No. 18-50730

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

WHOLE WOMAN'S HEALTH; BROOKSIDE WOMEN'S MEDICAL CENTER, P.A., doing business as Brookside Women's Health Center and Austin Women's Health Center; LENDOL L. DAVIS, M.D.; ALAMO CITY SURGERY CENTER, P.L.L.C., doing business as Alamo Women's Reproductive Services; WHOLE WOMAN'S HEALTH ALLIANCE; DR. BHAVIK KUMAR,

Plaintiffs-Appellees,

v.

CHARLES SMITH, Executive Commissioner of the Texas Health and Human Services Commission, in his official capacity,

Defendant-Appellant.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division
Case No. 1:16-CV-1300

BRIEF OF *AMICI CURIAE* THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN PUBLIC HEALTH ASSOCIATION, AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES AND IN SUPPORT OF AFFIRMANCE

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CHARLES SMITH, Executive Commissioner of the Texas Health and Human Services Commission, in his official capacity,

Defendant-Appellant.

CERTIFICATE OF INTERESTED PERSONS

Amici curiae, the American College of Obstetricians and Gynecologists, the American Public Health Association, and the American Medical Association, are non-profit organizations, with no parent corporations or publicly traded stock. The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Counsel for parties and *amici* in this case are as follows:

Plaintiffs-Appellees	**Plaintiffs-Appellees' Counsel**
Whole Woman's Health Brookside Women's Medical Center P.A., d/b/a Brookside Women's Health Center and Austin Women's Health Center Dr. Lendol L. Davis; Alamo City Surgery Center P.L.L.C., d/b/a Alamo Women's Reproductive Services; Whole Woman's Health Alliance Dr. Bhavik Kumar	Patrick J. O'Connell LAW OFFICES OF PATRICK J. O'CONNELL PLLC David Brown Dipti Singh Stephanie Toti Juanluis Rodriguez THE LAWYERING PROJECT Molly Duane Autumn Katz Caroline Sacerdote Emily B. Nestler CENTER FOR REPRODUCTIVE RIGHTS J. Alexander Lawrence Francesca Cocuzza ‡ MORRISON & FOERSTER, LLP ‡ *Indicates counsel has withdrawn*

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Other Interested Persons or Entities
Former Plaintiff: Nova Health Systems, Inc. d/b/a Reproductive Services Former Defendant: John Hellerstedt, M.D., Commissioner of the Texas Department of State Health Services, in his official capacity Texas providers of reproductive health care Patients of the Plaintiffs-Appellees

/s/ Susan J. Kohlmann

SUSAN J. KOHLMANN

Counsel for *Amici Curiae*

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (the "College" or "ACOG"), the American Public Health Association ("APHA"), and the American Medical Association ("AMA") submit this *amicus curiae* brief in support of Plaintiffs-Appellees.[1]

Amicus curiae **ACOG** is a non-profit, voluntary membership organization of obstetrician-gynecologists ("OB-GYNs") and other women's health care providers. With more than 58,000 members, ACOG is the premier professional organization dedicated to the improvement of women's health care. ACOG develops and publishes evidence-based practice guidelines, maintains the highest standards for continuing medical education, promotes high ethical standards in the practice of medicine, and fosters contributions to medical and scientific literature across all mediums and for all aspects of women's health.

The membership of the Texas District of ACOG includes 2,637 OB-GYNs who provide medical care to the women of Texas. ACOG recognizes that abortion is an essential health care service and opposes laws regulating medical care that are unsupported by scientific evidence and that are not necessary to achieve an

[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for *amici* certify that no person or entity other than *amici* and their counsel authored this brief in whole or in part or made a monetary contribution to the preparation or submission thereof. *Amici* also certify that all parties consent to the filing of this brief.

important public health objective. For these reasons, ACOG has been concerned with the instant changes to Texas law and regulations since the Texas Department of State Health Services first proposed amendments to its rules concerning embryonic and fetal tissue disposal in 2016. At that time, ACOG submitted comments to the proposed amendments during the rulemaking process. *See* ROA.76 (41 Tex. Reg. 9717 (Dec. 9, 2016)). The Texas District of ACOG also submitted comments to the Texas Health and Human Services Commission ("HHSC") when it promulgated new rules pursuant to Chapter 697. *See* ROA.5561 (43 Tex. Reg. 467 (Jan. 26, 2018)).[2]

