No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMEN'S HEALTH, ET AL.,

Petitioners,

v.

KIRK COLE, M.D., ET AL.,

Respondents.

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

AMICUS CURIAE BRIEF OF JANE'S DUE PROCESS, INC. IN SUPPORT OF PETITIONERS

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AMICUS CURIAE BRIEF OF JANE'S DUE PROCESS, INC. IN SUPPORT OF PETITIONERS

Pursuant to Supreme Court Rule 37.2, Jane's Due Process, Inc. ("JDP") respectfully submits this amicus brief in support of the petitioners.[1]

IDENTITY AND INTERESTS OF AMICUS CURIAE

JDP is a non-profit legal referral service for Texas minors facing unintended pregnancies. A group of Texas lawyers founded JDP in 2000, after Texas enacted a parental notification law for minors seeking abortions which included a judicial bypass process.[2] Because of the confidentiality requirements of legal representation and the anonymity requirement of judicial bypass proceedings, JDP

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[1] Pursuant to Supreme Court Rule 37.2, JDP obtained written consent to file this amicus curiae brief from counsel of record for all parties. Pursuant to Rule 37.6, the undersigned counsel certifies that: (1) no counsel for a party authored this brief in whole or in part, (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity, other than JDP or its counsel, made a monetary contribution for the preparation or submission of this brief.

[2] *See* TEX. FAM. CODE ch. 33. In 2005, the Texas law was amended to require parental consent rather than notification. Act of May 25, 2005, 79th Leg., R.S. ch. 269 § 1.42, 2005 Tex. Gen. Laws 733-35 (amending TEX. OCC. CODE § 164.052).

refers to the minors as "the Janes." *See Bellotti v. Baird*, 443 U.S. 622 (1979); TEX. FAM. CODE ch. 33.

JDP's initial purpose was to provide the Janes with lawyers trained in handling judicial bypass cases. Recognizing the diverse and difficult circumstances of many pregnant minors, JDP broadened its mission to provide assistance with *any* legal issues concerning their pregnancies to ensure that every Jane could effectively exercise her right to decide whether and when to become a parent rather than be forced into an outcome by legal barriers or outside pressure. JDP also assists Janes who wish to continue a pregnancy but are threatened with domestic violence or other abuse, Janes continuing their education but experiencing Title IX violations, and Janes seeking emancipation.

The organization operates a 24/7 hotline to conduct intakes and provide accurate, unbiased information. JDP has only two full-time employees, an executive director and a hotline coordinator. The hotline is answered at all hours thanks to the commitment of volunteers from professional backgrounds including lawyers, doctors, and social workers. Hotline staff and volunteers are trained to assess a Jane's family, pregnancy, and safety situation and to develop a feasible plan of action for Jane to achieve her own goals after consulting with the friends, relatives, and counselors she trusts. JDP referral attorneys provide representation either pro bono or, when applicable, seek fees under the bypass statute. *See* TEX. FAM. CODE § 33.007.

While Texas has previously kept no precise statistics on the number of bypass cases due to

confidentiality concerns, it does track the number of cases for which attorney fees were paid and JDP tracks the number of Janes it assists in bypass proceedings. Prior to 2011, there were approximately 400 cases per year. After cuts to family planning services in 2011, other legislation described below, and the clinic closings resulting from the passage of HB 2,[3] the number has dropped to around 200 cases. While JDP does not assist every Jane seeking a bypass in Texas, it strives to do so, and appears to have assisted in the vast majority.

Because the grounds for obtaining a bypass to parental consent include whether a minor is "mature and well informed," JDP hotline volunteers and referral attorneys interview Jane about her decision-making process and the information she has about pregnancy and abortion. *See Bellotti*, 443 U.S. at 647; TEX. FAM. CODE § 33.003(i)(1). A second ground under Texas law, whether involving a parent is in Jane's "best interest," also requires that the interviewer explore her family situation, or lack thereof, and her ability to access health care safely without parental assistance. *See* TEX. FAM. CODE § 33.003(i)(2). Through these discussions, JDP has learned much about the difficulties of accessing health care, the deeply individualized decisions Janes make, and the nature of trauma and abuse with the harms they inflict. The Janes' experiences also

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[3] *See* Act of July 12, 2013, 83rd Leg., 2d C.S., ch. 1, § 3, 2013 Tex. Gen. Laws 5013. JDP refers to the statutes and regulations challenged by the petitioners collectively as "HB 2."

reminds that human reproduction is precarious, unpredictable business.

In the fifteen years since JDP began operations, Texas has enacted numerous laws restricting access to abortion and birth control. As part of its mission advocating for Texas minors facing unintended pregnancy, JDP closely monitors the Texas Legislature's efforts to regulate abortion and contraception including HB 2. Abortion restrictions typically impose a greater burden on a minor without supportive parents (or parents at all) than on adult women.

The passage of HB 2's admitting privileges and ambulatory surgical center ("ASC") requirements challenged in this case and the resulting widespread and repeated clinic closures, made access to reproductive health care services extremely difficult for all women — but especially for minors. Consequently, JDP's role has transformed from offering basic information and legal referrals to providing extensive case-management services to assist minors in navigating the practical and financial obstacles caused by Texas's legal restrictions. In the current climate of reproductive health care in Texas, if JDP were to neglect the financial and practical needs the Janes, they simply would not be able to access reproductive care. In fact, the climate in Texas is so hostile to abortion and access to reproductive health care so difficult that adult women needing assistance now contact JDP's hotline, as the only 24-hour service available. In these instances JDP refers women to other organizations for logistical help in accessing abortion care, and, in the process, learns more about the

realities on the ground in Texas and the cruel absurdities of restrictions such as admitting privileges on women's health and safety.

Because the mounting abortion restrictions in Texas have caused unnecessary burdens and hardships to Texas teens and all Texas women facing unintended pregnancies, Jane's Due Process submits this amicus brief for the Court's consideration.

