¶ 39.

Many procedures commonly performed in office-based settings are comparable in safety to abortion or entail greater risks. Such procedures include dilation and curettage, endometrial ablation; colonoscopy, cystoscopy, vasectomy, and plastic surgery. Raymond Direct at ¶¶ 28-30; Fine Direct at ¶¶ 11, 18; Grossman Direct at ¶ 38. Colonoscopy, for example, has a mortality rate that is roughly ten times higher than the mortality rate for abortion. Raymond Direct at ¶ 30; Layne-Farrar Direct at ¶¶ 63-64.

While, abortion is extremely safe throughout pregnancy, the medical risks of abortion increase with gestational age. Raymond Direct at ¶¶ 16, 55; Fine Direct at ¶ 43. As a result, women who are delayed in accessing abortion care are exposed to increased risks. Raymond Direct at ¶¶ 16, 55; Fine Direct at ¶ 43.

Although Drs. Thompson and Anderson contend that abortion-related complications are underreported, neither has a credible basis for doing so. Dr. Thompson admitted during cross-examination that she had not reviewed the sources concerning abortion-related mortality on which Dr. Raymond relies, which include data published by the CDC; that she was unfamiliar with the methodology used by the CDC to collect data about abortion-related mortality; and that

she reviewed only one of the nine studies cited by Dr. Raymond concerning abortion-related morbidity. Tr. Vol. 3 (Rough) at 31:5-34:3. And Dr. Anderson admitted that his opinions about abortion-related complications are based on anecdotal experience rather than data. Tr. Vol. 3 (Rough) at 75:23-25 ("It just seems, from my anecdotal experience, that it's more frequent than the numbers I read. But I don't have any data to validate that."). He also testified that his anecdotal experience is from more than a decade ago, prior to when he ended his emergency room practice in 2005. Tr. Vol. 3 (Rough) at 83:14-85:17.

IV. Plaintiffs Have Been Providing High-Quality Reproductive Health Care Services to Texas Women for Decades.

Plaintiff Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") is a nonprofit organization founded by Marilyn Eldridge and her late husband, Myron Chrisman, who was a Christian minister. Tr. Vol. 2 (Rough) at 19:25-20:22. Its mission is to provide high-quality and affordable reproductive healthcare services, including abortion services, to women in underserved communities.[3] Eldridge Direct at ¶ 1; Tr. Vol. 2 (Rough) at 20:19-22. Ms. Eldridge graduated from the University of Texas Law School in 1963, one of only five women in her graduating class. Tr. Vol. 2 (Rough) at 18:25-19:8. Due to sex discrimination, which was prevalent at that time, she could not get a job as a lawyer in Texas. Tr. Vol. 2 (Rough) at 19:9-15. Instead, she began to volunteer at Planned Parenthood, and eventually founded Reproductive Services with Rev. Chrisman. Tr. Vol. 2 (Rough) at 19:16-20:16. In March 1973, following the Supreme Court's decision in *Roe v. Wade*, Reproductive Services opened the first nonprofit

[3] In 1987, the principals of Reproductive Services founded a nonprofit organization called Adoption Affiliates, whose mission is to make professional, nonjudgmental adoption services available to women with unintended pregnancies. *Id.* at ¶ 3. Adoption Affiliates personnel worked on-site at the El Paso clinic to assist women who wished to place their children for adoption. *Id.*; Tr. Vol. 2 (Rough) at 21:8-22:12. Over the years, it facilitated the placement of more than 800 children. Tr. Vol. 2 (Rough) at 21:14-23.

abortion clinic in the State of Texas. Tr. Vol. 2 (Rough) at 20:14-16. It operated continuously in the State until its El Paso facility (the "El Paso clinic") was forced to close earlier this year because it could not meet the admitting privileges requirement. Eldridge Direct at ¶ 2. Plaintiff Pamela J. Richter, D.O., served as Medical Director of the El Paso clinic for the past 20 years and would like to resume that role. Eldridge Direct at ¶¶ 13, 27. If the admitting privileges and ASC requirements were enjoined, Reproductive Services would reestablish a licensed abortion facility in El Paso. Eldridge Direct at ¶ 27.

Plaintiff Whole Woman's Health has been providing high quality reproductive health care services, including abortion services, to Texas women for over a decade. Hagstrom Miller Direct at ¶ 1; Tr. Vol. 2 (Rough) at 89:25-90:8. It offers a safe and supportive environment to women seeking abortion services and prides itself on providing a holistic approach to abortion care that includes counseling services and emotional support for patients. Tr. Vol. 2 (Rough) at 68:3-6; 89:22-90:8. It currently operates licensed abortion facilities in Fort Worth and San Antonio. Hagstrom Miller Direct at ¶ 1. In addition, it operates a licensed ASC in San Antonio. *Id.* Until recently, Whole Woman's Health also operated licensed abortion facilities in Austin, Beaumont, and McAllen (the "McAllen clinic"). *Id.* These facilities closed as a result of the admitting privileges and ASC requirements. *Id.* If those provisions were enjoined, Whole Women's Health would reestablish licensed abortion facilities in Austin and McAllen. *Id.* at ¶¶ 3, 20.

Plaintiff Sherwood C. Lynn, Jr., M.D., is a board-certified ob-gyn with over 38 years of experience practicing medicine. Lynn Direct at ¶ 1. He currently serves as the Medical Director of the Whole Woman's Health facilities in San Antonio, and he seeks to provide abortion services at the McAllen clinic. *Id.* at ¶¶ 3, 7. Although Dr. Lynn retired from most facets of his

medical practice in 2006, he continues to provide abortion services because he believes that there is a critical need for those services but not enough physicians in Texas willing to provide them. *Id.* at ¶ 1.

Plaintiff Austin Women's Health Center operates a licensed abortion facility in Austin. Until recently, its sister clinic, Plaintiff Killeen Women's Health Center, operated a licensed abortion facility in Killeen. That facility closed in anticipation of the ASC requirement's implementation. Davis Direct at ¶ 6; Tr. Vol. 1 (Rough) at 27:10-28:6. Together, Austin Women's Health Center and Killeen Women's Health Center (collectively, the "Health Centers") have provided high quality reproductive health care services, including abortion services, to Texas women for over 35 years. Davis Direct at ¶ 3. Throughout that time, Plaintiff Lendol L. "Tad" Davis, M.D., board-certified ob-gyn, has served as the Medical Director of those facilities. *Id.* at ¶¶ 1, 3.

Each of the clinic Plaintiffs is a member of the National Abortion Federation ("NAF") and is therefore required to comply with NAF's Clinical Policy Guidelines. Eldridge Direct at ¶ 5; Hagstrom Miller Direct at ¶ 2; Davis Direct at ¶ 3.

V. After Providing Safe Abortion Care for Decades, the McAllen and El Paso Clinics Were Forced to Close as a Result of the Admitting Privileges Requirement.

A. The McAllen Clinic.

Prior to its recent closure, the McAllen clinic had operated continuously since January 2004. Hagstrom Miller Direct at ¶ 4. The McAllen clinic provided abortion services up to 16 weeks of pregnancy. *Id.* at ¶ 5. The highest level of sedation offered to patients was moderate sedation/analgesia, also known as conscious sedation. *Id.* at ¶ 6. In addition to abortion services, the McAllen clinic provided a variety of gynecological and family planning services to women in the Rio Grande Valley. *Id.* at ¶ 3. During its ten years of operation, the McAllen clinic provided

abortion services to over 14,000 patients. *Id.* at ¶ 7. Only two of these patients required transfer from the clinic to a hospital. *Id.* In both cases, the patients were successfully treated at the hospital. *Id.*

After the admitting privileges requirement was enacted, four physicians affiliated with Whole Woman's Health, including Dr. Lynn, sought to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. Hagstrom Miller Direct at ¶ 8; Lynn Direct at ¶ 7. All four physicians are board-certified ob-gyns with years of experience performing abortion procedures, and three of them maintain admitting privileges at hospitals in other parts of the State. Hagstrom Miller Direct at ¶ 8; Lynn Direct at ¶¶ 1, 6. Dr. Lynn, for instance, has admitting privileges at hospitals in San Antonio and Austin. Lynn Direct at ¶ 6.