Amicus curiae **APHA** is an organization the mission of which is to champion the health of all people and all communities; strengthen the profession of public health; share the latest research and information; promote best practices; and advocate for public health issues and policies grounded in scientific research. APHA is the only organization that combines a nearly 150-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

[2] The laws and regulations at issue in the current appeal—Tex. Health & Safety Code §§ 697.001-.004, 697.007-.009 and 25 Tex. Admin. Code §§ 138.1-.7—are substantively the same as the amendments to Title 25, §§ 1.132−1.137 of the Texas Administrative Code published on December 9, 2016. *See* 41 Tex. Reg. 9709−41 (Dec. 9, 2016) (the "2016 Amendments"). The 2016 Amendments were effectively repealed when the 2018 HHSC rules came into force. *See* 43 Tex. Reg. 3242 (May 18, 2018).

APHA has long recognized that access to the full range of reproductive health services, including abortion, is a fundamental right integral both to the health and well-being of individual women and to the broader public health. APHA opposes restrictions that deny, delay, or impede access to reproductive health services, increasing women's risk of injury or death. APHA opposes legislation that makes these services unnecessarily difficult to obtain, imposes physical or mental health risks on women seeking these services without valid medical reason, and reduces the number of abortion providers and the availability of abortion services.

APHA has over 23,000 members, of whom more than 1,000 reside in Texas. It also maintains a connection to the public health community in Texas through its affiliate, the Texas Public Health Association, which has provided over 90 years of public health service.

Amicus curiae **AMA** is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups seated in AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in AMA's policymaking process. AMA's objectives are to promote the science and art of medicine and the advancement of public health. AMA members practice in all fields of medical specialization and in every state, including Texas.

ACOG, APHA, and AMA have previously appeared as *amici curiae* in various courts throughout the country, including in the U.S. Supreme Court and the U.S. Court of Appeals for the Fifth Circuit. In addition, *amici*'s work has been cited frequently by the Supreme Court and other federal courts seeking authoritative medical data relating to reproductive health.[3]

[3] *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing ACOG and AMA's *amicus* brief several times in striking down Texas abortion regulations, including citation to their *amicus* brief as among those that "set forth without dispute" that admitting privileges have common prerequisites unrelated to the ability to perform medical procedures); *Stenberg v. Carhart*, 530 U.S. 914, 924−25, 932−36 (2000) (quoting AMA reports and policies and ACOG's statement and *amicus* brief extensively, and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue, including in comparison with childbirth); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG's *amicus* brief in evaluating disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG and APHA publications in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170−71, 175−78, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's *amicus* brief and ACOG and APHA's congressional submissions regarding abortion procedures); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 168 (4th Cir. 2000) (extensively discussing ACOG's guidelines and describing those guidelines as "commonly used and relied upon by obstetricians and gynecologists nationwide to determine the standard and the appropriate level of care for their patients").

SUMMARY OF ARGUMENT

The tissue disposal law and implementing regulations at issue—contained in Chapter 697 of the Texas Health and Safety Code and Chapter 138 of Title 25 of the Texas Administrative Code, and published on January 26, 2018 in the Texas Register, 43 Tex. Reg. 465−73 (the "Acts")—create a special requirement for the disposal of embryonic and fetal tissue from health care facilities.[4] Instead of permitting the disposal of embryonic and fetal tissue in the same manner as all other human tissue removed during surgery, autopsy, or biopsy, the Acts mandate that embryonic and fetal tissue be disposed of by interment or cremation. Any ashes resulting from cremation must be interred or scattered as required for human remains and cannot be deposited in a landfill with other medical waste.

As Texas has conceded throughout the litigation, these disposal requirements provide no medical, public health, or safety benefits; in fact, they may increase the risk to public health. The Acts depart from the standard of care long practiced by *amici*'s members in the disposal of embryonic and fetal tissue and have the potential to increase miscarriage-related complications. The Acts also impose heightened burdens on health care facilities disposing of embryonic and fetal tissue that will likely lead to reduced health care access for many Texas women. Abortion clinics,

[4] As noted above, this case began as a challenge to the 2016 Amendments. *See* 41 Tex. Reg. 9709−41 (Dec. 9, 2016). The instant laws challenged here have substantially the same requirements as the 2016 Amendments. *See supra* note 2.

in particular, may be forced to close as a result of the increased burden of compliance or their inability to find third-party providers willing to transport and dispose of the embryonic and fetal tissue of their patients. Even if compliance were not exceptionally burdensome, the Acts are intrusive, undermining women's rights to bodily autonomy and independent reproductive decision-making, and interfere with the patient-physician relationship.

