No. 15-274

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, *et al.*,

Petitioners,

v.

JOHN HELLERSTEDT, M.D. COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *et al.*,

Respondents.

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

BRIEF OF *AMICI CURIAE* BIPARTISAN AND BICAMERAL COALITION OF 121 TEXAS LEGISLATORS SUPPORTING RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

By its Constitution, the Texas Legislature is bicameral, with a State Senate and a State House of Representatives. The Senate has 31 members. The House has 150 members. The Bipartisan and Bicameral Coalition of Texas Legislators includes 121 Senate and House members, and former members who voted on HB2.

The Coalition members are:

Anderson, Charles, "Doc"	Bonnen, Dennis
Anderson, Rodney	Bonnen, Greg
Ashby, Trent	Burkett, Cindy
Aycock, Jimmie Don	Burns, DeWayne
Bell, Cecil	Burrows, Dustin
Bettencourt, Paul	Burton, Konni
Birdwell, Brian	Button, Angie Chen
Bohac, Dwayne	Campbell, Donna

1. The parties have consented to the filing of this brief. Under Rule 37.3(a) a letter reflecting the consent of the parties is submitted contemporaneously with this brief. Under Rule 37.6, *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than *amici* and their counsel made a monetary contribution intended to fund the preparation or submission of this brief.

Capriglione, Giovanni

Clardy, Travis

Cook, Byron

Craddock, Tom

Creighton, Brandon

Crownover, Myra

Cyrier, John

Dale, Tony

Darby, Drew

Elkins, Gary

Eltife, Kevin

Estes, Craig

Faircloth, Wayne

Fallon, Pat

Farney, Marsha

Fletcher, Allen

Flynn, Dan

Frank, James

Fraser, Troy

Frullo, John

Galindo, Rick

Geren, Charlie

Goldman, Craig

Gonzales, Larry

Hall, Bob

Hancock, Kelly

Harless, Patricia

Harper-Brown, Linda
(former member voting on HB2)

Hegar, Glenn
(Current Comptroller, former member voting on HB2)

Huberty, Dan

Huffines, Don

Huffman, Joan
Hughes, Bryan
Hunter, Todd
Isaac, Jason
Kacal, Kyle
Keffer, Jim
Keough, Mark
King, Ken
King, Phil
King, Susan
Klick, Stephanie
Kolkhorst, Lois
Koop, Linda
Krause, Matt
Kuempel, John
Landgraf, Brooks
Larson, Lyle
Laubenberg, Jodie
Leach, Jeff
Lozano, J.M.
Lucio, Jr., Eddie
Metcalf, Will
Meyer, Morgan
Miller, Doug
Miller, Rick
Morrison, Geanie
Murphy, Jim
Murr, Andrew
Nelson, Jane
Nichols, Robert
Otto, John
Paddie, Chris
Parker, Tan

Patrick, Dan
(Current Lt. Gov., former member voting on HB2)

Paul, Dennis

Pena, Gilbert

Perry, Charles

Phelan, Dade

Phillips, Larry

Price, Four

Raney, John

Riddle, Debbie

Rinaldi, Matt

Sanford, Scott

Schaefer, Matt

Schofield, Mike

Schubert, Leighton

Schwertner, Charles

Seliger, Kel

Shaheen, Matt

Sheets, Kenneth

Sheffield, J.D.

Simmons, Ron

Simpson, David

Smith, Wayne

Smithee, John

Spitzer, Stuart

Springer, Drew

Stephenson, Phil

Stickland, Jonathan

Straus, III, Joe

Taylor, Larry

Taylor, Van

Thompson, Ed

Tinderholt, Tony

Turner, Scott

VanDeaver, Gary

Villalba, Jason

White, James

White, Molly

Workman, Paul

Wray, John

Zedler, Bill

Zerwas, John

SUMMARY OF THE ARGUMENT

These Bipartisan and Bicameral Texas Legislators submit this brief in support of Respondents to highlight the legislative evidence that House Bill 2 (HB2) is the result of the Legislature's rightful concern to protect the health of Texas women. One of the core functions of the Legislature is to reasonably regulate the practice of medicine in Texas. TEX. CONST. art XVI, § 31. That responsibility includes the Legislature's obligation to intentionally and consistently assure access to quality women's health care.

This Court is already aware of the Kermit Gosnell tragedy in Pennsylvania, which resulted in a grand jury recommendation that facilities providing abortion services be held to standards similar to those imposed on ambulatory surgical centers. R.Br. 1. Gosnell's conduct triggered public outcry, and Texas citizens called for legislative action. *See* Maryclaire Dale, Associated Press, *Gosnell Case Fuels Bitter U.S. Abortion Debate*, BOSTON HERALD, May 16, 2016 (describing the impact of the Gosnell trial on legislatures nationwide); Allison Sullivan, *Texas Conservatives Hail Gosnell Conviction*, HOUSTON CHRONICLE, May 13, 2013 (summarizing the positions of several state legislators).

As described in more detail below, the bill that the Legislature eventually enacted was based on careful study of medical information. The Legislature encouraged public participation in its deliberations. It heard many days of public testimony from citizens and respected medical practitioners. Extensive medical evidence and discussion buttressed the Legislature's ultimate conclusion that HB2's ambulatory-surgical-center and admitting-privileges

requirements will protect the health of Texas women. But the district court below did not review *any* of the evidence that the Legislature considered before enacting HB2. Instead, the district court relied nearly exclusively on contrary medical evidence that Petitioners offered during the litigation and gave no weight to Respondents' rebuttal evidence. This, despite this Court's warning in *Gonzales v. Carhart*, 550 U.S. 124 (2007), that a legislature must have a "margin [for] error . . . to act in the face of medical uncertainty." *Id.* at 166 (citations omitted).

Because "[c]onsiderations of marginal safety . . . are within the legislative competence," *id.*, the Bipartisan and Bicameral Coalition of Texas Legislators support Respondents' request that this Court affirm the Fifth Circuit's judgment.