There are eight hospitals located within 30 miles of the McAllen clinic. Each of them requires, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. Lynn Direct at ¶¶ 8-10; Hagstrom Miller Direct at ¶¶ 9-10; Tr. Vol. 2 (Rough) at 82:1-21. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements. Lynn Direct at ¶¶ 8-10; Hagstrom Miller Direct at ¶¶ 9-10; Tr. Vol. 2 (Rough) at 82:1-21. Although Whole Woman's Health and Dr. Lynn reached out to numerous physicians with hospital admitting privileges in the McAllen area, only one was willing to serve as a designated alternate physician for the doctors affiliated with the McAllen clinic, and that physician had privileges at only one area hospital: Doctors Hospital at Renaissance. Hagstrom Miller Direct at ¶ 11; Lynn Direct at ¶ 11; Tr. Vol. 1 (Rough) at 162:22-164:4.

Thus, the physicians affiliated with the McAllen clinic were only able to satisfy the application criteria for Doctors Hospital at Renaissance. Hagstrom Miller Direct at ¶ 12; Lynn Direct at ¶ 12. At this hospital, the first step in applying for admitting privileges is to submit a written request for an application for admitting privileges. Hagstrom Miller Direct at ¶ 13; Lynn Direct at ¶ 13. In September 2013, all four physicians submitted such requests. Hagstrom Miller Direct at ¶ 13; Lynn Direct at ¶ 13; Ex. P-069. Two months later, each of the physicians received a letter in response stating that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Hagstrom Miller Direct at ¶ 14; Lynn Direct at ¶ 14; Exs. P-068, P-071. The letters noted that the "decision of the Governing Board was **not** based on clinical competence consideration." Exs. P-068, P-071 (emphasis in original).

Despite extensive efforts, Whole Woman's Health was also unsuccessful in recruiting physicians who already possessed admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic. Hagstrom Miller Direct at ¶ 15. As a result, the McAllen clinic has been unable to comply with the admitting privileges requirement. It was forced to stop providing abortion services when the requirement took effect on October 31, 2013. *Id.* at ¶ 3. For four months, it remained open providing non-abortion services. *Id.* But it ceased operations altogether on March 6, 2014, after ten years of providing safe abortion care to women in the Rio Grande Valley. *Id.*

B. The El Paso Clinic.

Prior to its recent closure, the El Paso clinic had operated continuously since 1977. Eldridge Direct at ¶ 5. It was legally permitted to provide abortion services up to 16 weeks of pregnancy, Tex. Health & Safety Code Ann. §171.004, and it also offered a variety of other

gynecological and family planning services, Eldridge Direct at ¶ at ¶¶ 6-7. The highest level of sedation used at the El Paso clinic was minimal sedation. *Id*. at ¶ 7. During the ten years prior to its closure, the El Paso clinic did not experience a single medical emergency requiring transfer of a patient to the hospital; over 17,000 abortions were performed there during that time. *Id*. at ¶¶ 24, 29; Tr. Vol. 2 (Rough) at 7:16-20.

The Medical Director of the El Paso Clinic was Dr. Pamela Richter, who served in that role for over twenty years. Eldridge Direct at ¶ 8; Tr. Vol. 2 (Rough) at 11:8-10. Dr. Richter is a board-eligible family medicine physician licensed to practice medicine by the State of Texas. Eldridge Direct at ¶ 8. She graduated from the Texas College of Osteopathic Medicine in 1983, then completed an internship at the Corpus Christi Osteopathic Hospital. *Id*. Dr. Richter is a warm and caring physician with an excellent bedside manner. *Id*. at ¶ 9; Tr. Vol. 2 (Rough) at 11:11-12. For more than two decades, she provided outstanding care to the patients at the El Paso clinic. Eldridge Direct at ¶ 8. In addition, Dr. Richter works for the State of Texas. *Id*. at ¶ 10. She serves as a staff physician for the state supported living center ("State Center") in El Paso operated by the Texas Department of Aging and Disability Services ("DADS"). *Id*. There, she provides general medical care and gynecological services to people with intellectual and developmental disabilities who are medically fragile or have behavioral problems. *Id*.

From 1990 to 2009, Dr. Richter was board certified in family medicine. *Id*. at ¶ 12. She did not seek recertification after 2009 because the nature of her practice did not require board certification. *Id*. Dr. Richter maintained admitting privileges at a hospital in El Paso from 1990 to 2000. *Id*. at ¶ 13; Tr. Vol. 2 (Rough) at 5:23-6:5. She resigned from the hospital staff in June 2000 because, at that point, the nature of her practice did not require her to admit patients to the hospital and she was having difficulty satisfying the hospital's minimum patient contact

requirement and holding emergency room call as frequently as the hospital required. Eldridge Direct at ¶ 13; Tr. Vol. 2 (Rough) at 6:6-10.

After passage of the admitting privileges requirement, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso clinic. Eldridge Direct at ¶ 15. The administrator of the El Paso clinic assisted her with this process. Tr. Vol. 2 (Rough) at 14:11-15. They identified four hospital groups within a 30-mile radius of the clinic: Las Palmas del Sol ("Las Palmas"), which includes two qualifying hospitals, Las Palmas Medical Center and Del Sol Medical Center; University Medical Center of El Paso ("UMC"); Sierra Providence Health Network ("Sierra Providence"), which includes three qualifying hospitals, Providence Memorial Hospital, Sierra Medical Center, and Sierra Providence East Medical Center; and Foundation Surgical Hospital of El Paso ("Foundation"). Eldridge Direct at ¶ 16. To date, Dr. Richter has been unable to secure permanent admitting privileges at any of these hospitals. *Id*. at ¶ 17.

At Foundation, Dr. Richter was granted temporary privileges for 120 days beginning on January 13, 2014. Eldridge Direct at ¶ 20; Ex. P-030. Subsequently, Foundation sent a letter dated February 12, 2014, stating that Dr. Richter's application for permanent privileges was being denied. The letter stated that "it is the decision of the Governing Body to deny your application for the reason that you do not meet requirement [sic] for successfully completing a residency in the field of specialty for which clinical privileges are required." Eldridge Direct at ¶ 21; Ex. P-060. This was curious because the application form for family medicine privileges at this hospital indicates that completion of a family medicine residency is not required if the physician can demonstrate "active participation in the examination process leading to certification in family practice . . . ." Ex. P-062. In fact, Dr. Richter had registered to take the

board examination for family medicine in November 2014, which is the next available testing period. Eldridge Direct at ¶ 21. The hospital's C.E.O. candidly told a DSHS investigator that, after learning that Dr. Richter was an abortion provider, the hospital combed through its own bylaws looking for a reason to deny her privileges. Ex. P-046 ("He stated the facility was not aware that Dr. Richter provided abortion services. He stated after finding out she provided these services that the facility looked at the bylaws and application to see if there was a reason to deny privileges to Dr. Richter."). Subsequently, Reproductive Services was informed through its attorney that Foundation Hospital would no longer honor Dr. Richter's temporary privileges. Eldridge Direct at ¶ 22.