Texas has a history of manufacturing ways to restrict access to important reproductive health care under the guise of improving public health. The 2016 Amendments—the precursor to the Acts at issue here, with substantially the same restrictions—were published only four days after the U.S. Supreme Court struck down other Texas regulations restricting abortion access in *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016). While an appeal of the preliminary injunction against those 2016 Amendments was pending, the Texas legislature passed the law at issue here.[5] By mandating certain methods for the disposal of embryonic and fetal tissue with no tangible health benefit, the Acts require an unnecessary action that may create needless trauma for women during what may already be a difficult

[5] *See* ROA.1603, ROA.1635−36. The enactment separately included a ban on the most commonly performed second-trimester abortion method, *see* 2017 Tex. Sess. Law Serv. 1165, which has since been held unconstitutional, *see Whole Woman's Health v. Paxton*, 280 F. Supp. 3d 938 (W.D. Tex. 2017), *appeal docketed*, No. 17-51060 (5th Cir. Dec. 1, 2017).

period. *Amici* respectfully request that the Court affirm the decision below, permanently enjoining the Acts from taking effect.

ARGUMENT

I. The Acts Provide No Medical Benefit and Instead May Jeopardize Women's Health.

There is no medical or public health benefit to the embryonic and fetal tissue disposal requirements contained in the Acts. The prior law already obligated Texas OB-GYNs—like other medical professionals—to dispose of pathological waste in a sanitary manner. As they existed until 2017, the approved disposal methods were nearly identical for various tissues and medical waste,[6] reflecting that disease risks from disposal do not differ based on the type of tissue involved.[7]

In gynecologic and obstetrical practice, common events require disposal of human tissue, including biopsies and other excisions, surgeries in which organs are removed (such as hysterectomies and oophorectomies), and removal of tissue from failed and/or terminated pregnancies.[8] In such situations, *amici*'s members in Texas

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[6] *See* 14 Tex. Reg. 1457−62 (Mar. 21, 1989) (prior Texas Department of Health regulations on disposal of medical waste) (formerly 25 Tex. Admin. Code §§ 1.132, 1.136−1.137), amended by Act of June 6, 2017, 85th Leg., R.S., ch. 441, 2017 Tex. Sess. Law Serv. 1165.

[7] *See, e.g.*, Int'l Comm. of the Red Cross, *Medical Waste Management*, at 13 (Nov. 2011), https://www.icrc.org/en/doc/assets/files/publications/icrc-002-4032.pdf (categorizing all anatomical or infectious tissue in a single risk category of medical waste).

[8] Ten to twenty percent of known pregnancies in the United States end in spontaneous miscarriage before the twentieth week of gestation. *See* Mayo Clinic, *Miscarriage: Overview* (July 20, 2016), http://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/home/ovc-20213664. To limit complications from a miscarriage and to afford patients a shorter recovery time, doctors often employ surgical procedures to remove miscarried tissue from the uterus,

do what law and ethics require: they dispose of the tissue in a safe and sanitary manner.[9] For example, physicians typically direct that embryonic and fetal tissue be incinerated, then deposited in a sanitary landfill.[10] This is the most widely-accepted method for disposal of pathological waste, and the method of disposal recommended by the American College of Pathologists.[11]

If permitted to go into effect, the Acts would depart from the current standard of care by eliminating the expert-preferred incineration-sanitary landfill method for the specific category of embryonic and fetal tissue. There is no medical or health basis for this change, and Texas concedes as much.[12] The approved methods under

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especially when patients present with excessive bleeding or signs of infection. *See* American College of Obstetricians and Gynecologists, *ACOG Practice Bulletin No. 200: Early Pregnancy Loss*, 132 Obstetrics & Gynecology e197, e201 (2018), https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb200.pdf?dmc=1&ts=20181217T1750202115; American College of Obstetricians and Gynecologists, *Frequently Asked Questions FAQ062: Dilation and Curettage (D&C)*, at 1 (Feb. 2016), http://www.acog.org/~/media/For%20Patients/faq062.pdf.

[9] *See, e.g.*, ROA.76 (41 Tex. Reg. 9717 (Dec. 9, 2016)) (describing ACOG's comments to the 2016 Amendments, including ACOG's position that "current laws and professional standards already require safe and respectful disposition of medical waste").