ARGUMENT

I. The Texas Legislature Enacted HB2 With The Express Purpose Of Protecting Women's Health.

This Court has recognized that, even in the context of abortion, weighing "the balance of risks [is] within the legislative competence when the regulation is rational and in pursuit of legitimate ends." *Gonzales*, 550 U.S. at 166. In enacting HB2, the Texas Legislature considered the ample medical evidence put before it and acted to protect women's health.

A. Regulating the practice of medicine is within the province of the legislature.

It is both the right and obligation of the state to ensure the health and welfare of its citizenry. *See, e.g. United States v. Salerno*, 481 U.S. 739, 755 (1987) (recognizing that "the safety and indeed the lives of its citizens" is the "primary concern of every government"); *Hennington v. Georgia*, 163 U.S. 299, 309 (1896) (referring to the state's obligation to "provide for the health, comfort, and safety of its people"). Texas has faithfully executed that duty for nearly 200 years.

From the earliest days of the Republic, Texas actively fostered the health and welfare of its people by regulating the practice of medicine. The Texas Constitution charges the Legislature with "pass[ing] laws prescribing the qualifications of practitioners of medicine." TEX. CONST. art. XVI, § 31. In 1837, Texas lawmakers enacted the Medical Practice Act to standardize the practice of medicine. Act approved Dec. 14, 1837, 2d. Cong., R.S., 2 REPUB. TEX. LAWS 39 (1898). The Legislature installed the first state health officer in 1879, and in 1909 established standards for nursing care. *See, respectively,* Act approved Apr. 10, 1879, 16th Leg., R.S., ch. 77, § 1, 1879 TEX. GEN. LAWS 86, 86; Act of Mar. 25, 1909, 31st Leg., 1st C.S., ch. 117, § 3, 1909 TEX. GEN. LAWS 228, 229.

The Texas Legislature has taken specific interest in the health of women, as evidenced by a well-established legislative record. In 1906, while visiting the state, President Theodore Roosevelt commended Texans for recognizing "[t]he thing which the State most needs," and encouraged other states to follow Texas's lead. PRES.

THEODORE ROOSEVELT, 1 A COMPILATION OF THE MESSAGES & SPEECHES OF THEODORE ROOSEVELT 604–05 (1906). After visiting Austin and several other cities, he described the priority Texas affords as the most impressive aspect of his week-long trip to the state.

Texas lawmakers have continued to regulate in the interest of women's health. By the 1930s, the Legislature had published obstetric and midwifery regulations and debuted a maternity health initiative.[2]

The legislation under attack by Petitioners is not without substantial history. It is an extension of Texas lawmakers' long tradition of legislating in the interest of women.

B. The public demanded legislative action in response to concerns over women's abortion care.

In the months preceding HB2's enactment, thousands of Texas citizens appeared before the Texas Legislature to express their views about whether the state had paid sufficient attention to the quality of care women receive during and after an abortion. The Texas Senate and House held many hours of hearings on several proposed enactments that were eventually rolled into Senate Bill 1

2. *See, respectively,* Act of Apr. 5, 1907, 30th Leg., R.S., ch. 64, § 1, 1907 TEX. GEN. LAWS 135, 135; Act of Apr. 17, 1907, 30th Leg., R.S., ch. 123, § 7, 1907 TEX. GEN. LAWS 224, 226; Act of Aug. 11, 1919, 36th Leg., 1st C.S., ch. 87, § 1, 1919 TEX. GEN. LAWS 399, 415; Act of June 14, 1923, 38th Leg., 3d C.S., ch. 28, § 1 1923 TEX. GEN. LAWS 235, 255.

and House Bill 2 (companion bills).[3] The Senate and House also held some 21 hours of hearings on the predecessor proposals.[4]

At these hearings, numerous medical practitioners appeared as resource witnesses to lend necessary medical expertise to the health care debate. For example, the Senate heard from Dr. Mayra Jimenez Thompson:

> Thank you, Madam Chair, thank you, committee members for allowing me to speak with you today. My name is Mayra Jimenez Thompson, and I am a board certified Ob/Gyn licensed to practice in the state of Texas for approximately 29 years. I practice in Dallas, and I have a

3. *See* Hearing on S.B. 1 Before the S. Comm. on Health and Human Servs., 83d Leg., 2d C.S. (July 8, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=495 (15 hours, 44 minutes); Hearing on H.B. 2 Before the H. Comm. on State Affairs, 83d Leg., 2d C.S. (July 2, 2013) http://bit.ly/1na1xmP (8 hours, 38 minutes).

4. *See* Hearing on S.B. 5 and S.B. 24 Before the S. Comm. on Health and Human Servs., 83d Leg., 1st C.S. (June 13, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=525; Hearing on S.B. 537 Before the S. Comm. on Health and Human Servs., 83d Leg., R.S. (Mar. 19, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=842; Hearing on S.B. 1198 Before the S. Comm. on Health and Human Servs., 83d Leg., R.S. (Apr. 16, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=452; Hearing on H.B. 2816 Before the H. Comm. on State Affairs, 83d Leg., R.S. (Mar. 27, 2013), http://tlchouse.granicus.com/MediaPlayer.php?view_id=28&clip_id=6765; Hearing on H.B. 60 Before the H. Comm. on State Affairs, 83d Leg., 1st C.S. (June 20, 2013), http://tlchouse.granicus.com/MediaPlayer.php?view_id=28&clip_id=6849.

> specialty in minimally invasive surgery. I am here because of my concern for the safety of the women in this state.

Hearing on S.B. 537 Before the S. Comm. on Health and Human Servs., 83d Leg., R.S. (Mar. 19, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=842 [hereinafter Mar. 19, 2013 Hearing] at 1:21:02–1:25:45 (testimony of Dr. Mayra Jimenez Thompson). As another example, the House heard from Dr. Ingrid Skop:

> My name is Ingrid Skop. I'm an obstetrician/gynecologist in private practice in San Antonio. I'm here to speak in support of the Bill. There have been some excellent questions asked up here and I hope to be able to address some of them with my experience. I do want to start by saying that as we all recall when abortion was legalized the primary reason was for the safety of women. There were terrible things that were happening to women prior to the legalization. And I think that's a bipartisan issue. I think that all of us in this room can say that we want women to be safe.
>
> * * *
>
> Again, going back to the issue of safety, that's what we all want. I don't think anybody, even if we want ready access, I don't think any of us want these women to be -- to get their procedure by someone who's not competent to perform it. Convenience should not trump safety, in my opinion.