Reproductive Services has sought to recruit additional physicians to provide abortion services at the El Paso clinic, but has not succeeded in doing so. *Id*. at ¶ 25. As a result, upon learning that Foundation Hospital would no longer honor Dr. Richter's temporary admitting privileges, the El Paso clinic was forced to cease providing abortion services. *Id*. at ¶ 25. It closed completely on June 1, 2014, after 37 years of continuous service to the women of West Texas. *Id*.

VI. Absent Relief from the Court, Plaintiffs' Remaining Clinics Will be Forced to Close as a Result of the ASC Requirement.

None of the licensed abortion facilities currently operated by the Plaintiffs meet the new construction standards for ASCs set forth in 25 Tex. Admin. Code § 135.52. *See* Joint Stipulation of Facts ("Stipulation") at ¶ 4 (Dkt. No. 154); Johannes Direct at ¶¶ 7, 31. Further, it would not be possible to renovate any of those facilities to meet the new construction standards because their footprints are too small. *Id.* at ¶¶ 7, 32.

Of the licensed abortion facilities currently operated by Plaintiffs, only the one operated by Whole Woman's Health in Fort Worth could be expanded to meet the new construction

standards for ASCs. *Id.* at ¶¶ 7, 35. Doing so would cost approximately $2.6 million. *Id.* at ¶ 36. Whole Woman's Health sought to purchase an existing ASC in Fort Worth, which would allow it to avoid downtime during construction. It identified a facility that would meet its needs, which was appraised at $2.3 million. Tr. Vol. 2 (Rough) at 72:12-21. It was unable to obtain financing for the purchase, however, despite engaging a broker who approached more than fifteen banks. Tr. Vol. 2 (Rough) at 72:22-74:19.

Whole Woman's Health also attempted to lease one or more ASCs. Tr. Vol. 2 (Rough) at 69:11-21. The owners of the Fort Worth ASC discussed above were unwilling to enter into a lease agreement with Whole Woman's Health. Tr. Vol. 2 (Rough) at 75:15-17. Whole Woman's Health had a promising lead on an ASC in Austin that was available for lease, but it turned out that a restrictive covenant ran with the property prohibiting the performance of abortions on the premises. Tr. Vol. 2 (Rough) at 69:23-71:22; Ex. P-066. Whole Woman's Health also sought to lease an ASC in McAllen, but the owners had religious objections to abortion and would not move forward with the transaction. Tr. Vol. 2 (Rough) at 80:20-81:9. In addition, Whole Woman's Health investigated the possibility of purchasing one or more mobile ASC units. Tr. Vol. 2 (Rough) at 78:11-79:25; Ex. P-067. Amy Hagstrom Miller, the President of Whole Woman's Health, contacted DSHS in April 2014 to ask if the mobile unit would satisfy the new construction standards for ASCs. Tr. Vol. 2 (Rough) at 77:24-78:25; Ex. P-019. To date, she has not received a substantive response. Tr. Vol. 2 (Rough) at 79:1-10.

Dr. Davis and his wife, who are respectively the Medical Director and Executive Director of the Health Centers, would like to build an ASC in Austin so they can continue to serve their patients there. Davis Direct at ¶ 8 ("Given the high level of need for abortion services in Texas, and the devastating consequences that can result when women do not have access to safe

abortion care, I am doing everything in my power to be able to continue providing abortion services at the one remaining Health Center."). They used their retirement savings to purchase a piece of property for $1.125 million with the aim of constructing a facility on it that meets ASC standards. *Id.* at 9. But after retaining an architectural firm that specializes in healthcare facility design to conduct a feasibility study, they learned that the ASC would have to be over 7,000 square feet in area to satisfy all of the new construction standards for ASCs, and construction would cost roughly $3.116 million, exclusive of site development costs. *Id.* at ¶ 11; Ex. P-073. They are now unsure whether they will move forward with the project. Davis Direct at ¶ 12. They are concerned that, even if they are able to obtain financing for the project, in order to make the loan payments when the building is complete, they would have to raise the price of an abortion considerably, which could make it prohibitively expensive for their patients to obtain abortion care. *Id.* If they do move forward with the project, the construction would take at least eighteen months to complete. *Id.* at ¶ 13.

Marilyn Eldridge, on behalf of Reproductive Services, also expressed concern that the cost of operating an ASC would make abortion care prohibitively expensive for Reproductive Services' patients, many of whom are living in poverty. Eldridge Direct at ¶ 33.

As things stand, absent relief from the Court, all of Plaintiffs' remaining clinics will be forced to close when the ASC requirement takes effect on September 1, 2014.

VII. The Admitting Privileges Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care.

The evidence presented at trial shows that it is common and acceptable medical practice for a physician practicing in an outpatient setting to refer patients to a hospital at which the physician does not have admitting privileges. It does not enhance patient safety when physicians practicing in outpatient settings maintain admitting privileges. Raymond Direct at ¶¶ 9, 34-42;

Fine Direct at ¶ 26. In fact, the trend in medicine is toward bifurcation of outpatient practice and hospital-based practice, such that physicians are increasingly specializing in one type of practice setting or the other. *Id*. at ¶ 20. Coordination and continuity of care of a patient that is transferred from an outpatient setting to a hospital are achieved through communication between the physician referring the patient to the hospital and the physician treating the patient at the hospital. Tr. Vol. 3 (Rough) at 35:24-36:12; Thompson Dep. Tr. at 222:14-22; Keyes Dep. Tr. at 36:20-39:24. This is standard medical practice. Fine Direct ¶¶ 19-25; Raymond Direct ¶¶ 34-42.

Accordingly, the nation's leading accreditation bodies and medical associations—including the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Anesthesiologists, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, and the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or "JCAHO")—recognize that admitting privileges at a local hospital are not required for the safe performance of outpatient procedures. Raymond Direct at ¶¶ 35-40; Exs. P-029, P-189 – P-194; Keyes Dep. Tr. at 68:23-69:1, 69:16-71:2; Thompson Dep. Tr. at 154:4-11, 155:21-156:11. In addition, the Clinical Policy Guidelines of the National Abortion Federation do not require abortion providers to maintain admitting privileges at a local hospital. Raymond Direct at ¶ 41.

On those rare occasions when a patient who has had an abortion requires hospitalization, the quality of care that she receives at the hospital would not be affected by whether her abortion provider has admitting privileges there. *Id*. at ¶ 42; Fine Direct at ¶ 28. Upon the patient's arrival at the hospital via ambulance, an emergency room physician will evaluate the patient and consult with other specialists at the hospital as necessary. *Id*. The patient may require admission

to the hospital, or she may simply be treated in the emergency room and then released. *Id*. Either way, continuity of care can be maintained by direct communication between the abortion provider and the emergency room physician, regardless of whether the abortion provider has admitting privileges at the hospital. *Id*.; Raymond Direct at ¶ 42; Keyes Dep. Tr. at 36:20-39:24; Thompson Dep. Tr. at 222:14-22.

Moreover, in many of the cases in which a patient experiences a complication following an abortion procedure, the complication does not arise until after the abortion patient has been discharged from the clinic and returned home. Fine Direct at ¶ 30. If a woman experiences a complication that requires hospital treatment after she has returned home following an abortion procedure, it would be safest for her to seek treatment at the hospital nearest to her home. *Id*. at ¶ 31. Thus, a woman who lives more than 30 miles away from an abortion clinic should not travel back to the vicinity of the clinic in the event of an emergency to obtain hospital treatment; she should, instead, seek treatment at the emergency room nearest to her present location. *Id*.; *see also* Tr. Vol. 4 (Rough) at 6:24-7:3 ("Q: If she drove back home and she was 150 miles from the provider facility and that provider had privileges at a hospital within 30 miles, she would be 120 miles from that hospital; is that correct? A: I would assume that's right.").