[10] *See, e.g.*, ROA.4121−22 (testimony of Dr. Bhavik Kumar, medical director of Whole Woman's Health and Whole Woman's Health Alliance (collectively, "WWH"), that incineration and disposal in a landfill is the standard practice of disposing of all medical tissue); ROA.4331−32 (testimony of ACOG member and OB-GYN expert Dr. Lendol Davis, stating that his clinics dispose of tissue by incineration followed by disposition in a landfill "[b]ecause that's the medical standard"); *see also* Int'l Comm. of the Red Cross, *supra* note 7, at 62−67 (describing this disposal method).

[11] *See* ROA.4659 (testimony of ACOG member and OB-GYN expert Dr. Karen Swenson describing the organizations, including the American College of Pathologists, which recommend this disposal method).

[12] The legislature's only stated purpose for Chapter 697 is to "express the state's profound respect for the life of the unborn . . . ." Tex. Health & Safety Code § 697.001; *see also* ROA.5564 (43 Tex. Reg. 470 (Jan. 26, 2018)) (HHSC admitting the new rules are intended only to express

the Acts are not comparatively safer or better at preventing the spread of communicable disease than the previously-approved methods.[13] In fact, the Acts could have the opposite effect and heighten the risk of infection by deviating from the standard protocol for disposal of pathological waste.[14]

In addition, there is simply no public health reason to treat the disposition of embryonic or fetal tissue any differently from any other tissue (or body parts) extracted from the human body in a medical setting.[15] To the contrary, any notion that embryonic or fetal tissue requires exceptional rules for safe disposition is belied by common sense and the reality of women's experiences. Women may spontaneously miscarry early in pregnancy and pass the embryonic or fetal tissue

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"dignified disposition of embryonic and fetal tissue remains"). Texas does not dispute that prior law was sufficient to satisfy the public health mission for which the regulatory scheme exists. Indeed, Texas acknowledged as much in the Public Benefit statement accompanying the 2016 Amendments, which stated: "[T]he public benefit anticipated as a result of adopting and enforcing these rules will be the *continued* protection of the health and safety of the public by ensuring that the disposition methods specified in the rules *continue* to be limited to methods that prevent the spread of disease." ROA.91 (41 Tex. Reg. 9732 (Dec. 9, 2016)) (emphasis added); *see also* ROA.345 (41 Tex. Reg. 7660 (Sept. 30, 2016)) (The Amendments are "not intended to protect the environment or reduce risks to human health from environmental exposure."); ROA.68 (41 Tex. Reg. 9709 (Dec. 9, 2016)) ("These rules provide a comparable level of protection to public health [as the previous rules].").

[13] ROA.5561 (43 Tex. Reg. 467 (Jan. 26, 2018)) (comment to 2018 HHSC rules by Physicians for Reproductive Health that current procedures to dispose of embryonic or fetal tissue are already "sanitary and minimize exposure to pathogens and risk of infection").

[14] *See* ROA.4673 (testimony of Dr. Karen Swenson that deviating from the standard method of disposal can lead to more errors and complications).

[15] *See* ROA.4448 (testimony of Dr. Thomas Cunningham, an expert in clinical ethics and bioethics, explaining that "one of the virtues of the prior law" was that it treated all medical waste the same, and that under the Acts "only [non-embryonic and non-fetal tissue] will be treated in the way that the public health department has deemed to be preferential").

into a toilet or elsewhere at home[16]—a circumstance not covered by the Acts[17]—and unregulated disposal of other intrauterine matter, like menstrual fluid, is a routine part of life.

Not only is there is no public health benefit to the statutory and regulatory change, the Acts may actually impede health care services for women. Many women choose to have their miscarried tissue removed by an experienced physician at a health care facility after they learn of the miscarriage, and for women with high-risk miscarriages, surgery may be the only appropriate option.[18] Yet, Texas puts women with failing pregnancies in the position of distancing themselves from their doctors if they do not want their embryonic or fetal tissue to be subject to the Acts. For instance, women may forgo the surgical removal of miscarried tissue and choose to miscarry at home, which could lead to heightened risk of complications, particularly at later stages of gestation, including infection and heavy bleeding.[19]

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[16] *See* ROA.4660−61 (testimony of Dr. Karen Swenson).

[17] *See* 25 Tex. Admin. Code § 138.3(c) (2018).

[18] *See ACOG Practice Bulletin No. 200: Early Pregnancy Loss*, *supra* note 8, and accompanying text (recommending surgery for removal of miscarried tissue if a woman shows signs of infection, heavy bleeding, or other medical conditions).