Hearing on H.B. 2816 Before the H. Comm. on State Affairs, 83d Leg., R.S. (Mar. 27, 2013), http://tlchouse.granicus.com/MediaPlayer.php?view_id=28&clip_id=6765 [hereinafter Mar. 27, 2013 Hearing] at 2:40:47–2:48:15 (testimony of Dr. Ingrid Skop).

Other practitioners who testified included Dr. Mikeal Love, a board-certified obstetrician who is also the chairman of the continuing medical education committee that oversees physician education for seven Austin-area hospitals; obstetricians Dr. Jim Mauldin, Dr. Stephen J. Hilgers, and Dr. Pat Nunnelly; emergency-room physician Dr. Martha Garza; family practitioner Dr. Linda Flower, who also practiced and taught obstetrics; and anesthesiologist Dr. Mary Catharine Maxian. These practitioners all testified about how regulation of abortion providers affects the health of women. They told the Legislature that the new law would be "vitally important for the health of women in the state of Texas," *see* Hearing on S.B. 1 Before the S. Comm. on Health and Human Servs., 83d Leg., 2d C.S. (July 8, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=495 [hereinafter July 8, 2013 Hearing] at 7:08:00–7:09:05 (testimony of Dr. Stephen J. Hilgers), and would "provide much needed provisions for increasing the standard of care" for women undergoing abortions, Hearing on S.B. 5 and S.B. 24 Before the S. Comm. on Health and Human Servs., 83d Leg., 1st C.S. (June 13, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=525 [hereinafter June 13, 2013 Hearing] at 3:18:18–3:21:50 (testimony of Dr. Pat Nunnelly).

C. Legislators were clear that the purpose of HB2 was to protect women's health.

Throughout the extensive public debate about HB2, Texas legislators stated unequivocally that the bill's aim was to safeguard the health of Texas women who choose abortion. Referring to HB2's companion bill, Senate Bill 1, Senate sponsor Glenn Hegar stated on the Senate floor: "I firmly believe, from testimony, and everything I've read, that this bill raises the standard of care in Texas."[5] S. Floor Debate on S.B. 1 at 49:32 (July 12, 2013) http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=500 [hereinafter July 12, 2013 Floor Debate]. Though a critic of the legislation, Senator Leticia Van de Putte remarked: "I really believe my colleague Senator Hegar when he tells me that he really believes this is about the health and safety of women." *Id.* at 5:50:23. Senator Jane Nelson, co-author of SB 1, confirmed it was the Senate's job to make sure that patients are receiving care in a medically appropriate facility. *Id.* at 7:38:50. Responding to critics, Senator Nelson added:

> It may seem irrelevant to opponents whether these facilities have a door wide enough for an EMS or their doctor has admitting privileges, but I can assure you those issues would be very relevant to that woman whose life could be in danger. They are relevant to ensuring

5. House Bill 2 also added Subchapter. C, the Preborn Pain Act, to Health and Safety Code, Chapter 171. That subchapter prohibits a physician from performing an abortion if the physician determines that the probable post-fertilization age of the unborn child is 20 weeks or greater. This provision is not under attack here, though it was part of the legislative debates.

> that those horrific practices that we've heard about, of doctors like Gosnell, are never allowed to happen again and they sure aren't gonna happen in Texas.

Id. at 7:38:57–7:39:29.

Other senators echoed the concerns of the bill's sponsors. On the Senate floor, Senator Bob Deuell, a family practice physician, summarized studies finding worse complication rates for abortions performed at abortion clinics. He noted certain standards of care were not being followed, and he concluded: "It is up to the State, it's up to us, to intervene . . . [and] protect [women], and they're not being protected properly." *Id.* at 1:26:01. Senator Larry Taylor, remarking about the importance of physician credentialing in preventing doctors like Gosnell, emphasized: "Whether it's one doctor like that or ten, those—we shouldn't have any doctors like that treating any Texas women for any condition. *Id.* at 3:37:21. He went on to state: "So, by having this vetting process, the fact that you've actually been credentialed by some hospital, that you've been allowed to have admitting privileges at some hospital brings up the level of the bar, so to speak, of that doctor's professionalism. It might even help prevent-prevent some doctors like Doctor Gosnell and [Karpen] in Houston." *Id.* at 3:36:49–3:37:09. Senator Donna Campbell, an emergency room physician, commented: "This bill encourages the patient-doctor relationship, because it will improve care." *Id.* at 3:52:50. Senator Charles Schwertner supported the bill because it was important in protecting the health of women in Texas. *Id.* at 8:08:10. And Senator Eddie Lucio, Jr. praised the legislation because women deserved protection. *Id.* at 8:55:45.

Comments like these were not made only on the Senate floor. Introducing a similar legislative proposal that he co-authored, Senator Deuell testified to Committee:

> This bill is not intended to decrease abortions or to close any clinic that does abortions. . . . This bill is about raising the standards of clinics who do surgical abortions, to raise the standards and provide better care for those individuals.

Mar. 19, 2013 Hearing at 00:40–2:42.

The Senator went on to state:

> Members, the health and safety of all Texans is the top priority of this committee, and I think we want to make sure that our citizens know that any facility they will enter will offer a high standard of care and everything that is needed for their well-being.
>
> Abortion clinics are regulated by the State but they are not regulated as a surgical facility. They're governed by a lower standard than any other surgeries. This bill will provide that abortion facilities are regulated in the same manner as ambulatory surgical centers. This will only apply to clinics performing more than 40 abortions a year and will not apply to miscarriages.
>
> Members, this bill is generated in some controversy as any bill does in dealing with abortion, but my intent in filing this bill is

> simply to protect Texas women who undergo this procedure. I am pro-life, I make no secret of that. I make no secret of the fact that I don't think abortion should be legal. But I also face the reality that they are, and given that fact I think that we should take all precautions to make sure that an abortion, which is a surgical procedure, is done in the best manner possible.
>
> I would respectfully say that anyone that's opposing this bill is basically stating that they do not think that women who have made a decision to have an abortion should have the very, very best in medical care.