SUMMARY OF THE ARGUMENT

The ASC and admitting privileges requirements of HB 2 cannot be analyzed in a vacuum. Instead, they are part of a concentrated effort by Texas to eliminate access to abortion. HB 2 interacts with other medically unnecessary and often harmful restrictions to construct obstacles to abortion care that are insurmountable for many women and burden most the women and teenagers who can bear it least.

It is one thing for the State to express a preference for life. But it is another thing altogether for the State to sanction animus against abortion and engage in a campaign to bully, stall, and coerce women out of an effective, timely choice to obtain an abortion. By enacting abortion restrictions that do not in fact protect the health of women, Texas is picking a side in a religious and moral debate thus demeaning women's individual freedom of conscience.

The recent Texas experience demonstrates that the lack of scrutiny into the State purpose and actual effect of restrictions has been devastating to women's lives and health. The hostile climate has pushed abortion care almost exclusively into clinics — which

HB 2 now threatens to close — ending abortion access for many Texans.

ARGUMENT

I. When an abortion restriction fails to protect women then the State essentially picks a side in a religious debate — a matter that should be left to an individual's conscience.

The Court in *Roe* was wise to not "resolve the difficult question of when life begins," noting that when those trained in medicine, philosophy, and theology can not agree, the judiciary should not speculate on the answer. *Roe v. Wade*, 410 U.S. 113, 159 (1973). But it did accept that protecting *potential* life was a legitimate state interest even while noting that philosophers, faiths, and even those within particular faiths differ. *Id.* at 181.

In *Roe* and its progeny this Court steadfastly maintained its framework for reviewing abortion regulations. Before viability, a woman may obtain an abortion without undue interference from the state, and the state may not impose substantial obstacles to her effective right to choose abortion. *Gonzales v. Carhardt*, 550 U.S. 124, 140 (2007); *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992). After viability, the state may restrict abortion so long as the law contains exceptions for the life and the health of the woman. *Id.* Finally, the state has a legitimate interest from the outset of the pregnancy in protecting "the health of the woman *and* the life of the fetus that may become a child." *Id.* (emphasis added). As this Court explained in *Gonzales*, *Casey* struck a balance between prohibiting the state from

imposing an undue burden via regulations that have the "purpose or effect of placing a substantial obstacle in the path of the woman" and allowing the state to impose a structural mechanism to "express profound respect for the life of the unborn" so long as doing so is not likewise a substantial obstacle. *Gonzales*, 550 U.S. at 146; *Casey*, 505 U.S. at 877.

The Fifth Circuit's "large fraction" formulation of the undue burden test in this case requires women to be harmed by state restrictions before a constitu–tional violation is acknowledged — as though the right to decide when and whether to become a parent is a collective right rather than an individual one — and should not stand. *See Whole Woman's Health v. Cole*, 790 F.3d 563, 586-88 (5th Cir. 2015). In practice, multiple problems arise with the Fifth Circuit's formulation.

First, if a regulation serves only to express the state's interest in potential life and does not in fact improve or protect women's health, then the regulation essentially picks a side in moral and religious debate. The harm of this religious side-picking is more stark when the State treats pre-viability embryos and fetuses as life — rather than *potential* life — of equal or greater importance than women's autonomy and dignity. Second, given the complexity of women's lives and reproductive health, one can never predict which of the myriad of medically unwarranted regulations imposes a substantial obstacle on an individual woman's choice.

Third, allowing the State to discourage abortion via regulations that do not in fact protect women's health allows a legislative purpose of unfettered,

State-sanctioned animus against abortion. This animus places a stigma on those who seek abortions and those who provide them that has the effect of both diminishing access and justifying hostility and even violence. In addition, this animus has the effect of demeaning the lives of women who seek an abor–tion and other reproductive health care. That the State may treat an established fundamental liberty with such hostility is constitutionally unacceptable.

II. The whole weight of Texas anti-abortion legislation imposes a burden greater than the sum of the parts.

HB 2's ASC and admitting privileges require–ments do not function in a vacuum. Texas has enacted a plethora of anti-abortion legislation feigning good intentions for women. But, as the severity and frequency of legislation has increased, the legislative purpose has shifted to pure animus and a desire to make abortion access extremely difficult if not impossible.

A. Texas law once attempted to comport with this Court's precedents.

In 1999, Texas enacted the Parental Notification Act to encourage parental involvement in a minor's decision to have an abortion. Act of May 25, 1999, 76th Leg., R.S., ch. 395, 1999 Tex. Gen. Laws 2466 (codified at TEX. FAM. CODE ch. 33). In JDP's experience, the law as initially enacted was carefully drafted to comport with the precedents of this Court and has largely functioned well to ensure the safety of vulnerable and abused teenagers in Texas. *See Casey*, 505 U.S. 899-900; *Bellotti*, 443 U.S. at 642-48.

In 2003, Texas enacted the so-called Woman's Right to Know Act ("WRTK Act") defining a laundry list of items required for "informed consent" for abortion including requiring review of a state-printed pamphlet describing risks of abortion and illustrating in color the gestational development of embryos and fetuses in two-week increments. Act of May 23, 2003, 78th Leg., R.S., ch. 999, § 1, 2003 Tex. Gen. Laws 2930 (2003) (codified at TEX. HEALTH & SAFETY CODE ch. 171). The pamphlet is long on the list of abortion risks but deceptively short on those for pregnancy. Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119:2 OBSTETRICS & GYNECOLOGY 218 (Feb. 2012). While the law also required that the pamphlet be objective, nonjudgmental, and convey accurate, scientific information about gestational development, it includes the medically-inaccurate assertion that abortions raise the risk of breast cancer. TEX. HEALTH & SAFETY CODE §§ 171.012(A)(B)(iii), 171.016(c). The statute at least respected the patient-physician relationship by explicitly allowing medical professionals to correct the material when counseling patients. *See* TEX. HEALTH & SAFETY CODE 171.013(c).