[19] *See* ROA.4133 (testimony of Dr. Bhavik Kumar). The same may be true for abortion patients, who may choose to proceed with a medication abortion at home, rather than a surgical abortion, even when that treatment decision is counter to their own wishes and could present increased risks due to their particular situation. *See* ROA.4128−33 (testimony of Dr. Bhavik Kumar, discussing the reasons why some patients choose surgical abortions over medication abortions, and potential complications from medication abortions that might require medical attention). Women may also seek treatment options outside of the health care system, such as across the border in Mexico or

II. The Acts Impose Significant Burdens on Reproductive Health Providers, Which Will Negatively Impact Women's Access to Health Care.

Despite providing no health benefits, Texas's embryonic and fetal tissue disposal requirements impose significant new burdens on pregnancy-related services. As explained above, the Acts permit only two methods of fetal and embryonic tissue disposal—interment and scattering of ashes—which deviate from current (standard) medical practice.[20] Thus, to comply with the law, Texas health care providers must identify and contract with new business partners capable of providing the requisite cremation and interment services for the thousands of miscarriages and abortions that take place at Texas health care facilities each year.[21] By all estimates, there are an insufficient number of providers that are capable of and interested in handling the influx of tissue subject to the new law.[22] There is also

online, which could pose additional unnecessary medical risks. *See* ROA.4133−34 (testimony of Dr. Bhavik Kumar).

[20] *See supra* notes 9, 10, 11, and accompanying text.

[21] *See* Guttmacher Inst., *State Facts About Abortion: Texas*, at 1 (2014), https://www.guttmacher.org/sites/default/files/pdfs/pubs/sfaa/pdf/texas.pdf (Of 533,500 Texas pregnancies in 2011, approximately 80,000 (or 15%) ended in a miscarriage.); *accord* ROA.4660 (testimony of Dr. Karen Swenson); Tara C. Jatlaoui et al., *Morbidity and Mortality Weekly Report (MMWR): Abortion Surveillance – United States, 2015*, Centers for Disease Control and Prevention, at Table 2 (Nov. 23, 2018), https://www.cdc.gov/mmwr/volumes/67/ss/ss6713a1.htm (showing approximately 54,000 induced abortions in Texas in 2015).

[22] *See* ROA.4478−79 (testimony of Dr. Alan Braid, OB-GYN, that he knows of only one vendor that will work with his clinics to dispose of embryonic and fetal tissue from abortions, and that that vendor does not dispose of said tissue in a way that would comply with the Acts); ROA.4365 (testimony of Dr. Lendol Davis, expressing concerns about complying with the Acts because no vendor on the registry had reached out to him, and HHSC has specifically said it will not help health care providers find vendors).

no evidence that a market of such providers will develop.[23]

Compliance will therefore be difficult for health care facilities subject to the Acts. And providers of abortion services, in particular, will bear a disproportionate burden. Medical waste companies that work with abortion providers have long been subject to attacks by activist groups whose objective is to pressure vendors to stop providing services to abortion clinics.[24] Before implementation of the Acts, Whole Woman's Health clinics in Texas *already* faced significant hurdles finding medical waste disposal vendors in Texas willing to work with abortion providers;[25] the intensified difficulties from the Acts raise a potentially existential burden.

For instance, some providers of burial and cremation services may be categorically unwilling to work with abortion providers, while others may determine

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[23] *See* ROA.4325, ROA.4333 (testimony of Dr. Lendol Davis, that during 40 years of practicing gynecology he has *never* had a medical waste vendor that disposed of tissue by interment or cremation).

[24] *See, e.g.*, Meaghan Winter, *Why It's So Hard to Run an Abortion Clinic—And Why So Many Are Closing*, Bloomberg Businessweek (Feb. 24, 2016), https://www.bloomberg.com/features/2016-abortion-business ("[W]hen anti-abortion organizations in [Texas] 'hear a rumbling' about an abortion clinic coming to town, activists will . . . blast the contractors with phone calls and organize boycotts."); ROA.4036 (testimony of Amy Hagstrom Miller, CEO of WWH, that many vendors will not work with WWH at all because of "security concerns" or because they "don't want to go through picket lines, et cetera"); ROA.4366 (testimony of Dr. Lendol Davis that "[e]ven vendors that have been pro-choice eventually caved to harassment" and stopped providing services to his clinics).