Id. at 1:01:02–1:02:41.

Representatives made similar statements in the Texas House. On the House floor, Representative Jodie Laubenberg stated that HB2 "addresses the health and safety for a woman who undergoes an abortion procedure." H. Floor Debate on H.B. 2 at 31:12 (July 9, 2013) http://tlchouse.granicus.com/MediaPlayer.php?view_id=20&clip_id=5095. She also emphasized, in responding to a question about facility design, that "anything that's going to improve the facility, that's going to help get better health care to this woman in case any complication should arise, is always a good thing." *Id.* at 39:40. While discussing the merits of HB2, Representative Carol Alvarado complimented Representative Laubenberg: "I have served with you on the Public Health Committee, and I know that you are a person that cares about women and the overall health and safety." *Id.* at 59:40.

Also on the House floor, Representative Phil King explained: "The bill doesn't ask for [doctors] to be admitted for the purpose of performing abortions. It asks for them to be admitted for the purpose of being able to treat their patient. . . . Where the bill seeks admitting privileges [is] for them to be able to treat their patient in an emergency." *Id.* at 4:29:53. And Representative Charles Perry encapsulated the House's intent: "Here's the goal of HB 2: provide [a] safe environment for [abortion] procedures to be done." *Id.* at 7:47:52. Indeed, even those opposed to the bill acknowledged that the legislature was acting in the interest of women's health. *See id.* at 8:06:35 and 10:29:30 (Representative Donna Howard and Representative Jessica Farrar).

Texas's Governor and Lieutenant Governor likewise emphasized that HB2's goal was to protect women. When signing the bill into law, then-Governor Rick Perry announced that the bill would "improve the quality of care women receive, ensuring that any procedure they undergo is performed in clean, sanitary and safe conditions, by capable personnel." Jordan Smith, *Perry Signs HB 2: Fight over Abortion Regs Will Move to Courts*, Austin Chronicle, July 18, 2013, http://www.austinchronicle.com/daily/news/2013-07-18/perry-signs-hb2/. And then-Lieutenant Governor David Dewhurst declared: "This is a bill that will improve and better protect women's health."[6] Morgan Smith *et al.*, *Abortion Bill Finally Passes Texas Legislature*, The Texas Tribune, July 13, 2013,

6. Certain opposition amici cite a "tweet" from Lieutenant Governor David Dewhurst. The Lieutenant Governor presides over the Texas Senate, but is not a regular voting member, and Lieutenant Governor Dewhurst did not vote on this legislation.

http://www.texastribune.org/2013/07/13/texas-abortion-regulations-debate-nears-climax/.

II. The Legislature Heard Evidence That HB2's Ambulatory-Surgical-Center And Admitting-Privileges Requirements Would Enhance The Health And Safety Of Texas Women.

The many medical experts who testified during the hearings on HB2 and related bills made it clear that abortion is a medical procedure subject to serious risks and complications. They explained how the standards applicable to ambulatory surgical centers (ASCs) are important to the health of women undergoing both medical and surgical abortions and why requiring doctors who perform abortions to have admitting privileges at nearby hospitals also protects patients.

A. Experts testified that abortion is an invasive procedure that has serious risks and may cause life-threatening complications.

Abortion is an invasive surgical procedure. As several obstetricians testified, a surgical abortion "involves taking the uterus which is closed, the opening of the uterus is the cervix, and it is forcibly opened, which is called dilating, and the pregnancy contents are evacuated." Mar. 19, 2013 Hearing at 1:21:43 (testimony of Dr. Mayra Jimenez Thompson); *see also id.* at 1:23:22 (explaining that the uterus is forcibly opened with "metal dilators"). Early surgical abortions are performed by dilation and curettage (D&C), which "can be done either with a suction curette or with a sharp instrument, a curettage." Mar. 27, 2013 Hearing at 2:42:46–2:49:21 (testimony of Dr. Ingrid

Skop). Later abortions are often performed by dilation and evacuation (D&E), "which removes the fetal parts, often in a piecemeal fashion." June 13, 2013 Hearing at 2:33:26–2:37:39 (testimony of Dr. Ingrid Skop). Because it is "difficult to remove fetal parts entirely," "[t]his is a very, very tricky" and "dangerous" procedure. Mar. 27, 2013 Hearing at 2:43:35–2:49:21 (testimony of Dr. Ingrid Skop).

Even the earliest medical abortions performed with drugs may result in an invasive surgical abortion. Obstetricians testified that in medical abortions, "[t]wo medications are given, usually RU-486 and Misoprostol, which would withdraw the hormonal support of the pregnancy and induce contractions. However, about 20 percent of the time, these result in incomplete abortions. All of the tissue is not extruded. In those cases, a surgical D&C is required to complete the abortion." Hearing on S.B. 1198 Before the S. Comm. on Health and Human Servs., 83d Leg., R.S. (Apr. 16, 2013), http://tlcsenate.granicus.com/MediaPlayer.php?view_id=9&clip_id=452 [hereinafter Apr. 16, 2013 Hearing] at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop); *see also* Hearing on H.B. 60 Before the H. Comm. on State Affairs, 83d Leg., 1st C.S. (June 20, 2013), http://tlchouse.granicus.com/MediaPlayer.php?view_id=28&clip_id=6849 [hereinafter June 20, 2013 Hearing] at 03:48:34–03:51:39 (testimony of Dr. Mikeal Love) (presenting scientific study confirming that 20 percent of medical abortions resulted in adverse effects, including the "risk of incomplete abortion" and the "reevacuation of the uterus"). When a medical abortion is incomplete, "all the tissue has not passed and the woman experiences severe bleeding and often a lot of pain and she presents to an emergency room where she's generally admitted for an emergency D&C, sometimes for a blood

transfusion." Mar. 27, 2013 Hearing at 2:42:26 (testimony of Dr. Ingrid Skop).