VIII. The ASC Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care.

The record demonstrates that the ASC requirement is a significant departure from accepted medical practice. The vast majority of abortion procedures in Texas and nationwide are performed in office-based settings, not ASCs or hospitals. Fine Direct at ¶¶ 36-37; Raymond Direct at ¶¶ 43-45. Indeed, in Texas, many kinds of surgeries are performed in doctor's offices, including surgeries performed under general anesthesia. Tr. Vol. 4 (Rough) at 84:10-86:12; *see* 22 Tex. Admin. Code §§ 192.1-192.6. Of those outpatient surgeries that are performed in ASCs,

few are performed in facilities that meet the standards to which abortion clinics will be subject if the ASC requirement takes effect. More than three-quarters of licensed ASCs are exempt from new construction requirements due to grandfathering, *see* Stipulation at ¶ 6, and waivers from them are "frequently" granted on an oral basis, Perkins Dep. Tr. at 44:6-44:19; 45:19-46:2. Notably, ACOG's Guidelines for Women's Health Care recognize that abortion procedures can be safely performed in doctor's offices and clinics, and they expressly denounce the imposition of "facility regulations that are more stringent [for abortion procedures] than for other surgical procedures of similar risk." Raymond Direct at ¶ 45; Ex. P-192.

The evidence further shows that the ASC requirement will not serve to enhance the health or safety of abortion patients. With respect to abortion procedures performed prior to 16 weeks post-fertilization, complications do not occur with greater frequency at clinics than at ASCs. Grossman Direct at ¶¶ 41, 43-48; Lynn Direct at ¶ 16. This is not surprising because the construction standards for ASCs are largely aimed at maintaining an ultra-sterile operating environment. Grossman Direct at ¶ 42; Fine Direct at ¶ 38. These standards enhance the safety of surgeries that involve cutting into sterile body tissue by reducing the likelihood of infection. Grossman Direct at ¶42; Fine Direct at ¶ 38. But surgical abortion is not performed in this manner. Rather, it entails insertion of instruments into the uterus through the vagina, which is naturally colonized by bacteria. Grossman Direct at ¶ 42; Fine Direct at ¶ 38; Raymond Direct at ¶ 48; Ex. P-037 at 191; Keyes Dep. Tr. at 86:12-87:2 Tr. Vol. 1 (Rough) at 26:25-27:3. Accordingly, precautions aimed at maintaining a sterile environment, beyond basic hand-washing and use of sterile instruments, provide no health or safety benefit to abortion patients. Grossman Direct at ¶ 42; Fine Direct at ¶ 38; P-037 at 784; Keyes Dep. Tr. 86:12-87:2. Similarly, the nursing requirements for ASCs are geared toward surgeries that are more complex

than abortion. Grossman Direct at ¶ 42; Fine Direct at 41. Many of the personnel typically needed for those types of surgeries, such as scrub nurses and circulating nurses, are not needed for abortion procedures. Grossman Direct at ¶ 42; Fine Direct at ¶ 41.

Indeed, Defendants' own expert Geoffrey Keyes, M.D., President of the American Association for Accreditation of Ambulatory Surgery Facilities ("AAAASF"), testified at his deposition that, in general, ASC standards related to construction are not relevant to the quality of care that is provided in a facility. Keyes Dep. Tr. at 60:12-63:16. He further testified that the accreditation standards enforced by his organization are sufficient to ensure patient health and safety, and they do not contain detailed construction standards such as specifications for a building's HVAC system or the square footage of its operating rooms. *Id.* at 78:6-84:1; Ex. P-012. He also testified that more onerous standards for healthcare facilities do not necessarily equate to better standards. *Id.* at 100:3-5 ("Some of it is more onerous than our process and onerous doesn't translate necessarily into being better, it is just onerous."). Not surprisingly, Defendants did not call Dr. Keyes to testify at trial.

Further, medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of tablets. There is no medical basis for requiring the administration of those medications to take place in a facility designed to ensure sterile surgical conditions. Fine Direct at ¶ 42.

IX. Although the ASC Requirement Provides No Medical Benefit to Abortion Patients, It Imposes Substantial Costs on Both Patients and Abortion Providers.

Although the ASC requirement would provide no medical benefit to abortion patients, it would impose substantial costs on both abortion providers and women seeking abortion services in Texas. Layne-Farrar Direct at ¶¶ 36, 39, 40 & Table 3. To meet new construction standards,

an ASC would need to be at least 7,000 square feet in area.[4] Johannes Direct at ¶ 32; Davis Direct at ¶ 11; Exs. P-073-074. Construction of a 7,000 ASC in Texas would cost more than $3 million. Johannes Direct at ¶ 40; Davis Direct at ¶ 11; Ex. P-074. Remodeling an abortion clinic to meet ASC standards would generally cost about $2 million. Johannes Direct at ¶ 7 (providing estimates ranging from $1.7 to $2.6 million); Theard Dep. Tr. at 40:25-41:22 ($2 million estimate). Purchasing an existing ASC would be similarly expensive; the ASC that Whole Woman's Health sought to buy in Fort Worth was appraised at $2.3 million. Tr. Vol. 2 (Rough) at 71:24-72:21; Tr. Vol. 1 (Rough) at 101:17-102:17. In addition, the operating costs for an ASC exceed those for an abortion clinic by approximately $600,000 to $1 million per year. Layne-Farrar Direct at ¶ 40.

The reduction in the number and geographic distribution of abortion providers as a result of the ASC requirement will result in higher costs for abortion procedures and increased travel distances for women seeking abortion services. Layne-Farrar Direct at 42-44; Grossman Direct at ¶ 23 & Table 2. Defendants concede that, after the ASC requirement takes effect, at least 891,888 Texas women of reproductive age will live farther than 150 miles from a Texas abortion provider. Tr. Vol. 3 (Rough) at 116:17-117:4; Exs. D-040; D-041. That is more than the total population of reproductive-age women in 25 other states and the District of Columbia. Grossman Direct at Table 2.

[4] Dr. Kitz's testimony that an ASC need only be 3,000 square feet to meet the requirements imposed by Texas law lacks a reliable basis and should not be credited. In support of her opinions, she relied principally on printouts from the internet; she could not attest to the reliability of these sources and testified that she would not use them in her own consulting work. *See, e.g.*, Tr. Vol. 4 (Rough) at 49:19-82:9; Exs. D-225 – D-227. Further, Dr. Kitz did not take into account that more than three-quarters of all currently licensed ASCs are grandfathered, but abortion facilities will not be eligible for grandfathering when the ASC requirement takes effect. Tr. Vol. 4 (Rough) at 39:2-42:3.

The increased costs and travel distances will cause some women to delay accessing abortion care and others to forgo abortion altogether. Both of these outcomes impose significant health risks on women. Grossman Direct at ¶¶ 27, 28; Raymond Direct at ¶¶ 55-56; Fine Direct at ¶¶ 43-44; Layne-Farrar Direct at ¶¶ 49-52.

Additionally, some women who cannot access legal abortion services will instead attempt self-induction of abortion. Grossman Direct at ¶ 34; Hagstrom Miller at ¶ 19. Self-induction of abortion is already more prevalent among women in Texas, particularly along the Texas-Mexico border, than among women nationally. Grossman Direct at ¶ 32; *see* Eldridge Direct at ¶ 31; Hagstrom Miller Direct at ¶ 19. Many women in Texas are aware that misoprostol can be used to induce an abortion. Felix Direct at ¶ 30; Grossman Direct at ¶¶ 29, 30. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley and West Texas, which both border Mexico. *Id.* Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular woman's medical needs, or used incorrectly because a woman does not have adequate information. Felix Direct at ¶ 31; Grossman Direct at ¶ 35.