[25] *See* ROA.4030−37 (testimony of Amy Hagstrom Miller, describing the difficulties WWH has experienced in securing waste disposal vendors before passage of the Acts and the increased difficulties WWH is expected to face under the Acts); ROA.4334−35 (testimony of Dr. Lendol Davis, describing logistical problems presented when two medical waste vendors stopped collecting embryonic and fetal tissue from his clinics and nearly forced them to close).

that it is simply not worth the hassle in light of the inevitable pressure from activist groups. The Acts purported to address this issue by requiring the creation of a registry of "funeral homes and cemeteries willing to provide free common burial or low-cost private burial" as well as a list of nonprofit organizations willing to provide funding for burial or cremation.[26] But, in practice, the vendors on the registry have not made themselves available to providers, nor has HHSC provided any support to help health care providers find willing vendors.[27] Further, while Texas pointed to a non-contractual promise made by the Catholic Church and its affiliated cemeteries to provide disposition services, this is not a reliable option for health care providers, because the promise is non-contractual in nature and can be withdrawn at any time, and because the Catholic Church has offered no evidence that it is able to bury embryonic and fetal tissue remains throughout Texas.[28] Moreover, as discussed *infra*, such an option may be inconsistent with, or offensive to, women's spiritual and religious beliefs. Thus, without a concrete list of reliable vendors able to transport and dispose of the tissue as required by the Acts, abortion providers will be unable to comply with the Acts and their continued operation may be jeopardized.

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[26] Tex. Health & Safety Code § 697.005.

[27] *See, e.g.*, ROA.4365 (testimony of Dr. Lendol Davis).

[28] *See* ROA.4773−74 (testimony of Jennifer Carr Allmon, Executive Director of the Texas Conference of Catholic Bishops ("TCCB"), that the TCCB may withdraw its offer of burial services for fetal or embryonic tissue at any time); ROA.4753−54, ROA.4763−64 (testimony of Jennifer Carr Allmon that implementation of the burial ministry would be handled by local cemeteries, not the TCCB, and that she has no role in overseeing cemeteries).

A similar result occurred when Texas attempted to impose unnecessary and burdensome regulations on abortion providers via its 2013 bill known as "H.B.2." Among other requirements, H.B.2 mandated that abortion providers have admitting privileges at nearby hospitals, but, similar to the Acts here, abortion providers were at the mercy of third parties who roundly denied privileges for and refused to deal with doctors performing abortions.[29] H.B.2's attempt to restrict abortion access through these targeted regulations led to twenty-one clinic closures in the period between the law's passage and the U.S. Supreme Court's decision striking down the law as an unconstitutional and undue burden on abortion access.[30] In about a year, the number of women of reproductive age who lived more than 200 miles from an abortion facility increased dramatically, from 10,000 to 290,000.[31] Those clinic closures also led to longer wait times for women seeking abortions and, as a result, a higher number of second-trimester abortions, which, although still safe, pose more

[29] *See* Texas Policy Evaluation Project, *Access to abortion care in the wake of HB2* (July 1, 2014), http://liberalarts.utexas.edu/txpep/_files/pdf/AbortionAccessafterHB2.pdf (noting that almost all of the 21 clinic closures due to H.B.2 were related to difficulties obtaining hospital admitting privileges for physicians at those facilities).

[30] *See Hellerstedt*, 136 S. Ct. 2292; JC Sevcik, *Study: Texas women wait longer, self-induce abortions after HB-2 closes clinics*, UPI (July 24, 2014, 3:31 PM), http://www.upi.com/Top_News/US/2014/07/23/Study-Texas-women-wait-longer-self-induce-abortions-after-HB-2-closes-clinics/1451406139471; Texas Policy Evaluation Project, *supra* note 29.

[31] Sevcik, *supra* note 30.

risks than first-trimester abortions.[32]

The same result is likely to obtain here. Because the Acts will intensify and exacerbate the challenge of contracting with third-party entities capable of safe and lawful tissue disposal, health care providers may be forced to shut down simply because they cannot comply with the heightened disposal requirements of the new law.[33] In turn, women's access to important and constitutionally-protected reproductive health care, ranging from sexually transmitted infection testing and cancer screenings to safe abortion services, will be curtailed, endangering the health of Texas women.[34] Low-income women will be disproportionately impacted by such closures.[35]

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[32] *See* Sevcik, *supra* note 30; Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 735 (2004).