Given the nature of abortion procedures, serious complications can and do arise. In addition to the possibility of retained fetal tissue, another major risk is uterine perforation. *See* Mar. 19, 2013 Hearing at 1:21:01–1:25:45 (testimony of Dr. Mayra Jimenez Thompson); Mar. 27, 2013 Hearing at 2:40:47–2:48:05 (testimony of Dr. Ingrid Skop); Apr. 16, 2013 Hearing at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop); June 13, 2013 Hearing at 1:39:51–1:42:44 (testimony of Dr. Mayra Jimenez Thompson); Hearing on H.B. 2 Before the H. Comm. on State Affairs, 83d Leg., 2d C.S. (July 2, 2013) http://bit.ly/1na1xmP [hereinafter July 2, 2013 Hearing] at 03:25:08–03:26:11 (testimony of Dr. Mikeal Love). Because a pregnant woman's uterus "is much softer than a normal uterus," the "suction curette or the instruments used to evacuate the uterus can damage the soft tissue." Mar. 27, 2013 Hearing at 2:40:47–2:48:05 (testimony of Dr. Ingrid Skop); *see also*, Mar. 19, 2013 Hearing at 1:21:01–1:25:45 (testimony of Dr. Mayra Jimenez Thompson). In a D&E procedure in which fetal parts are removed in pieces, "perforation can occur from the bones" of any fetal parts that are missed. Mar. 27, 2013 Hearing at 2:40:47–2:48:05 (testimony of Dr. Ingrid Skop). To make matters worse, "[s]ometimes a woman will have an acute tilt in the uterus" or "she'll have had previous scarring from previous procedures. All of those things increase the risk of uterine perforation." *Id.* Upon perforation, "sharp instruments can be introduced directly into peritoneal cavity, bowel can be lacerated, vessels can be lacerated, bladder can be lacerated." *Id.*; *see also* Apr. 16, 2013 Hearing at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop) (testifying that, "[i]f perforation

occurs, there could be damage to bowel, bladder, and intraabdominal vascular structures, these can be life threatening complications").

The consequences of uterine perforation or retained fetal tissue from a medical or surgical abortion can be deadly. Numerous physicians warned that such complications can lead to hemorrhage and infections, including sepsis:

> I know as well as any other Ob/Gyn who performs D&Cs that the D&C has known risks and complications. These complications have been known to include hemorrhage, uterine perforation, as well as very definitive risk of hysterectomy and loss of fertility in the future.

June 13, 2013 Hearing at 1:39:51–1:42:44 (testimony of Dr. Mayra Jimenez Thompson).

> I've experienced this. I've experienced having to take care of complications such as hemorrhage and infection.

Id. at 3:20:07 (testimony of Dr. Pat Nunnelly).

> [T]issue is not completely expelled [in an incomplete medical abortion], resulting in severe bleeding and pain, sometimes infection and need for transfusion.

Id. at 2:33:26–2:37:39 (testimony of Dr. Ingrid Skop).

> When there's complications from abortion a lot of times you can diagnose it as something like sepsis or hemorrhage, or something like that, and that's often what the death certificate is going to say.

July 2, 2013 Hearing at 03:17:50–03:18:36 (testimony of Dr. Mary Catharine Maxian).

> As a resident I worked in one of the largest abortion facilities in Louisville, Kentucky, and we also took care of the complications from that facility at the hospital where we worked. So we saw that periodically where a uterus had been perforated or a hemorrhage would occur. I mean hemorrhage is actually common.

Id. at 03:25:08–03:25:25 (testimony of Dr. Mikeal Love).

> I've taken care of a septic abortion before. The last case was a lady who did come in New Year's Eve who was six weeks post RU486 bleeding and still had her fetal tissue inside.

Id. at 03:23:18–03:24:49 (testimony of Dr. Mikeal Love).

> [Women who have an incomplete medical abortion] suffer severe blood loss and run the risk of infection for retained products of conception.

***

> Complications that can occur [in women who undergo a D&C or D&E include] perforation of the uterus, incomplete evacuation of the products of conception, bleeding, possibly requiring transfusion.
>
> ***
>
> [Women whose abortions are performed by injection of saline, prostaglandin, or potassium chloride] are at risk for . . . bleeding, infection, amniotic fluid embolics, retained placenta, possibly requiring an additional procedure.

Apr. 16, 2013 Hearing at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop).

One Texas emergency room physician recounted the details of three cases of uterine perforation and retained fetal tissue that she had encountered:

> [A] 13-year old Mexican- American teenaged girl [was] brought in by her mother who was taken for an abortion. They had been told to go to any hospital for any complications. The clinic did not have a physician or nurse to handle after-hours calls. On exam, she was found to be septic, high temperature, high white blood cell count, hypocardiac, et cetera, with two leaks of lacerated intestines coming through the vagina from a hole in the uterus created through the abortion procedure. Though the woman was discharged about two months later, permanently sterile, menopausal, I had

> to resect the uterus and the ovaries to save her life.
>
> The second [patient] related that she came to San Antonio from Laredo for the RU 486, uncomplicated procedure, she almost hemorrhaged to death in the shower, thinking she was bleeding to death, passing out and coming to several times.
>
> ***
>
> Third patient is a 35-year old married woman who had a surgical procedure which she failed to reveal to me until on sonograms, working her up for sepsis, I saw a fetal head in the uterus.

July 8, 2013 Hearing at 3:32:01–3:34:42 (testimony of Dr. Martha Garza); *see also id.* at 7:08:00–7:09:05 (testimony of Dr. Stephen J. Hilgers) (testifying that, as a doctor "in a busy emergency room for four years," he took care of "many women who suffered complications from [abortion] procedures").

B. Experts testified that facilities that meet ambulatory-surgical-center standards are more qualified to treat the serious risks and complications that attend abortion procedures.

In light of the surgical nature of many abortions and the grave complications that women can suffer from both medical and surgical abortions, medical experts repeatedly testified that abortion facilities should meet ASC requirements. Compared to an office or clinic

setting, doctors explained, ASCs have physical-plant standards that better safeguard the health of abortion patients. For example, ASCs "have laminar [air]flow, so that we can prevent infections." June 20, 2013 Hearing at 4:18:40–4:20:16 (testimony of Dr. Beverly Nuckols). "[A]nybody who has mixed IVs, TPN, knows you've got to have special airflow to keep infection down. That's what we're asking when we're talking about an airflow system. It's about decreasing the risk of an infection." July 12, 2013 Floor Debate at 8:44:36–8:46:32 (statement of Dr. Donna Campbell).