During the four month period of time when the McAllen clinic was open but not providing abortion services, clinic staff members encountered a significant increase in the number of women seeking assistance after attempting self-abortion. Hagstrom Miller Direct at ¶¶ 18, 19. These women used a variety of methods in addition to misoprostol, including herbal teas, douches, and physical trauma to the abdomen. *Id.* During this period, Defendants also received reports about women attempting to self-induce abortions using misoprostol and about healthcare providers rendering treatment when such attempts were unsuccessful or resulted in complications, a process dubbed "miscarriage management." Exs. P-020, P-022, P-024.

Implementation of the ASC requirement will cause a further increase in the number of women attempting self-abortion, particularly in the Rio Grande Valley and El Paso, where there will be no abortion clinics and where there is easy access to misoprostol from across the border in Mexico. Grossman Direct at ¶ 35.

Self-induction of abortion carries significant health risks and the methods used may be quite dangerous. Grossman Direct at ¶ 33; *see McCormack v. Hiedman*, 694 F.3d 1004, 1008 (9th Cir. 2012) (concerning a pregnant woman who attempted abortion by ingesting drugs purchased over the internet because she could not access professional abortion services); *In re J.M.S.*, 280 P.3d 410, 411 (Utah 2011) (concerning a pregnant woman who attempted abortion by soliciting a stranger to punch her in the abdomen because she could not access professional abortion services); *Hillman v. State*, 503 S.E.2d 610, 611 (Ga. App. 1998) (concerning a pregnant woman who attempted abortion by shooting herself in the abdomen with a handgun because she could not access professional abortion services); *State v. Ashley*, 701 So.2d 338, 339 (Fla. 1997) (same). The ASC requirement will undoubtedly result in exposure to these risks by an increased number of women.

X. The Burdens Imposed by the Admitting Privileges and ASC Requirements Will Have the Greatest Impact on Women in the Rio Grande Valley and West Texas.

Women in the Rio Grande Valley and West Texas are far more likely to be impeded by the need to travel long distances to obtain an abortion than women in other areas of the state because many of them are poor and lack access to reliable transportation, childcare, and the ability to take time off work. Felix Direct at ¶¶ 9-11; Hopkins Direct at ¶¶ 5, 17; Layne-Farrar Direct at ¶ 13. A large number of women in these regions are disadvantaged and have fewer resources to overcome obstacles to accessing medical care than women in other parts of Texas. Hopkins Direct at ¶ 5.

The Rio Grande Valley is comprised of Starr, Hidalgo, Willacy, and Cameron counties along the eastern border of Texas and Mexico. Felix Direct at ¶ 1; Layne-Farrar Direct at Table 1. The vast majority of people living in the Rio Grande Valley are Latino. Felix Direct at ¶ 8; Layne-Farrar Direct at ¶ 13. The region is largely rural, and a substantial percentage of its residents are poor, with an average median income that is $19,000 less than the state average. Felix Direct at ¶¶ 6-8; Layne-Farrar Direct at ¶ 13. A majority of the women of reproductive age in the Rio Grande Valley do not have health insurance. Hopkins Direct at ¶ 10. Similarly, West Texas is a predominantly rural area with a high level of poverty, with an average median income that is $10,000 less than the state average, and with nearly 20% of residents living below the federal poverty line. Layne-Farrar Direct at ¶ 12. Over 40% of women of reproductive age in El Paso County lack health insurance. Hopkins Direct at ¶ 10.

Prior to the enactment of the ASC and admitting privileges requirements, there were two licensed abortion facilities in the Rio Grande Valley (the McAllen clinic and Reproductive Services of Harlingen), and two in El Paso County (the El Paso clinic and Hilltop Women's Reproductive Clinic). Grossman Direct at Table 1. Three of those four clinics are now closed. Hagstrom Miller Direct at ¶ 3 (McAllen clinic); Stipulation at ¶ 5 (Reproductive Services of Harlingen); Eldridge Direct at ¶ 26 (El Paso clinic). The fourth, Hilltop Women's Reproductive Clinic will close before September 2014 because it does not meet the ASC requirement. Stipulation at ¶ 4; Theard Dep. Tr. at 40:25-44:3. According to Defendants' own testimony, at least 332,637 women of reproductive age in the Rio Grande Valley now live father than 150 miles from the nearest Texas abortion provider. Giberson Direct at 6; Giberson Cross, Tr. Vol. 3 (Rough) at 16:54:49-16:55:39; Ex. D-040. It is undisputed that these women, along with those in West Texas, will have to travel greater distances to reach an abortion provider in Texas once the

ASC requirement takes effect, because there will only be abortion facilities available in Dallas-Fort Worth, Houston, Austin, and San Antonio. Grossman Direct at ¶ 23; Giberson Direct at 4; Tr. Vol. 3 (Rough) at 113:18-114:8.

The burden of travel on women in the Rio Grande Valley and West Texas is not alleviated even with the availability of financial assistance. For example, after the admitting privileges requirement took effect and the Rio Grande Valley was left without an abortion provider, Whole Woman's Health worked with a nonprofit organization to provide gas cards or bus tickets to women who presented at the McAllen clinic seeking abortion services, to enable them to travel to a licensed abortion facility in San Antonio. Hagstrom Miller Direct at ¶ 18. Even though every woman who presented at the McAllen clinic was offered assistance to travel to a licensed abortion facility, amounting to approximately 50-60 women per week over a four-month period, only about eight or nine women in total accepted a gas card or bus ticket from Whole Woman's Health. Tr. Vol. 2 (Rough) at 48:23-49:20, 66:3-15. Many of the women cited the inability to find childcare or take time off work as the reason they could not use the financial assistance. Hagstrom Miller Direct at ¶ 18. Many women also reported having a lawful immigration status that permitted them to be present in the region of the United States bordering Mexico, but did not permit them to travel north of Falfurrias, as required to reach the licensed abortion facility in San Antonio. *Id.*; Tr. Vol. 2 (Rough) at 48:23-49:20.

The evidence demonstrates that women in the Rio Grande Valley and West Texas will be particularly burdened by having to travel to access abortion services.

ARGUMENT

I. The ASC Requirement Is Unconstitutional on Its Face, As Applied to the McAllen and El Paso Clinics, and As Applied to Medical Abortion.

A. On its Face, the ASC Requirement Fails to Satisfy the Undue Burden Standard.

This case is governed by the undue burden standard set forth in *Planned Parenthood of Se. Pa. v. Casey*. *See* 505 U.S. 833, 876-77 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.). To understand the proper application of this standard, it is necessary to consider briefly its origin.

In *Roe v. Wade*, the Supreme Court held that the Due Process Clause of the Fourteenth Amendment protects a woman's right to terminate her pregnancy as an exercise of her liberty. *See* 410 U.S. 113, 153 (1973). Accordingly, the Court held that restrictions on abortion were permissible only if narrowly tailored to serve a compelling state interest. *See id.* at 155. It explained that a state's interest in the health of pregnant women became compelling at the point in pregnancy at which abortion-related mortality was greater than or equal to mortality from childbirth, which in 1973, was approximately the start of the second trimester. *See id.* at 163. It also explained that a state's interest in the potential life of the fetus became compelling at the point in pregnancy at which the fetus became viable, which in 1973 was approximately the start of the third trimester. *See id.* *Roe*'s regime for assessing the constitutionality of abortion restrictions became known as the "trimester framework." *See, e.g.*, *Casey*, 505 U.S. at 872.