[33] *See* ROA.4367 (testimony of Dr. Lendol Davis that, because his clinics have limited space, they "would have to stop providing abortions" if the tissue was not collected and disposed of regularly); ROA.4031, ROA.4036 (testimony of Amy Hagstrom Miller that she is worried that the Acts might make WWH unable to "provide services without interruption," because "there can be a law on the books" like the admitting privileges requirement "that actually is impossible to comply with, and so, it serves as a way to shutter" clinics).

[34] *See* American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Committee Opinion No. 613: Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060, at 2 (2014, *reaffirmed* 2017), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20181227T2249358961 ("[W]here abortion is illegal or highly restricted, women resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, self-medication with a variety of drugs, and reliance on unqualified abortion providers." (citations omitted)); American College of Obstetricians and Gyneologists, *Frequently Asked Questions FAQ085: Cervical Cancer Screening*, at 1 (Sept. 2017), https://www.acog.org/Patients/FAQs/Cervical-Cancer-Screening (underscoring the importance of routine cervical cancer screenings).

[35] *Committee Opinion No. 613: Increasing Access to Abortion*, *supra* note 34, at 1−2. (explaining that under-served women, including those who are low-income, experience the highest rates of

III. The Acts Infringe upon Women's Dignity and Autonomy and Interfere with the Patient-Physician Relationship.

In addition to the exceedingly burdensome compliance issues, the Acts are problematic because they intrude on women's autonomy and on her relationship with her health care provider. They have the potential to interfere with a woman's reproductive decision-making and impose significant emotional burdens at what may already be a difficult time in a woman's life.

The Supreme Court has long recognized that a woman's liberty interest encompasses her right to bodily autonomy, dignity, and respect in her private decision-making about her reproductive health. *See Obergefell v. Hodges*, 135 S. Ct. 2584, 2597, 2599 (2015) (explaining that the liberty right "extend[s] to certain personal choices central to individual dignity and autonomy" including "choices concerning contraception, family relationships, procreation, and childrearing"); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992) (noting that *Roe v. Wade* "may be seen not only as an exemplar of [the liberty right relating to reproductive decisions] but as a rule . . . of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate

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unintended pregnancy and abortion, and noting the importance of contraceptive care in reducing abortion rates); Heather D. Boonstra, Guttmacher Inst., *Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters*, Guttmacher Policy Review (July 14, 2016), https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters (finding that the unintended pregnancy rate among women with an income below the federal poverty level in 2011 was more than five times the rate among women with an income at or above 200% of poverty).

medical treatment or to bar its rejection"). The end of a pregnancy, whether spontaneous or induced, can be a challenging time. A woman's reproductive decisions should be informed by her doctor's sound medical advice and her own lived experience; the private decisions she makes that are legal and safe should be respected.

The vast majority of women who miscarry do not seek burial or cremation and interment of the embryonic or fetal remains of their pregnancy.[36] In fact, most women do not ask their doctors how such tissue will be disposed of at all.[37] Before the Acts, women already had the option under Texas law to request the miscarried remains for burial, cremation, or interment, if they so desired.[38] By mandating that women choose a method required for the disposal of human bodies, however, the Acts impose the State's own view of personhood, interfere with women's private

[36] *See, e.g.*, ROA.4647, ROA.4663−64 (testimony of Dr. Karen Swenson that in over 31 years of practice, she could not recall a single patient with a pregnancy loss before 20 weeks who requested a burial or cremation). Further, most women handle miscarriages at home, where the tissue is disposed of in a sanitary sewer. *See* ROA.4660−61 (testimony of Dr. Karen Swenson). While the Acts prohibit health care providers from disposing of embryonic or fetal tissue in a sanitary sewer, women who miscarry at home may still use this method. *See* 25 Tex. Admin. Code § 138.3(c)(5) (2018).

[37] *See* ROA.4661−62 (testimony of Dr. Karen Swenson that her patients "generally don't ask the specifics as to how the [embryonic and fetal] tissue is handled").

[38] Texas law previously treated embryonic and fetal tissue as pathological waste, which could be disposed of by interment. *See* 25 Tex. Admin. Code §§ 1.136(a)(4)(A)(ii), (a)(4)(B)(i) (1994); 25 Tex. Admin Code § 1.132 (1994) (definition of "interment"); *see also* ROA.4000 (testimony of Amy Hagstrom Miller, that WWH has "always offered [cremation or funeral services] at the patient' [sic] request"). Section 241.010 of the Texas Health & Safety Code permits hospitals to release fetal remains to parents for burial purposes.

decision-making, and add shame and distress to what is often an already stigmatized and emotional event.