ASCs also meet sterile pre-operating and operating room standards. These protect not only against grossly inhumane conditions, such as those described in the facilities of Kermit Gosnell and Houston doctor Douglas Karpen, but also against more subtle threats to a sterile environment, like the commingling of street clothing and cleaning supplies with the operating environment. "Why have lockers? Because they [health care technicians] change their clothes and you put them up in a locker so we don't contaminate the environment of the operating room. A janitor's closet. How many of you want to go have a procedure where the dirty mop is in close proximity to the operating room?" *Id.*

Additionally, ASCs do "[s]imple things," "like have a generator in case the power goes out" during a surgical procedure. Mar. 19, 2013 Hearing at 1:27:00–1:28:54 (testimony of Dr. Linda Flower). "Does anybody want a procedure to be in progress when the electricity goes out? The electricity needed at the least for an abortion procedure includes cautery to stop bleeding, suction, lights, a monitor for vital signs. Is a backup generator

really too much to ask to help protect a woman's health and safety in a procedure?" July 12, 2013 Floor Debate at 8:44:36–8:46:32 (statement of Dr. Donna Campbell).

ASC inspection requirements also provide other layers of protection for women. In addition to inspections by the state health department, one obstetrician explained, "national organizations . . . also inspect these facilities," so there is a "much higher level of care that they have to respond to." July 8, 2013 Hearing at 2:02:20–2:07:13 (testimony of Dr. Mikeal Love). The obstetrician further recounted his conversation with a safety and quality assurance expert who deals with ASC inspections annually: "I said, give me your opinion of where is it safest to have [abortion] procedures performed. . . . [A]nd she said, by far and away an ambulatory surgery center is safer. It has a higher level of responsibility." *Id.*

When complications do arise, facilities that satisfy ASC standards are better prepared to respond. For example, such facilities are stocked and staffed with emergency supplies and personnel. In a non-ASC setting, experts testified, "[t]here may not be blood supply available to transfuse the patient. There may not be the liquids that you need to provide stabilization of this patient. And there may not be even an ambulance readily available to transfer this patient. These things are not true in an ambulatory surgery center." Mar. 19, 2013 Hearing at 1:21:01–1:25:45 (testimony of Dr. Mayra Jimenez Thompson). Moreover, "ambulatory surgical centers have a higher standard with regard to emergency care because they have to have emergency personnel on staff." Mar. 27, 2013 Hearing at 2:13:36–2:13:58 (testimony of Jerri Lynn Ward); *see also* Mar. 19, 2013 Hearing at 1:27:00–1:28:54 (testimony

of Dr. Linda Flower) (testifying to the CPR training that ASC staff receive). In sum, at an ASC-level facility, "[e]verything is there" and "there are trained personnel to handle all the complications that can occur." *Id.* at 1:21:01–1:25:45 (testimony of Dr. Mayra Jimenez Thompson).

Physical-plant requirements also better enable ASC-level facilities to transport abortion patients in emergencies. As one obstetrician testified, ASC "facility requirements are there to put patients first. We have wide walls so that our gurneys can get through, so that EMS can rescue patients if they need to. We have the low thresholds so that we can get wheelchairs and walkers through." June 20, 2013 Hearing at 04:18:40–04:20:16 (testimony of Dr. Beverly Nuckols). Another doctor similarly explained: "Why would we want a wider hall? I haven't found a gurney yet that turns well, especially around a corner. You need a wider hall and wider rooms to bring a gurney in just in case there's a complication or an emergency. Is it needed every day? No. But how many lives or complications do we have to have before it mounts up to enough reason to put forth some dollars to protect women's health[?]" July 12, 2013 Floor Debate at 8:44:36–8:46:32 (statement of Dr. Donna Campbell). And yet another physician concluded, "[i]f we did raise the standards of our clinics to the ambulatory surgical care center standards then we can avoid problems like what happened in the Gosnell clinic where a patient died, as you heard testimony, because the hallways do not meet the guidelines that would have been required under the ambulatory surgical care cente[r]" standards. July 2, 2013 Hearing at 03:17:50–03:18:14 (testimony of Dr. Mary Catharine Maxian).

Not only do ASC standards help medical professionals treat complications that occur during an abortion procedure, but they also facilitate care for complications that arise after abortion patients are discharged. For one thing, ASC standards would require abortion facilities "to provide for services when the clinic is not open just as the ASCs must do, which will aid women who have complications after hours." July 8, 2013 Hearing at 4:47:20–4:49:32 (testimony of Jerri Lynn Ward). For another, ASC medical-records requirements would ensure that women have quicker access to documentation of their procedure and thus the information they need to help medical professionals treat subsequent complications. "[S]ome of the most vital information about the woman's condition upon the finalization of the abortion is in the progress notes[,] and [abortion] facilities are [presently] given 10 days before they have to give those to the woman. . . . [I]t's not good for continuity of care." *Id.*

To demonstrate just how essential ASC-level facilities are to the health and safety of abortion patients, one doctor emphasized that many physicians will only perform D&Cs in an ASC or hospital setting. "I only do D&Cs either in a hospital or an approved ambulatory surgery center because I know that the risk, which is known, of uterine perforation, which can lead to an injury of a major blood vessel which can cause a hemorrhage, can occur in any patient." Mar. 19, 2013 Hearing at 1:21:01–1:25:45 (testimony of Dr. Mayra Jimenez Thompson). Indeed, physicians who perform D&Cs on patients who have miscarried …

> do not do these procedures in their offices or in a facility like we currently have as abortion

> facilities. They take them to the operating room. Why? Because they have to forcibly open the cervix, they have to dilate it to a size that is not easily done, and then they have to introduce a suction curette which has a very powerful suction that can actually take the uterine wall along with the products that are inside and possibly injure a blood vessel and then cause again a major injury which could lead to hemorrhage, death, and possibly at the very least infertility for the future.