The 2003 Act included other provisions restricting abortion unrelated to consent, such as restricting abortions of "fetus age"[4] of 16 weeks or

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[4] Texas abortion restrictions are riddled with medically inaccurate terms, undefined terms, and language enacted without deference to science. While Section 171.004 uses the

more to an ASC and allowing only physicians to perform abortions. *See* TEX. HEALTH & SAFETY CODE §§ 171.003, 171.004. In addition, the Act lowered the trigger for abortion clinic licensing from performing 300 abortions annually to either performing ten a month *or* merely advertising abortion services. *See* TEX. HEALTH & SAFETY CODE §§ 245.004. This forced physicians who performed abortions as part of a larger medical practice to start referring their patients to the clinics.

B. Texas has recently amplified the intensity and frequency of its anti-abortion legislation.

In the last five years, abortion restrictions in Texas have become more ruthless and further removed from standards of medical practice. Any provider who "affiliates" with an abortion provider is prohibited from receiving state funding. Medical emergency exceptions are more onerous and ignore the inherent uncertainty of pregnancy health risks. Finally, the ruse of an intent to protect women's

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term "fetus age" other statutes refer to the stage of a pregnancy in terms of last menstrual period ("lmp"). *E.g.*, 25 Tex. Admin. Code § 139.2(53). HB 2 added "post-fertilization age" a part of its ban on abortions after 20 weeks. TEX. HEALTH & SAFETY CODE § 171.042. Texas law also defines "fetus" as a human organism from "fertilization until birth" even though to medical professionals the term denotes development from the end of eight weeks gestation. *Cf.* TEX. FAM. CODE § 33.001(2); 25 Tex. Admin. Code § 139.2(19) *to Fetus*, THE FREE DICTIONARY, http://medical-dictionary.thefreedictionary.com–/fetus (collecting medical definitions).

health has given way to an overt, biennial political sport of anti-abortion legislation.

In 2011, Texas drastically cut family planning funding and strictly enforced a ban on funding to anyone or institution that "affiliated" with an abortion provider, such as Planned Parenthood, which then had an extensive network of family planning clinics (distinct from abortion clinics) throughout Texas.[5] *See* TEX. HUM. RES. CODE § 32.024(c-1) (no women's health care funds "used to perform or promote elective abortions, or to contract with entities that perform or promote elective abortions or affiliate with entities that perform or promote elective abortions"). In an attempt to recreate the longstanding network of family planning providers, Texas created the "Texas Women's Health Program" ("TWHP"). To participate in TWHP all providers must sign a certification that they will not:

- perform or promote abortions even outside the scope of TWHP (i.e., for physicians in private practice),
- "affiliate" with an entity that "performs or promotes elective abortions," or
- "promote" abortion within the scope of TWHP.

25 Tex. Admin. Code §§ 39.31, 39.38.[6]

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[5] Tan Thanh, *Day 15: Texas Family Planning Slashed*, TEX. TRIBUNE, Aug. 15, 2011, *at* http://www.texastribune.org/2011/–08/15/day-15/.

[6] *See* TWHP Certification Form, *at* http://www.tmhp.com/–Provider_Forms/F00124_Texas_Womens_Health_Certification.pdf.

Also in 2011, Texas enacted legislation to amend the WRTK Act requiring that the *same* physician performing the abortion perform a sonogram on the patient 24 hours before the procedure, display and explain the results, and play any fetal heartbeat. Act of May 5, 2011, 82nd Leg., R.S., ch. 73, §§ 1-3, 2011 Tex. Gen. Laws 342. The same-physician requirement proved, as intended, extremely disruptive because clinics, like hospitals and other medical facilities, are staffed by physicians with varying schedules. Moreover, a sick day or family emergency for a clinic physician becomes a denial of health care for the patients scheduled that day because another physician cannot be substituted.

The exceptions to protect the health and life of the woman have become more onerous. The law formerly defined medical emergencies more broadly as when an abortion is "necessary to prevent the death or a substantial risk of serious impairment to the physical or mental health of the woman." Act of May 30, 1987, 70th Leg., R.S., ch. 469, § 1, 1987 Tex. Gen. Laws 2058 (codified at TEX. HEALTH & SAFETY CODE § 170.002(b)(2)). More recently enacted definitions limit medical emergencies to physical conditions even exempting self-inflicted physical harm. TEX. HEALTH & SAFETY CODE §§ 171.002(3), 171.046 (exempting from "medical emergency" a diagnosis that "the woman will engage in conduct that may result in her death" or serious physical harm). Multiple medical emergency definitions also require an "immediate" abortion to avoid death or physical harm. TEX. HEALTH & SAFETY CODE §§ 171.046(a)(1), 285.202(a)(1). This immediacy requirement ignores the difficulty of determining

exactly when a pregnancy could turn fatal as illustrated by the experience recounted in part III.C. below.

The biennial anti-abortion legislation continued in 2015 with fundamental re-write of the parental bypass law which repealed protections for the anonymity and confidentiality of the minor and the expeditiousness of the process. Tex. HB 3994, 84th Leg., R.S. (2015); *see Bellotti*, 443 U.S. at 644.

C. The obstacles Texas law places in the paths of women seeking abortion are as individualized as each woman's decision.

Just as the decision to terminate a pregnancy is very individual, the logistical obstacles Texas imposes on a woman are very individualized as they are dictated by her circumstances in life and by geography. One woman's road bump may be another's insurmountable obstacle. For those minors who do not have parents or parental support in their decision, the burdens are more difficult to bear. The myriad of restrictions have a multiplying effect as one exacerbates the harm of another, resulting in a whole burden that is greater than the sum of the individual burdens imposed by state law. Moreover, when abortion restrictions in practice eliminate clinics, there are no exceptions for rape, fetal abnormality, health, or medical emergencies.