For women seeking an abortion, the Acts may also interfere with their decision-making process. The tissue disposal requirements create an additional emotional hurdle to overcome for women deciding whether to terminate their pregnancies.[39] Women who do not want their tissue to be subject to the Acts may choose medication abortions instead of surgical abortions, even if surgical abortion is more in line with their physical and emotional needs.[40] As with miscarriages, the tissue disposal requirements may unnecessarily interfere with the patient-physician relationship,[41] which should be open, positive, and trusting.[42]

Moreover, doctors and other clinicians recognize the diversity of religious and philosophical perspectives among their patients concerning pregnancy and abortion.

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[39] *See* ROA.3984−85 (testimony of Amy Hagstrom Miller, explaining that patients seeking abortions at WWH already often struggle with their religious community's "framework of stigma and . . . shame" and their own independent grief).

[40] *See* ROA.4128−33 (testimony of Dr. Bhavik Kumar that certain women may prefer surgical abortions for, *inter alia*, privacy reasons).

[41] *See* ROA.5561 (43 Tex. Reg. 467 (Jan. 26, 2018)) (Texas District of ACOG commenting that the Acts may "compromise compassionate conversations between doctors and patients" about various types of pregnancy losses).

[42] Even if there is no benefit to a woman in making the decision, it is still hers to make. Texas's suggestion, in its response to public comments, that health care facilities should make the disposal determination without informing women of their options is paternalistic and incongruous with an open and trusting patient-physician relationship. *See* ROA.5564 (43 Tex. Reg. 470 (Jan. 26, 2018)) ("[T]he rules do not require that a patient be informed of or choose the disposition method."). If women are not informed of the disposal methods, they may become distressed to later learn that their embryonic or fetal tissue was disposed of in ways that conflict with their personal beliefs, such as in a burial by a private religious organization.

They are taught to be respectful of their patients' religious and spiritual differences.[43] By requiring the disposal of embryonic and fetal tissue in the manner associated with human remains, the Acts elevate certain religious beliefs over others and make compliance with the State's views a condition of obtaining medical care. Patients should not have to bear such an imposition on their autonomy, privacy, religious expression, or physical and mental health.[44]

CONCLUSION

In summary, Texas's embryonic and fetal tissue disposal requirements depart from the accepted standard of care, create increased risk to women's health, and intrude on women's bodily autonomy and the patient-physician relationship, all while providing no medical or public health benefits. The requirements needlessly burden pregnancy-related care and abortion services and may force the closure of abortion clinics, reducing access to reproductive care. *Amici* remain committed to ensuring access to the highest-quality reproductive health services for all women, and therefore respectfully request that the Court affirm the judgment of the District Court below finding the Acts unconstitutional.

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[43] ROA.3979−86, ROA.4011−12 (testimony of Amy Hagstrom Miller describing the extensive training WWH counselors go through, including on patients' "religious and spiritual beliefs" and describing how women may involve their religious beliefs and practices in the abortion procedure).

[44] ROA.4664−65, ROA.4669−79 (testimony of Dr. Karen Swenson that a policy of an Austin hospital to bury all fetal remains at a Catholic cemetery caused patients distress because it was inconsistent with patients' religious and philosophical beliefs).

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), I hereby certify that this brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 32(a)(7)(B) and 29(a)(5).

1. This brief complies with the typeface requirement of Federal Rule of Appellate Procedure 32(a)(5) and Fifth Circuit Rule 32.1 and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in proportionally-spaced Times New Roman font with 14-point type using Microsoft Word 2013, with the exception of the footnotes, which have been prepared in proportionally-spaced 12-point Times New Roman font.

2. Exclusive of the exempted portions of the brief, as provided in Federal Rule of Appellate Procedure 32(f) and Fifth Circuit Rule 32.2, the brief contains 5,549 words. As permitted by Federal Rule of Appellate Procedure 32(g)(1), I have relied upon the word count feature of Microsoft Word 2013 in preparing this certificate.

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CERTIFICATE OF SERVICE

I hereby certify that on January 10, 2019, I electronically filed the foregoing Brief of *Amici Curiae* the American College of Obstetricians and Gynecologists, the American Public Health Association, and the American Medical Association in Support of Plaintiffs-Appellees and in Support of Affirmance with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the CM/ECF system. Counsel for all parties to the case and *amici curiae* are registered CM/ECF users and will be served by the CM/ECF system.

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