In *Casey*, the Court reaffirmed the "essential holding" of *Roe*, that a woman has the fundamental right to terminate her pregnancy prior to viability, *see Casey*, 505 U.S. at 846, 871, but held that *Roe*'s trimester framework was too rigid to permit a proper balancing of the important interests at stake, *see id.* at 873 ("A logical reading of the central holding in *Roe* itself, and a necessary reconciliation of the liberty of the woman and the interest of the State in

promoting prenatal life, require, in our view, that we abandon the trimester framework as a rigid prohibition on all previability regulation aimed at the protection of fetal life."). As a result, the Court replaced the trimester framework with the undue burden standard, which governs this case. *See id.* at 876-77. This standard is intended to afford courts more flexibility in balancing women's right to access abortion services, which, for forty years, has facilitated "[t]he ability of women to participate equally in the economic and social life of the Nation," *Casey*, 505 U.S. at 856, with a state's interest in protecting potential life, *id.* at 873. It is not intended, however, to diminish the status of the abortion right or to permit states to restrict that right when doing so would not further a compelling state interest. *See, e.g., id.* at 851 (explaining that rational basis review is not sufficient for regulations that "intrude upon a protected liberty" like the abortion right).

Under the standard announced in *Casey*, states may not impose an undue burden on the right to terminate a pregnancy prior to viability. *See id.* at 876 (joint opinion of O'Connor, Kennedy & Souter, JJ); *Jackson Women's Health Org.*, slip op. at 8. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877. "A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.* "And a statute which, *while furthering* the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Id.* (emphasis added). In addition, an abortion regulation violates due process if it subjects women to

"significant health risks," *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006)); *accord Casey*, 505 U.S. at 880.

Thus, to satisfy constitutional review, a law regulating abortion must (1) have a valid purpose; (2) further a compelling state interest; (3) avoid imposing substantial obstacles in the path of women seeking previability abortion services; and (4) avoid subjecting women to significant health risks. On its face, the ASC requirement fails this test.

1. The ASC Requirement Does Not Further a Compelling State Interest.

i. <u>The ASC requirement does not further the State's interest in potential life in a permissible way.</u>

With respect to the State's interest in potential life, "the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion." *Casey*, 505 U.S. at 878. The State may not, however, further this interest simply by making abortion services more difficult to obtain. *Id.* at 877 ("[T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it."). Here, the ASC requirement does not serve in any way to inform or persuade a woman seeking an abortion. To the extent that the ASC requirement advances the State's interest in potential life, it does so only by reducing the availability of abortion services in Texas, and thereby forcing some women who seek abortions to carry their pregnancies to term. But this is not a permissible way of advancing the State's interest in potential life.

ii. <u>The ASC requirement does not further the State's interest in women's health.</u>

With respect to the State's interest in women's health, the State may enact abortion regulations that are consistent with accepted medical practice, *see Simopoulos v. Virginia*, 462 U.S. 506, 516-17 (1983), and further women's health in a demonstrable way, *see City of*

Akron v. Akron Ctr. for Reproductive Health, Inc., 462 U.S. 416, 430 (1983).[5] But health regulations that are inconsistent with accepted medical practice or fail to advance women's health in a demonstrable way cannot be sustained. *Id.* at 434. Thus in *Danforth*, the Court struck down a statutory provision banning the use of saline amniocentesis as a method of second-trimester abortion because the State failed to demonstrate that it was "a reasonable regulation for the protection of maternal health." *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 79 (1976); *see Carhart*, 550 U.S. at 164-65 (treating *Danforth*'s invalidation of the ban on saline amniocentesis as vital and relevant precedent).

Here, the overwhelming weight of the evidence shows that the ASC requirement is a departure from accepted medical practice. *See supra* at 21-23. And the evidence further shows that the ASC requirement will not serve to enhance the health or safety of abortion patients. *Id.* Accordingly, the ASC requirement does not further the State's interest in women's health.

2. The ASC Requirement Operates as a Substantial Obstacle for a Large Fraction of Women for Whom It Is Relevant.

In *Casey*, the Court struck down a provision of Pennsylvania law requiring that married women notify their husbands before obtaining abortion services on the ground that it imposed a substantial obstacle in the path of women seeking those services. *See Casey*, 505 U.S. at 893-94 ("The spousal notification requirement is . . . likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle."). In so doing, the

[5] In *Danforth*, for example, the Court upheld certain documentation and recordkeeping requirements in the wake of a challenge by abortion providers. *Danforth*, 428 U.S. at 80-81. Subsequently, the Court explained that the "decisive factor" in its decision "was that the State met its burden of demonstrating that these regulations furthered important health-related State concerns." *City of Akron*, 462 U.S. at 430.

Court rejected the Commonwealth's argument that the provision should not be invalidated on its face because it would affect less than one percent of all women seeking abortions in Pennsylvania—namely, married women seeking abortions who would not notify their husbands absent the statutory mandate. *Id.* at 894. It explained that: "The analysis does not end with the one percent of women upon whom the statutes operates; it begins there. . . .The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* Ultimately, the Court concluded that the provision must be invalidated on its face because, "in a large fraction of the cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Id.* at 895.

Here, the group for whom the law is relevant is comprised of those women who could have accessed abortion services in Texas prior to implementation of the ASC requirement, but will face increased obstacles as a result of the law. The dispositive issue is whether those obstacles are substantial for a large fraction of the women, and the evidence shows, unmistakably, that they are.

The record before the Court in this case stands in stark contrast to the record in *Abbott*. There, the record reflected that, after implementation of the admitting privileges requirement, women seeking abortion services would have to travel, at most, 150 miles to reach an abortion provider, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583 597-98 (5th Cir. 2013), and "[a]ll of the major Texas cities, including Austin, Corpus Christi, Dallas, El Paso, Houston, and San Antonio, continue to have multiple clinics where many physicians will have or obtain hospital admitting privileges," *id.* at 598. Here, it is undisputed

that, upon implementation of the ASC requirement,[6] at least 891,888 Texas women of reproductive age would live more than 150 miles from the nearest Texas abortion provider, *see supra* at 26, and there would be at most seven licensed facilities providing abortion services, clustered in four metropolitan areas in the eastern part of the State. Grossman Direct at ¶ 23; Giberson Direct at 4; Tr. Vol. 3 (Rough) at 113:18-114:8; Ex. D-040. There would not be a single licensed facility providing abortion services west or south of San Antonio. *See id*.

Ample evidence demonstrates that this dramatic reduction in the number and geographic distribution of abortion providers will result make it impossible for some women to obtain desired abortions in Texas. First, Dr. Grossman's research shows that, during the period from November 1, 2012, to April 30, 2014, there was a 46% reduction in the number of licensed facilities providing abortion care (from 41 to 22), which corresponded to a 13% reduction in the Texas abortion rate, three times greater than the change in the national abortion rate. Grossman Direct at ¶¶ 10, 15. During the period from April 30, 2014, to September 1, 2014, there will be a further 68% reduction in the number of licensed facilities providing abortion care (from 22 to 7), which will lead to a further reduction in the abortion rate as more women are unable to access an abortion provider. Grossman Direct at Table 1.