The vastness of Texas and difficulty of travel for anyone, particularly those young or poor women who may not have a car, cannot be overstated. In West Texas for example, the closure of clinics in Midland, San Angelo, Abilene, and Lubbock immediately imposed substantial burdens on West Texas women.

From San Angelo, a city with a university and a military base, the nearest open clinic is in excess of 200 miles and a three-hour drive one way. From Lubbock, a city with a major public university of approximately 35,000 students, the nearest open clinic is in excess of 300 miles and a four-and-a-half hour drive one way. From Midland, an area reeling economically from the drop in oil prices, the nearest open clinic is in about 300 miles and in excess of a four-hour one-way drive. Even if Texas could rely on other states to comport with the Constitution, the nearest New Mexico clinic is even farther. There is no public transportation system to connect many small towns to larger ones. Bus service from the larger towns to the cities with the remaining clinics is infrequent and even more time consuming.

For the undocumented, travel poses greater hazards. The presence of border patrol, Texas Department of Public Safety, and Texas National Guard[7] make travel within Texas itself difficult for more than 100 miles into Texas. Checkpoints exist not only on highways running north to San Antonio such as IH-35 or U.S. Highway 281, but also on east-west routes such as U.S. Highway 90 and IH-10.[8]

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[7] *See* Julián Aguilar, *Abbott Orders National Guard to Stay in Place On Border*, TEX. TRIBUNE, Dec. 15, 2015, http://www.–texastribune.org/2015/12/15/abbott-orders-national-guard-stay-place/.

[8] *See* Wikipedia, United States Border Patrol Interior Checkpoints, *at* https://en.wikipedia.org/wiki/United_States_–Border_Patrol_interior_checkpoints.

Even in urban areas, the travel times caused by closed clinics can match those experienced by rural women. The Whole Women's Health clinic that closed in Austin was near suburban Williamson County (population in excess of 400,000). Traveling the thirty miles south to the remaining two clinics in Austin, south of the Colorado River, may take up to two hours given the heavy traffic that plagues the fast-growing area and routinely bottle-necks at the river crossings. Women from the next county north, Bell County (population in excess of 300,000 and home to Fort Hood, one of the largest military bases in the country), face even greater traffic hurdles traveling through Williamson County with its additional routine and unpredictable bottle-necks at major highway intersections.

It bears repeating that time is of the essence when access to abortion is the issue. Individual women facing unintended pregnancies do not have time to vindicate their fundamental rights and liberty in federal court. In addition to the develop–mental nature of pregnancy, its unpredictable symptoms may delay a woman discovering she is pregnant. She may not menstruate regularly and thus not suspect she was pregnant for several weeks or even a few months. She may have had surgery or a medical condition that caused irregular bleeding and masked her pregnancy. She may also be simply too young to recognize what the changes to her body indicate.

Moreover, the few weeks between discovering she is pregnant and approaching the second-trimester move quickly when she is seeking medically-reliable information and resources. Texas policy of

ostracizing abortion providers and their "affiliates" is coupled with guiding women to centers that do not provide health care but exist to discourage abortion may further delay her access to a bona fide abortion clinic. She may seek a pregnancy test and sonogram at a state-supported "crisis pregnancy center" only to be told to come back for the sonogram the next week, or the week after that.[9] Indeed, JDP regularly encounters Janes who were effectively stalled for weeks by the tactics of these clinics.

State-imposed delays often push women past fourteen-weeks gestation and thus force them to undergo a dilation and evacuation ("D&E") rather than dilation and curettage ("D&C"). D&Cs are far safer than childbirth (as all abortion procedures are) and somewhat safer than D&Es.[10] D&Es are a two-day procedure and require the patient to leave the clinic with laminaria inserted in the cervix which serve as natural osmotic dilators and return on the second day for the abortion. *See Gonzales*, 550 U.S. at 135-36. For patients with medical conditions, returning home the second day can be frightening

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[9] *See* TEX. HEALTH & SAFETY CODE §§ 171.012(a)(3)(B)(iv), 171.015(1)(A)(iv) (requiring information on agencies that offer free sonograms but do not provide abortions); NARAL ProChoice Texas, *Crisis Pregnancy Centers Exposed*, Delay Tactics (2014), *at* http://txpregnancy.org/delay-tactics/.

[10] *See* Linda A. Bartlett *et al.*, *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103:4 OBSTETRICS & GYNECOLOGY 729 (Apr. 2004) (relative risk increases 38% per gestational week); Raymond & David at 217. In fact, the relative safety of abortion compared to pregnancy has increased substantially since legalization. *Id.* at 217.

and expose them to greater risk. For women living in an abusive household who have concealed the pregnancy from their abuser, returning home exposes them to great risk of abuse should the pregnancy be discovered. That the State through its regulations can delay access to health care and force a woman to undergo a more invasive, more expensive, and more dangerous procedure cannot comport with the Due Process protections of the Constitution.

III. Texas law driven by animus against abortion endangers the health and harms the dignity of Texas women.

The individual experiences of Janes, minors with parental support, and even adult women demonstrate the burdens the clinic closures and ongoing, unfettered State-sanctioned animus against abortion impose. The drumbeat of Texas abortion restrictions has made access to abortion an undignified game of chance. When women with compromised pregnancies need or prefer having their abortion in a hospital, as a practical matter, doing so is next to impossible.[11]

A. The logistical difficulty of accessing abortion care is more burdensome for the Janes.

Having helped prepare thousands of Janes for bypass hearings over the last fifteen years, JDP has a

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[11] Typically less than one-quarter of one percent of abortions in Texas occur in a hospital. *See* Dept. of State Health Servs., Vital Statistics Annual Reports, Abortions, Table 38 http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm (.21% in 2013).

deep understanding of how unique, individualized, and personal each Jane's experience and decision are. JDP and its referral attorneys interview each Jane about what she thinks — not what someone has told her to think — about her pregnancy and her decision. By encouraging the Janes to articulate the deeper reasons for their decision to prepare them for court, JDP helps them find a sense of autonomy and dignity their family and other life circumstances may have denied them. Some Janes view abortion as a medical procedure no different from any other, not sharing the views of those who see it as a horrific immoral act. Other Janes view abortion as a morally complex subject and make their decision based on their personal values, faith, and situation. Some Janes were opposed to abortion on moral or religious grounds until they were faced with an unintended pregnancy and the gritty reality of their situation changed their views.