Id. Even patients who are not pregnant at least get the benefit of an ASC-level facility, and they are often at lower risk. As the same doctor related:

> Just this morning before I came here to testify I went to an ambulatory surgery center where I performed a D&C for a procedure to remove a mass inside a patient. I had to talk to the patient ahead of time, talk to the anesthesiologist, make sure the patient's medical history was well-documented, consents were obtained, all medical and surgical histories were documented also, and that the patient was prepared for the surgery. All this is done in a patient who has the uterus which is less likely to have a complication than the soft pregnant uterus.

June 13, 2013 Hearing at 1:39:51–1:42:44 (testimony of Dr. Mayra Jimenez Thompson).

> Pregnant Texas women who choose abortion deserve no less. In sum, physicians urged,

"women should not be subjected to a clinic . . . that has less standards than a man has to go through for a colonoscopy." Mar. 19, 2013 Hearing at 1:18:00–1:20:50 (statement of Dr. Donna Campbell). Because "abortion is a surgical procedure," "any abortion clinic has to be held to the highest level of standards." July 8, 2013 Hearing at 3:32:03–3:34:42 (testimony of Dr. Martha Garza). "[T]he heightened standards for these clinics is vitally important for the health of women in the state of Texas." *Id.* at 7:08:00–7:09:05 (testimony of Dr. Stephen J. Hilgers).

C. Experts testified that requiring abortion doctors to have admitting privileges at a nearby hospital protects the health of women undergoing abortions.

In addition to the ample testimony supporting HB2's ASC requirement, the Legislature heard expert testimony that requiring doctors who perform abortions to have admitting privileges at a hospital within 30 miles provides important safeguards for women. First, a doctor with admitting privileges at a local hospital can provide continuity of care to a patient suffering complications from an abortion. Second, the admitting-privileges requirement raises the quality of care because hospitals will deny admitting privileges to unqualified doctors and will monitor the performance of those doctors who have privileges.

Medical professionals agreed that continuity of care is very important for women who may suffer from

complications of abortion. For example, one obstetrician testified:

> What is the benefit for the patient if her abortion provider has hospital privileges? For one thing she will not feel abandoned if she does have a complication. She can be counseled in advance where to go if she has problems after a termination. The physician who performed the termination can care for her through the complication or, if he's not able to do that, he can let another physician know of the circumstances.

June 13, 2013 Hearing at 2:33:26–2:37:39 (testimony of Dr. Ingrid Skop). Another doctor similarly stated:

> [I]t's the responsibility of every surgeon to continue to care for their patient when complications arise from procedures that they perform and there will always be complications. That often requires hospitalization and in which case having antibiotics or even further surgery is necessary. Without hospital privileges other physicians are left to take care of an abortion provider's most serious complications.

July 8, 2013 Hearing at 7:02:56–7:03:27 (testimony of Dr. Jim Mauldin). Indeed, one obstetrician emphasized, "[t]here is no similar surgical procedure of the same complexity and the same possible risk that does not require hospital privileges." Apr. 16, 2013 Hearing at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop). In short, "[r]equiring hospital privileges for physicians who perform

abortions is the general standard of care," and a "physician who does not have hospital privileges is practicing patient abandonment." *See* Appendix A, Written testimony of Mikeal Love, M.D. Supporting S.B. 1, S. Comm. on Health and Human Servs. (July 8, 2013).

Physicians further testified that, despite this well-established standard of care, they had witnessed the consequences of patient abandonment by doctors who perform abortions without admitting privileges. In particular, they testified about problems that arose as a result of doctors who performed an abortion not being present at a hospital to treat complications. They described patients who did not know what abortion procedures had been performed, and the difficulty in treating a patient without that history. One doctor stated:

> Several times a year I am seeing patients that had complications of abortion. And it seems that they have been unable to get ahold of their abortion provider, they were told to go to the emergency room. This is in a large community, Austin, Texas. And it seems that once the abortion is performed that many patients are just turned out on their own. And I've experienced this. I've experienced having to take care of complications such as hemorrhage and infection. And it is very difficult when you are taking care of somebody else's problem.

June 13, 2013 Hearing at 3:18:18–3:21:48 (testimony of Dr. Pat Nunnelly). Another doctor testified that she had "cared for women in the emergency room after abortions who could not give me the name of the clinic, the procedure

type nor the name of the abortionist." July 8, 2013 Hearing at 4:59:35–5:01:45 (testimony of Dr. Linda Flower). She described a particular case in which the woman who had the abortion "didn't know for sure what kind of procedure had been performed," and physicians were forced "to deduce that by maybe what they knew the gestational age might be and performing an ultrasound to find out what size the uterus was." Apr. 16, 2013 Hearing at 1:42:08–1:44:14 (testimony of Dr. Linda Flower). Another physician emphasized the health risks to women when a doctor is forced to treat abortion complications in another doctor's patient:

> In terms of the usefulness of having the doctors who perform the abortions being -- having privileges. I think it was discussed earlier that it's useful in terms of getting records. In my experience a lot of these young girls, they're scared. They come away from the abortion, they don't know what procedure they had and they don't know who the doctor was. And so it's very, very difficult to get a good history out of them. As I mentioned earlier, depending on the type of procedure, we may be looking at the difference between a -- you know, a suction procedure that wouldn't be expected to cause that much trauma, if we knew that it was a sharp curettage, that may heighten our suspicion for much more serious complications.

Mar. 27, 2013 Hearing at 2:46:49–2:49:21 (testimony of Dr. Ingrid Skop); *see also* July 8, 2013 Hearing at 7:08:00–7:09:05 (testimony of Dr. Stephen J. Hilgers) (emphasizing that, "as an OB/GYN who's taken care of these patients," "enhancing communication, information for these patients,

along with the ability to obtain information for these patients," is "vitally important for the health of the women in the state of Texas").

In addition to continuity of care, medical experts testified that requiring doctors to maintain admitting privileges would help guarantee doctor quality. Doctors must be initially approved by a hospital to obtain admitting privileges, and then continue to be monitored by the hospital to maintain those privileges. *See* Mar. 27, 2013 Hearing at 2:44:49 (testimony of Dr. Ingrid Skop) (explaining that doctors who apply for admitting privileges are "subjected to examination of their credentials."). Thus, "quality care committees within hospitals, if there were a trend of adverse events, would have the opportunity to investigate, possibly educate a physician, possibly discipline, and if needed, withdraw privileges if they were providing substandard care." Apr. 16, 2013 Hearing at 1:44:20–1:48:17 (testimony of Dr. Ingrid Skop); *see also* July 8, 2013 Hearing at 7:02:56–7:03:27 (testimony of Dr. Jim Mauldin) (stating that "[b]y requiring privileges not only would [there be] continuity of care but the peer review processes of the hospital would be brought to bear and ensure quality.").