Dr. Grossman's findings are consistent with other studies reported in the medical literature showing that lengthy travel distances prevent women from accessing legal abortion services. Grossman Direct at ¶ 27; Raymond Direct at ¶ 56; Tr. Vol. 3 (Rough) at 129:3-7. They

[6] It is important to note that many licensed abortion facilities have begun to close in anticipation of the implementation of the ASC requirement. As their licenses or building leases have come up for renewal in recent months, those facilities, knowing that they could not remain open beyond September 1, 2014, have been closing. *See, e.g.*, Davis Direct at ¶ 6; Tr. Vol. 1 (Rough) at 27:10-28:6; Hagstrom Miller Direct at ¶¶ 1, 20. Thus, the ASC requirement has already been exerting its effects, even though it will not be enforced until September.

are also consistent with Texas' experience following the 2003 enactment of a law limiting the performance of abortions at 16 weeks or later to ASCs and hospitals. A detailed study by economists found that, when the law took effect, there was an immediate and dramatic reduction in both the number of licensed facilities in Texas able to provide abortion services at 16 weeks and later and in the number of abortions performed in Texas at those gestational ages. Grossman Direct at ¶ 28. Two years later, the abortion rate for those gestational ages remained 50% below what it was prior to the law's enactment. *Id.*; Tr. Vol. 3 (Rough) at 127:11-21.

Even if the Court declines to hold that the ASC requirement, on its face, imposes a substantial obstacle on women seeking abortion services, it should hold that ASC requirement, as applied to the McAllen and El Paso clinics does so. First, women in those regions will face the greatest travel distances to obtain abortion care. It is a 235-mile trip from McAllen to San Antonio, and a 549-mile trip from El Paso to San Antonio.[7] Those staggering distances undoubtedly constitute substantial obstacles to accessing abortion services.

Second, a significant number of women in those regions are economically disadvantaged and have fewer resources to overcome obstacles to accessing abortion than women in other parts of the State. *See supra* at 28-30. Many do not have cars and cannot afford to ride the bus. Felix Direct at ¶¶ 18, 22, 27. And the record shows that other obstacles, including lack of reliable childcare or time off work, and immigration status, serve to prevent women from traveling the

[7] Although Defendants have argued throughout this case that women in El Paso would not be unduly burdened by the closure of all of the abortion clinics in West Texas because they could travel to New Mexico to obtain abortion services, the Fifth Circuit's recent decision in *Jackson Women's Health Org. v. Currier* flatly rejects that argument, holding that "the proper formulation of the undue burden analysis focuses solely on the effects within the regulating state." ___ F.3d ___, 2014 WL 3730467, at *9 (5th Cir. July 29, 2014).

required distances to access abortion care. Felix Direct at ¶¶ 9-11; Hopkins Direct at ¶¶ 5, 17; Layne-Farrar Direct at ¶ 13; Tr. Vol. 2 (Rough) at 48:23-49:20.

3. The ASC Requirement Subjects Women to Significant Health Risks.

In addition, the ASC requirement will subject a large fraction of women to significant health risks. By eliminating abortion providers from all parts of Texas except the State's four largest metropolitan areas, the ASC requirement will increase the costs of an abortion procedure as well as the distances that a woman must travel to obtain abortion services. *See supra* at 26-27. The undisputed evidence shows that such increases in cost and distance delay women in accessing abortion services. Grossman Direct at ¶¶ 22, 27, 28. Although abortion is safe throughout pregnancy, the risks of abortion increase with gestational age, *see supra* at 11. Thus, the ASC requirement will lead directly to an increased risk of abortion complications for many women. Moreover, for some women, the barriers to accessing abortion care raised by closing so many clinics will be insurmountable; these women will either carry an unwanted pregnancy to term, or turn to black market drugs or other methods to self-induce an abortion. *See supra* at 27-28. In Texas, carrying a pregnancy to term is roughly 100 more risky than having an abortion. *See supra* at 10. For a woman who wishes to have a child, that risk is surely worth it. But a woman who wishes to have an abortion is put at significantly increased risk when she is denied access to the procedure. The risks from black-market or illegal abortions are self-evident, including the potential for harm arising from ingesting counterfeit drugs, from misusing medication, or from self-caused physical trauma. *See supra* at 27-28. The health risks for women denied access to legal abortion by the ASC requirement are thus tangible and substantial.

4. The ASC Requirement Has an Improper Purpose.

When a statute's purpose is to place a substantial obstacle in the path of a woman seeking a previability abortion, the statute "is invalid because the means chosen by the State to further

the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Casey*, 505 U.S. at 877. In *Jane L.*, for example, the court held that a Utah statute banning abortion after twenty weeks' gestation, except in limited circumstances, had an unconstitutional purpose. *Jane L. v. Bangerter*, 102 F.3d 1112, 1116-17 (10th Cir. 1996), *cert. denied sub nom. Leavitt v. Jane L.*, 520 U.S. 1274 (1997) ("[W]e conclude that [the challenged statute] was enacted with the specific purpose of placing an insurmountable obstacle in the path of a woman seeking the nontherapeutic abortion of a nonviable fetus after twenty weeks, and it therefore imposes an unconstitutional undue burden on her right to choose under *Casey*.").

Similarly, in *Heineman*, the court granted a preliminary injunction against the operative provisions of a statute that imposed civil liability on abortion providers for failing to comply with certain disclosure requirements. *Planned Parenthood of the Heartland v. Heineman*, 724 F.Supp.2d 1025, 1031 (D. Neb. 2010). In relevant part, the statute required abortion providers, at least one hour prior to the performance of an abortion, to screen each woman seeking an abortion for "risk factors associated with abortion," to counsel the woman about the risk factors and associated complications, and to make certain written findings about the woman's risk of injury from abortion. *Id.* at 1033. The court held, *inter alia*, that the plaintiffs demonstrated a likelihood of success on the merits of their claim that the statute had an unconstitutional purpose. *Id.* at 1046. ("[T]his Court finds that Plaintiffs are likely to succeed on the merits of their Due Process liberty-and-privacy-interest claim, because the purpose of the bill appears to be the preservation of unborn human life through the creation of substantial, likely insurmountable, obstacles in the path of women seeking abortions in Nebraska.").

Many areas of constitutional law require courts, from time to time, to examine the purpose underlying legislative enactments or other state action. In determining whether the

purpose of a law restricting access to abortion is invalid, it is appropriate for a court to look to this jurisprudence for guidance. *See Okpalobi v. Foster*, 190 F.3d 337, 354 (5th Cir. 1999) ("We are not without guidance, however, as abortion law is not the only realm of jurisprudence in which courts are required to question whether a measure has been adopted for an impermissible purpose."), *vacated*, 201 F.3d 355 (5th Cir. 2000)[8]; *cf. Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 540 (1993) ("In determining if the object of a law is a neutral one under the Free Exercise Clause, we can also find guidance in our equal protection cases.").

The purpose of a law may be determined from both direct and circumstantial evidence. *See Church of the Lukumi*, 508 U.S. at 540; *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266 (1977). Relevant considerations include the text of the law, *Church of the Lukumi*, 508 U.S. at 533, "the effect of [the] law in its real operation," *id.* at 535, whether the law restricts more conduct than is necessary to achieve the stated governmental interest, *id.* at 538, and its legislative history, *id.* at 540. In reviewing a preliminary injunction entered against a Wisconsin admitting privileges requirement, the Seventh Circuit recently noted that "[a] fuller enumeration of considerations based on purpose would include," *inter alia*, "the apparent absence of any medical benefit from requiring doctors who perform abortions to have such privileges at a nearby or even any hospital, [and] the differential treat of abortion vis-à-vis medical procedures that are at least as dangerous as abortions and probably more so." *Planned Parenthood of Wisc. v. Van Hollen*, 738 F.3d 786, 790-91 (7th Cir. 2013).