A Jane who shared the Catholic faith of her parents, when asked how she reconciled her faith with her decision replied: "My God is a loving God, and I know He will forgive me." Another Jane had protested with her church the very clinic from which she sought health care. When faced with an unintended pregnancy herself, she weighed her individual situation, and decided abortion was the best course for her. Each Jane, as does each woman who chooses abortion, exercises her "right to define [her] own concept of existence, of meaning, of the universe, and of the mystery of human life." *See Lawrence v. Texas*, 539 U.S. 558, 574 (2003) (quoting *Casey*, 505 U.S. at 851).

A Jane living near Corpus Christi no longer could obtain abortion care in the city closest to her home. Instead, she had to travel more than 100 miles (or about an hour and a half by car) to San Antonio to receive medical care for her unwanted pregnancy. She had to make two trips — one for the WRTK sonogram lecture and one for the abortion itself. She was able to get a ride from friends for the first visit and convince them to wait and drive her home.

But on the second visit, after she received a judicial bypass from a court near her home, her friends could not provide a ride. She did not have a car nor enough money to pay for the $50 bus ride. Even if she did have the $50, there were only a few buses from her small town to San Antonio each day, and none would get her to San Antonio early enough for her clinic appointment. Changing her appoint–ment to a slot later in the day would mean waiting about two more weeks until an appointment was available. The Jane could take a bus to San Antonio the night before, but she would have nowhere to sleep, as she was too young to check into a hotel and did not have the money.

JDP found a volunteer to drive to Jane's home town at 6 a.m. to pick her up where she was waiting on the side of the highway, and drive her to the clinic in San Antonio. Her boyfriend then took the bus to San Antonio so that he could be there when she was done with the procedure, planning to take the bus home with her. Jane called JDP for help again after her procedure because the teenagers did not know how to get from the clinic to the bus station — they were walking along the highway at dusk, neither of them having taken a taxi before. After JDP made

several calls to different taxi companies, one came and picked them up. The teens arrived back home around midnight.

Even Janes who have parental support face State-imposed obstacles. Indeed, during the period when the McAllen clinic was closed, a mother in the Rio Grande Valley called JDP seeking assistance with a judicial bypass for her pregnant daughter. While the mother supported her daughter's decision to terminate a pregnancy, because of her immigration status she was unable to accompany her daughter to San Antonio to sign the parental consent form in person. Her daughter, a U.S. citizen, would be able to travel freely through the checkpoint. The mother also wanted to accompany her to support her and did not want to her daughter to travel on her own and navigate getting from the bus station to clinic and back home by herself.

All told, the time JDP spends with each Jane has increased dramatically since HB 2. Before, the hot–line staff simply explained the bypass process to a Jane and referred her to a trained attorney. Now, the hotline staff stays involved from the first call until the Jane returns home safely after the procedure, spending hours helping her obtain an available clinic appointment and navigate transpor–tation options, and coordinating with sources of abortion funds to help her pay the mounting costs.

B. For a family in crisis, the burden to obtain an abortion is unsurmountable without the help of JDP and other organizations.

June[12] is the mother of four daughters ranging from school age to adulthood. A few years ago, her husband was sent to state jail for theft, leaving her a single mother. She left her home for the West Texas oil patch searching for employment that would support her family. She found a good office job, but housing was in short supply and extremely expensive given the then-booming local economy. She took in a co-worker as a boarder to help pay bills and help him with a place to live. At times, he helped look after her younger daughters while she worked. Over time, the roommates became a couple.

As oil prices fell and the oil patch turned sour, June and her new boyfriend moved back to Central Texas to look for work. Their initial searches were not successful. One day her oldest daughter took her youngest, Nancy, a fifth grader who had just turned twelve, for an outing, while June and her boyfriend ran errands.

While the sisters were together, the oldest noticed a mark on her little sister's neck. Nancy was strangely reluctant to talk about it, so her sister asked more questions and coaxed answers. Nancy explained her mother's boyfriend made the mark, and he had been doing things to her she did not like for

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[12] June consented to publicly telling her family's story but because her daughter is a minor she chose to use pseudonyms.

quite a while. She was scared. He had threatened her that if she told anyone what he did he would hurt her mother. Her sister drove her straight to the emergency room.

The doctors examined the girl and discovered she was more than seventeen weeks pregnant. They had a sexual assault nurse exam (commonly known as a "rape kit") conducted to gather evidence. When they explained to the girl that she was pregnant, she was quite adamant that she did not want to have a baby. Her older sister had recently given birth so she understood how much childbirth hurts and what having a baby around to take care of was like. Nancy had only reached menarche a few months earlier. Her stature and the width of her hips were those of a small-framed child and not those of an adolescent.

The hospital contacted law enforcement and child protective services ("CPS"). Back at the family's apartment, June knew nothing was amiss until she and her boyfriend were walking through the parking lot. She heard someone call their names and turned to see two police officers. The female officer separated June and told her that her boyfriend was "messing with your daughter." June was puzzled but, as she began to understand what the officer meant, she assumed she meant her oldest. When the officer told her Nancy was in the hospital June took off running after her boyfriend, who had been walked in another direction by the male officer, swinging her purse at him while scanning the ground for the biggest rock she could find. The officers restrained her and arrested him for sexual assault.