Moreover, having patients with complications admitted by the doctor who had performed the abortion would allow abortion doctors to better monitor the safety of their own procedures. If the doctor who performs abortions continues the care of the patient admitted to a hospital, that doctor will be aware of the rate and seriousness of complications among his or her patients. As one physician explained:

> [I]f the doctor is performing abortions and there are a lot of complications, any conscientious physician I think would want to know. If they are in an outpatient clinic they may never get the feedback that these women are being injured. If there's a clinic where something, maybe hygiene or whatever where complications are occurring more than they should be, I would think that everyone involved with that situation would want to know.

Mar. 27, 2013 Hearing at 2:47:40—2:48:05 (testimony of Dr. Ingrid Skop).

In sum, the evidence before the Legislature shows that women who suffer from abortion complications will receive better continuity of care if their doctors have admitting privileges at a nearby hospital. It also shows that an admitting-privileges requirement will help ensure quality care because hospitals will monitor doctors' performance as a condition of maintaining admitting privileges. The medical testimony presented to the Legislature supports its conclusion that requiring abortion doctors to maintain admitting privileges at a nearby hospital will protect the health of Texas women.

CONCLUSION

The judgment of the United States Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

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February 3, 2016

APPENDIX

APPENDIX — SUPPORT OF SENATE BILL 1 BY MIKEAL LOVE, M.D., SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Mikeal Love, M.D.
Supporting Senate Bill 1
Senate Committee on Health and Human Services

I am here to voice my support for SB 1. I am representing myself today and not the hospital or any other organization.

I particularly want to address my support for SECTION 2, which requires abortion providers to maintain active hospital admitting privileges at a local hospital; SECTION 3, SUBCHAPTER D, which requires physicians who perform RU-486 abortions to follow FDA regulations; and SECTION 4, which requires abortion facilities to meet the same standards as ambulatory surgical centers.

I am a board certified OBGYN physician. During my residency training, I worked at one of the largest abortion facilities in Louisville, Kentucky. I began my private practice in 1992 and am a Fellow in the American Congress of Obstetrics and Gynecology. I have delivered approximately 6,000 babies in that time. I manage extreme high risk patients which include women with mental, behavioral and neurodevelopmental disorders. I have managed obstetrical care for women with diagnoses ranging from major depression to bipolar disorders to schizophrenia. I have managed their pregnancies including their medications resulting in excellent outcomes for the mother and the baby.

I am the current Chairman of the CME Committee which oversees physician education for seven area hospitals in Central Texas. I sit on the Blood Utilization Committee. I am a member of the American College of Medical Quality.

I have been the Chairman of the OB/GYN Section of St. David's Medical Center and have signed off on privileges. I serve as an expert witness in matters of standard of care for plaintiff and defense counsels.

I support Senate Bill 1 because it raises the standard of care for women who choose to terminate their pregnancies. It raises their level of care to that currently received by all other patients. This is necessary to protect the health and safety of women currently receiving abortions in Texas.

SECTION 2

Requiring hospital privileges for physicians who perform abortions is the general standard of care. With all medical and surgical fields, the patient can expect to call the physician for complications and be treated at the hospital, if necessary. I recently spoke to a local physician who provides abortion services in this community. When I asked him about his thoughts on hospital privileges, he responded, "Any physician who does not have hospital privileges is practicing patient abandonment."

These are general OBGYN privileges. When I was the Chairman of the OBGYN Section at St. David's Medical Center, I approved privileges for physicians including those who performed elective abortions outside the hospital.

As physicians who treat significant medical issues, we accept the principle of being readily available as the standard of care.

According to ACOG Practice Bulletin No. 67, Medical Management of Abortion, "surgical curettage must be available on a 24-hour basis for cases of hemorrhage. Clinicians who wish to provide medical abortion services either should be trained in surgical abortion or should work in conjunction with a clinician who is trained in surgical abortion." This is the standard of care.

SECTION 3, SUBCHAPTER D

Following the FDA regulations for medication abortions would be a substantial improvement to the current standard of care for women who receive during medication abortions. This was first approved by the FDA in 2000. The protocol has been revised and approved by the FDA several times since then, most recently in June 2011.

A study out of Finland published in *Obstetrics & Gynecology* in 2009 is the best reference to date, "Immediate Complications After Medical Compared With Surgical Termination of Pregnancy." It is the gold standard as a reference.

The study found the overall incidence of adverse effects is four-fold higher with medical abortion as compared to surgical abortion (20% vs. 5.6%). This article shows an eight-fold increase in the risk of hemorrhage, a five-fold increase in risk of incomplete abortion, and a two-fold

increase in surgical evacuation when comparing medical abortion to surgical abortion.

Whenever a drug is administered with potential serious adverse effects, the physician should be readily available to treat complications. The administration of medication for a medical abortion is not the same as treating a simple infection of the ear or sinus. The physician needs to be on site and readily available when the medication is dispensed both times: when Mifiprex is administered and two days later when misoprostol is administered, consistent with the FDA guidelines. Furthermore, because of the increased risk of complications (such as the risk of infection, incomplete abortion, and the risk of surgical evacuation) after 49 days, the drug should be limited to 49 days gestation and not beyond.

SECTION 4

Finally, I support raising the standards for abortion facilities to those of ambulatory surgical centers, because part of the standard of care means not only being available to diagnose, but being able to handle significant complications following an abortion. Hemorrhage and incomplete abortion, for example, should be handled in a hospital or ASC setting. I would only perform a dilation and curettage after a miscarriage in a hospital or ASC setting, because that is the standard of care women deserve. Women receiving elective abortions deserve no less.

This is not an issue of restricting services but of providing services that meet current standards of care to protect the health and safety of women.