[8] Although the panel's decision in *Okpalobi* was vacated upon the grant of rehearing *en banc*, the subsequent *en banc* decision did not address the purpose issue. *See Okpalobi v. Foster*, 244 F.3d 405, 429 (5th Cir. 2001) (holding that the court lacked subject-matter jurisdiction over the case). Accordingly, the panel's discussion of purpose, while not controlling, remains persuasive authority.

Here, there are numerous indications that the ASC requirement has an improper purpose. First, it singles out facilities in which first and early second-trimester abortion procedures are performed for the imposition of construction requirements that are not imposed on facilities performing any other medical procedures. More than three-quarters of licensed ASCs are exempt from these construction requirements due to grandfathering, *see supra* at 24, and waivers from them are "frequently" granted on an oral basis, *id*. (Abortion facilities, of course, are prohibited by the Act's implementing regulations from seeking grandfathering or waivers. *See* 38 Tex. Reg. 6536, 6540 (declining to apply 25 Tex. Admin. Code § 135.51(a)).) And, apart from abortion providers, practice in an ASC setting is completely voluntary for physicians. Texas law expressly authorizes physicians to perform major outpatient surgeries—using forms of anesthesia, such as general anesthesia and deep sedation, that render the patient no longer ambulatory—in their offices, provided that they register with the Texas Medical Board and satisfy certain training and reporting requirements. *See* 22 Tex. Admin. Code §§ 192.1-192.6; Robinson Direct, Vol. 4 (Rough) at 84:3-85:5. The Executive Director of the Texas Medical Board testified that "several thousand" Texas physicians perform such surgeries in their offices. *Id.* at 85:6-9. Given that first and early second-trimester abortion is extremely safe overall and is as safe or safer than many other procedures performed in outpatient settings, *see supra* at 10-12, the targeting of abortion for heightened regulation indicates an improper purpose.

Second, the utter lack of evidence that the ASC requirement will enhance the health or safety of abortion patients, *see supra* at 23-25, supports an inference of improper purpose, as does the staggering costs of compliance, *see supra* at 25-28. The ASC requirement is essentially a multi-million dollar tax on the performance of abortion procedures, and it produces no offsetting benefit. *Id.*

Third, the record shows that the ASC requirement was a solution in search of a problem. Abortion was already extensively regulated prior to the enactment of the ASC requirement, and there is absolutely no evidence that suggests that existing regulations were insufficient to ensure the health and safety of abortion patients. *See supra* at 7-9. To the contrary, all evidence shows that legal abortion in Texas is extremely safe, and one-hundred times safer than the alternative. *See supra* at 10.

Fourth, Defendants' repeated contention that women unable to access abortion services in Texas can travel to New Mexico to obtain them is compelling evidence that the purpose of the ASC requirement is to reduce access to abortion services in Texas rather than to protect the health and safety of abortion patients. New Mexico does not have an ASC requirement in effect for abortion providers. It appears that the State of Texas has no health or safety concerns about women obtaining abortion services in facilities that do not meet ASC construction standards, provided that they are unable to obtain those services within the State's borders.

Finally, the most damning evidence of the ASC requirement's purpose is its effect. *Cf.*, *Church of the Lukumi*, 508 U.S. at 535; *Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997) (holding that it was erroneous to conclude that a law had the purpose of imposing a substantial obstacle to abortion when there was no evidence that any "woman seeking an abortion would be required by the new law to travel to a different facility than was previously available."). Defendants admit that all existing licensed abortion facilities will be forced to close if the ASC requirement takes effect, leaving at most seven ASCs in four metropolitan areas to meet the demand for abortion services throughout the entire State. *See supra* at 30, 36. And some of those ASCs are currently unable to provide abortion services because of the admitting privileges

requirement. *Id.* This reduction in the availability legal abortion services is dramatic and unprecedented since the Supreme Court's decision in *Roe v. Wade*.

In sum, while any one of these factors in isolation may not be dispositive of the ASC requirement's purpose, considered together they can lead to only one conclusion: the purpose of the ASC requirement is to eliminate legal abortion services from the vast majority of Texas.[9]

II. The Admitting Privileges Requirement is Unconstitutional as Applied to the McAllen and El Paso Clinics.

The evidence clearly demonstrates that, as applied to the McAllen and El Paso clinics, the admitting privileges requirement fails the undue burden test. With respect to these two clinics in particular, the admitting privileges requirement does not advance the State's interest in women's health. Both Dr. Lynn and Dr. Richter are qualified and highly experienced abortion providers who have been providing safe abortion care for decades. *See supra* at 12-13, 17. Dr. Lynn currently holds admitting privileges at hospitals in Austin and San Antonio, Lynn Direct at ¶ 6, and Dr. Richter previously held admitting privileges at a hospital in El Paso, Eldridge Direct at ¶ 13; Tr. Vol. 2 (Rough) at 5:23-6:10. The record shows that Dr. Lynn and his colleagues at Whole Woman's Health were denied admitting privileges at Doctors Hospital at Renaissance for reasons unrelated to their clinical competence, *see supra* at 16, and Dr. Richter was denied

[9] At least some of the Act's sponsors were candid about its true aim. *See* H.B. 2 – 039 – Closing Arguments by Rep. Jason Villalba, https://www.youtube.com/watch?v=DM8mAcgB-KI at 3:40 ("So, regardless of what this debate may—where this debate may go, please understand that our intentions are honorable because we care for, and we fight for, human baby lives. When you ask about the inconvenience of driving a thousand miles, when you worry about a twenty-dollar ticket, when you talk about the issues that arise, we do so because we are protecting human baby lives."); H.B. 2 – 003 – Rep. Laubenberg Questioned by Rep. Farrar, https://www.youtube.com/watch?v=Be1EhiRmXM0 at 10:32 ("In response to your question on what other procedures would require the extra, higher standards, our answer to you is that the abortion—abortion is the only medical procedure where the result or the expected outcome is the taking of a life. This is a very unique procedure.").

admitting privileges at Foundation Surgical Hospital for pretextual reasons after the hospital's C.E.O. learned that she was an abortion provider, *see supra* at 18-19.

Further, for the reasons discussed above, the closure of the McAllen and El Paso clinics have imposed substantial obstacles on women in the Rio Grande Valley and West Texas who are seeking abortion services, leading to a disproportionate decline in the abortion rates in those regions and a surge in attempts at self-induced abortion. *See supra* at 27, 36. For these obstacles to be removed, the Court must strike down both the ASC requirement and the admitting privileges requirement as applied to the McAllen and El Paso clinics. *Cf. Van Hollen*, 738 F.3d at 796 ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.").

CONCLUSION

For the reasons set forth above, Plaintiffs respectfully request that the Court:

a. Issue a declaratory judgment that the ASC requirement is unconstitutional and unenforceable:
   i. on its face; and/or
   ii. as applied to the McAllen clinic; and/or
   iii. as applied to the El Paso clinic; and/or
   iv. as applied to the provision of medical abortion; and/or

b. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the ASC requirement:
   i. on its face; and/or
   ii. as applied to the McAllen clinic; and/or
   iii. as applied to the El Paso clinic; and/or
   iv. as applied to the provision of medical abortion; and/or

c. Issue a declaratory judgment that the admitting privileges requirement is unconstitutional and unenforceable:

   i. as applied to the McAllen clinic; and/or

   ii. as applied to the El Paso clinic; and/or

d. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the admitting privileges requirement:

   i. as applied to the McAllen clinic; and/or

   ii. as applied to the El Paso Clinic; and/or

e. Grant such other and further relief as the Court deems just, proper, and equitable.

Dated: August 12, 2014

/S/ Stephanie Toti

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CERTIFICATE OF SERVICE

I hereby certify that, on August 12, 2014, the foregoing was served on all counsel of record via the CM/ECF system.

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