When June got to the hospital she initially was not allowed to see her daughter. Out of caution, law enforcement and CPS were making sure that Nancy's mother was not involved in the sexual assaults. CPS met with the family and asked June to agree to place her daughter temporarily with a family friend. Confusion as to who could consent to Nancy's further medical care ensued.[13] The medical providers were unsure whether and when the mother could see her daughter. An adolescent health care specialist met with Nancy and again provided her with options counseling about her pregnancy. Again, the child was adamant: she did not want to have a baby.

Although Nancy was kept overnight at the hospital, no steps were taken to perform the abortion she wanted. The hospital had a committee that would have to approve terminating the pregnancy. The ob-gyns were not trained in or accustomed to performing the D&E procedure the stage of Nancy's pregnancy required. In addition, nurses and other medical staff would have to be recruited and assembled for the team. Finally, the hospital had now merged with a religiously affiliated hospital, so there was a question of how much latitude the committee would have. It was easier just to refer the family elsewhere.

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[13] A Texas CPS caseworker may not approve or authorize an abortion or sign abortion-related medical consent forms. TEX. DEP'T OF FAMILY AND PROTECTIVE SERVS., CHILD PROTECTIVE SERVS. HANDBOOK, § 11751(3), *at* https://www.dfps.state.tx.us/–handbooks/CPS/Files/CPS_pg_x11700.asp#CPS_11750.

The stress and confusion of her daughter's rape by a man she trusted and the criminal and CPS investigations were overwhelming. June's mind also raced about the pregnancy. She had always been opposed to abortion on religious grounds. She wondered if her daughter could continue the pregnancy, then have labor induced at a later stage, and give the baby up for adoption. But after talking to the physicians and understanding their concern for her daughter's health she quickly agreed with her daughter's decision to have an abortion.

Arranging to get her daughter to an abortion provider was another ordeal. The ongoing criminal investigation and temporary "voluntary" placement of Nancy outside the home complicated matters. In the days between the initial hospitalization and the abortion, June went to visit her daughter at her friend's home and found a detective there. The detective knew the family had chosen abortion because she had been tasked with retrieving the fetal tissue for DNA testing as evidence of the sexual assault. She proceeded to question that choice, cloaked with the power of the State, and offered to find a family to adopt the child if June would force her twelve-year old daughter to continue the pregnancy and give birth. With much trepidation, as she knew she was under investigation and risked losing her daughter, June declined.

Because June's legal status as a parent and continued access to her daughter were in question and because the time to obtain a legal abortion was short, Nancy went through the judicial bypass process to ensure the clinic could legally perform the abortion. June had no car for transportation and no

money to pay for the procedure or housing in a distant city while the two-day procedure took place. JDP arranged for an attorney to represent Nancy then helped June and Nancy's temporary foster mother connect to Fund Texas Choice[14] and other sources to help pay for travel to and housing in a city where there was a clinic that could adequately handle Nancy's treatment. All told, obtaining an abortion for Nancy took two weeks given the reluctance of the hospital, the confusion of the ongoing investigation, the preliminary legal requirements for an abortion, and the availability of a clinic that could perform a D&E on so delicate a patient. In retrospect, June does not know how she would have been able to get the health care her daughter needed and wanted without the help of Jane's Due Process, the abortion funds created after HB 2's passage, and the extraordinary efforts of abortion clinic's staff.

C. For a mother, Texas laws make accessing abortion dangerous and traumatizing — and her physician's admitting privileges are of no help.

Because of the conditions in Texas after HB 2, adult women contact JDP looking for help. The story of one illustrates how State-sanction animus against abortion both harms women's health by limiting access to abortion care and demeans their dignity.

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[14] Fund Texas Choice is one of many abortion funding and logistics organizations that Texans formed after HB 2. *See* http://fundtexaschoice.org/about-us/.

Sarah[15] is a teacher, a wife, and a mother. In early March, she learned she was pregnant with her second child — news that thrilled her and her husband. But by late April she started bleeding heavily accompanied by cramping that left her bed ridden. Initially, examinations and sonograms could not diagnose anything wrong with her pregnancy. At approximately seventeen weeks, she had her anatomical screening at a maternal fetal health facility and was diagnosed with placenta previa — a condition where the placenta partially or completely blocks the endocervical os (the opening of the cervix into the birth canal).[16]

Women with placenta previa and related conditions of abnormal placenta placement must deliver via cesarean section or risk fatal hemorrhaging during delivery.[17] These conditions

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[15] Sarah is a pseudonym. When Sarah first contacted JDP and decided to tell her story, she intended to use her complete real name. But the November fatal shooting at the Colorado Planned Parenthood clinic changed her mind in the interest of her daughter's and her family's safety. *See* Julie Turkewitz & Jack Healy, *3 Are Dead at Colorado Springs Shootout at Planned Parenthood Center*, NEW YORK TIMES, Nov. 27, 2015, http://www.nytimes.com/2015/11/28/us/colorado-planned-parenthood-shooting.html?_r=0.

[16] Silver, Robert, M., M.D., *Abnormal Placentation: Placenta Previa, Vasa Previa, and Placenta Accreta*, 126:3 OBSTETRICS & GYNECOLOGY 654 (Sept. 2015).

[17] *See* Silver at 656; Comm. on Obstetric Practice, Am. College of Obstetricians and Gynecologists, Comm. Op. No. 529, *Placenta Accreta* (July 2012); H. Jacob Saleh, M.D., *Placenta Previa and Accreta*, Etiology/Pathogenesis, GLOB. LIBR. WOMEN'S MED.,

are major causes of maternal morbidity and mortality.[18] The incidence of previa has increased dramatically over the last few decades.[19]

Sarah's physicians advised her that a cesarean section may be required for her to deliver her baby safely and requested she return in four weeks to see if her placenta had migrated to a safe position as commonly occurs with previa.[20] Her physicians also warned that should she go into labor and start delivery vaginally she would hemorrhage danger–ously. A week later, while on a planned vacation out-of-state to visit family, Sarah began to bleed heavily. She went to a local emergency room where a physician examined her and told her that her water had broken, she would miscarry within six days, and should be on bed rest. She called her ob-gyn at home in Texas who was not so sure of the inevitability of a miscarriage and wished to confirm that Sarah's water had broken. As is often the case with women's reproductive health and pregnancy, it is difficult to know even an approximation of the risk of harm to a woman's health. On Saturday July 4, after a few days' bed rest, she flew home to Texas. She had to be

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(2008), *at* http://www.glowm.com/section_view/item/121/–recordset/18975/value/121.

[18] ACOG Comm. Op. No. 529; Saleh, Introduction, Treatment.

[19] Silver at 654. Current incidence in the United States is about 1 in 200 pregnancies. *Id*. The prevalence of placenta accreta has increased dramatically in the last few decades from 1 in 30,000 pregnancies in the 1960s to rates as high as 1 in 300 pregnancies today. *Id*. at 659.

[20] *Id*. at 655.

transported on and off the plane in a wheelchair and was terrified throughout the flight that she would begin hemorrhaging uncontrollably.

On Monday, she went to an appointment her ob-gyn had arranged with a maternal fetal health specialist (an ob-gyn who specializes in high-risk pregnancies). The specialist informed her that she indeed faced the worst-case scenario: her water had broken, her baby had no chance of survival, and she was in danger of hemorrhaging, potentially fatally, should she go into labor or otherwise complete her inevitable abortion.[21]

Her physicians advised she obtain an abortion as soon as possible. If she did not, she could experience "catastrophic" hemorrhaging, and her husband could come home to find her on the floor in a pool of blood. But neither of her physicians could perform the abortion on their patient. Both physicians told Sarah this was so because the fetus "still had a heartbeat." The reasons her two physicians could not give their patient the care she needed immediately are many and driven by Texas's statutory scheme discouraging abortion, the nature of modern medical practice, and

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[21] "Inevitable abortion" is not a turn of phrase but a term of science to describe a pregnancy that has failed and spontaneous abortion (or miscarriage) is inevitable but has not occurred. *See* Craig Griebel *et al.*, *Management of Spontaneous Abortion*, 72(7) AM. FAM. PHYSICIAN 1243-50 (Oct. 2005), *at* http://www.aafp.–org/afp/2005/1001/p1243.html#; *Inevitable Abortion*, THE FREE DICTIONARY, *at* http://medical-dictionary.thefreedictionary.–com/inevitable+abortion (collecting medical definitions).

the effects of years of state-sanctioned animus against abortion.

Texas defines "abortion" to exclude procedures to evacuate a dead fetus from a woman's body and include procedures that "cause the death" of a fetus, then heavily regulates "abortion" and facilities where an "abortion" takes place. *See* TEX. HEALTH & SAFETY CODE §§ 171.001(1), 171.002(1); 39 Tex. Admin. Code § 139.2(1). This is despite the fact that medicine commonly defines "abortion" as any act to evacuate an embryo or a fetus from a woman's body, including "spontaneous abortions" or miscarriages.[22] These Texas statutory definitions are written without regard to the health and safety of the woman or the natural course Sarah's pregnancy took where miscarriage is inevitable, but there is still a lingering fetal heart–beat. If a procedure meets the State's definition of abortion then the rest of Texas's anti-abortion statutory scheme comes into play pushing procedures almost exclusively to abortion clinics.

Second, while modern medical practice has increasingly moved to a specialist, assembly line model of treatment, physicians have long referred their patients to abortion clinics where the procedure could be provided in a more cost-effective manner in a specialized, supportive environment. *See* CAROLE JOFFE, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER *ROE V. WADE* 27-54 (Beacon Press 1995).

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[22] *See* Griebel *et al*.

Third, the stigma and animus surrounding abortion marginalize the practice to the clinics. The violence against abortion providers scares many physicians away from the practice. As the animus against abortion has increasingly become State-sanctioned in Texas, any physician whose practice is touched by government funding of any form fears endangering that funding. *See* TEX. HUM. RES. CODE § 32.024(c-1).

Sarah's maternal fetal health physician immediately phoned a physician at Planned Parenthood to refer her patient for abortion care. The Planned Parenthood physician is one of the few who has been able to obtain admitting privileges. Both physicians explained to Sarah that the options for obtaining the abortion were at the abortion clinic or a hospital, but that a hospital would have to first ask an "ethics" committee that would decide if performing an abortion on her was acceptable.

As scary as waiting for the decision of such a committee was to her, Sarah much preferred to be in a hospital and not at an out-patient ASC. Because of the stage of her pregnancy, the abortion procedure would be a D&E. She was at risk for massive blood loss and wanted to be in the safest place possible overnight. As a mother going through the loss of a child, she wanted the privacy of a hospital room for her recovery. Additionally, she wanted to be fully anesthetized for the procedure because she knew given the stage of her pregnancy, the abortion would be physically painful, and, as a mother losing a pregnancy she very much wanted, she also knew undergoing the procedure would be especially

emotionally traumatizing if she could remember every aspect rather than sleep through it.

Sarah went to Planned Parenthood to get the process of obtaining an abortion in Texas started with the 24-hour wait, detailed informed consent procedure, and sonogram required by the WRTK Act. *See* TEX. HEALTH & SAFETY CODE §§ 171.011-.018. When Sarah arrived at the clinic she asked to request that a hospital host her abortion. The Planned Parenthood physician called the hospital where she had admitting privileges to request a meeting of the ethics committee. Sarah then had yet another sonogram and still had to endure almost all of WRTK Act requirements. *See* TEX. HEALTH & SAFETY CODE § 171.0122. Under the Act, a woman has to receive a litany of information to meet Texas's standard for informed consent for abortion — a level of detail for medical consent that exists for no other procedure in Texas law. While this informed consent law contains a "medical emergency" exception it would not apply in Sarah's case of waiting for an emergency to occur nor would it take into account her emotional and mental suffering. *See* TEX. HEALTH & SAFETY CODE §§ 171.002(3), 171.0124.

Sarah had to sign a statement that, among other things, she understood "the nature and consequences of abortion" as though they were not burned into her consciousness losing a pregnancy she wanted. TEX. HEALTH & SAFETY CODE §§ 171.012(a)(5). While she could decline to view the sonogram image or hear the fetal heartbeat her physician was still required to display the image and play the sound, and she still had to hear the physician explain the sonogram images. TEX. HEALTH & SAFETY CODE §§ 171.0122.

Sarah cried harder and turned her head away as the clinic staff gently complied with the law. The exceptions to this medical lecture include rapes reported to law enforcement, minors who have judicial bypass court orders, and fetal anomalies. *Id.* Abortions required to preserve the life or health of the woman is not among the exceptions, nor may a physician not explain the images when a patient is having an abortion in a wanted pregnancy no matter how much mental suffering the physician observes in her patient. The Planned Parenthood staff apologized for putting her through this cruel and medically unnecessary "Right to Know" ordeal and treated her with great dignity and kindness, but the experience still added to her trauma.

That afternoon, Sarah called the clinic to find out what the hospital had said. She learned that the committee chair was out of town for eight days and the vice chair would be out of town for six. The Planned Parenthood physician explained to Sarah that she would be waiting at least a week for the committee to meet, that the decision could take 24-48 hours, and then a team of hospital employees would have to be gathered who could do the procedure. It was also unclear whether her physician would be able to do the procedure or whether operating room space could be procured. The bureaucratic procedures of "ethics" committees vary by hospital. Some meet only weekly or even monthly. Some, as was the case here, would not call a meeting when the chair was away. There was no emergency procedure even though there was a patient in an emergency.

Even if a committee does meet timely and approve an abortion there is the matter of who will

staff the procedure. Many ob-gyns, even maternal fetal health specialists, are not well trained in performing a D&E. Because hospitals so rarely perform abortions, there are no regular — much less experienced — teams of medical personnel. One must be assembled *ad hoc* resulting in further delays.

Indeed, the cumbersome nature of the hospital committee today raises many of the same problems recognized in *Doe v. Bolton*, 410 U.S. 179, 195-98 (1973). Given these bureaucratic hurdles, her physician advised Sarah would be best served undergoing the procedure at Planned Parenthood. Sarah reluctantly agreed because a delay of unknown length was too risky.

Thus, the physician's admitting privileges were of no help to Sarah or her health and safety. To be admitted to the hospital she would have to run the risk of waiting until she was hemorrhaging and rush to the ER, then be treated by whatever physicians happened to be at work who would not know her medical history or have the time to learn it. If she went into labor and was lucky, she would make it to a hospital in time for an emergency cesarean section which could harm her and her ability to have children in the future (and increase her risk for previa in the future). If she were not lucky, she would die, leaving her three-year old daughter with no mother.

Sarah, her husband, his mother, and her best friend spent the afternoon attempting to find another hospital to host her abortion. They got nowhere.

Sarah's anguish over the loss of her child and fears about her safety were then mixed with an

intense feeling of violation. She was being denied the medical care that she needed and wanted. She had considered going out of Texas for the procedure but the danger of hemorrhaging while traveling eliminated that option. Her only safe option was Planned Parenthood.

She returned the next day to begin the abortion procedure. She was now 19.7 weeks pregnant. Although her physician and Planned Parenthood's staff treated her with great compassion, she became hysterical with fear of hemorrhaging because she had to go home for the night. Her physician had to talk her down and explain again the dangers of delaying the procedure further while a hospital decided or having to start the whole legal procedure for an abortion again.[23] She had no choice but to return to Planned Parenthood for the second day of the procedure.

Finally, the next day, more than a week after her water broke, Sarah's abortion was completed. She was unable to be fully anesthesized at the ASC as she would have been at a hospital.[24] The procedure was painful physically and as she had feared, she could

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[23] Because he same physician who conducts the informed consent procedure must also perform the abortion once the process begins, if for any reason the patient needs to change physicians, she must start the process over again. *See* TEX. HEALTH & SAFETY CODE § 171.012(a)(1)-(4).

[24] Texas regulations limit what forms of anesthesia are available at abortion clinics including ASCs. 25 Tex. Admin. Code §§ 135.11, 139.53(a)(6), 139.59.

hear and feel each detail of the procedure, emotionally traumatizing her.

The wounds to Sarah's dignity have not healed. Since the ordeal she has regular nightmares. She has developed depression, extreme anxiety, and post-traumatic stress disorder and is receiving mental health care treatment. Sarah's experience comports with what JDP sees in the Janes. Trauma and psychological harm are not caused by abortion or pregnancy *per se*, but by being forced to do something with her life and her body she does not want to do and by being belittled, shamed, and abused because of her pregnancy or her choice to seek abortion care.

Sarah credits Planned Parenthood — which provided her with abortion care when no one else would — with saving her life and her future reproductive capacity. While her physician and the staff at Planned Parenthood did everything they could to make her experience as bearable as possible, Texas law tied their medical hands. In retrospect, she feels as though she "the State of Texas sexually assaulted and tortured me" and hopes by telling her story no one will have to endure what she did. She is now pregnant and at ten weeks gestation. She lives in constant fear that she could develop previa, lose her pregnancy, and have to climb again over the obstacles Texas places in her path to abortion care.

* * *

For Texas to claim its legislation is meant to protect the health of women when all logic, reason, and evidence demonstrates otherwise is absurd. Allowing Texas to enforce HB 2 calls into question whether Texas women really have our "own equal

dignity" under the law. *See Obergefell v. Hodges*, 135 S. Ct. 2584, 2608 (2015). Without this Court's intervention, Texas will continue to use State power to restrict the liberty of individuals no matter what faith or philosophy the individuals embrace or what painful medical difficulties they endure. This the Constitution cannot allow.

CONCLUSION

The decision of the Fifth Circuit should be reversed.

Respectfully submitted,

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